The Royal Wolverhampton NHS
NHS Trust

CLINICAL AUDIT ANNUAL REPORT

2013-2014

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Date: May 2014

Version: 2

CONTENTS PAGE

Executive Summary

Clinical audit is a multi-disciplinary quality improvement activity that systematically and objectively measures the effectiveness of healthcare and service delivery against agreed and proven standards to implement, where necessary, improvements/changes at an individual, team or service level.

With the heightened focus on clinical audit activity across NHS organisations, the Clinical Audit Group (CAG) reviewed and made significant changes to the Clinical Audit Policy (OP45). During 2012/2013 the audit completion rate had fallen significantly across Divisions and Directorates to only (48%), with considerable variability across Directorates.

This report therefore outlines the clinical audit activity carried out across the Trust during April 2013 to March 2014. This report also describes the management of clinical audit during the year, completion rate performance and outlines the future planned improvements to the management and delivery of clinical audit across the Trust during 2014/2015.

Overall during 2013/2014, 455 audits were authorised for completion. Of these 304 (67%) were local audit projects, 79 (17%) were national audits and 39 (9%) were identified to be NICE guideline audits, there were 33 (7%) other audit projects undertaken. The Trusts overall completion rate during 2013/2014 is 85% (adjusted figure of 93% to exclude those national audits which were not expected to be completed within the 2013/2014 financial year). This is a significant improvement from the previous year where the completion rate was 48%, this performance needs to be sustained during 2014/15.

A review of completed audits has been undertaken to identify the outcomes of audits and how these are being used for service improvement in Directorates. For the majority of audits completed 275 (71%) have demonstrated either full compliance or minor non-compliance.

During 2014/2015, Directorates and Divisions will need to ensure they continue to monitor progress against the audit plans on a monthly basis, to enable areas of concern to be addressed in a timely manner. Changes introduced last year will continue to be implemented, for example limiting local audits to 10 in the first instance and not registering new local audits in the last quarter of the financial year. However, there is acceptance that in exceptional cases where an audit is needed as a part of urgent service development or improvement this will be allowed at the discretion of the Trust Clinical Audit Lead. A scoping exercise is currently on-going to identify all applicable NICE guidance in order to ensure inclusion in relevant audit plans (with Technology Appraisals as a priority). Use of the clinical audit database and the level of detail and completeness by Directorates and Conveners remains a challenge and the Governance Department will continue to support Directorates, Audit Conveners and leads to ensure the most up to date and accurate information is available. Audit Convener attendance at Clinical Audit Group will be monitored and reported through Directorate and Division Governance meetings.

During 2014/2015, there will be a more focused approach on the aims and objectives of audits, ensuring re-assessment as to whether these have been achieved, and where there is poor or non-compliance actions have been identified to address the shortfall to improve future compliance.

1.0 Introduction:

Clinical audit is an important process which allows the Trust to support continuous improvement in patient care and outcomes against evidence based standards. The clinical audit process therefore helps to ensure patients and service users receive the right treatment from the right person in the right way. Everyone who is involved in the provision of healthcare should be involved in clinical audit.

As stated in the (OP45) Clinical Audit and Effectiveness Policy *"The Royal Wolverhampton NHS Trust is committed to developing a robust clinical audit programme as part of the process through which the Trust can discharge its duty to ensure the quality of service is of the highest standard and that improvements are continuously implemented"*

Through the delivery of the clinical audit programme/plans the Trust is able to demonstrate a methodical process for continuous monitoring and evaluating the level of care and service provided to patients and service users in order to make sustainable quality improvements.

This report outlines the clinical audit activity carried out across the Trust during April 2013 to March 2014. This report also describes the management of clinical audit during the year, completion rate performance and outlines the future planned improvements to the management and delivery of clinical audit across the Trust during 2014/2015.

2.0 Clinical Audit Definition:

'Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.'
New Principles of Best Practice in Clinical Audit (HQIP, January 2011)

Clinical audit is a multi-disciplinary quality improvement activity that systematically and objectively measures the effectiveness of healthcare and service delivery against agreed and proven standards to implement, where necessary, improvements/changes at an individual, team or service level.

3.0 Clinical Audit Plans 2013/2014 Development

The 2013/2014 clinical audit plans were developed by the Audit Convenors in conjunction with the responsible Governance Officer. Directorates were asked to prioritise the audit projects to be undertaken during 2013/2014 and were restricted to identify a limit of only 10 local audits. These plans were then agreed at a local Directorate Governance meeting. Following this, the Healthcare Governance Manager for the Division presented the Directorate approved plans to the Divisional Management Team at a Divisional Governance meeting to seek Divisional approval.

Clinical audit plans included contributions to National Clinical Audit and Patient Outcomes Programme (NCAPOP) and various other National Audits, NICE (National Institute of Clinical Excellence) guidance, CQUIN and NHS Litigation Authority (NHSLA) audits. Furthermore, locally driven Trust audits were included.

4.0 Monitoring of Clinical Audit Plans

The 2013/2014 clinical audit plans were monitored on a monthly basis via the audit completion rate report (Appendix 1). This report was included on the Integrated Governance Reports presented monthly to the Directorates by the Governance Officers at their local Directorate Governance meetings. Healthcare Governance Managers also presented the audit completion rate report on a monthly basis at the Divisional Governance meetings. Progress, in terms of completion of audit projects and attainment of the clinical audit plans were reported bi-monthly to the Trusts Clinical Audit Group (CAG) and quarterly to Quality Standards Action Group (QSAG). Progress with the National Clinical Audit and Patient Outcomes Programme (NCAPOP) has been monitored on a quarterly basis at the Clinical Quality Review Meeting (CQRM).

5.0 Changes to the management of Clinical Audit across the Trust during 2013/2014

With the heightened focus on clinical audit activity across NHS organisations, the Clinical Audit Group (CAG) reviewed and made significant changes to the Clinical Audit and Effectiveness Policy (OP45). During 2012/2013 the audit completion rate had fallen significantly to only (48%), with considerable variability across Directorates. The following changes were introduced to improve the management of clinical audit and the completion of these audit projects during 2013/2014:

1. Audits projects are to be managed through the Directorates, by the Audit Convenors and Clinical Director's with support from the Governance department.

2. There will be a named clinical lead for each individual audit project and this should be a Consultant or senior clinical staff member.

3. Audit projects registered on the clinical audit database are to be monitored on a quarterly basis. Local audits registered onto the clinical audit database have to show progress within 3 months of registration and 6 months for completion of the audit, otherwise the audit project will be classified as abandoned (excluding national audits).

4. Audit Convenors will approve the clinical audit activity to be undertaken in their Directorate and ensure that the clinical audit database is kept up to date as "live" record detailing progress with individual audit projects.

5. Audit projects identified to be undertaken within the Directorate must be approved by the Audit Convenor in advance of the audit beginning.

6. It is the responsibility of the Consultant to ensure nominated audits projects are completed within a timely manner.

7. Audit Convenors must attend at least 70% of the Clinical Audit Group meetings.

8. Directorates will be limited on the number of local audits per Directorate – this was agreed to be 10.

9. There will be no new local audits registered in the final quarter of the year, unless needed as a part of urgent service development or improvement and will be at the discretion of the Trust Clinical Audit Lead.

10. An audit project is recognised as complete when there is an audit report as per NHSLA guidance and this report has been uploaded onto the clinical audit database.

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6.0 Summary of Clinical Audit Activity at Year End (2013/2014)

6.1 Clinical Audit Activity

The table below provides an overview of the 455 audits authorised for completion during 2013/2014.

Divisional Activity	Audits on Original Plan	Additional Audits Authorised in year	Authorised Abandoned Audits	Total Audits
Division 1	152	112	48	**216**
Division 2	210	84	55	**239**
Overall Trust	362	196	103	**455**

6.2 Types of Audits undertaken

The table below demonstrates the different types of audits which were authorised for completion during 2013/2014.

Divisional Activity	National	Local	NICE	Other Audits	Total Audits
Division 1	30 (14%)	165 (76%)	8 (4%)	13 (6%)	**216 (47%)**
Division 2	49 (21%)	139 (58%)	31 (13%)	20 (8%)	**239 (53%)**
Overall Trust	79 (17%)	304 (67%)	39 (9%)	33 (7%)	**455 (100%)**

6.2.1 National Clinical Audit and Patient Outcomes Programme (NCAPOP)

NCAPOP is a set of national clinical audits, registries and outcome review programmes which measure healthcare practice on specific conditions against accepted standards. These projects give healthcare provider's benchmarked reports on their performance, with the aim of improving the care provided. Most of these projects involve services in England and Wales; some also include services from Scotland, Northern Ireland and other regions.

There are 46 audits identified on NCAPOP, of these 39 are applicable to the Trust. The Trust is participating in 37 (95%) of the applicable audits (Appendix 2). The reasons for non-participation in the remaining 2 audits have been detailed in the table below:

Audit Title	Directorate	Reason for non-participation
National Audit of seizure management (NASH)	Emergency Department	Audit undertaken last year, recommendations not yet implemented due to on-going discussions re action required.
National Cardiac Arrest	Critical Care	Directorate is currently looking at registration for this audit, however funding is required and this has not been secured at present.

Progress against the National Clinical Audit and Patient Outcomes Programme is monitored by the Clinical Quality Review Meeting.

6.2.2 NHSLA Audits:
There were 9 NHSLA Audits scheduled for completion during 2013/2014. They are as follows:

NHSLA Audits	Reporting Frequency	Completed
Transfer	Annual	Report due June 2014
Discharge	Annual	Report due May 2014
ViEWS (Track and Trigger) Early Warning Signs	Bi-Annual	• Bi-Annual Report completed Sept 2013 • Annual Report completed Apr 2014
Falls	Annual	Report due May 2014
Patient Documentation	Quarterly	• Q1. Report Completed Sept 2013 • Q2. Report Completed Dec 2013 • Q3. Report Completed Feb 2014 • Q4. Report Completed Mar 2014
DNAR	Annual	Report due June 2014
Written Consent	Annual	Report due July 2014
Delegated Consent	Quarterly	• Q1. Report Completed June 2013 • Q2. Report Completed Oct 2013 • Q3. Report Completed Jan 2014 • Q4. Report due June 2014
Patients Manual Handling	Annual	Report due July 2014

Since 2012/2013 the NHSLA audits have been undertaken by the Governance Department instead of individual Directorates. This change in practice was due to the issues previously encountered during the processing of NHSLA audits, collection of data and central monitoring by the policy author.

Overall, the data collection process has been undertaken in 100% of NHSLA audits during 2013/2014. By year end, ViEWS (Track and Trigger) Early Warning Signs and Patient Documentation have been completed; the other audits are due to be completed during May, June and July 2014.

6.2.3 NICE Guideline Audits

There were 39 NICE Audits scheduled for year 2013/2014, of these 33 (85%) of these audits have been completed. This is a positive improvement from 2012/2013 when the completion rate was (76%).

Commissioners have requested that all Technological Appraisal (TA) guidelines which have been identified as applicable to the Trust should be audited. A scoping exercise is currently on-going to identify all applicable NICE guidance in order to ensure inclusion in relevant audit plans (with Technology Appraisals as a priority) during 2014/15. Of the 39 NICE Audits authorised for completion during 2013/2014, 19 (49%) related to TA guidance and of these 16 (84%) have been completed in year.

The table below provides a breakdown of NICE Guidance audited during 2013/2014:

	Division 1	Division 2	Total
Technological Appraisal (TA)	--	19	19
Clinical Guidelines (CG)	7	10	17
Interventional Procedure (IPG)	1	--	1
Quality Standard (QS)	--	1	1
Not identified	--	1	1
Overall Total	**8**	**31**	**39**

6.3 Completion of Types of Audits

The table below demonstrates the Divisional and Trust completion figures for the different types of audits authorised for completion during 2013/2014.

Divisional Activity	National	Local	NICE	Other Audits	Totals
Division 1	13 (30) = 43%	150 (165) = 91%	7 (8) = 88%	12 (13) = 92%	182 (216) 84%
Division 2	27 (49) = 55%	134 (139) = 96%	26 (31) = 84%	20 (20) = 100%	207 (239) 87%
Overall Trust	40 (79) = 51%	284 (304) = 93%	33 (39) = 85%	32 (33) = 97%	389 (455) 85%

6.4 Comparison of Completion Rates

The table below provides a comparison overview of the Divisional and Trust audit completion rates.

Total Completion rate	2013/2014	2012/2013	2011/2012	2010/2011
Division 1	84%	36%	74%	93%
Division 2	87%	53%	58%	80%
Overall Trust	85%	48%	64%	85%

6.5 Adjusted Completion Rate

The Trust has participated in 79 national audits projects during 2013/2014 of which only 40 (51%) have been completed within year. Due to the complexity and reliance on set national timescales, a vast majority of these audits were not expected to be completed within the 2013/2014 financial year, despite the contribution of data through-out the year. These audits therefore remain on-going and will be included on the 2014/2015 audit plans. The on-going national audits will only be classified as completed when the national results have been collated, distributed and Trust actions for improvement have been identified in line with Trust policy.

Therefore, to allow for this discrepancy an adjusted completion rate figure has been provided below (this excludes on-going national audits):

Total Completion rate	2013/2014
Division 1	91%
Division 2	95%
Overall Trust	93%

8.0 Outcomes of Audits Completed

A review of completed audits has been undertaken to identify the outcomes of audits and how these are being used for service improvement in Directorates. Audit Conveners were asked to confirm the compliance status of the audits undertaken within their Directorates.

The table below provides a breakdown of completed audits by level of compliance; it is evident that for the majority of audits completed 275 (71%) are demonstrating either full compliance or minor non-compliance

Level of compliance	Number	%
Fully Compliant	96	25%
Minor non compliance	179	46%
Moderate non compliance	75	19%
Significant non compliance	31	8%
N/A	8	2%
Total	**389**	**100%**

It is crucial that where audits have identified poor or non-compliance, actions are taken to address the shortfall to improve future compliance.

8.0 Examples of Good Practice Audits

The reports of local clinical audits completed have been reviewed in 2013/2014 and the following are examples of actions that have been taken to address any areas of poor or non-compliance to improve the quality of healthcare being provided. Further details have been provided in (Appendix 3):

- An acute handover care toolkit has been developed to improve handover time;
- Introduced a clinical condition-specific profile for suspected menopause that has reduced inappropriate tests, more efficient used of laboratory resources and standardised patient care pathways;
- A new Pulmonary Embolus Pathway has been developed;
- Enhanced and improved the drop-in provision for young people where services are available
- Mandatory training updated to reflect MUST on Vitalpac and ulna length as an alternative height measure;
- Change of bowel preparation – patients are no longer required to have a low residue diet pre-op;
- Prescription sheet changed to include pre-printed times for oxygen checking;
- Cardiothoracic providing endoscopic vein harvesting (EVH) to all eligible patients;
- Training and induction updates undertaken to ensure that all registered nurses are aware of safe practice in correct placement of naso-gastric feeding tubes;
- All new patients with a diagnosis of MS are now referred to Clinical Nurse Specialist and a new diagnosis pathway has been developed;
- The HIV 3 monthly follow up proforma has been amended to show the CVD risk assessment monitoring and the monitoring of plasma glucose and lipids;
- Signage within the Malting's has been reviewed and some signs have been changed to allow for easy access for patients and carers
- A number of staff did not have fundamental equipment i.e. tympanic thermometer/ sphygmomanometer, therefore replacement equipment has been sourced to ensure all staff have basic equipment's to continue care. Each locality will also hold a small buffer stock.
- All new starter insulin pump patients are issued with a starter pack of written information which is discussed with them at a 'pump specific' clinic at the Diabetes Centre.
- Local practice changed to ensure chin straps and footstocks are used as standard practice. This has automatically reduced the amount of imaging required.
- The wingboard used with the U-Grip and the Q-Fix tilting base improved patient set-up and accuracy. They will be used as standard practice for both sites. This will reduce the amount of imaging required.

9.0 Audit of Clinical Audit & Effectiveness Policy (OP45)

An audit was performed quarterly during 2013/2014 to assess whether the clinical audits produced within the Trust comply with Clinical Audit and Effectiveness Policy (OP45). The criterions for the audit are enlisted in the table below followed by the results.

Criteria	Evidence Source	
	Clinical Audit Database	Active Document
1) Is there an audit report?	✓	
2) Does the audit report have an introduction section?	✓	
3) Does the audit report have a methodology section?	✓	
4) Does the audit report have a results section?	✓	
5) Does the audit report have a conclusions section?	✓	
6) If this project is a re-audit does the report contain results f previous audit?	✓	
7) Is there an action plan relevant to this audit on the database?	✓	
8) Have actions been added to the database?	✓	
9) Discussed at an appropriate meeting, i.e., Directorate Governance Meeting/Clinical Audit meeting or Specialist Group meeting?		✓
10) Have **all** actions been completed within timescales?	✓	
11) Where re-audit required – has this been added to next year's plan?	✓	✓

Compliance Results:

Compliance scale	Grading
0 - 50%	Red
51% - 74%	Amber
75% - 100%	Green

The overall compliance for the Trust is as follows:

Criteria	Compliance % May-June 2013 (Q1)	Compliance % July-Sept 2013 (Q2)	Compliance % Oct-Dec 2013 (Q3)	Compliance % Jan-March 2014 (Q4)
1) Is there an audit report?	98	100	99	99
2) Does the audit report have an introduction section?	98	95	96	99
3) Does the audit report have a methodology section?	98	95	93	98
4) Does the audit have a results section?	100	100	99	99
5) Does the audit report have a conclusions section?	98	92	96	98
6) If this project is a re-audit does the report contain results of previous audit?	50	37	**22**	81
7) Is there an action plan relevant to this audit on the database?	93	97	96	98
8) Have actions been added to the database?	90	96	93	97
9) Discussed at an appropriate meeting i.e., Directorate Governance Meeting/Clinical Audit meeting or Specialist Group meeting	81	99	99	94
10) Have all the actions been completed within the timescales?	71	47	**47**	68
11) Where re-audit required –has this been added to next year's plan?	91	93	91	95

There were 133 audit projects completed for Quarter 4 between: 1st January to 31st March 2014.

Results show significant improvements have been made to the overall compliance of audit completion. However, it was noted there was one area of non-compliance showing 68% in relation to the completion of all actions within the deadlines set. In conclusion, Directorates have been advised to address this area of low compliance using the action plan devised. Please view (Appendix 4) for the full audit report.

10.0 Future Plans for strengthening Clinical Audit during 2014/2015

There has been a significant improvement in 2013/2014 in relation to the completion rate of audits by the Directorates from 48% to 85% (adjusted figure of 93% to exclude those national audits which were not expected to be completed within the 2013/2014 financial year), this performance needs to be sustained during 2014/2015. Directorates and Divisions will continue to monitor progress against the audit plans on a monthly basis, which enables any areas of concern to be addressed in a timely manner. Changes introduced last year will continue to be implemented, for example limiting local audits to 10 in the first instance and not registering new local audits in the last quarter of the financial year. However, there is acceptance that in exceptional cases where an audit is needed as a part of urgent service development or improvement this will be allowed at the discretion of the Trust Clinical Audit Lead.

Commissioners have requested that all Technological Appraisal (TA) guidelines which have been identified as applicable to the Trust should be audited. A scoping exercise is currently on-going to identify all applicable NICE guidance in order to ensure inclusion in relevant audit plans (with Technology Appraisals as a priority).

Use of the clinical audit database by Directorates and Audit Conveners as a tool for updating audit projects remains a challenge, although all audit projects are registered, the level of detail and completeness of information can be variable. The Governance Department will continue to work with Directorates, Audit Conveners and leads to ensure the most up to date and accurate information is available. Resource has now been identified from IT and work has commenced to resolve the historic issues with reporting, once this phase of work has been completed further updates will be made to the system to improve data collation and ease of use.

Audit Convener attendance at Clinical Audit Group has improved slightly, however there are a number of Directorates who consistently do not attend. To improve this, attendance levels will be monitored and reported through Directorate and Division Governance meetings.

During 2014/2015, there will be a more focused approach on the aims and objectives of audits, ensuring re-assessment as to whether these have been achieved, and where there is poor or non-compliance actions have been identified to address the shortfall to improve future compliance.

APPENDIX 1 - Figures as at 2 April 2014

					Type of Audits being undertaken					Types of Audits completed										
Division 1	**Audits on original Plan**	**Additional Audits added**	**Authorised Abandoned Audits**	**Total audits - minus any authorised abandoned audits**	**National Audits**	**Local Audits**	**NICE Audits**	**Other Audits**	**Total Audits Completed**	**National Audits**	**Local Audits**	**NICE Audits**	**Other Audits**	**Total Audits in Progress**	**Total Audits Pending**	**Total completion rate**	**National completion rate**	**Local completion rate**	**NICE completion rate**	**Other completion rate**	**Combined Local, NICE and Other completion rate**
Audiology	3	0	0	3	0	3	0	0	3	0	3	0	0	0	0	**100%**	**N/A**	**100%**	**N/A**	**N/A**	**100%**
Cardiology	9	9	3	15	10	4	0	1	10	5	4	0	1	5	0	**67%**	**50%**	**100%**	**N/A**	**100%**	**100%**
Cardiothoracic Surgery	14	4	0	18	5	12	0	1	15	2	12	0	1	3	0	**83%**	**40%**	**100%**	**N/A**	**100%**	**100%**
Critical Care	11	15	3	23	5	15	1	2	12	1	10	0	1	11	0	**52%**	**20%**	**67%**	**0%**	**50%**	**61%**
Dental	10	2	2	10	0	8	2	0	10	0	8	2	0	0	0	**100%**	**N/A**	**100%**	**100%**	**N/A**	**100%**
General Surgery	7	23	13	17	3	13	0	1	15	1	13	0	1	2	0	**88%**	**33%**	**100%**	**N/A**	**100%**	**100%**
Gynaecology	8	4	1	11	0	10	0	1	7	0	6	0	1	4	0	**64%**	**N/A**	**60%**	**N/A**	**N/A**	**64%**
Head & Neck	11	13	6	18	1	14	2	1	18	1	14	2	1	0	0	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Obstetrics	13	2	3	12	0	11	0	1	12	0	11	0	1	0	0	**100%**	**N/A**	**100%**	**N/A**	**N/A**	**100%**
Ophthalmology	19	9	1	27	0	24	2	1	26	0	23	2	1	1	0	**96%**	**N/A**	**96%**	**100%**	**N/A**	**96%**
Pathology	7	2	1	8	2	5	1	0	6	1	4	1	0	2	0	**75%**	**50%**	**80%**	**100%**	**N/A**	**83%**
Radiology	10	3	2	11	0	9	0	2	10	0	8	0	2	1	0	**91%**	**N/A**	**89%**	**N/A**	**100%**	**91%**
SALT	8	1	0	9	0	9	0	0	9	0	9	0	0	0	0	**100%**	**N/A**	**100%**	**N/A**	**N/A**	**100%**
Trauma & Orthopaedics	8	18	4	22	2	19	0	1	17	0	16	0	1	5	0	**77%**	**0%**	**84%**	**N/A**	**100%**	**85%**
Urology	14	7	9	12	2	9	0	1	12	2	9	0	1	0	0	**100%**	**100%**	**100%**	**N/A**	**100%**	**100%**
TOTALS	**152**	**112**	**48**	**216**	**30**	**165**	**8**	**13**	**182**	**13**	**150**	**7**	**12**	**34**	**0**	**84%**	**43%**	**91%**	**88%**	**92%**	**91%**

					Type of Audits being undertaken					Types of Audits completed											
Division 2	**Audits on original Plan**	**Additional Audits added**	**Authorised Abandoned Audits**	**Total audits - minus any authorised abandoned audits**	**National Audits**	**Local Audits**	**NICE Audits**	**Other Audits**	**Total Audits Completed**	**National Audits**	**Local Audits**	**NICE Audits**	**Other Audits**	**Total Audits in Progress**	**Total Audits Pending**	**Total completion rate**	**National completion rate**	**Local completion rate**	**NICE completion rate**	**Other completion rate**	**Combined Local, NICE and Other completion rate**
Accident & Emergency	5	0	0	5	3	1	0	1	2	0	1	0	1	3	0	40%	**N/A**	**100%**	**N/A**	**100%**	**100%**
Acute medicine	13	5	2	16	2	13	0	1	16	2	13	0	1	0	0	100%	**100%**	**100%**	**N/A**	**100%**	**100%**
Adult Community Services	6	2	0	8	0	6	1	1	8	0	6	1	1	0	0	100%	**N/A**	**100%**	**100%**	**100%**	**100%**
Care of the Elderly	9	9	4	14	4	9	0	1	10	1	8	0	1	4	0	71%	**25%**	**89%**	**N/A**	**100%**	**90%**
Children's Services Group - ACUTE	15	9	5	19	5	10	4	0	19	5	10	4	0	0	0	100%	**100%**	**100%**	**100%**	**N/A**	**100%**
Children's Services Group - COMMUNITY	9	2	1	10	0	5	4	1	8	0	5	2	1	2	0	80%	**N/A**	**100%**	**50%**	**100%**	**80%**
Dermatology	12	0	3	9	2	6	0	1	9	2	6	0	1	0	0	100%	**100%**	**100%**	**N/A**	**100%**	**100%**
Diabetes	14	2	5	11	3	5	2	1	8	1	5	1	1	2	1	73%	**33%**	**100%**	**50%**	**100%**	**88%**
Gastroentero logy	10	2	5	7	4	0	2	1	5	2	0	2	1	2	0	71%	**50%**	**N/A**	**100%**	**100%**	**100%**
Gastro - Dietetics	2	6	2	6	0	6	0	0	6	0	6	0	0	0	0	100%	**N/A**	**100%**	**N/A**	**N/A**	**100%**

Gastro - Endoscopy	11	1	1	11	10	1	0	0	8	7	1	0	0	3	0	73%	**70%**	**100%**	**N/A**	**N/A**	**100%**
Malting's	9	1	1	9	0	8	0	1	8	0	7	0	1	1	0	89%	**N/A**	**88%**	**N/A**	**100%**	**89%**
Neurology	6	3	1	8	0	4	3	1	6	0	2	3	1	2	0	75%	**N/A**	**50%**	**100%**	**100%**	**75%**
Oncology & Haematology	27	19	11	35	7	17	9	2	26	0	17	7	2	9	0	74%	**N/A**	**100%**	**78%**	**100%**	**93%**
Pharmacy	4	5	2	7	0	6	0	1	7	0	6	0	1	0	0	100%	**N/A**	**100%**	**N/A**	**100%**	**100%**
Renal medicine	17	8	2	23	1	20	1	1	22	1	19	1	1	1	0	96%	**100%**	**95%**	**100%**	**100%**	**95%**
Respiratory medicine	12	4	8	8	5	2	0	1	7	4	2	0	1	1	0	88%	**80%**	**100%**	**N/A**	**100%**	**100%**
Rheumatology	11	2	2	11	1	5	4	1	10	0	5	4	1	1	0	91%	**N/A**	**100%**	**100%**	**100%**	**100%**
Sexual Health	9	2	0	11	1	8	0	2	11	1	8	0	2	0	0	100%	**100%**	**100%**	**N/A**	**100%**	**100%**
Stroke	3	0	0	3	1	0	1	1	3	1	0	1	1	0	0	100%	**100%**	**N/A**	**100%**	**100%**	**100%**
Therapy Services (Acute)	3	2	0	5	0	4	0	1	5	0	4	0	1	0	0	100%	**N/A**	**100%**	**N/A**	**100%**	**100%**
Therapy Services (Community)	3	0	0	3	0	3	0	0	3	0	3	0	0	0	0	100%	**N/A**	**100%**	**N/A**	**N/A**	**100%**
TOTALS	**210**	**84**	**55**	**239**	**49**	**139**	**31**	**20**	**207**	**27**	**134**	**26**	**20**	**31**	**1**	**87%**	**55%**	**96%**	**84%**	**100%**	**95%**

APPENDIX 2

NATIONAL AUDITS 2013/14 - Update as at (7.5.14)				
National Clinical Audit	**Directorate**	**Applicable**	**Participating**	**If participating status of audit**
Adult community acquired pneumonia	Respiratory	Yes	Yes	Completed
Diabetes (Paediatric)	Paediatrics	Yes	Yes	Completed
Non-invasive ventilation	Respiratory	Yes	Yes	Completed
Rheumatoid and early inflammatory arthritis	Rheumatology	Yes	Yes	Completed
Acute Coronary Syndrome or Acute Myocardial Infarction	Cardiothoracic Services	Yes	Yes	In Progress
Adult Cardiac surgery	Cardiothoracic Services	Yes	Yes	In Progress
Adult Critical Care (Case Mix Programme)	Critical Care	Yes	Yes	In Progress
Bowel cancer	Oncology & Haematology	Yes	Yes	In Progress
Cardiac Arrhythmia	Cardiothoracic Services	Yes	Yes	In Progress
Congenital Heart Disease (paediatric cardiac surgery)	Cardiothoracic Services	Yes	Yes	In Progress
Coronary Interventions (Angioplasty / PCI)	Cardiothoracic Services	Yes	Yes	In Progress
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Diabetes	Yes	Yes	In Progress
Elective surgery (PROMs)	Trauma & Orthopaedics	Yes	Yes	Completed
Emergency use of oxygen	Respiratory	Yes	Yes	Completed
Epilepsy 12 (Childhood Epilepsy)	Paediatrics	Yes	Yes	Completed
Falls and Fragility Fractures Audit programme, includes National Hip Fracture database	Trauma & Orthopaedics (National Hip Fracture) and Care of the Elderly (Inpatient Falls)	Yes	Yes	Completed
Head and neck oncology	Oncology & Haematology	Yes	Yes	In Progress
Heart failure	Cardiothoracic Services	Yes	Yes	In Progress
Lung cancer	Oncology & Haematology	Yes	Yes	In Progress
Moderate/severe asthma in children (ED)	A&E	Yes	Yes	In Progress
National audit of dementia audit	Care of the elderly	Yes	Yes	In Progress

National Clinical Audit	Directorate	Applicable	Participating	If participating status of audit
National comparative audit of blood transfusion	Pathology	Yes	Yes	In Progress
National emergency laparotomy audit	Critical Care (Lead)/General Surgery	Yes	Yes	In Progress
National joint registry	Trauma & Orthopaedics	Yes	Yes	Completed
Neonatal intensive and special care - NAPP	Paediatrics	Yes	Yes	Completed
Oesophago-gastric cancer	Oncology & Haematology	Yes	Yes	In Progress
Paediatric asthma	Paediatrics	Yes	Yes	Completed
Paracetamol overdose (care provided in ED)	Emergency Department	Yes	Yes	In Progress
Prostate cancer	Onc&Haem / Urology	Yes	Yes	In Progress
Renal replacement therapy (Renal Registry)	Renal	Yes	Yes	Completed
Sentinel Stroke National Audit Programme (SSNAP) includes SINAP	Stroke	Yes	Yes	Completed
Severe sepsis and septic shock	Emergency Department	Yes	Yes	In Progress
Severe Trauma (TARN)	Trauma & Orthopaedics	Yes	Yes	In Progress
Specialist rehab for patients with complex needs	Neurology	Yes	Yes	In Progress
Chronic Obstructive Pulmonary Disease	Respiratory	Yes	Yes	Abandoned
Inflammatory bowel disease IBD	Gastroenterology	Yes	Yes	Completed
Ophthalmology	Ophthalmology	Yes	Yes	Pending
National Audit of seizure management (NASH)	Emergency Department	Yes	No	N/A
National Cardiac Arrest	Critical Care	Yes	No	N/A

APPENDIX 3 Examples of Good Audits

Division	Directorate	Audit number	Audit Title	What was the positive impact on the service/what change of practice occurred and how did this impact on the patient
1	Cardiothoracic	**1000**	Local : Benefit of endoscopic vein harvesting	Results showed a markedly reduced pain score for the EVH group, a reduction in leg wound infection in the EVH group, a tendency to reduce hospital stay for EVH group. However, there is an increased cost for EVH technology. Overall, EVH provides much better patient outcomes and it has been agreed that going-forward Cardiothoracics will provide EVH to all eligible patients.
1	General Surgery	**1226**	Local: Varicose Veins	Training for ward nurses on nurse-led discharge. Operating Consultants/Registrars should clearly document 'Home today with nurse led discharge'. Varicose Vein Vascular Society leaflets to be distributed to all. This will speed up patient discharge and improve patient journey.
1	Head and Neck	**1178**	Bone Anchored Hearing Aid - an audit of intraoperative, post-operative complications and the need for revision surgery	Altered the surgical technique and the results of the audit confirmed the reasoning. Change to the type of implant used and increased the size of the implant. This will be an improvement to Patient care and Treatment
1	Ophthalmology	**1148**	NICE TA229: Intravitreal dexamethasone implant (ozurdex) for macular oedema following retinal vein occlusion.	Urgent referral for all new RVO patients with macular oedema documented on OCT to one of the Med Ret Cons and dedicated service for RVO
1	Pathology	**936**	Local Audit of test requesting patterns for menopause screening.	Introduction of a clinical condition-specific profile for suspected menopause that has reduced inappropriate tests, more efficient use of laboratory resources and standardisation of patient care pathways

Division	Directorate	Audit number	Audit Title	What was the positive impact on the service/what change of practice occurred and how did this impact on the patient
1	Special Care Dental Service	**1437**	Local : Assessment of completion of the Modified Dental Anxiety Scale questionnaire	Prompted staff training sessions and the team have decided to use the MDAS tool for complex adult patients only at point of referral. The outcome for patients is that clinical teams are now aware of anxiety levels prior to a clinical appointment and can ensure the patient receives appropriate care that they are able to cope with, which will hopefully in the long term reduce anxiety and enable routine care.
2	Acute Medicine	**1097**	Local Audit - Investigating Suspected Pulmonary Embolus on the Acute Medical Unit	A new Pulmonary Embolus Pathway has been developed which has improved practice. As a result of following the new pathway, improvements include reduction in length of time for imaging and more appropriate imaging.
2	Adult Community	**1521**	Local Nursing Bag Audit	A number of staff did not have fundamental equipment i.e. Tympanic thermometer/ sphygmomanometer at the time of audit. Replacement equipment has been. It will be recommended that each locality hold small buffer stock to accommodate when staff's equipment requires repair.
2	Care of the Elderly	**1478**	Completion of antimicrobial stickers for patients who have been started on antibiotics during their stay on Ward A7	More stickers completed from greater awareness
2	Children's - ACUTE	**1251**	Local Audit - Local Audit - Meningococcal Sepsis, An audit of long-term follow-up services	1. Audiology appointments prior to discharge - Consultants to highlight these patients as post-meningococcal disease when making appointments. This practise will aid to patients being offered appointments within appropriate times. 2. Overbook clinics to ensure patient is seen within 4-6 weeks 3. This potentially highlights not lost to follow patients with symptoms.

Division	Directorate	Audit number	Audit Title	What was the positive impact on the service/what change of practice occurred and how did this impact on the patient
2	Children's - ACUTE	**1476**	NICE Audit CG72 - Diagnosis of ADHD: Development of a multi-agency care pathway and ADHD assessment and review group	1. The Group now meets on a regularly basis since August 2013. 2. The database is reviewed and updated during these sessions. 3. Protocol for the diagnosis of ADHD and guidelines is now on intranet and available for use by the team. 4. ADHD pathway shared with stakeholders and monthly meeting is used to update the database. 5. Letter published in BMJ
2	Childrens - COMMUNITY	**1239**	Local Audit - Drop in Audit (School Children Use of Drop in Centre)	Enhanced and improved the drop-in provision for young people where services are available. Funding has been obtained to train additional 2 members of staff for them to do a CASH course in April 2014. This is expected to further increase support and availability for patients.
2	Childrens - COMMUNITY	**1240**	Local Audit - Case Conference Reports Audit (Safeguarding)	Information on safeguarding to be made available in training package. The audit findings to participating services (Midwifery, Health Visiting & School Nursing) to make them aware of current safeguarding practices. This awareness will help community midwives to improve their reports when produced.
2	Dermatology	**1201**	GP Communication audit for skin cancer	Medical staff are providing the required paperwork in a timelier manner.
2	Dermatology	**904**	Audit of Efficacy of treatment of BCCs with Photodynamic therapy	More precise selection of patients for treatment basing on histology findings and clinical thickness of lesions in order to achieve better therapeutical efficacy. Previous histology reports are also being given greater attention.
2	Diabetes	**1411**	Wolverhampton Insulin Pump Audit CSII	All new starter insulin pump patients are issued with a starter pack of written information which is discussed with them at a 'pump specific' clinic at the Diabetes Centre. All staff working on this clinic are fully trained on how to use insulin pumps.

Division	Directorate	Audit number	Audit Title	What was the positive impact on the service/what change of practice occurred and how did this impact on the patient
2	Gastro/Dietetics	**1192**	Local: Correct placement of naso-gastric tubes (Never Event).	All RNs are now aware of safe practice in correct placement of Naso-Gastric feeding tubes. Nurse induction updated. Updated Level 2 mandatory training. This has improved patient care and treatment.
2	Gastro/Dietetics	**1197**	Local: MUST Assurance audit	MUST has been included on VitalPAC and alternative height measures (e.g. ulna length). Updated nurse induction session - July & August 13 sessions delivered using new presentation. Ulna length also included in desktop VitalPAC training. This will improved patient care
2	Gastro/Dietetics	**1198**	Local: Nutritional contribution of snacks for adult inpatients	Business case approved and snacks provided from charitable funds. Snacks make a significant contribution to energy intake and should be offered to all patients.
2	Gastro/Dietetics	**1197**	Local MUST Audit	On-line mandatory training updated to reflect MUST on VitalPAC and ulna length as an alternative height measure.
2	Gastro/Endoscopy	**1414**	Local BCS - Bowel Preparation Audit	Sourced alternative bowel prep -effective bowel preparation.
2	Neurology	**908**	An Audit relating to NICE: Multiple Sclerosis Service Audit 2013	A new Diagnosis Pathway has been developed by the group. In addition, all new patients with a diagnosis of MS are now referred to Clinical Nurse Specialist.
2	Oncology & Haematology	**1273**	Improving immobilisation for 3/4 field patients	Local practice changed to ensure chin straps and footstocks are used as standard practice. This has automatically reduced the amount of imaging required.
2	Oncology & Haematology	**1575**	Implementing new radiotherapy immobilisation equipment for brain and thorax patients	The wingboard used with the U-Grip and the Q-Fix tilting base improved patient set-up and accuracy. They will be used as standard practice for both sites. This will reduce the amount of imaging required.

Division	Directorate	Audit number	Audit Title	What was the positive impact on the service/what change of practice occurred and how did this impact on the patient
2	Pharmacy	**1272**	A Local Audit assessing Warfarin Prescribing in Medical and Surgical Patients	A new prescription chart has been developed to incorporate not only Warfarin prescribing, but a number of other issues that have been raised following feedback from the users.
2	Renal	**322**	CKD - review of the control of acidosis	A protocol for management of acidosis in CKD has been developed to identify all CKD patients with bicarb levels of <22 mmol/l (Source Emed). Consider referral of all patients >65 years for the national study. Offer NaHCO3 to all suitable patients, provided there are no contraindications. Commence bicarbonate supplements and dose titrate to achieve a bicarb >22 mmol/l and record all medications in Emed to offer follow up.
2	Respiratory	**1244**	National Emergency Oxygen (BTS)	Changed prescription sheet to include pre-printed times for oxygen checking which increases the likelihood of the nursing staff signing off that oxygen has been checked on drug rounds.
2	Respiratory	**824**	National Adult Community Acquired Pneumonia	Simplification and condensement of current guidance and also incorporating links to pneumonia care bundle and hospital antibiotic prescribing guidance -
2	Respiratory	**1244**	National Emergency Oxygen (BTS)	Pharmacy has been made aware of oxygen incident (via the minutes from the Medical Gases Committee). Some wards are poor at oxygen prescribing - Pharmacy now receive alerts for oxygen incidents. This will raise awareness and help reduce/eliminate poor oxygen prescribing to improve practice.
2	Rheumatology	**958**	Rituximab treatment in RA	Developed a checklist/protocol to ensure all information is recorded at one time and then immediately added to the notes. Recording the justification for those starting Rituximab without fulfilling all the criteria. At 3-6 month follow-up, another checklist/protocol is used to ensure all information is recorded at one time and then immediately added to the notes. If there is no recorded improvement DAS>1.2 another biologic therapy is suggested rather than continuation of Rituximab

Division	Directorate	Audit number	Audit Title	What was the positive impact on the service/what change of practice occurred and how did this impact on the patient
2	Sexual Health	**1027**	A Local Audit on Cardiovascular disease monitoring in HIV patients	The HIV 3 monthly follow up proforma has been amended to show the CVD risk assessment monitoring and also the monitoring of plasma glucose and lipids.
2	The Malting's	**1209**	User Experience Survey 2013	The aim of this survey was to understand patient issues and provide an action plan to improve patient satisfaction. Signage has been reviewed within the centre (MMC) for visiting patients and carers. This includes signage of toilets, access to refreshments, the second waiting area (away from the sliding doors with TV) and access to wheelchairs in the fitting rooms (for use when limb in the workshop). Some signage has now been changed. In addition, feedback was given to the Transport Department to improve upon the service operating from New Cross Hospital. Lockers were also provided for the service users.

APPENDIX 4

Audit of OP45: Clinical Audit & Effectiveness Policy

Governance Department

The Royal Wolverhampton NHS Trust

May 2014

Content

Introduction

The purpose of this report is to assess compliance with the OP45 Clinical Audit and Effectiveness Policy. The audit policy states that a report is required for each audit that is completed.

Method

Audit projects were included in this audit if they had been completed on the clinical audit database between 1st January 2014 and 31st March 2014.

This led to 133 projects being included.

An electronic pro-forma was used to collect data against the criteria shown in Table 1. Data collection took place in January, February and March 2014 (Quarter 4). Evidence of report content was sought from the Trust's Clinical Audit database.

Table 1: Audit template

Criteria	Evidence Source	
	Clinical Audit Database	Active Document
1) Is there an audit report?	✓	
2) Does the audit report have an introduction section?	✓	
3) Does the audit report have a methodology section?	✓	
4) Does the audit report have a results section?	✓	
5) Does the audit report have a conclusions section?	✓	
6) If this project is a re-audit does the report contain results f previous audit?	✓	
7) Is there an action plan relevant to this audit on the database?	✓	
8) Have actions been added to the database?	✓	
9) Discussed at an appropriate meeting, i.e., Directorate Governance Meeting/Clinical Audit meeting or Specialist Group meeting?		✓
10) Have **all** actions been completed within timescales?	✓	
11) Where re-audit required – has this been added to next year's plan?	✓	✓

Results

Table 2: Comparison results table

Criteria	Compliance % May-June 2013 (Q1)	Compliance % July-Sept 2013 (Q2)	Compliance % Oct-Dec 2013 (Q3)	Compliance % Jan-March 2014 (Q4)
1) Is there an audit report?	98	100	99	99
2) Does the audit report have an introduction section?	98	95	96	99
3) Does the audit report have a methodology section?	98	95	93	98
4) Does the audit have a results section?	100	100	99	99
5) Does the audit report have a conclusions section?	98	92	96	98
6) If this project is a re-audit does the report contain results of previous audit?	50	37	**22**	81
7) Is there an action plan relevant to this audit on the database?	93	97	96	98
8) Have actions been added to the database?	90	96	93	97

Criteria	Compliance % May-June 2013 (Q1)	Compliance % July-Sept 2013 (Q2)	Compliance % Oct-Dec 2013 (Q3)	Compliance % Jan-March 2014 (Q4)
9) Discussed at an appropriate meeting ie, Directorate Governance Meeting/Clinical Audit meeting or Specialist Group meeting	81	99	99	94
10) Have all the actions been completed within the timescales?	71	47	**47**	68
11) Where re-audit required –has this been added to next year's plan?	91	93	91	95

Compliance results

Compliance scale	Grading
0 - 50%	Red
51% - 74%	Amber
75% - 100%	Green

The table above shows data from Q1, 43 projects were completed during May to June 2013.

Q2 was based 78 audit projects completed during July to September 2013, Q3 was based on 101 audit projects completed October to December and finally, Q4 based on 133 audits completed during January to March 2014. A total of 264 projects completed.

Conclusions

Quarter 4 show 10 out of 11 standards achieved over 75% compliance and 99% compliance against the OP45 policy which included both a report and presentation **(Table 2).**

It was noted Ophthalmology Directorate uploaded a presentation without a report to support their audit.

Slight improvements are shown in Questions 2, 3, 5, 7, 8, and 11.

Further analysis shows significant improvements have been seen in Question 6; if this project is a re-audit does the report contain results of previous audit? from 22% to 81% compliance.

A reduction in compliance has been shown for Question 9: Discussed at an appropriate meeting i.e., Directorate Governance Meeting/Clinical Audit meeting or Specialist Group meeting? from 99% to 94%. It was noted at the time of reporting some audits were due for presentation at forthcoming Directorate/Specialist Group meetings.

Question 10: Have all the actions been completed within the timescales? This criterion now shows an increase in compliance to 68% from 47% the previous Quarter.

Outstanding improvements have been made by Oncology and Haematology Directorate regarding the standardisation of their report headings.

In summary, significant improvements have been made on Questions 6 and 10 during Quarter 4 from Quarter 3.

Finally, compliance to Quarter 3 action plan will be achieved no later than June 2014.

Action plan

Recommendation	Action	Lead	Due Date
1. Feedback results to Directorates	Governance Officers to feedback results to their respective Directorates at their next Governance meeting	Governance Officers	June 14
2. Ophthalmology Directorate to upload all audits with a report template	Governance Officer to feedback non-compliance to the Ophthalmology Directorate and ensure a report has been added to the clinical audit database	Governance Officer	June 14
3. Re-audits must include previous results	Governance Officers to feedback to all non-compliant directorates, the requirement to include previous results in re-audit reports.	Governance Officers	June 14

4. Audit leads to ensure re-audits are included in the title on the clinical audit database	Governance Officers to monitor that where re: audits have been identified; this has been included in the project title.	Governance Officers	June 14
5. Directorates to develop action plans with realistic timeframes for completion	Realistic time framed actions to be uploaded to the clinical audit database by Directorates	Directorate Governance Leads	June 14
6.To complete actions on the clinical audit database within the agreed timeframes	Governance Officers to monitor actions through Governance, clinical audit or specialist meetings using the action tracker system/clinical audit database/IGR. To advise directorates if any actions are about to become overdue	Governance Officers	
7. To upload evidence on the clinical audit database of completed audits	Governance officers to upload minutes on the clinical audit database of completed audits	Governance Officers	June 14

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