University Hospitals Coventry and Warwickshire NHS Trust

2013–2014

Clinical Audit & Effectiveness Annual Report

We Care, We Achieve, We Innovate

Contents

3 **Section 1**
3 1.1 Introduction to Clinical Audit
4 1.2 National Audit
7 1.3 Local Audit
8 1.4 Overview of Clinical Audits registered during 2013-14
10 1.5 Key Achievements 2013-14
12 1.6 Further Developments for 2014-15

13 **Section 2**
13 2.1 Introduction to Mortality
14 2.2 Trust Mortality Performance for 2013 - 2014
16 2.3 Learning from Mortality Review
17 2.4 Changes in practice

18 **Section 3**
18 3.1 Introduction to Clinical Guidance
18 3.2 Trust Clinical Guidelines
19 3.3 NICE Guidance
21 3.4 Further Developments for 2014-15

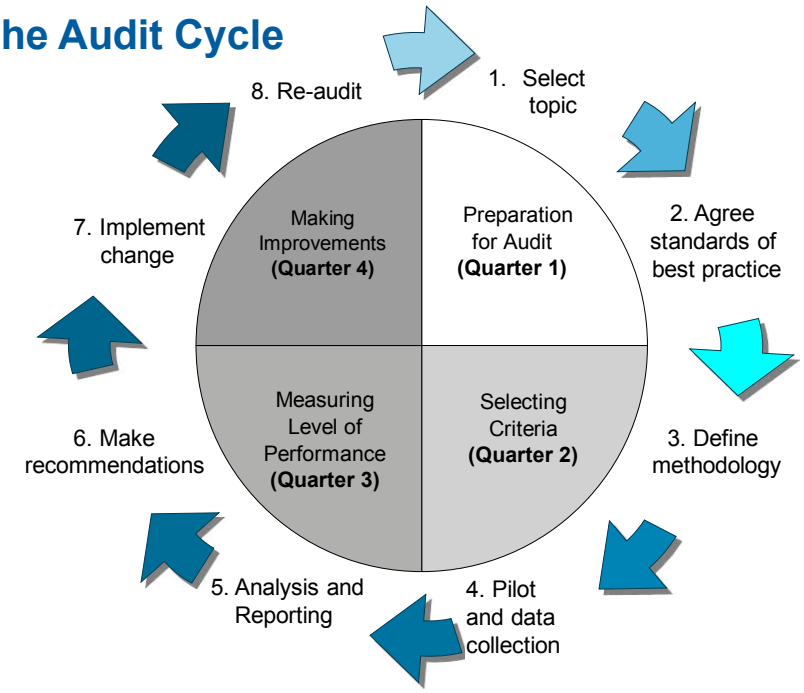
Section 1

1.1 Introduction to Clinical Audit

UHCW NHS Trust is committed to improving services through systematic clinical audit.

"Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards of high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes"

(Healthcare Quality Improvement Partnership (HQIP), New Principles of Best Practice in Clinical Audit, 2011).



This clinical audit & effectiveness annual report has been developed to augment the information provided in the UHCW Quality Account, section 2.4.2. It provides additional detail regarding the benefits gained through participation in both national and local audits and the rationale for non participation in certain national audits. Participation rates for audits that UHCW took part in during 2013/2014 are detailed in the main Quality Account document.

Clinical audit is important because it allows performance to be reviewed ensure that what should be done is being done, and if not it provides a framework to enable improvements to be made. It is the responsibility of all health professionals to critically review their work to ensure care is given according to the best available evidence. Involvement in clinical audit is a means for all healthcare professionals to reflect on their own and their team's practice. Clinical audit should be effectively carried out by all clinicians throughout the organisation in order to improve the quality of care received by patients.

The Clinical Audit Department is responsible for facilitating all clinical audit projects,

incorporating both national and local priorities, throughout UHCW. It is an integral part of the Quality and Patient Safety Department which is accountable to the Chief Medical Officer. The Clinical Audit Department provides expertise and support to clinical specialties to monitor and improve patient care through:

- Clinical audit training, awareness and support to all clinicians
- Support and facilitation to clinicians and other relevant staff conducting and/or managing clinical audits
- A formal review of the Clinical Audit & Effectiveness Programme to ensure that it meets the organisations aims and objectives as part of the wider quality improvement agenda.

Progress reports on clinical audit activities are presented quarterly to the Patient Safety Committee. The Patient Safety Committee is responsible for receiving and monitoring assurances and these are then reported to the Quality Governance Committee who in turn report to Trust Board. In accordance with the requirements set out in the NHS Audit Committee Handbook, the Clinical Audit Department also reports twice a year on clinical audit activity to the Audit Committee.

Clinical specialties also hold monthly QIPS (Quality Improvement & Patient Safety) meetings at which they cover standing quality agenda items which include clinical audit. Clinical audit findings are presented at QIPS meetings and specialty groups also use this time to plan how they will implement the recommendations made as a result of clinical audits. They also review the QPS (Quality & Patient Safety) dashboard reports for their specialty which include a section detailing progress against the specialty clinical audit programme. The QIPS meetings provide an opportunity for clinical audit to link with other quality improvement activities such as mortality reviews, monitoring of clinical adverse events, complaints, patient involvement and guidelines.

1.2 National Audit

National clinical audit is designed to improve patient outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in a systematic evaluation of their clinical practice against standards and to facilitate improvement in the quality of treatment and care. National clinical audits are largely funded by the Department of Health and commissioned by HQIP which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

National audits meet the following criteria:

- National coverage (achieved or intended)
- The main focus is improving the quality of clinical practice
- Evaluate practice against clinical criteria/guidelines and/or collects outcomes data
- Apply the complete audit cycle and/or monitor clinical/patient outcomes data in an ongoing way as part of a programme of driving change.

Participation in national audits is important because it enables UHCW NHS Trust to demonstrate that it monitors quality in an ongoing, systematic manner to board level. A high level of participation provides a level of assurance that our organisation takes quality seriously and that clinical teams and individual clinicians monitor and improve their practice.

The value of national clinical audits comes not only from our participation but also from our willingness to use the information obtained to take action to make improvements. The Clinical Audit Department ensures that the data from national clinical audits and the relevant local and national knowledge gained is used to take action to improve patient care.

The reports of 18 national clinical audits were reviewed by UHCW in 2013/2014 and action plans were developed.

The audit action plan should be a tool for turning recommendations (made following review of the audit results) into practice, therefore realising benefits for both patients and/or staff.

The following are brief summaries of some of the key actions we have taken to improve the quality of healthcare as a result of the review of national clinical audit reports:

Audit title	Key Action
National Audit of Dementia 2012 (2nd Round)	A dementia (forget-me-not) dashboard has been developed which includes a number of statistics on patients with dementia to ensure that this data is available to the Executive Board. Discharge information has now been improved; a diagnosis of delirium is now included on the Clinical Results Reporting System (CRRS) and an automated process is now in place which sends a letter to the patients' GP. Previous admissions with delirium can now be viewed on CRRS. Blue pillow slips have now been introduced to highlight to clinical staff those patients who require extra assistance e.g. patients with dementia.
CEM Renal Colic 2012-13	The Emergency Department nursing documentation pack has now been updated to incorporate the re-evaluation of analgesia. This will improve the pain management in patients' with renal colic. A pathway has been developed to ensure patients with renal colic over the age of 60 receive a Computed Tomography Scan of their Kidneys, Ureters and Bladder (CTKUB) to rule out the possibility of an Abdominal Aortic Aneurysm (AAA).
Parkinson's disease (National Parkinson's Audit)	Introduction of medical notes stickers and the Impulsive/Compulsive Behaviour in Parkinson's Assessment Tool to allow patients to be monitored closely and counselled for the potential side effects of medications.
NCEPOD Bariatric Surgery	Bariatric Surgery Teams now follow-up patients by telephone 7 days post surgery. This enables any post-operative complications to be identified early and also improves outpatient follow-up times.
NCEPOD Peri-operative Care Study - Knowing the Risk	Development and implementation of a Pre-Operative Pathway will ensure that the decision to operate on high risk patients is made at Consultant level and will involve surgeons and those who will provide intra and post operative care. This will ensure the safety of high risk patients' pre and post surgery.
BTS Emergency Oxygen	Nursing care plans have now been updated to ensure that patients' saturation and oxygen levels are continually monitored. This will result in improved oxygen prescribing and ensure the safety of patients' receiving oxygen.

The following table details those audits included in the Quality Account list published by the Department of Health in which UHCW did not participate.

Of six national audits, UHCW is eligible to participate in one - the National Cardiac Arrest Audit. Of the rest, in two we do not provide the relevant service, in one UHCW does not perform the procedure and the other two are not applicable to Acute Trusts

UHCW has established a group dedicated to ensuring we both comply with the continuing data collection requirements for the National Cardiac Arrest Audit and for ensuring we address the recommendations of the NCEPOD report Time to Intervene. We plan to register for participation in 2014-15.

Audit title	Rationale for non-participation
National Cardiac Arrest Audit	UHCW is currently putting systems in place to guarantee 100% submission of minimum data set required before registering. It is anticipated that registration to this ongoing audit will take place during 2014-15.
Elective surgery (National PROMs Programme)	Not eligible – service not provided at UHCW
Pulmonary Hypertension Audit	Not eligible – service not provided at UHCW
Paediatric intensive care (PICANet)	Not eligible - procedure not performed
Prescribing in mental health services (POMH)	Not eligible - not applicable to Acute Trusts
National audit of Schizophrenia (NAS)	Not eligible – not applicable to Acute Trusts

Local Priorities 2013/2014	Target	2010/11	2011-12	2012-13	2013-14	Comments on performance
Participation in the National Clinical Audit and Patient Outcomes Programme (NCAPOP)	None	100%	95% (non-participation in 1 audit)	98% (non-participation in 1 audit)	97% (non-participation in 1 audit)	Participation in the national cardiac arrest audit is due to commence in 2014-15.

As detailed in the Quality Account, section 2.4.2, there were three national clinical audits that had a lower than expected participation rate. UHCW has investigated the reasons why this occurred as described below:

Audit title	Participation rate	Rationale for low participation rate
NCEPOD Tracheostomy Care	78%	This study incorporated 5 different elements including questionnaires to be completed based upon Insertion, Critical Care, Ward Care and the Ward. The study also included a case note review. The percentage participation rate reflects our participation in all five elements of the study.
Sentinel Stroke National Audit Programme (SSNAP)	94.5%	Not all hospitals are currently participating in SSNAP which has implications on the data submitted locally. If patients have been transferred to UHCW from a Trust not currently participating in the audit this data cannot currently be submitted. The Royal College of Physicians (RCP) criteria is to submit at least 80% of patients to SSNAP and UHCW exceeds this criteria.
National Bowel Cancer Audit Programme (NBOCAP)	0%	The Health & Social Care Information Centre (HSCIC) is currently updating the national audit dataset therefore data cannot be submitted until this has been done. 100% of data for period 01.04.13 to 31.03.14 has been collected locally and is on track to be submitted to the HSCIC by the national deadline which is 01.10.14.

1.3 Local Audit

Most clinical audit activity in NHS trusts will involve individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team; these are classified as local clinical audit. Each specialty has the opportunity to develop a local clinical audit programme which includes the clinical audits which they consider to be a local priority.

These audits can be identified in a number of ways as follows:

- those audits which were on the clinical audit programme for the previous financial year which had not been started
- potential re-audits
- risk management issues and/or incidents
- service priorities
- local guidelines
- identified deficiencies in care
- topics of clinician interest.

The reports from 42 local clinical audits were reviewed by UHCW in 2013/2014.

The following are brief summaries of some of the key actions we have taken to improve the quality of healthcare as a result of the review of local clinical audit reports:

Audit title	Key Actions
Re-audit of Door to ECG Times	A guide aimed at clinical staff has been developed and implemented within the Emergency Department which lists the clinical symptoms for when an ECG should be considered appropriate. This ensures that patients' receive an ECG in a timely manner and reduces the amount of ECGs being performed inappropriately.
Audit of Refeeding Syndrome	The reformatting of the re-feeding proforma has resulted in the introduction of pre-printed stickers. This ensures that the correct advice is available for medical teams when treating patients.
Audit of Catheter Associated Urinary Tract Infections	Nursing staff have received education on HOUDINI which is a nurse led protocol for the removal of urinary catheters. The Infection Prevention and Control Team have presented HOUDINI to the Infection Prevention and Control link nurses so they can introduce the concept on to their wards. The Infection Prevention and Control Team have added HOUDINI to the catheter care pathway. By introducing HOUDINI this will help to reduce the number of infections associated with catheter urinary tract infections.
Re-Audit of Fluid Balance & Hydration	Fluid chart and care plan has been updated to ensure patients' receive the appropriate hydration during their admission. Education and training has been provided to clinical staff following the introduction of the new fluid chart and care plan.
Audit of Status Epilepticus Guideline	The local guideline has now been revised to make it clearer which medications should be prescribed to patients and what dose is applicable. The revised guidelines have been communicated to all clinical teams involved in the care and treatment of patients with status epilepticus.
Audit of induction of labour (IOL)	The IOL booking form has been updated; this will aid adherence to the local guidelines and improve the quality of care provided to patients.
Management of Diabetic Ketoacidosis (DKA)	A medical emergency chart for DKA has been developed and is now in use within the Emergency Department. This incorporates all the key stages of DKA management and will improve the care of patients. This Trust DKA clinical guideline has also been updated to incorporate the new medical emergency chart.

Audit title	Key Actions
Audit of postoperative prescription of oxygen therapy	Clinical guideline has been written for postoperative oxygen prescription. The new guidance will ensure oxygen is prescribed and administered correctly to patients thus improving patient safety.
Audit of Falls Prevention For Neuro Patients	A Falls Prevention Pack has been developed and implemented on Ward 42 Neurosciences. The pack ensures that each patient on admission is risk assessed to identify if they are at risk of falling. The purpose of this is to reduce the number of patient falls from happening. Falls alarms have also been supplied to Ward 42 for use with beds and chairs for those patients who are identified, as per the Trust Falls Risk Assessment, most at risk of falling. The falls alarm reacts to the patients' movement and will alert nursing staff sooner that the patient may fall so the fall can be avoided.
Re audit of the appropriateness of the information leaflet for patients referred to nerve conduction studies and electromyography clinics at UHCW	The Patient Information Leaflet has now been updated to include appropriate photos of different procedures in Nerve Conduction Study and Electromyography clinics. Patients are now fully informed of what is going to happen during their electrodiagnostic consultation which helps to alleviate any worries or concerns they may have prior to their consultation.

1.4 Overview of Clinical Audits registered during 2013-14

At any one time, there are numerous clinical audit projects being undertaken within the Trust. There were a total of 258 clinical audit projects registered with the Clinical Audit Department in 2013-14; these are classed as mandatory audits, local audits and clinician ad-hoc audits. Mandatory audits are considered to be a Trust priority (e.g. national audits, NHSLA required audits, audits in response to newly implemented NICE guidance etc) and local audits are identified by clinical specialties according to their own service needs. Clinician Ad Hoc audits are not planned for on the Clinical Audit Programme but are completed by clinicians on an ad hoc basis throughout the year and are considered for full registration by the Clinical Audit Department upon receipt of a completed report and action plan.

The Clinical Audit Department were notified of a total number of 122 clinician ad hoc audits taking place during 2013-14. Of these, 16 audits have been fully registered as a result of receiving a completed report and action plan; 13 were abandoned and 97 audits are in progress and will be considered for full registration upon receipt of a completed report and action plan.

Figure 1 demonstrates the breakdown of audits by type registered with the Clinical Audit Department between 1st April 2013 and 31st March 2014. Figure 2 breaks the audits down further and demonstrates whether the audits were facilitated and managed locally in the Trust, nationally or regionally.

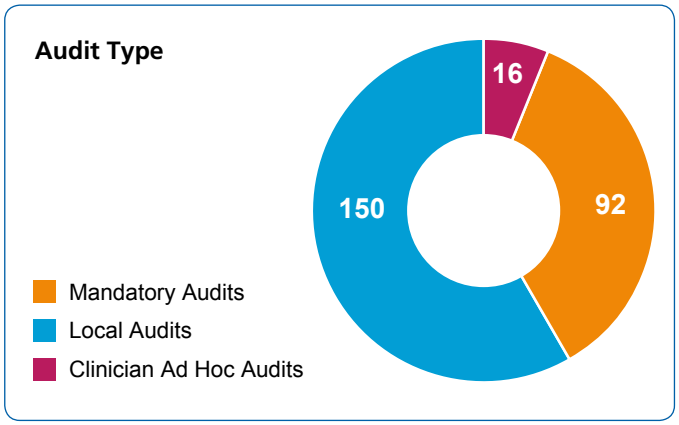


Figure 1

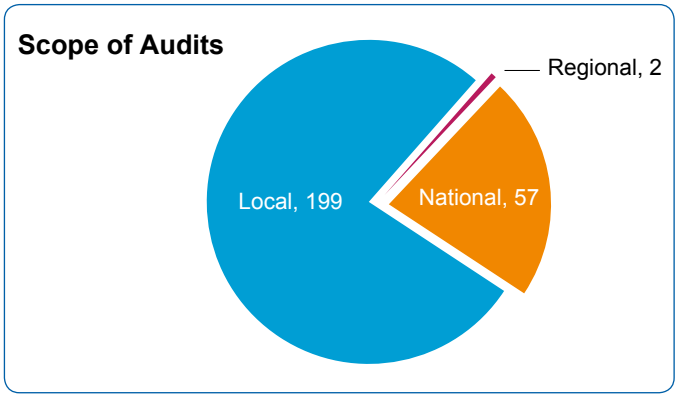


Figure 2

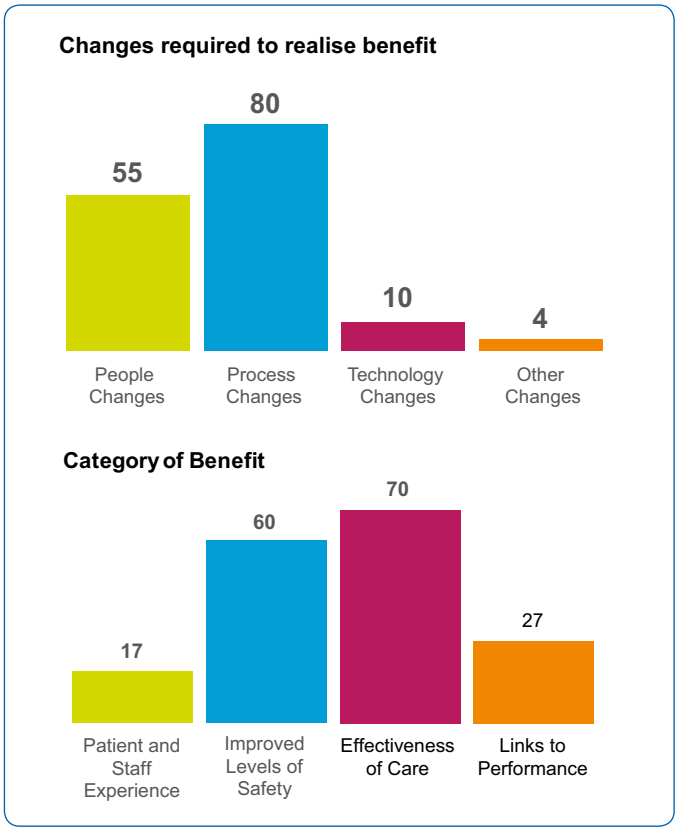


Figure 3

Benefits Realisation

Following the completion of a clinical audit project there is a need to ensure that it has resulted in some form of benefit. Each action on a clinical audit action plan is now required to include an anticipated measure of benefit. In order to effectively record and monitor the expected and achieved benefits of a clinical audit project the anticipated measures of benefit have been broken down into the following categories:

- Patient and staff experience
- Improved levels of safety
- Effectiveness of care
- Links to performance

The changes which need to take place in order to achieve the desired benefit have also been categorised as follows:

- People changes
- Process changes
- Technology changes
- Other changes

Figure 3 demonstrates the changes required to realise the benefits resulting from clinical audits which have reached a completion stage during 2013-14. It also identifies the category the benefit will impact upon and ultimately the area which will result in improvement.

The Clinical Audit Department is working to further implement benefit realisation during 2014-15 (see section 1.6).

1.5 Key Achievements 2013-14

Clinical Audit Training

During 2013-14, a total of five Introduction to Clinical Audit training sessions have been held at UHCW. The sessions have been attended by a variety of staff including nurses, midwives, specialist registrars, radiologists and management staff.

Some of the feedback received from delegates is detailed:

All of the delegates found defining clinical audit, the clinical audit cycle and practical exercises informative and very useful. All delegates stated that they felt the session had increased their knowledge and understanding of clinical audit.

UHCW clinical audit competition

Clinical staff of all disciplines were invited to submit their audit projects for consideration for the UHCW 2013 Clinical Audit Prize.

Individual or group entries registered with the UHCW Quality & Effectiveness Department were eligible and were made by submitting the audit report and presentation.

The panel of judges comprised:

- Meghana Pandit, Chief Medical Officer
- Martin Lee, Medical Director (Arden, Herefordshire and Worcestershire), NHS England
- Mark Radford, Chief Nursing Officer
- Peter Winstanley, Dean of Medical School and Non-Executive Director
- Michelle Hodgetts, Quality & Effectiveness Co-ordinator

The panel assessed the seven qualifying entries against a set of ten criteria in order to shortlist three finalists: Chris Harrold, Specialist Registrar; Angela Sherwood, Transfusion Liaison Nurse; and Carolyn Letchford, Practice Facilitator.

The finalists delivered a ten minute presentation of their audits at the Grand Round on Friday 5th July 2013 for final judging. A prize of an iPad was awarded to Carolyn Letchford. Her Audit of Oxygen Therapy was considered by the panel to most effectively demonstrate application of the recognised clinical audit cycle in accordance with UHCW policy and to have contributed / have the potential to contribute the most to quality improvement.

A summary of the Audit of Oxygen Therapy is below:

Audit of Oxygen Therapy – Carolyn Letchford, Practice Facilitator

The administration of supplemental oxygen (O2) is an essential element of appropriate management for a wide range of clinical conditions; however oxygen is a drug and therefore requires prescribing in all but emergency situations. Failure to administer oxygen appropriately can result in serious harm to the patient. The safe implementation of oxygen therapy with appropriate monitoring is an integral component of the Healthcare Professional's role.

The aims of the audit were:

1. To ensure that oxygen use is monitored safely and in accordance with UHCW guidelines
2. To ensure that appropriate actions are taken when saturations or respirations are not in optimal ranges.

The electronic records (VitalPAC) and nursing records of 52 patients were reviewed in order to gather audit data.

Findings

Areas of good practice that achieved 90% compliance or above:

- The patient's oxygen saturation should be recorded alongside other physiological variables
- The patient's respiratory rate should be recorded alongside other physiological variables
- The oxygen delivery system is recorded alongside other physiological variables
- Where the patient's oxygen saturation is below the target saturation action should be taken

Areas that achieved 50-89% compliance and require improvement:

- Where a patient's oxygen saturations are less than 90% action should be taken
- Where a patient's respiratory rate is outside of the MEWS 0 range (8-21rpm) the MEWS protocol should be adhered to
- Where an abnormal respiratory event occurs there should be nursing documentation to support this

Main areas for improvement that achieved compliance below 50%:

- Pulse oximetry is measured / recorded at clinically appropriate intervals; when on continuous oxygen therapy this should be 4 hourly
- Pulse oximetry is measured / recorded at clinically appropriate intervals; when on intermittent oxygen therapy this should be 8 hourly

Actions

As a result of this audit the following actions are being undertaken at UHCW NHS Trust:

1. The guideline "The prescription, administration and weaning of oxygen therapy for the management of hypoxia in adults." (UHCW NHS Trust. 2011) is being reviewed, updated and disseminated trust wide. The review is taking into account the views of the following staff/groups in order to ensure consistency across the Trust:
   - Deputy Medical Director
   - ADN Q&S
   - Oxygen Working Group
   - Critical Care Outreach
2. Training is being provided via roving boards and presentations to student nurses.
3. The existing generic nursing care plans are being reviewed and updated.
4. The updated care plans are being incorporated into trust documentation and education plans.

The audit competition will become an annual event.

Clinical Audit Awareness Week

The Clinical Audit Department ran a series of events during the HQIP (Health Quality Improvement Partnership) Clinical Audit Awareness Week, Monday 7th until Friday 11th October 2013 to promote clinical audit and quality improvement.

Clinical Audit staff were available throughout the Trust to give advice on all aspects of clinical audit and staff were invited to take part in a clinical audit quiz and complete surveys on their views of the Clinical Audit Department.

The results of the survey are detailed below:

77% of the staff who completed a survey knew the name of their Clinical Audit Facilitator

69% of staff knew how to register an audit

80% of the staff who had used the Clinical Audit Department had found it useful

The Clinical Audit Department plans to participate in Clinical Audit Awareness Week in 2014.

1.6 Further Developments for 2014-15

Key Performance Indicators

Key Performance Indicators (KPIs) are being developed in order to provide measurements around key clinical audit activities for the Trust as a whole, specialty groups and individual specialties. KPIs will demonstrate areas of effectiveness and areas for improvement in clinical audit activity such as the completion of clinical audit projects on the clinical audit programme, participation in national audits, the production of clinical audit reports and the agreement of and timely completion of action plans. The Clinical Audit Department is currently updating its internal processes in order to provide good quality data for the reporting of KPIs in the future.

Benefits Realisation

The Clinical Audit Department is planning to continue to develop a way of measuring the benefits realised from completed clinical audits. The purpose of this is to enable the Trust to clearly demonstrate and evidence the improvements made to patient care which have resulted from clinical audit activity. Processes are in place to monitor the benefits realised and the Clinical Audit Department aims to show that benefits have been realised through the completion of re-audits during 2014-15.

Section 2

2.1 Introduction to Mortality

Mortality review has become increasingly important for Trusts to provide assurance and evidence that patient outcomes are being monitored, and any issues relating to the quality of patient care are being addressed to ensure the highest possible standard of care for all patients. This forms part of the Outcomes Framework section 1 (preventing patients from dying early) and section 5 (ensuring the safety of patients).

UHCW is committed to accurately monitoring and understanding its mortality outcomes. It subscribes to Dr Foster's Quality Investigator (QI) tool and has been monitoring Hospital Standardised Mortality rates (HSMR) for a number of years with clinicians being able to access their own specialties information. HSMR is calculated using the number of deaths at a hospital Trust compared with the number of patients who would be expected to die, taking into account age, complexity of illness, deprivation and gender. The baseline for England is set at 100 and a lower figure indicates fewer patients died than expected.

The Trust has an extensive mortality review system where all inpatient deaths, over the age of 18, are reviewed by the consultant responsible for the patients care at point of death. This system utilises the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading system to classify overall patient care. Any case that does not have a NCEPOD grade A (Good Care) has a more in depth, secondary, review that highlights learning and any necessary actions. This learning is disseminated through the Trusts governance processes.

Dr Foster data analysis is used to monitor specific diagnosis and procedure groups, as well as specialty mortality through an alert system. The Trust has a robust process for investigating mortality alerts, which involves a clinical and coding review and triangulation of outcomes with those found in the Trust wide mortality review process (see above). Any actions and learning are fed back through the Trusts governance processes.

The above is overseen by the Trust Mortality Review Committee (MRC). This is chaired by the Chief Medical Officer and the membership is comprised of a representative from the CCG, a representative from Dr Foster, Trust Clinical Lead for Mortality, senior clinicians and nurses, clinical coding, clinical governance and senior representatives from key specialty areas, such as Critical Care, Neurosurgery and Palliative Care. The Committee meets twice each month and has a range of functions. It receives monthly dashboards that monitor the Trust's mortality performance and reports from specific alert investigations are presented to the meeting. The Committee also discusses and approves any new developments for the mortality processes in the Trust. Finally it reports into the Trust's Patient Safety Committee. Furthermore mortality data is reported to the Trusts Quality Governance Committee and a monthly basis and to Trust Board six monthly.

2.2 Trust Mortality Performance for 2013 - 2014

Dr Foster Data

The HSMR is a standardised measure of hospital mortality devised by Professor Sir Brian Jarman of Imperial College London, and published every year by Dr Foster in the Good Hospital Guide. It is the observed number of in-hospital spells resulting in death divided by an expected figure, for a basket of 56 diagnoses which represent 80% of hospital mortality in England. Day cases are excluded unless the patient died. The expected figure is derived from a logistic regression model which adjusts for case-mix factors. The national benchmark for HSMR is 100 and the data is provided monthly by Dr Foster, but this data is two months in arrears.

The Trust's current HSMR for January 2013 to December 2013 was 98.48. This, in essence, means that 1.4% less people died than expected. Every year Dr Foster rebases its figures. Rebasing is needed because the HSMR figure is a comparison with expected mortality. This expected value is calculated from actual mortality figures from all hospitals and normalised to a value of 100. As standards in hospitals improve, actual mortality rates will decrease. However Dr Foster keeps the expected value at 100 and mortality ratios are adjusted in relation.

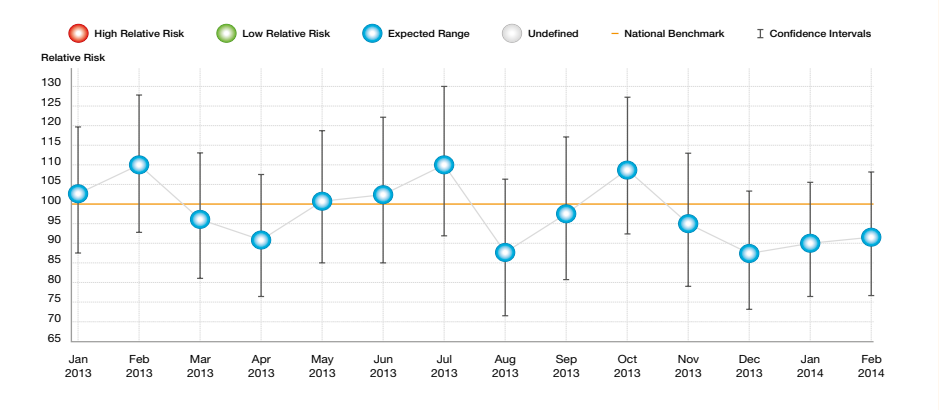


Figure 4 2013 HSMR based on basket of 56 diagnoses – Source Dr Foster Intelligence

As stated above the Trust monitors its HSMR on a monthly basis. Figure 4 shows the HSMR Trend for January 2013 to December 2013.

As is clear from the above chart there has been some fluctuation in the HSMR across 2013. However the HSMR has been within expected ranges across this time period. There have been two peaks in HSMR for July 2013 and October 2013. Both of these peaks have been thoroughly investigated to ascertain the cause(s) of the rise. Whilst no one single cause was found several contributory factors were identified and actions have been put in place to mitigate these.

The Trusts HSMR is within expected ranges when compared to its peers. Again the Trust is performing similar to other comparative sized Trusts as demonstrated in Figure 5.

This national indicator is published by the NHS Health and Social Care Information Centre and called the SHMI. The indicator can be used by hospitals to help them better understand trends associated with patient deaths. The national benchmark is also 100 and the data is provided on a quarterly basis. This data is six months in arrears.

As stated in section 2.4.9 the Trust SHMI score is 0.9867. This score is then converted by Dr Foster to allow for easy comparison with HSMR, rending a score of 98.67. Figure 6 shows how UHCW compares to its peers for the time period July 2012 to June 2013. As is clear from the chart overleaf UHCW is within expected range and is performing better than a number of its peers.

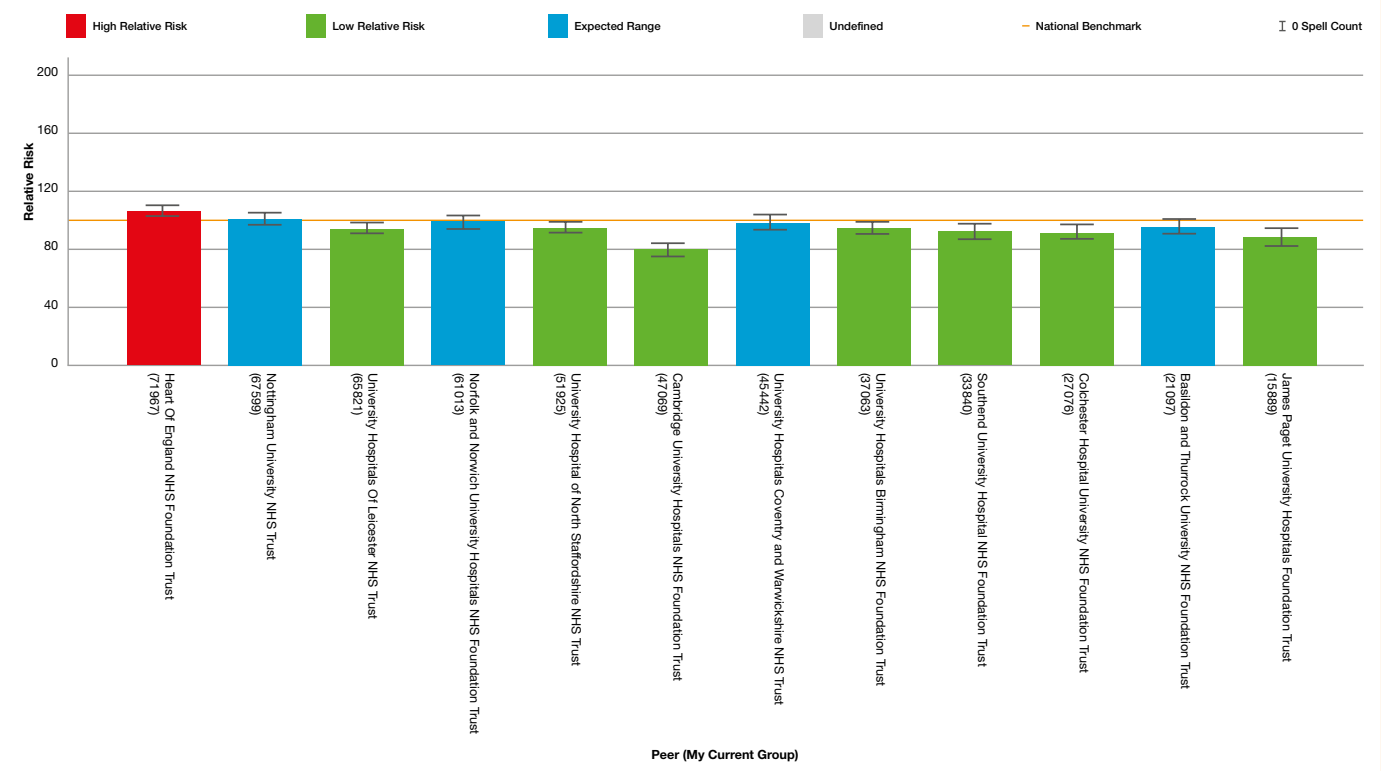
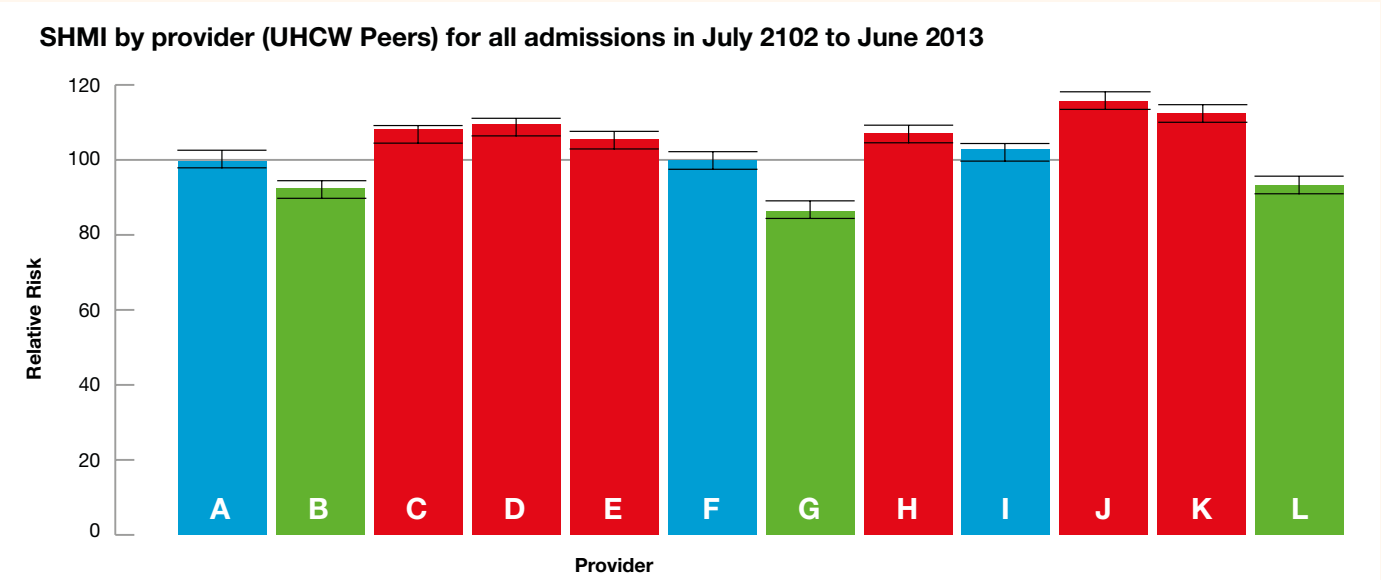


Figure 5 2013 HSMR peer comparison based on basket of 56 diagnoses – Source: Dr Foster Intelligence



PROVIDER		SHMI SPELLS	SHMI
A.	University Hospitals Coventry and Warwickshire	83567	98.67
B.	Nottingham University Hospitals NHS Trust	12015	91.69
C.	University Hospitals of Leicester NHS Trust	140149	107.06
D.	Heart of England NHS Foundation Trust	147312	108.55
E.	University Hospital of North Staffordshire NHS Trust	100351	104.58
F.	Norfolk and Norwich University Hospitals NHS Foundation Trust	87467	98.86
G.	Cambridge University Hospitals NHS Foundation Trust	71017	85.60
H.	University Hosputals Birmingham NHS Foundation Trust	58337	106.19
I.	Southen University Hospital NHS Foundation Trust	49302	101.90
J.	Colchester Hospital University NHS Foundation Trust	51348	114.61
K.	Basildon and Thurrock University Hospitals NHS Foundation Trust	50461	111.26
L.	James Paget University Hospitals NHS Foundation Trust	33688	92.34

Figure 6 UHCW Peer Comparison for SHMI July 2012–June 2013 – Source: Dr Foster Intelligence

Trustwide Mortality Review

Since the inception of the Trustwide Mortality Review (TWMR) process in July 2011 there has been continual promotion of the importance of reviewing mortality as a central aspect of monitoring patient safety.

It should be noted that the data for FY 2011-2012 is from July 2011 to Mar 2012. This accounts for the fewer deaths during that period. It should also be noted that the number of reviews to be completed has also increased. This is testament to the support this process receives from specialties and the work conducted by QaED in continuing to promote this process and provide support wherever necessary. Learning from mortality review is shared throughout the Trust by a mortality newsletter. This is produced on quarterly basis and contains data analysis, case learning and performance data.

	Completed Reviews	Total Deaths	Percentage Completed
FY 2011-2012	1206	1394	87%
FY 2012-2013	1563	1896	82%
FY 2013-2014	1466	1925	76%

2.3 Learning from Mortality Review

Mortality Review provides an excellent opportunity to retrospectively review cases and learn from them. Therefore allowing for actions to be taken to ensure the future care the Trust provides is of a world class standard.

Mortality Review	Key Actions and Learning
NCEPOD E Deaths	• Resuscitation status and ceilings of treatment should be considered for all inpatients especially those who are admitted with conditions carrying a substantial chance of death. • Fluid balance and cumulative fluid balance should be clearly documented and are important in deciding ongoing care. Ineffective fluid challenges should not be repeated beyond 2 litres. • The assessment of the severity of alcohol withdrawal by using the questionnaire recommended should be done when alcohol dependency is suspected. This should be done at the initially before starting the regime. Assessing the severity of alcohol withdrawal might be difficult in confused patients. Lesser dose of benzodiazepines must be used in frail elderly patients and in those with multiple co-morbidities.
Dr Foster Alert Investigations	• Good practice in treatment of UTI patients - Early aggressive treatment in many cases - Good decision making about ceiling of therapy in several patients, especially SPICT tool commended in the care on one patient - Good multi-specialty and multi-disciplinary input - especially from Speech and Language Therapy and physiotherapy - Good care from junior doctors - Regular senior involvement • The majority of patients with an Intracranial Injury were appropriately treated. There were two cases which had specific learning points. These have been disseminated. Furthermore the majority of patients were unfit for Neurosurgical intervention and were treated in a general medical setting, with Neurosurgical input. The following actions were agreed from this alert investigation: - Improve Care of the Elderly Advice. There are two CQUINs for Gerontology, Improving outcomes for elderly surgical patients and improving the assessment and care of frail elderly. - Improve identification and involvement of EOL/Palliative Care treatment for patients not suitable for surgical intervention. - Head Injury Pathway to be completed - Transfer protocol to be clarified

2.4 Changes in practice

During 2013/2014 there have been a number of changes to mortality review processes at UHCW. There has been a drive to improve the completion rates of both primary and secondary mortality reviews. There have been process changes to facilitate this. This had led to an increase in the completion rates of both types of review.

The new Dr Foster tool, Quality Investigator, has been adopted along with a new system for investigating all diagnosis and procedure group alerts.

There have been in depth investigations into the causes of changes in mortality rates which have led to changes concerned with palliative care coding, fostering of closer links with other aspects of the quality agenda (for example clinical audit, clinical risk) and further investigation into specific groups of patients.

Despite the number of changes in the past financial year there is always the need to revisit, revitalise and re-launch. Thus in the coming financial year the Trust is aiming to develop these key areas of mortality processes within the Trust:

- The development and implementation of key performance indicators for mortality
- Further development of the secondary mortality review process. With the particular drive towards making the process more accessible on Trust electronic systems.
- Greater use and analysis of mortality data. The purpose of this will be to use this data to drive changes within the organisation.
- Foster closer links with the other governance processes in the Trust, such as Clinical Risk, Clinical Audit and Complaints.

Section 3

3.1 Introduction to Clinical Guidance

Clinical Guidance reduces variations in practice and provide a focus for discussion among health professionals and patients. They enable professionals from different disciplines to come to an agreement about treatment and devise a quality framework, against which practice can be measured. Clinical Guidance can help commissioners and purchasers to make informed decisions and provide managers with a useful framework for assessing treatment costs.

3.2 Trust Clinical Guidelines

Clinical guidelines are systematically developed statements designed to help practitioners and patients decide on appropriate healthcare for specific clinical conditions and/or circumstances.

By using clinical guidelines that are developed using the best available research evidence they can improve:

- Quality of care
- Clinical outcomes
- Consistency of care
- Patient safety

eLibrary is the Trust's in-house electronic Records Management System for the management of Trust-wide clinical and non-clinical information which incorporates clinical guidelines. There are currently 916 clinical guidelines on the eLibrary system.

Status	Number
Current	752 (82%)
Expired	84 (9%)
Under review	80 (9%)
Total	916

The ultimate aim is to ensure the information held within the clinical guidelines directory is effective, up to date and standardised. To ensure this all clinical guidelines must meet specified criteria and are subject to a robust approval process prior to publication on the system.

Figure 7 shows the status of clinical guidelines on eLibrary as at 1/4/2014.

eLibrary activity for 2013-14

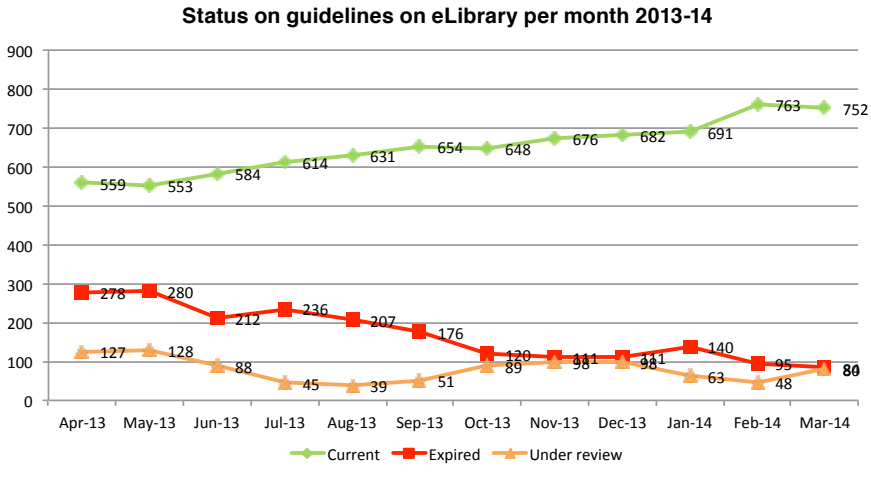


Figure 7

eLibrary clinical guidelines activity for period April 2013 – March 2014 (Figure 8) shows on average 11 new guidelines and 36 reviewed guidelines have been updated on eLibrary each month against an average of 17 that expired.

To encourage timely review of guidelines Quarterly Specialty Group reports are distributed to Clinical Directors, Modern Matrons and Group Managers, detailing the overall numbers and the status of guidelines within each Specialty.

Details of expired guidelines and those due to be reviewed are included in monthly Quality and Patient Safety (QPS) reports that are submitting at specialty Quality Improvement and Patient Safety Meeting (QIPS) meetings.

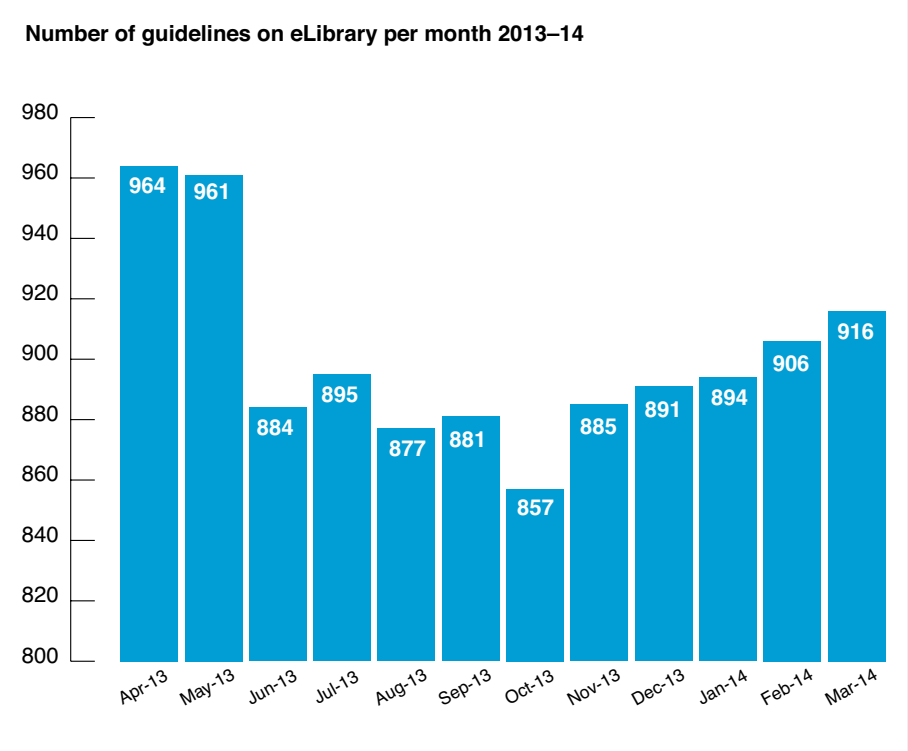


Figure 8

3.3 NICE Guidance

The National Institute for Health and Care Excellence (NICE) was established as a Special Health Authority in April 1999 to promote clinical excellence and effective use of resources within the NHS. NICE is an independent organisation which provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. Its recommendations are based on evidence of both clinical and cost effectiveness.

NICE currently produces seven types of guidance/standards,

- Technology appraisals (TAs)
- Clinical guidelines (CGs)
- Public Health Guidance (PHG)
- Interventional Procedures Guidance (IPGs)
- Quality Standards
- Medical Technologies Guidance (MTG)
- Diagnostics Guidance (DG)

Putting NICE guidance into practice benefits everyone – people who use health and social services and their carers, the public, NHS organisations, local authorities, health and social care professionals, and policy makers. It can help

organisations to meet the legal requirements of the NHS Constitution and Health and Social Care Act. NICE guidance and quality standards can also help UHCW meet regulatory requirements from organisations such as the Care Quality Commission.

Using NICE guidance may also help cut costs, while at the same time maintaining and improving services, by ensuring that the care provided is both clinically and cost effective.

Compliance with NICE guidance recorded on the NICE database

268 pieces of guidance have been issued since 2011 when the NICE database was developed to record implementation, with an overall compliance of 67% (Guidance that has been identified as not applicable to UHCW has been removed to calculate compliance rate).

Compliance for 2013-14

There were 99 piece of NICE guidance issued in the 2013-14 financial year. Figure 9 shows the compliance status for each type of guidance for this period. (6 pieces of guidance where issued in March 14 these have not been included in the figures as there is insufficient time for responses to be returned).

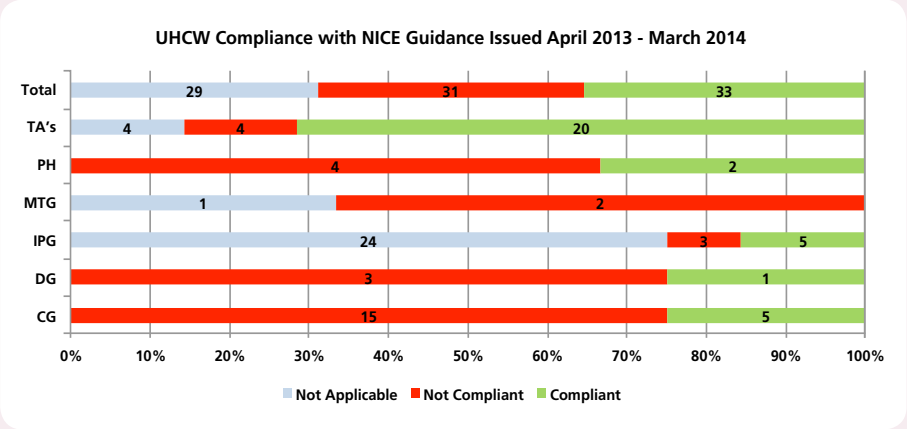


Figure 9

- 'compliant' guidance includes guidance where the Trust is fully compliant with all recommendations within the guidance and/or where a conscious decision has been taken not to implement some or all of the recommendations made and this has been recorded on the departmental risk register;
- guidance will be identified as 'not applicable' when the procedure or service is not provided by UHCW; and
- 'non compliant' includes guidance where no response has been received from clinicians with regard to the compliance status.

Technology Appraisals (TAs)

The DH select the technologies for appraisal by NICE. The technologies chosen will have a significant impact on patient health, health inequalities [and therefore government policy] or NHS resources. The process involves manufacturers, patient groups and professional organisations. It is a statutory duty for all Trusts to implement the recommendations made within technology appraisals within 90 days of issue.

UHCW formulary showing NICE TA compliance has been uploaded to the Trust Internet site (published on a public facing medium as required by the Strategic Health Authority). An Excel spreadsheet shows the formulary status of all medicines that have been reviewed as part of a NICE Technology Appraisal and includes a link to the NICE guideline.

3.4 Further Developments for 2014-15

During 2014 /15 the existing NICE Implementation Group (NIG) will be developed to incorporate the monitoring and reporting of local Trust clinical guidelines on eLibrary in addition to overseeing the implementation of NICE guidance within the Trust.

Two Consultants have been identified in the Trust as the new Chairs for the committee with one overseeing NICE and the other local Trust clinical guidelines. The committee will be re-branded to the Clinical Guidance Governance Group (CGGG) to reflect this change.

CGGG will oversee the development of the following key areas:

- Development and agreement of reports to incorporate monitoring of local Trust clinical guidelines on eLibrary,
- The development and implementation of key performance indicators for guidance,
- Oversee the development of eLibrary with the aim to result a more user friendly system for storing and monitoring local Trust Clinical Guidelines, and
- Development and implementation of the NICE TA Pathway to improve Trust compliance with implementing Technology Appraisals within the 90 day deadline.

University Hospital
Clifford Bridge Road
Coventry CV2 2DX

Hospital of St Cross
Barby Road
Rugby CV22 5PX

www.uhcw.nhs.uk
024 76964000

For further information on Clinical Audit please contact the Quality and Effectiveness Department at clinicalaudit@uhcw.nhs.uk or 02476 968282

'If you need this information in another language or format, we will do our best to meet your need. Please contact the Health Information Centre on 024 76966051