HQIP Healthcare Quality Improvement Partnership

Improving care through national audit

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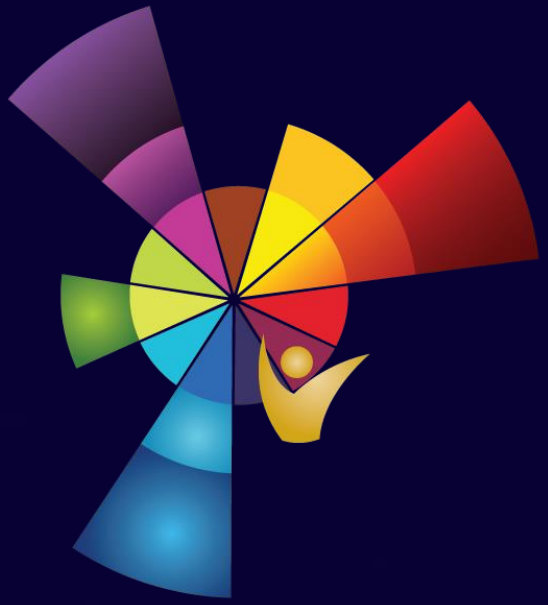
Director of Operations
Quality Improvement and Development



Sharing the Learning

How to get improvement and assurance from NCA participation

King's College Hospital NHS
NHS Foundation Trust

- Framework for NCA
  - participation
  - reporting / findings
  - action planning
  - monitoring improvement

Participation

- Identify
  - HQIP QA web page
- Allocate
  - MD /Assistant MD notifies divisional management of relevant NCAs
  - Clinical Audit Lead keeps the division informed of key requirements and dates

Divisional Quality Governance Leads

- Each NCA has a designated audit lead (senior clinician) responsible for coordinating participation, ensuring data quality, reviewing the audit report and driving improvement.
- Registration is completed and data submitted in line with the deadlines set by the audit supplier.
- Any issues that may result in non-participation are addressed within the Division.
- Any issues that may result in non-participation that cannot be resolved within the Division are immediately escalated to the CE Committee.

Reporting

- Trust level mortality data is presented at the Mortality Monitoring Committee
- All NCAs are subject to review with the aim of identifying any areas in which clinical and/or process improvements can be made, and taking action to address these.
- The Clinical Effectiveness Department produces an executive summary for each NCA report published.
  - Executive summary
  - Headline data slide

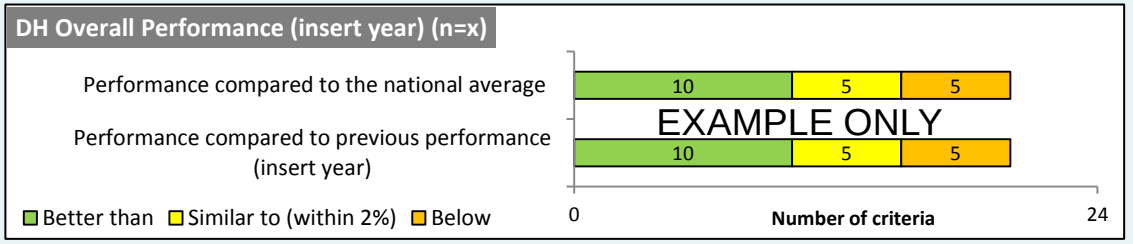
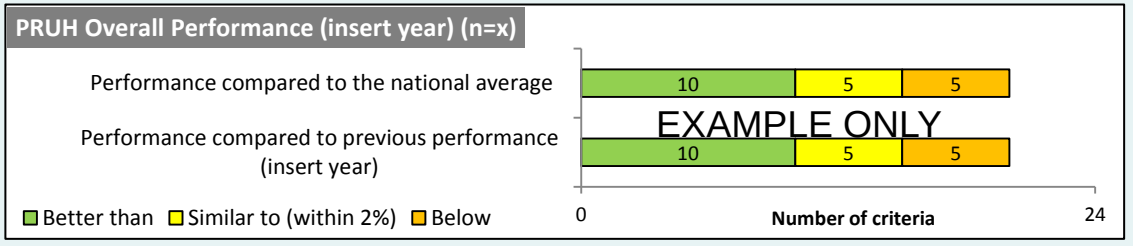
Reporting

- Executive summary & headline data to the CEC within 4 – 6 weeks of publication

This enables the Committee to:

- Have sight of the data at the earliest opportunity.
- Query areas of low compliance.
- Identify areas that require immediate attention.
- Review actions already agreed and suggest additional actions, as required.
- Request further feedback from the Division

[Insert title], published [insert date] (1/3)

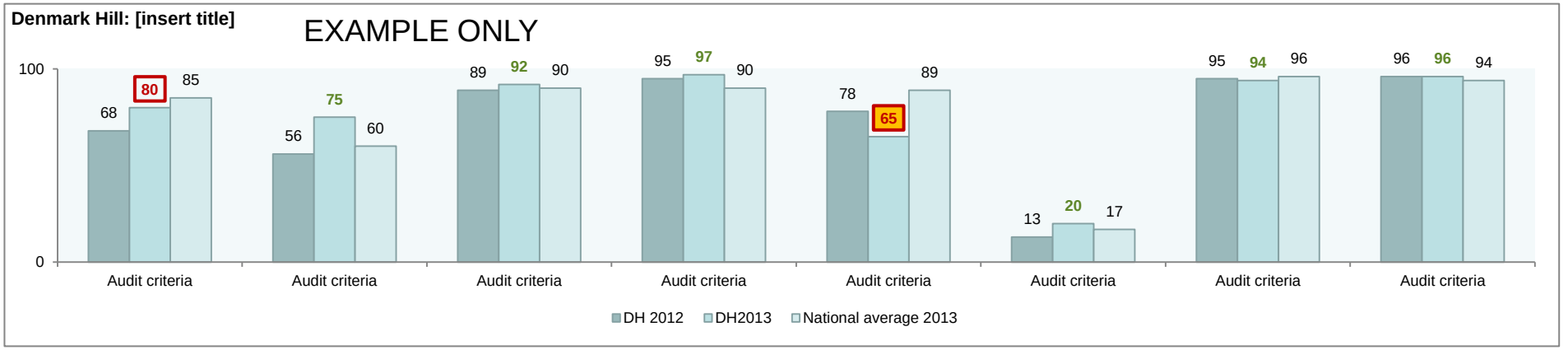
National Audit	Headline results and actions taken	DH rating	PRUH rating
Insert title **Published:** month year **Audit Period:** dd/mm/yy - dd/mm/yy **Sample Size:** • **DH:** xx% (xx patients) • **PRUH:** xx% (xx patients)	For audit specific examples please see the King's Quality Account 2013/14. **Headline** – particular piece of good news e.g. King's ranked joint highest nationally/ King's ranked within the top 5 performing Trusts nationally/ mortality at King's is below expected and is comparable to Trusts with a similar casemix/ more trauma patients admitted to [insert site] are surviving compared to the number expected based on the severity of their injury. • A trust-wide action plan is in development to support further improvement. • A detailed action plan has been implemented at [site] to improve xxxxx. This includes the implementation/ development/provision of x, y and z. • A [site] action plan is currently in development.   		

Required by:	NHS Standard Contract and/or Monitor
Audit lead(s):	Insert title, name, job title, hospital site.

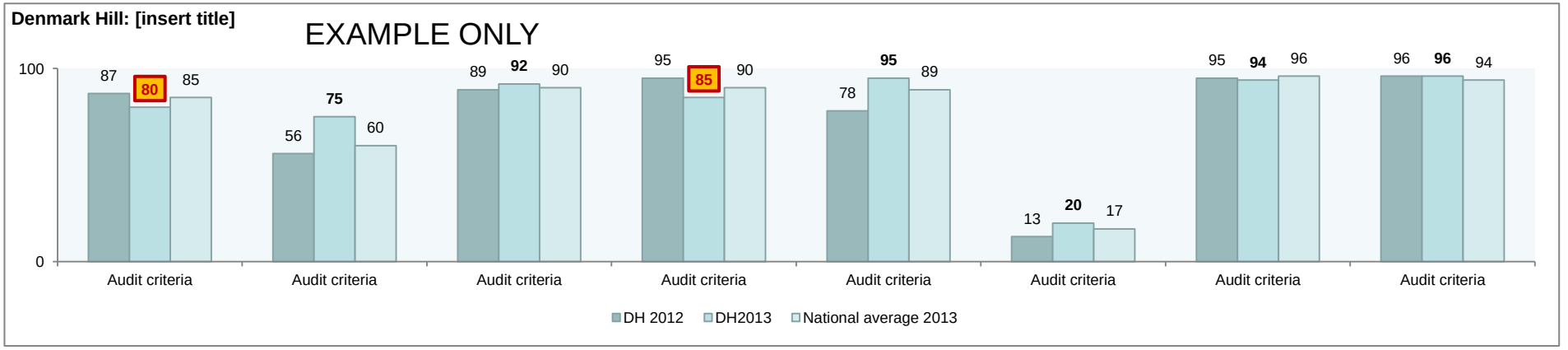
[Insert title], published [insert date] (2/3)

KEY	Below the national average by more than 2%	Performance below previous by more than 2%

Denmark Hill: [insert title]



Denmark Hill: [insert title]



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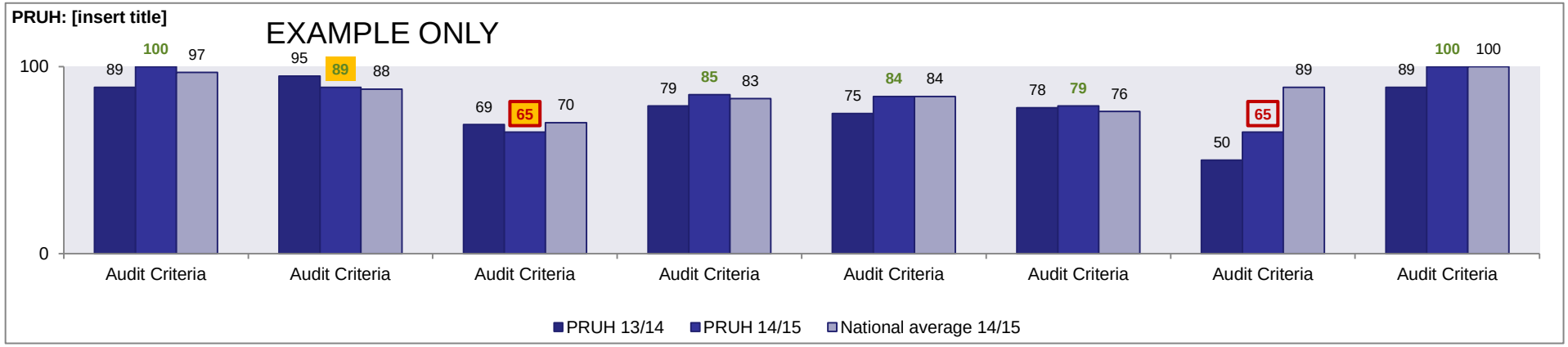
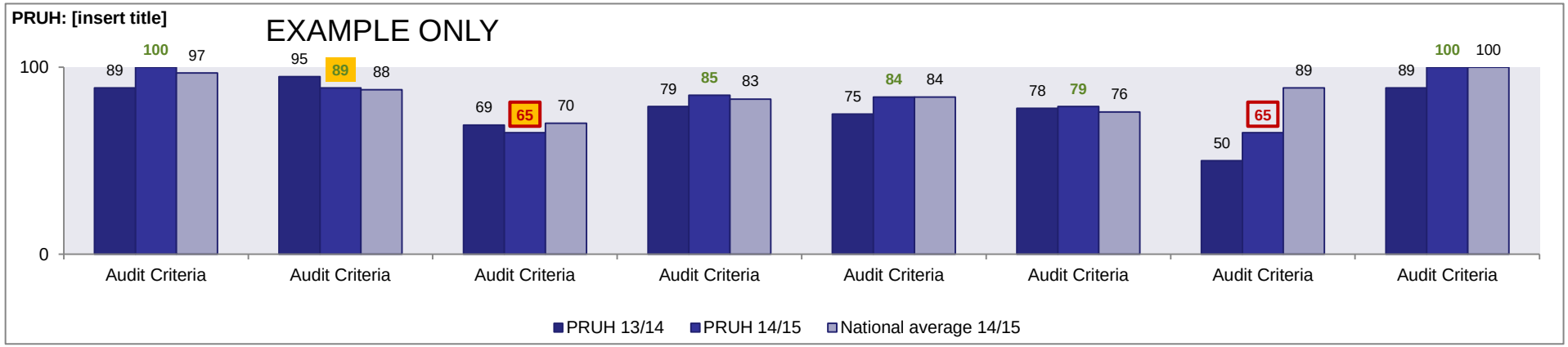
KEY	Below the national average by more than 2%	Performance below previous by more than 2%





Trust Level Reporting

The NCA headline results and key actions are reported to the:

- Patient Outcomes Committee
- Quality and Governance Committee
- Board of Directors
- Commissioners

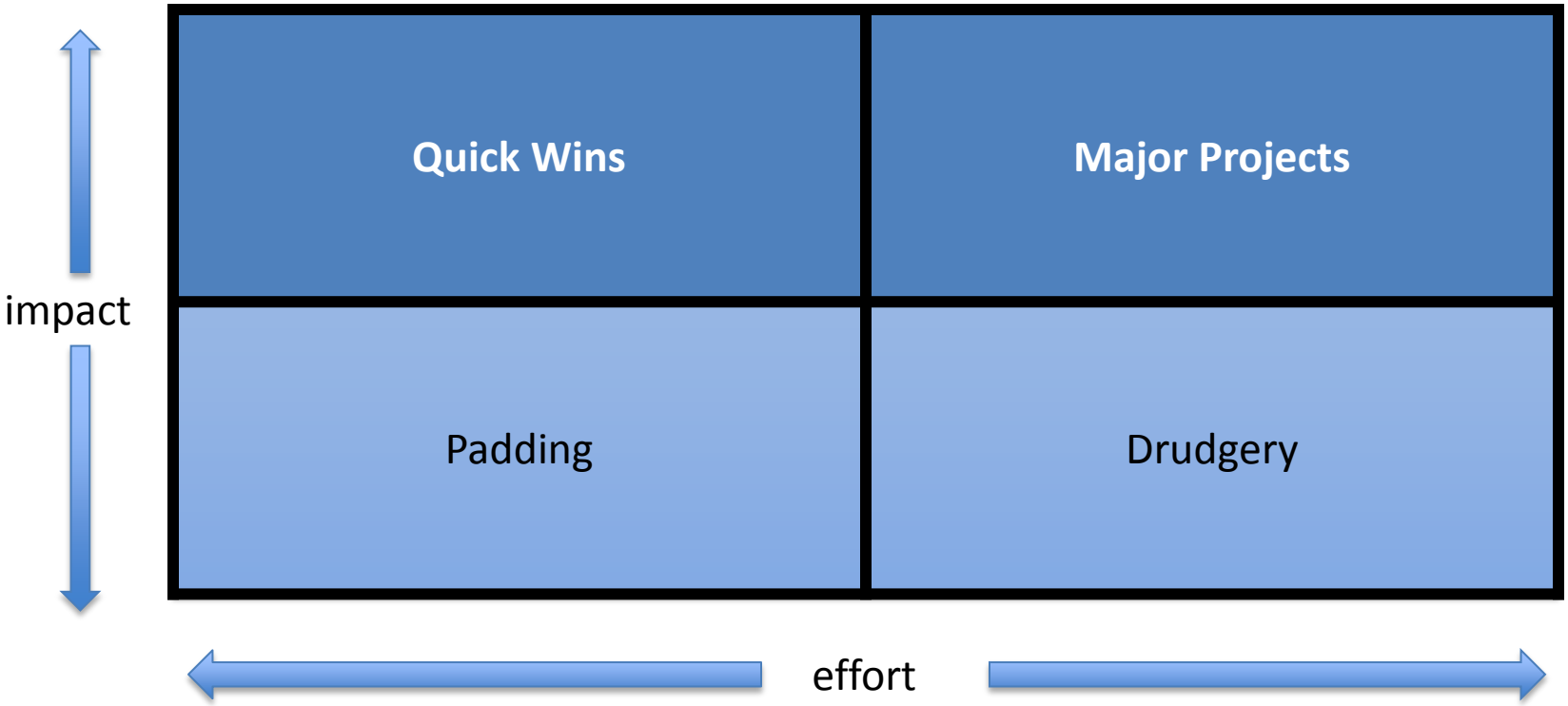
Action Planning

- Developed by clinical audit lead, or other senior clinician delegated by the Division/specialty, in conjunction with all relevant stakeholders
- Monitored by Divisional Quality Governance Committee
- Reviewed by relevant trust level committee
- Escalation – Patient Outcomes Committee

CAST (Commercial Aviation Safety Team) model

- Complicated action plan with multiple options for improvement - Prioritise actions
- Using a seven point scale actions are rated on two aspects –
  - how effective will the action be?
  - how strongly do staff believe the action can be implemented in their work setting?
- The scores are multiplied (so the highest possible rating is 49) and the actions with the highest score get priority for implementation.

Action Priority Matrix



Medical and Surgical Clinical Outcome Review Programme

- Current supplier; NCEPOD (National Confidential Enquiry into Patient Outcome & Death)
- Critical examination by appropriate specialists of medical and surgical clinical topic areas, using anonymised case note review methodology
- Quality of care, organisational features
- Recommendations
- Local audit toolkits to help support local action planning
- Local reporters, audit staff & clinicians in every Trust are critical to success
- http://www.ncepod.org.uk/2014tc.htm

Measuring the Units

Southport & Ormskirk Hospital NHS Trust
providing safe, clean and friendly care

An audit of alcohol documentation in patients

Recommendations

All patients presenting to hospital services should be screened for alcohol misuse. An alcohol history indicating the number of units drunk weekly drinking pattern, recent drinking behaviour, indicators of dependence and risk of withdrawal should be documented

Within Southport and Ormskirk Hospitals NHS Trust all patients should have a screening tool completed asking patients about alcohol consumption

All patients presenting to acute services with a history of potentially harmful drinking should be referred to alcohol support services for a comprehensive physical and mental assessment. The referral outcomes should be documented in the patient case notes.

Within Southport and Ormskirk Hospitals NHS Trust patients who score over 7 should be referred to the alcohol liaison specialist nurse who will undertake a Severity of Alcohol dependency Questionnaire.

Results & Action Plan

Patients having alcohol screening

- A&E: 44% to 74%
- Inpatients: 86% to 93%

No of patients scoring over 7 using screening tool

- 10 to 34

No of patients referred to alcohol liaison specialist

- 7 to 28

Overall improvements

- Training for all ward and A&E staff
- Champions on wards and in A&E
- Posters
- ''Its everyones role''

Poster submitted by; A.Owens, M.Smith, N.Taylor, K.Wooldridge, R.Burrows, K.McCall, B.McDaid

A Time to Intervene?

Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

An audit/case note review of cardiac arrests on a cardio-respiratory unit

Key issues

- Failure to recognise deteriorating patients
- Failure to involve senior clinicians
- Failure to make prompt and appropriate DNAR

Findings

- **Senior Review**; Average time from last senior review to arrest was 29 hours (4-67) 39% had no senior review in preceding 24 hours
- **Response to abnormal observations**; 50% of patients had MEWS of 3 or more prior to arrest of which 45% were not escalated appropriately
- **DNAR**: 54% of patients that arrested CPR was deemed inappropriate on Case note review in view of patients pre morbid state

Actions

- Introduction of a ward round checklist including a prompt to regularly review ceilings of care
- Introduction of monthly mortality review meetings in which all patients who have died are discussed with particular focus on ceilings of care and end of life decisions
- Introduction of w-end respiratory consultant reviews
- Run chart; Pre action plan 2-6 arrests, post 0-2

Poster submitted by C.Hayton, L.Smith, E.Barthorpe, K.Chalten, J.Derricott, K.Haslam, A.Ashish

Questions/Comments?