South and East London Clinical Audit and Improvement Network

Date	27th June 2017	Location	Emily MacManus Room, Counting House, Guys Hospital
Start time	Finish time		
13:30	16:00		

In Attendance		Trust/Title
Andy Cantrell (Acting chair)	AC	Quality Improvement and Patient Safety Manager, GSTT
Carol Kibble (co-chair)	CK	Clinical Audit Facilitator, Moorfields Eye Hospital
Philip Thompson (co-chair)	PT	Quality Assurance Manager & QI Coach, East London NHS FT
Annette Fogarty	AF	Senior QIPS Manager, GSTT
Bieta Diop	BD	Senior Audit Facilitator, OXLEAS
Elaine Hayden	EH	Clinical Audit and Database Facilitator, Moorfields
Emily Cannon	EC	Interim Clinical Audit Manager, London Ambulance Service
James Thornton	JT	Communications Manager, HQIP
Janarthani Gnanendran	JG	Quality Improvement and Patient Safety Coordinator, GSTT
Kathryn Chapman	KC	Clinical Effectiveness Administrator, Lewisham and Greenwich NHS Trust
Mike Patel	MP	Clinical Audit Facilitator, NHS Blood & Transplant
Philip Twells	PhT	Senior Clinical Effectiveness Coordinator, South West London & St George's Mental Health NHS Trust
Rachael Williams (minutes)	RW	Quality Improvement and Patient Safety Coordinator, GSTT
Ryan Lord	RL	Senior Audit Facilitator, OXLEAS
Sylvia Tan	ST	Clinical Audit Officer, Royal Marsden

Apologies	Trust/Title
Emma-Kate Chawishly	Senior Clinical Audit Facilitator, NHS BT
Karamjeet Chana	Governance Facilitator, East London NHS FT
Kate Hutt	Clinical Effectiveness and Audit Manager, St George's University hospitals NHS FT

Minutes	Action
Welcome AC welcomed everyone to the meeting and introductions were made. The distribution list was updated. AC advised that this is the first meeting post Ann with Andy, Philip and Carol as co-chairs. AC advised that we have a speaker from HQIP and also a presentation on mortality and how this affects Trusts **Apologies** Apologies were noted.	

Minutes Minutes were agreed from the last meeting, which took place at Guys Hospital, 2nd February 2017. **Matters Arising and discussion**: AC invited agenda items for forthcoming meetings: • Talk from NICE and measuring quality standards • ST mentioned methodology that behaviour change is important for audits - engagement and getting people involved was stressed as a focus for improving the clinical audit system. • Discussed the need to engage with clinicians more and in regards to report writing. • AC mentioned the emerging school of Resilience in healthcare. • Completing action plans from national audits. Challenges around lack of specificity and adapting broad recommendations into local action. • Engaging clinicians on action plans and ensuring they are effectively addressed. • Clarification of different criteria and common terminology. • Implementation of change • Combined meetings and joint network events • Increase learning from each other to improve systems. • RL described audit training at Oxleas including jelly baby audit exercise and sharing of audit training ***Action:*** **RL to circulate information on jelly baby training** ***Action:*** **Members to bring any items of interest on their training programmes to next meeting.** • In regards to shared learning o Health innovation network – an academic and healthcare collaboration within South London that involves networking for improving systems for patient safety and experience. AC advised that we need to put out the feelers around Quality Improvement and get them involved in the group. AC advised that there are other networks and that we don't talk to each other.	**RL** **All**
Feedback from NQICAN – Andy Cantrell The NQICAN met on 9th March and 5th June 2017 (minutes awaited) and unfortunately we were missed off the list for the June meeting. AC provided feedback from the March meeting: • Formic and SNAP, a provider of surveys software, have offered to build an online networking portal and will work with the NQICAN to produce and support an online sharing and communication portal: o Discussed potential content: audit tools, sampling and discussion forums. o It will be free and support in the long term will depend on how many use	

it. ○ Noted limited uptake following previous attempts by the National Clinical Audit Forum and the Clinical Audit Support Centre. ○ NQICAN agreed support in principle and a working group to be established (Anne Jones circulated request for members 31/03/17) SELCAIN members were broadly supportive of the proposal. • In summer 2016 a Freedom of Information Requests had been sent to all Trusts requesting information on clinical audit. The requester was investigating effectiveness of clinical audits and attended NQICAN to discuss his findings: ○ Average 7.5% improvement from audits ○ Average 6% audits showed absolute improvement (all standards) ○ Some deterioration for around a quarter of criteria ○ Action plan improvement around 9% so questions if audit worth it. ○ Alternative methods of quality improvement was felt not to be effective ○ The author has his own website and he has been invited to recirculate the report once it has been completed ○ NQICAN challenged the methodological rigour, noted that some criteria are more important than others in an audit (compromising the implication around effectiveness) and that the study could have been more effective with an open approach. AC noted the results were broadly similar to the Cochrane reviews of clinical audit and effectiveness. ***Action*: AC circulate FOI investigation findings and Cochrane reviews** • NHS England update: ○ New guidance on outliers for the NCAPOP programme to be released shortly ○ National Data Guardian review- opt-out system for the use of patient identifiable data in audits ▪ Substantial time and energy requirements ▪ Potential to skew data as certain groups of people may be more likely to participate/opt-out than others ▪ Would be difficult with safeguarding where many patients will opt out EC mentioned that the ambulance service already include details on their paperwork for patients to opt out and have never had patients calling to actually do so. Discussed potential use of tools that automatically anonymise/pseudonymous patient data such as CRIS. AC said that this system is currently being used by Research and is an option but was not user friendly, although this may have changed. ○ Trusts expected to pay £3500 plus VAT per site towards IBD registry.	**AC**

Trusts may need to pay to participate in national audits outside of the NCAPOP programme but not all of them are obligatory.

- Trusts already paying £10,000 for NCAPOP audits

- 7 day service audit
  - Further data will be collected for this later in the year (October) Trying to use data already out there as labour intensive. Very fast 2 week turnaround

- HQIP National audit benchmarking project (JT presented under agenda) to be published on HQIP website

Update from HQIP – James Thornton

- NCAPOP six month publication schedule and HQIP clinical audit and QI tools: A guide to HQIP resources booklet distributed at meeting.

- Discussed National Audit benchmarking
  - To be published on HQIP site in July/August 2017
  - Snapshot of how data will be presented was displayed which showed the NCACPOP audits for each Trust and compliance for each audit as a dashboard.
  - Dashboard format showing expected range and outliers
- Latest resource publications highlighted
- Discussed changes to clinical service accreditations, HQIP role and how they are they are managing them.
- Changes to release date of NCAPOP publications – to be released second Thursday of every month
- The Medical Director of each Trust has been given access for their Trust to check information. The audit can show for the hospital but also drill down to ward/department.
- There will be 2 further tranches around November/December.
- The CQC ad commissioners will review data and it will also be available in the public domain.
- They have received positive feedback so far and have had a few small tweaks

Update around the CQC is that they will be inspecting Trusts annually ad they will have pre-inspection packs to make the process easier. This will involve data collection, reporting and inspection.

JT advised that he needs feedback on the information governance guide he has been working on. Good feedback received so far. A question was asked around using patient records without consent and JC advised this was certainly covered but he would get back to us

JT advised that the clinical services accreditation has now moved to HQIP and

will be getting other projects involved. These will be used as part of the CQC inspection and is still being rolled out. JC felt that this would be live by the end of July 2017. Trusts would be expected to participate in relevant accreditation which would reduce the need for inspection as they would use existing data. 6 guides cover self-assessment different models. JT added that they have a monthly publication schedule and lists of these were handed out to the group. NHS England had asked them to do this which has its pros and cons. It is used to benchmark and can drill down to speciality and consultant level. Stage 2 will start once it has been officially launched with the consultation. The public will be able to benchmark across Trusts and similar to NHS choices. These represent audits in NCAPOP so some Trusts may be under represented. The number of mental health audits will be increasing. AC asked if JT was aware of anyone who could provide training on action planning. JT said he would get back to us ***Action:*** **Circulate presentation slides.** ***Action:*** **JC to get back to chair around consent issue raised and also on training for action planning**	**AC**
Mortality and Structured Judgement review – Annette Fogarty AF explained the background of the mortality review requirement was around a CQC publication ad was around patients who died in 2013. NHS England asked the CQC to review. The review is around how Trusts learn from deaths and often resulted in poor investigations, concerns not taken into consideration, no streamline process, no prioritisation process of deceased patients, involving other organisations and having a good SI process. From the review the CQC recommended a streamline process with prioritisation from 1st April 2017 that all deaths are recorded, reviewed and that learning has taken place. • Mortality Structured Judgement review forms and the procedure used at Guy's and St. Thomas' (GSTT) presented and explained • Streamlined approach using Datix module. AF advised that there is a mortality review form, which was created by the Royal College of Physicians and is 9 pages long. AF advised that they have manged to get the form down to 2 pages. The form is called a structured judgment review and judges on avoidance and overall care. As well as patient details the form includes admission and date of death, patients with a disability or mental illness, they have also added homeless patients as vulnerable patients which was not a CQC recommendation. Summary of details of the patient's death, aspect of care ad if there is anything that indicates it should go down the SI route. There should be root cause analysis ad if anything could have been done differently. Information on the coroner, bereavement for the family, cause of death if they had an inquest. The second page of the form	

automatically comes up if any cause for concern is ticked goes on to discuss the mortality meeting date, actions take, lessons learnt. There is a meeting every month with action plans which is chaired by the MD. If care is either very poor or poor this will activate the SI route. This will look into if it was avoidable, lessons learnt and actions take. AF advised that 195 deaths 10% of deaths should go onto a form 2 and was a recommendation from the CQC. Trust have until Qtr. 2 September 2017 for their policy to be in place and processes around learning around patients deaths. At the moment this is inpatient deaths but will include patients who have died up to 30 days after discharge and will include community patients. This will mean working more with other Trusts. Trusts are expected to have their processes in place by Qtr. 3 December 2017. Family should be involved in the process and ensure concerns are viewed. Trust has a bereavement office where death certificates are issued. Central group for mortality, action plans with an action log. Patient safety team challenges and issues extracts of learning • Mortality Structured Judgement review forms and the procedure used at Guy's and St. Thomas' (GSTT) presented and explained • Streamlined approach using Datix module. Focus is currently on inpatient deaths. Discussed difficulties around deaths 30 days from discharge and applicability to different Trusts. There were common queries around Severe Mental Illness criteria and Learning Disabilities thresholds. ***Action:*** **Circulate presentation slides.**	**AC**
Round Table Discussion • Oxleas have plans for a new quality improvement team. Their clinical audit system has moved from a spreadsheet to being managed on Datix using the safety alerts module. It was suggested that using Datix may be economical where Trusts have paid for the license anyway. Although it is not currently linked to the other modules the potential is there to link audits with risks, incidents, complaints etc. The system will monitor audits overdue, outstanding action plans as well as viewing the volume of work. They entered last year's audits onto it and relabelled as audit with all audits now in one place • Recent CQC inspection at Lewisham and Greenwich NHS Trust. First draft report awaited and action plan anticipated. There was a huge emphasis on national audit and action plans. It was reported that these are often hard to get back. Discussions are taking place for a tracking system to address this. CQC also queried whether they RAG rate NICE recommendations. At least two of the	

organisations present currently do this. One option is to use impact x likelihood/frequency model. • Guy's and St. Thomas current focuses include mortality and shared learning. AC reported that they have separate QI team, Assurance team, transformation team, nursing directorate covering QI work and all need to be working together. Junior doctors are encouraged to complete QI projects as lack of reauditing and lower numbers of one offs. • Royal Marsden are holding a clinical audit competition internally with 3 prizes to encourage and promote clinical audit. • LAS had a recent CQC inspection and a main outcome was to clarify governance structures. They also mentioned RAG rating for minimum improvement and also where they report to. • Moorfields Eye Hospital has adopted the audit module of Ulysses which already collects data on incidents and complaints and has appointed a database facilitator to manage the system. • East London NHS FT has implemented a CQC readiness system with self - assessments. Regular team inspections will ensure the Trust is ready for CQC inspection and remove the panic of CQC • Blood and Transplant - Have had challenges with using 2013 Microsoft software which is no longer supported • South West London and St George's Mental Health NHS Trust - had a recent CQC inspection. They have also changed from having borough based directorates to a service line system for more consistency. The Trust has also purchased the audit module from Ulysses to help standardise the process. They are also looking at how best to set up a system for reviewing NICE guidelines and standards.	
AOB – none	
Date of next meeting: Agreed to have one meeting every 3 months including a joint meeting with North London Clinical Audit Network. Date of next meeting to be confirmed.	