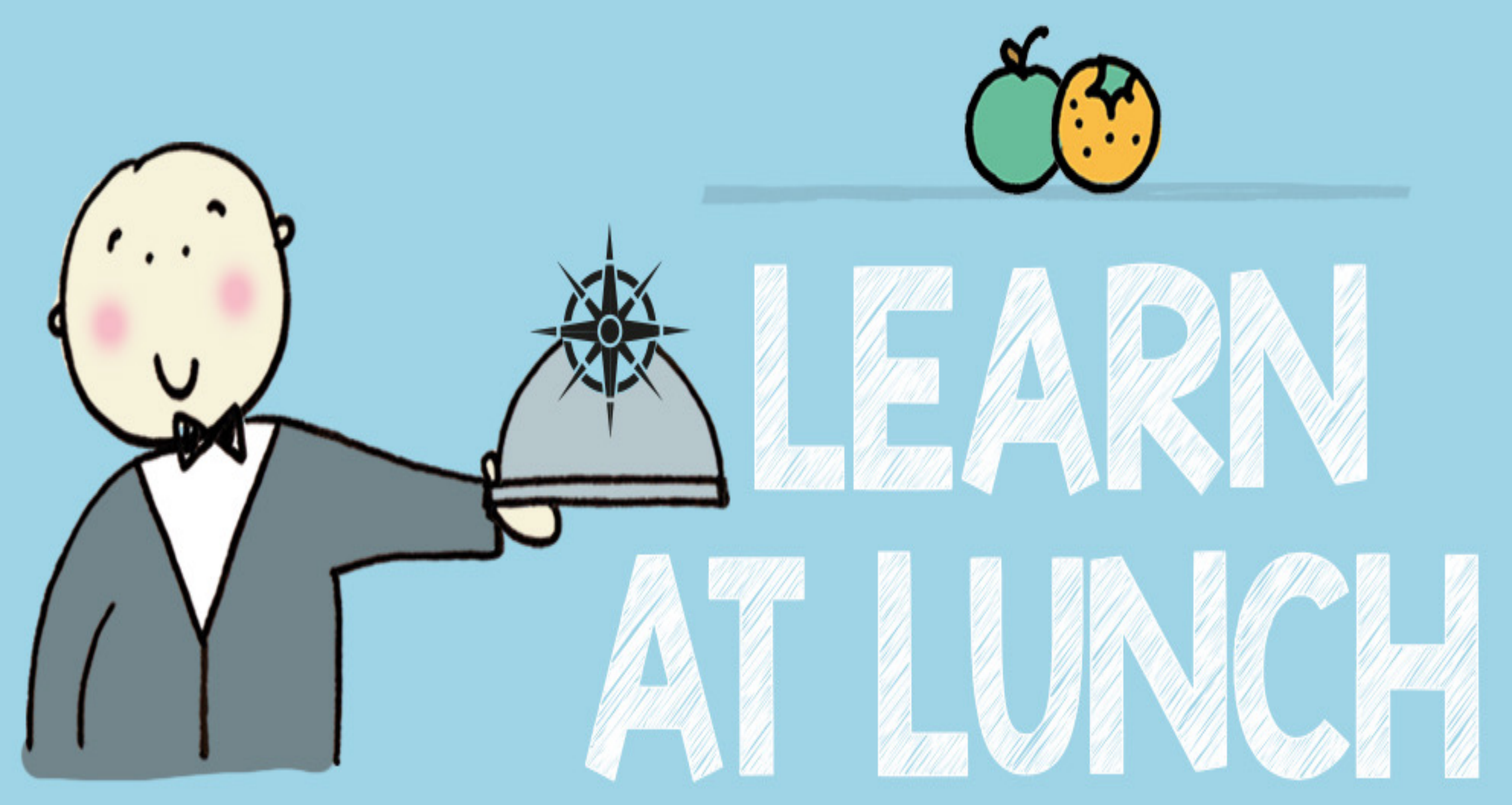
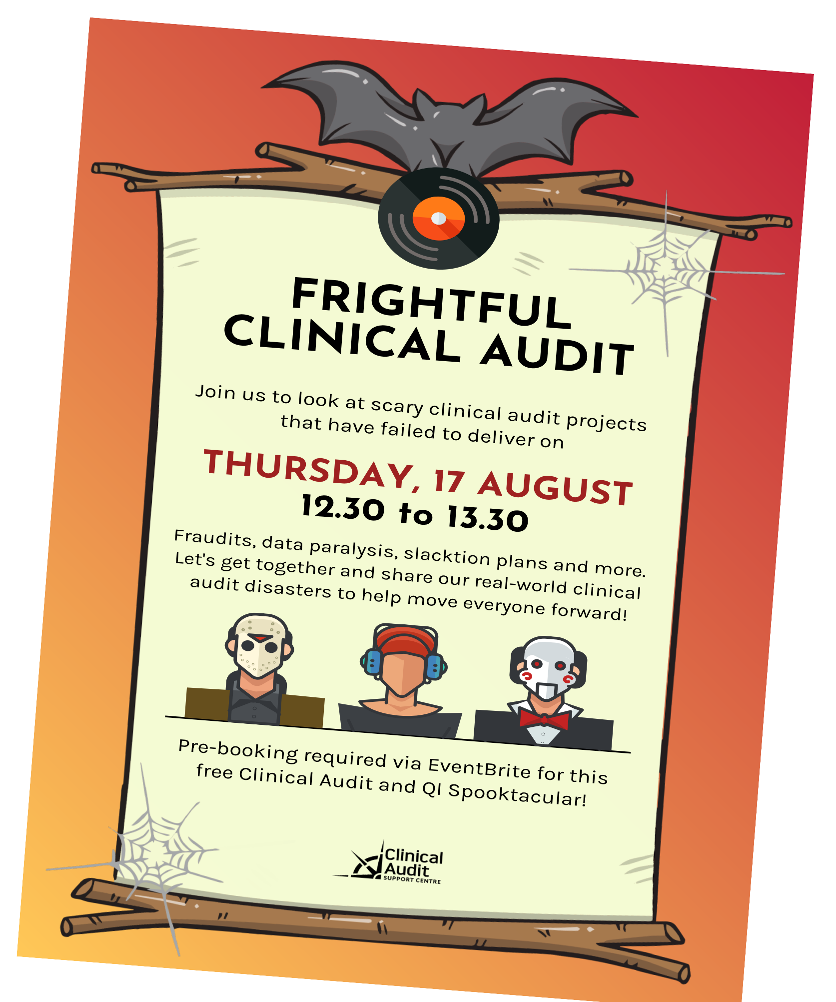


For more information visit **www.clinicalauditsupport.com**

Follow us on Twitter @cascleicester

The plan for today…

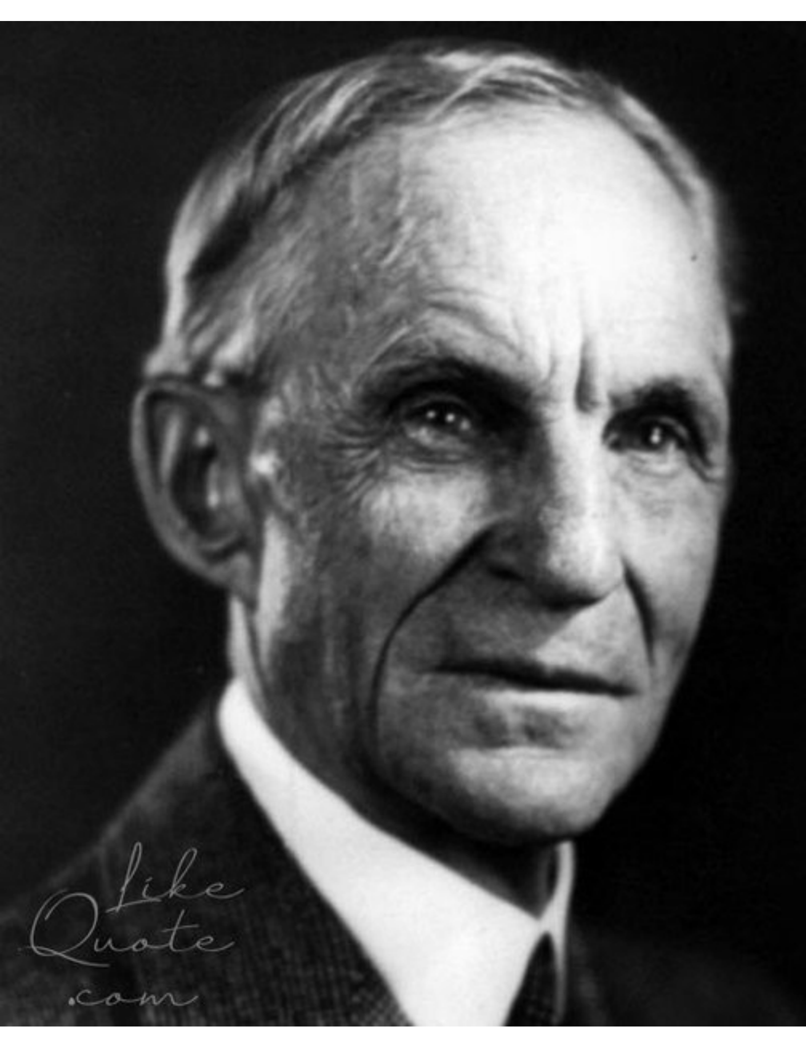
- Stephen and Tracy's experiences
- Feedback from others
- YOUR experiences
- Summing up…



Why ‘Frightful Audits’?

MR. PERFECT
Roger Hargreaves

LITTLE MISS
Perfect

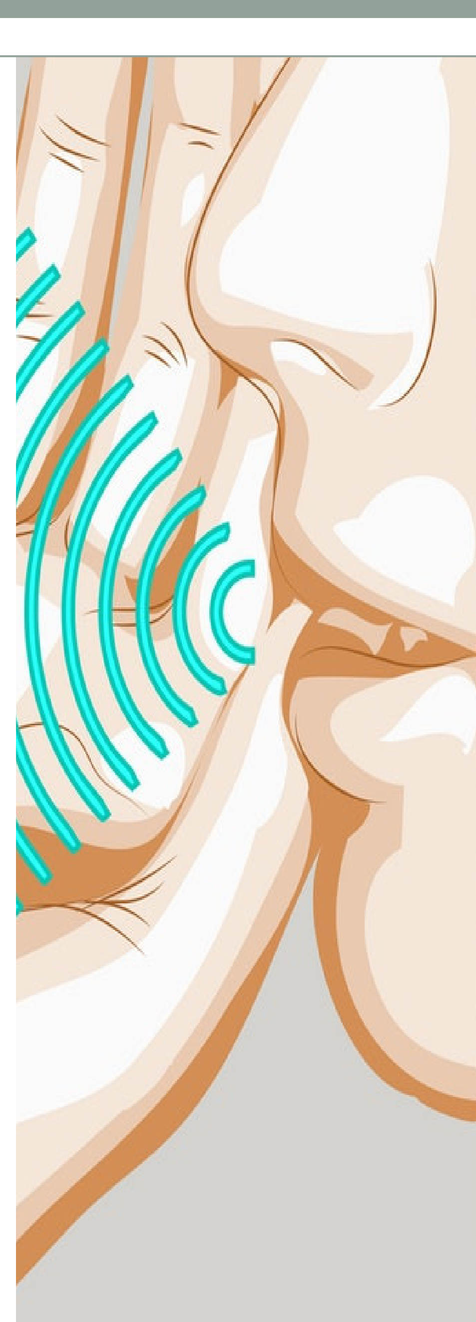


"Failure is simply the opportunity to begin again, this time more intelligently."

~ Henry Ford

It may surprise you to know that the word audit is derived from the words '**audire**' and '**auditus**' in Latin.

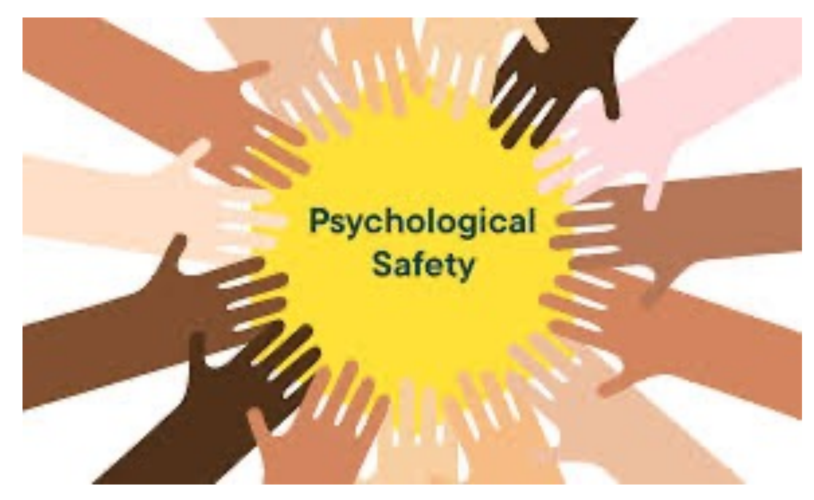
Historically these latin words convey that audit is about '**being able to hear**', 'paying attention' and 'listening to people'.



Important for today…

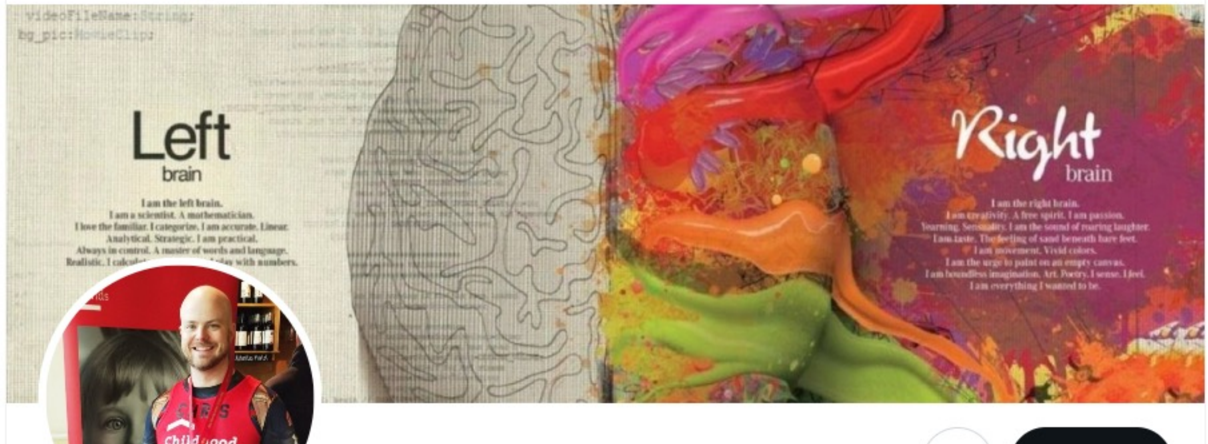
Chatham House Rule

When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.



LATEST NEWS
AND UPDATES

Meet the new HQIP CEO



Follow

Chris Gush

@Chris_Gush

Chief Executive Officer at Healthcare Quality Improvement Partnership (HQIP). My views are my own.

Sevenoaks, UK   Joined December 2010

652 Following   **164** Followers

NQICAN news

5th HQIP Impact Report

SYSTEM How the project supports policy development & management of the system

End of life: Regional gap analysis undertaken. NHSE pushing planning to regions and so will be useful tool from which regional priorities should flow

Asthma/COPD: Taskforce for Lung Health PR data tracker. Data from the 2021 Organisational Audit and 2021-22 Drawing Breath report is being used to update the latest Taskforce PR data tracker and can be viewed on Pulmonary Rehabilitation for people with COPD | Taskforce for Lung Health (blf.org.uk)

Child Health CORP: One recommendation from 'On the Right Course?' was that there should be a national consent form for children and young people undergoing cancer treatment – this has now been developed.

Child Health CORP: The paediatric critical care, Getting it Right First Time (GIRFT) report has made numerous references to 'Balancing the Pressures' (2020), a review of the care provided to children and young people receiving long-term ventilation.

Child Health CORP: The recommendations from 'On the Right Course?' (2018), a review of cancer services for children and young people, have informed the service specifications for children's cancer services for Principal Treatment Centres and Paediatric Oncology Shared Care Units, which have now been published.

Vascular: NVR results are used by the national commissioners for vascular surgery and often feed into discussions about the on-going reorganisation of vascular services in the UK and recovery of vascular services following the COVID-19 pandemic.

Paediatric diabetes: Results are used within dashboards of key metrics scrutinised by the NHSE Diabetes Transformation Team

Mental Health CORP: CQC guidance development for inspectors: ligature points, early follow up.

Medical and Surgical CORP: The GIRFT report on Respiratory Medicine, in October 2021, heavily referenced the 2017 NCEPOD report on non-invasive ventilation 'Inspiring Change'.

Medical and Surgical CORP: The Centre for Perioperative Care, working in partnership with Diabetes UK, has updated guidance for the care of people with diabetes undergoing elective and emergency surgery that encompasses the whole perioperative pathway. It was stated that "*The impetus for the collaboration arose from the recommendations of the NCEPOD report into the management of patients with diabetes undergoing surgery (Highs and Lows (2018)), CPOC was commissioned by the Academy of Medical Royal Colleges to develop this guidance.*"

End of life: Agreement reached with CQC on which are the key metrics to be used from NACEL to inform site visits/inspections

Child mortality: Successful pilot programme to demonstrate regional reporting for child death overview panels completed in the East of England.

Emergency laparotomy: NELA continue to support the Best Practice Tariff for Emergency Laparotomy for high-risk patients by providing participants with quarterly data.

Epilepsy: Epilepsy12 are represented on the new NHS England Epilepsy Oversight Group. Cohort 2 & 3 data packs were shared with the group reporting audit data at NHS region, ICS & Trust level to support policy and improvements in 4 priority areas of epilepsy care.

Neonatal: Reported metrics have been aligned with the MatNeoSIP goals and measurement in England, providing longer term QI support, quality assurance and national benchmarking to sustain the aims of MatNeoSIP.

Prostate Cancer: The findings from the NPCA have contributed to the NICE review and recent update of recommendations on using a 5-Tier, rather than 3-Tier, prostate cancer risk stratification (published in December 2021).

Prostate Cancer: Key peer reviewed publications since June 2021 include:
- Impact of COVID-19 on the diagnosis and treatment of men with prostate cancer Jan 2022
- Urinary incontinence and the utilisation of incontinence surgery after radical prostatectomy Nov 2021
- Hospital volume and outcomes after radical prostatectomy Sept 2021
- Determinants of variation in radical local treatment for men with high-risk localised or locally advanced prostate cancer in England Sept 2021

All publications are announced on the NPCA website and on Twitter

Arthritis: NEIAA data are used to evidence meeting standards around clinical effectiveness for the BSR Quality Review Scheme. Three pilot sites were involved in the accreditation process in October and November 2021.

CVDPrevent: Using the Data & Improvement Tool, systems (STPs) can benchmark their outcomes, evaluate how close they are to achieving their goals and understand where to invest extra resources e.g.:
- For AF 90% anticoagulation goal. STP range 84%-93%
- For BP 80% treatment to target goal, STP range 73%-85% in Mar 22 (compared to 53%-72% in Mar 21)
- Recent smoking status was recorded in 67% of cases; variation across STPs (59%-73%)

Psychosis: Performance in England was scored and provided to NHSE in 2021/22 to assess progression towards objectives in the EIP access and waiting times standard.

Child mortality: NCMD studies on Covid-19 mortality in children directly informed JCVI policy in vaccinating children More.

Child mortality: An article on NCMD's deprivation report is published in Public Sector Focus's May/June edition, distributed to around 60,000 readers including policymakers.

Child mortality: "As ever, stunning and essential work" – Daniel Devitt, Health & Wellbeing Programme Lead, Department of Health and Social Care, on Suicide report.

Arthritis: Data collected on the NEIAA organisational form fed into the BSR workforce report providing insight into the rheumatology workforce.

Arthritis: To support the implementation of one of the recommendations set in the NEIAA second annual report, the BSR clinical affairs committee published a national adult rheumatology referral guidance.

Arthritis: NEIAA results are used to justify individual unit's award of the Best Practice Tariff (BPT) for early inflammatory arthritis. For April 2021- March 2022, 59 Trusts achieved the BPT.

Paediatric critical care: PICANet informs and contributes to the development of the Paediatric Critical Care Society's (PCCS) Quality Standards.

Child mortality: NCMD contributes research to support two all-party parliamentary groups: one focused on baby loss, the other on temporary accommodation.

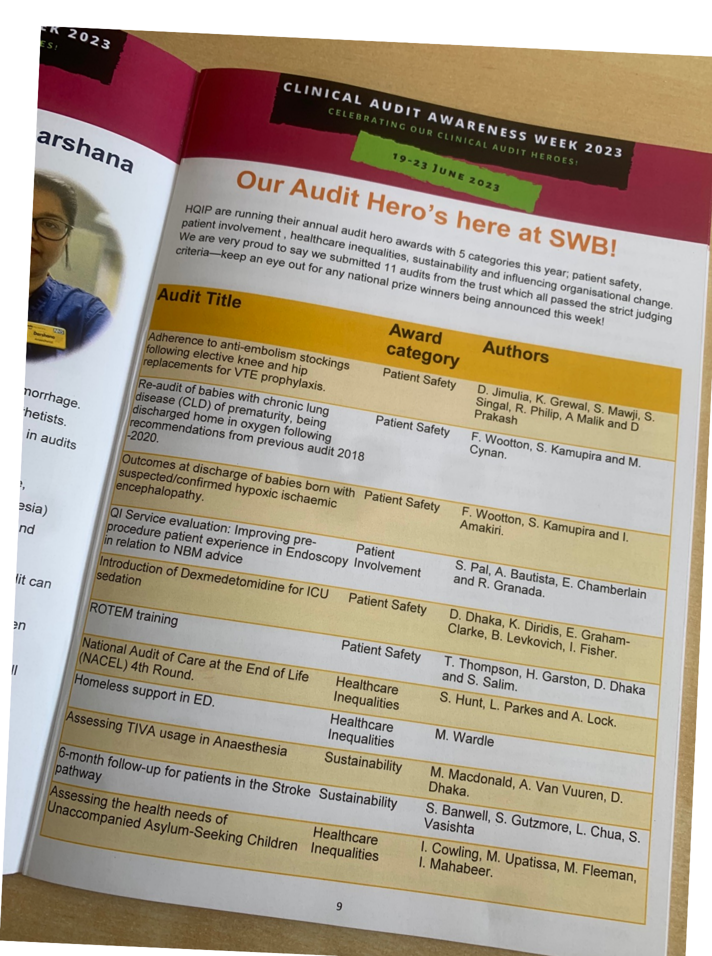
Psychosis: In 2023, a novel dashboard was built to collect and display data that indicates performance against the NHS Long Term Plan.

Opportunities…

Recent study findings

The intensity of networking within a healthcare setting is a good indicator for the assessing the likelihood of continuous improvement

Sandwell and West Birmingham NHSFT



CLINICAL AUDIT AWARENESS WEEK 2023

CELEBRATING OUR CLINICAL AUDIT HEROES!

19-23 JUNE 2023

Our Audit Hero's here at SWB!

HQIP are running their annual audit hero awards with 5 categories this year; patient safety, patient involvement, healthcare inequalities, sustainability and influencing organisational change. We are very proud to say we submitted 11 audits from the trust which all passed the strict judging criteria—keep an eye out for any national prize winners being announced this week!

Audit Title	Award category	Authors
Adherence to anti-embolism stockings following elective knee and hip replacements for VTE prophylaxis.	Patient Safety	D. Jimulia, K. Grewal, S. Mawji, S. Singal, R. Philip, A Malik and D Prakash
Re-audit of babies with chronic lung disease (CLD) of prematurity, being discharged home in oxygen following recommendations from previous audit 2018 -2020.	Patient Safety	F. Wootton, S. Kamupira and M. Cynan.
Outcomes at discharge of babies born with suspected/confirmed hypoxic ischaemic encephalopathy.	Patient Safety	F. Wootton, S. Kamupira and I. Amakiri.
QI Service evaluation: Improving pre-procedure patient experience in Endoscopy in relation to NBM advice	Patient Involvement	S. Pal, A. Bautista, E. Chamberlain and R. Granada.
Introduction of Dexmedetomidine for ICU sedation	Patient Safety	D. Dhaka, K. Diridis, E. Graham-Clarke, B. Levkovich, I. Fisher.
ROTEM training	Patient Safety	T. Thompson, H. Garston, D. Dhaka and S. Salim.
National Audit of Care at the End of Life (NACEL) 4th Round.	Healthcare Inequalities	S. Hunt, L. Parkes and A. Lock.
Homeless support in ED.	Healthcare Inequalities	M. Wardle
Assessing TIVA usage in Anaesthesia	Sustainability	M. Macdonald, A. Van Vuuren, D. Dhaka.
6-month follow-up for patients in the Stroke pathway	Sustainability	S. Banwell, S. Gutzmore, L. Chua, S. Vasishta
Assessing the health needs of Unaccompanied Asylum-Seeking Children	Healthcare Inequalities	I. Cowling, M. Upatissa, M. Fleeman, I. Mahabeer.

9

Won 2 HQIP awards!

FRIGHTFUL CLINICAL AUDIT

Join us to look at scary clinical audit projects that have failed to deliver on

THURSDAY, 17 AUGUST
12.30 to 13.30

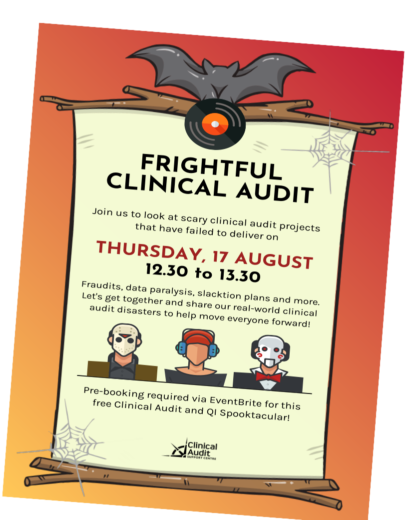
Fraudits, data paralysis, slacktion plans and more. Let's get together and share our real-world clinical audit disasters to help move everyone forward!

Pre-booking required via EventBrite for this free Clinical Audit and QI Spooktacular!

Clinical Audit SUPPORT CENTRE

Example 1: repeat prescribing audit

- Leicester PCAG project
- Aim to create central audit for up to 150 GP practices in Leicestershire
- Lack of best practice in relation to repeat prescribing
- Initial steps: invited 10 local GPs to help create the audit (agree standards and capture tool)
- **Took 9 months from first meeting to initial data collection**
- 90 practice participated

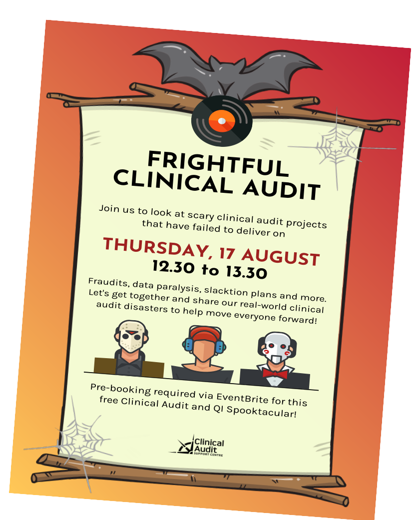


Example 1: lessons learned

- Stakeholders are key to the success of a project
- The fallacy: more involved people = better
- The reality: more people = more engagement, more opinions, more time
- Additional learning: key to get people in one room / virtual space and you can't please everyone!

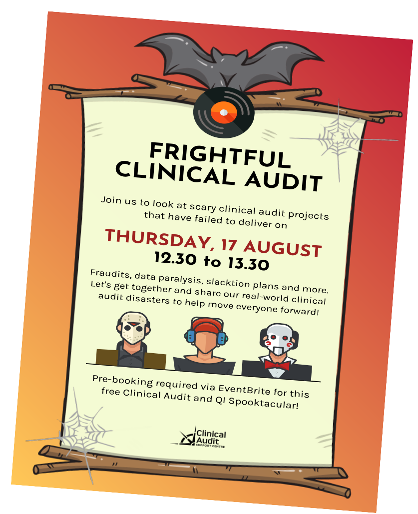
Example 2: GPAQ survey

- Leicester PCAG supported all GP practices to undertake the annual GPAQ survey
- The General Practice Assessment Questionnaire was a nationally approved tool (University of Cambridge)
- PCAG managed over 40,000 surveys per year
- **In year 1, we printed 1,000 surveys with a front page that stated the word ‘pubic’ not ‘public’**
- We also identified a key problem with the data returns



Example 2: continued

- Q12 asked ‘all things considered, how satisfied are you with you practice?
- All positive answers for Q1 to 11 were on the right-hand side
- For Q12 the ‘completely satisfied’ response was placed on the left
- We estimated that over 1,000 responses (2.5%) incorrectly rated practices as ‘completely dissatisfied’
- Which significantly distorted the scoring for some pracitces



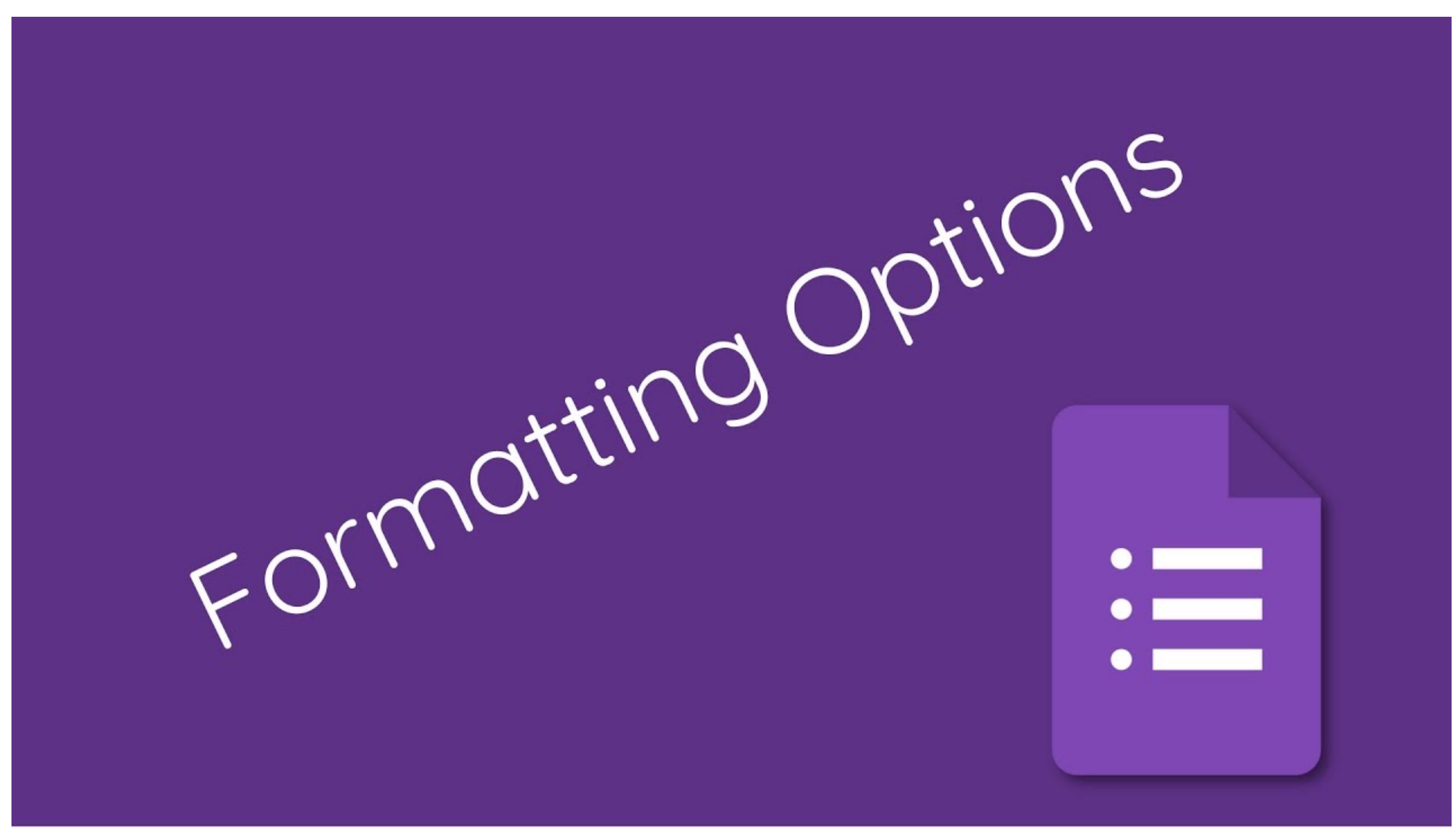
Example 2: lessons learned

- Small mistakes kill you!
- Makes sure there are robust checking mechanisms for any audits / surveys being created
- Don’t trust national tools
- Always dig into the data to see if you can find anomalies or issues
- Be particularly careful with calculations and formulae

Martin Ferris MBE Audit

- We met Martin for a catch-up on Tuesday
- He recalled an audit he carried out in Sheffield
- The project was with school nurses
- Data collection forms were sent out on **30 July**…

For successful clinical audit…



End of Life Care National Audit

4.4	Is there documented evidence within the last episode of care of discussion regarding the **patient's** spiritual/religious/cultural /practical needs with the **nominated person(s) important to the patient?**	☐ Yes ☐ No ☐ **No but** it is recorded that the attempts made to contact the nominated person(s) important to the patient were unsuccessful ☐ **No but** there was no nominated person(s) important to the patient
COMMUNICATION AT THE TIME OF DYING WITH THOSE IMPORTANT TO THE DYING PERSON		
4.5	Were those important to the patient notified of the patient's imminent death? **If no but, go to 4.4ii**	☐ Yes ☐ No ☐ **No but** there was no person(s) important to the patient ☐ **No but** the notes indicate the patient died suddenly and unexpectedly

Share

Frightful clinical audits: shared experiences

'A fail of mine was sending out a patient questionnaire but not clicking double-sided print, so I got half a questionnaire back!'

Frightful clinical audits: shared experiences

'Not piloting a data collection form prior to starting my audit. This resulted in me having to start again'

Frightful clinical audits: shared experiences

'Being over-ambitious with the sample identification, which meant that collecting the data took forever to complete'

Frightful clinical audits: shared experiences

'I sent out results from a national QI project without checking them first! It turned out that the results were incorrect and I felt rather embarrassed'

Frightful clinical audits: shared experiences

'My biggest mistake would be not checking my figures before presenting results of a project and being pulled to pieces during the meeting'

Frightful clinical audits: shared experiences

'In my early days as a clinical audit facilitator, working with an enthusiastic junior doctor I didn't realise the project wasn't supported by the senior medics. Even though the audit identified improvements were needed, recommendations were not adopted'

THANK YOU