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Southport & Ormskirk Hospital NHS Trust

Clinical Audit Annual Report
1st April 2015 – 31st March 2016

Janette Mills
Head of Audit and Effectiveness

Date: May 2016

Clinical Audit Annual Report

Introduction

Welcome to the Clinical Audit Annual Report which aims to report the work undertaken by everybody in Southport and Ormskirk Hospital NHS Trust towards supporting and completing the Clinical Audit Programme set out in 2015 / 2016.

We would like to take this opportunity to record our many thanks to the clinical audit and effectiveness department staff for their hard work during the period. Chrissy Guizzetti left the team in July 2015 to enjoy her retirement and Carla Howgate left in December 2015 to work for the HSCIC.

Once again we have had a busy year supporting the Trust in delivering its quality agenda.

Janette Mills (BSc, BSc hons, MA)
Head of Audit and Effectiveness

Definition of Clinical Audit and Effectiveness

Clinical Audit is defined as:

"A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change"

(Principles of Best Practice in Clinical Audit NICE 2002)

Clinical Effectiveness includes the provision of care in accordance with high quality evidence-based clinical guidelines. The evaluation of practice through the use of Clinical Audit or outcome measures can lead to further improvement in quality of care.

Role of the Clinical Audit and Effectiveness Department

The Clinical Audit and Effectiveness Department forms part of the Integrated Governance and Quality Business Unit which is accountable to the Director of Nursing and Quality. The overall purpose of the Department is to provide support to the Clinical Business Units to monitor the quality of care provided to patients and the resulting outcomes through Clinical Audit and Effectiveness Projects. Current Responsibilities of the team are:

- Facilitating all Audit Projects on the Clinical Audit Forward Plan across both sites including casenote pulling, guidance, information requests.
- Undertaking and supporting NHSLA acute and CNST maternity audits, pulling casenotes, developing proforma, requesting information, coordinating data extraction, data entry, data analysis, report and presentation.
- Facilitating NICE guidelines (see Clin Corp 58 for more details)
- Facilitating Confidential Enquiries (see Clin Corp 58 for more details)
- Facilitating all National Audits
- Facilitating National Patient Surveys
- Updating and Monitoring Effectiveness Projects for each Clinical Business Unit
- Facilitating audit meetings, i.e. taking minutes etc
- Advancing Quality lead for organisation

Review of Objectives set for 2015 / 2016

	Completion Date
The Trust has introduced a priority system for clinical audit projects as outlined by HQIP. The clinical audit officers will need to work closer with the speciality audit leads when developing the forward plan and agreeing adhoc projects. The Head of Audit and Effectiveness will sign off all audit project proposal forms in conjunction with the research and development manager. Before signing off the projects each proposal form must have a priority level documented and the agreement of the supporting audit officer to proceed with the project.	September 2015
The clinical audit policy already contains a priority scoring framework based on the HQIP document. 2015 / 2016 is the first year the framework was taken to each business unit's governance meeting for completion when agreeing the clinic audit forward plan for the year. The clinical audit team need to continue to use the priority levels for projects and discuss with the speciality clinical audit leads.	September 2015
The Trust has a clinical effectiveness strategy which is due to be re-written in 2015. The Trust quality strategy is also being reviewed and the suggestion would be to include a strategy for clinical audit within the Trust overall quality strategy as clinical audit should not sit alone.	October 2015
Consider introducing a clinical audit committee.	October 2015
Investigate possibility of having clinical audit included in the Trust induction process.	October 2015
Revise the Clinical Audit Policy to include the top level responsibility as that of the CEO and indicate clearer reporting lines within the governance arrangements.	October 2015
Review the clinical audit project final report and update in the clinical audit policy, to include a methodology section.	September 2015

Clinical Audit Forward Plan

The department follows a schedule for audit each year, the clinical specialities in conjunction with the audit department formulate a Clinical Audit Forward Plan for the following year. This is based on national priorities from NICE, NSF's, Confidential Enquiries, NHSLA, CNST, NPSA, National Audits, other speciality clinical priorities are discussed and added to the Clinical Audit Forward Plan.

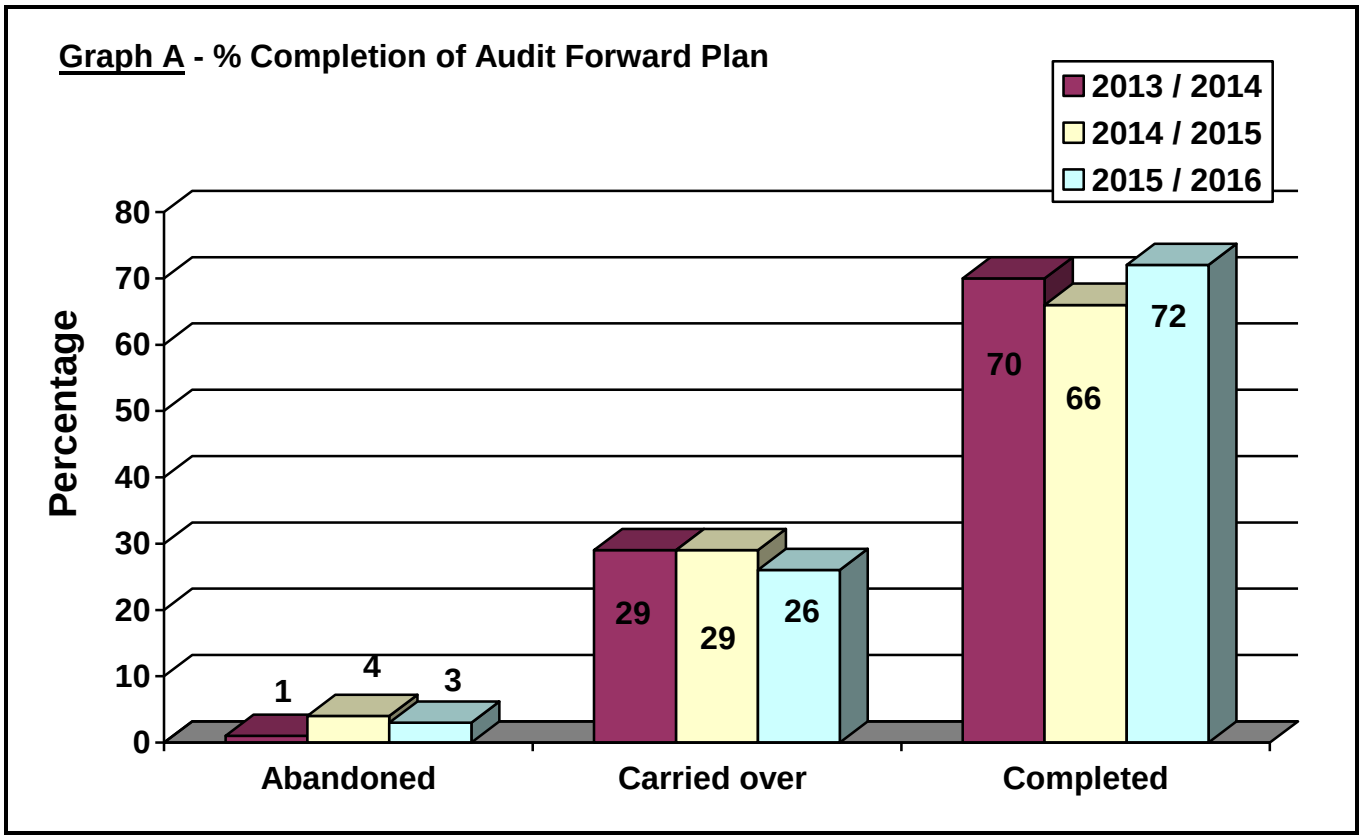
The Plan is agreed at the Trust Quality & Safety Committee in April of each year and then monitored on a Dashboard monthly to highlight progress against each audit.

The clinical audit forward plan also recorded patient experience activity in 2015 / 2016 to ensure the work is recorded and reported to the patient experience group. The patient experience projects are reported separately from clinical audit projects.

Table 1 below illustrates completion of the forward plan with 251 (72%) clinical audit projects on the forward plan being completed. (excluding patient experience projects)

Table 1

Business Unit	2014 – 2015 Number of audit projects on forward plan	2014 – 2015 % of audit projects completed	2015 – 2016 Number of projects on forward plan	2015 – 2016 % of audit projects completed
Community and Continued Care	58	48%	44	77%
Integrated Governance & Nursing	39	82%	20	95%
Planned Care	122	66%	113	66%
Medical Directors	47	60%	28	64%
Urgent Care	84	71%	69	67%
Women's and children	83	70%	76	78%
Total	**433**	**287 (66%)**	**350**	**251 (72%)**



Patient Experience Questionnaires

36 patient experience questionnaires were registered with the audit department.

Table 2

Business Unit	2015 – 2016 Number of patient experience projects on forward plan
Community and Continued Care	21
Planned Care	7
Service Improvement and Support	1
Urgent Care	4
Women's and children	3
Total	**36**

Audit Meetings

During 2015 / 2016 each speciality organised meetings to present the results of clinical audit findings and discuss action plans.

Table 3 illustrates the number of meetings undertaken in each specialty

Table 3

Speciality	Number of audit meetings held during 2013 - 2014	Number of audit meetings held during 2014 - 2015	Number of audit meetings held during 2015 - 2016
General Surgery	6	6	6
Community and continuing care	6	4	6
A&E / MDT Trauma Audit Group	3	4	4
General Medicine	2 (3 scheduled but one cancelled)	3	3
Paediatrics	2	4	3
Ophthalmology	5	5	5
Obs & Gynae	5	3 (+ 2 teaching sessions)	8
Radiology	4	4	4
Sexual Health	5	5	3
Spinal Unit	4	4	3
Anaesthetics	9	9	10
Urology	6	6	6
Orthopaedics	6	6	6

Projects no longer required

Planned Care	Spinal Unit	Orthotics
Planned Care	Radiology	Re-audit of Percutaneous ultrasound guided neck and thyroid FNA (carried over)
Planned Care	General Surgery	Audit of VTE prophylaxis of surgical/ urological patients in 15a/15b
Planned Care	general surgery	Discover: Auditing surgical complications in the overweight
Planned Care	Orthopaedics	Re- Audit of #NOF nailing
Planned Care	Radiology	Lumbar spine magnetic resonance imaging for chronic lower back (carried over)
Planned Care	Orthopaedics	An audit to improve the accuracy of clinical coding in Orthopaedic upper limb surgery
Planned Care	Max Facial	Retrospective audit on surgical excision rates and waiting times for skin cancer patients at ODGH Maxillofacial Unit
Urgent Care	General Medicine	Use of ambulatory care on medical wards
Urgent Care	CCU	Out of hours Internal transfer from CCU
Community & Continued Care	EOL	Discharge information sent to DN's re EoL care (carried over)

Objectives for 2016 / 2017

Increase the number of projects measuring compliance against NICE guidelines
Develop a method for reporting national audit compliance to the Trust Board and relevant governance committees.
Review the structure of the audit team in conjunction with a review of the integrated governance team
Implement any changes required as a result of the CQC inspection report due for publication in Summer of 2016.

Involvement in National Clinical Audit Projects

The Trust has participated in all the mandatory national clinical audit projects as stated in the HQIP quality accounts list.

Listed below are highlights from our participation in the national projects.

National Emergency Laparotomy Audit (NELA)

As part of the data analysis being performed for the second NELA Patient Report they compared how the various participating hospitals are performing on key patient process measures as well as the quality of the data being submitted.

We are delighted that The Trust has been identified as one of the most improved sites in these measures, with Southport District General Hospital appearing in the top five most improved sites for the following:

- Preoperative Risk Documentation

Our project leads Mr Ainsworth and Dr Hammond have introduced a laparotomy pathway which is now compulsory to complete at the point of booking a laparotomy in the theatre complex. Part of the data to complete for the single sheet laparotomy booking form is a section for P-POSSUM with the necessary requirements of surgical and anaesthetic staff being clearly stated on the form. More importantly there has been overall acceptance of data entry directly onto the website and the highlighted areas have included P POSSUM.

National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis

The Trust was identified as an outlier for this project due to our low patient submission rates and as a result our Trust was not included in the first report for this national audit project. To resolve this issue an early arthritis clinic was established to increase the number of patients.

National Inpatient Diabetes Audit

The results for this audit were published in March 2016. There are a number of areas where the Trust is an outlier compared to national practice and will require improvement. An action plan has been developed for improvement.

	Trust	National
Average diabetes specialist nursing hours per week per patient 2015	1.38	1.58
Average dietitian hours per week per patient 2015	1.39	0.47
Average podiatrist hours per week per patient 2015	0.14	0.51
Average diabetes specialist pharmacist hours per week per patient 2015	0.28	0.04
Received a foot risk assessment within 24 hours of admission 2015	13.2%	28.7%
Received a foot risk assessment during stay 2015	17.0%	34.0%
Appropriate blood glucose testing 2015	5.5	6.5
Medication errors 2015	36.8%	38.1%
Prescription errors 2015	21.1%	22.0%
Insulin errors 2015	28.9%	22.6%
Patients reporting timing of meals suitable 2015	56.0%	62.2%
Patients reporting choice of meals suitable 2015	49.1%	54.3%
Patients reporting that they could take control of their diabetes care 2015	50.5%	59.5%
Patients reporting that all or most staff looking after them knew enough about diabetes to meet their needs 2015	59.4%	65.5%
Patients reporting that they were satisfied or very satisfied with the overall care of their diabetes while in hospital 2015	84.6%	84.3%

National End of Life Audit

The results of this project were published in March 2016. The results of this audit project are very positive however, an action plan has been developed to take forward the areas where we are lower than the national average.

		National result	Your site
Cases in clinical audit		9302	**34**
CLINICAL AUDIT INDICATOR		% OF CASES	**% of YOUR cases**
1	Is there documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days**? %YES**	83%	**82%**
2	Is there documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient? **%YES**	79%	**79%**
3	Is there documented evidence that the patient was given an opportunity to have Concerns listened to? **%YES or NO BUT**	84%	**97%**
4	Is there documented evidence that the needs of the person(s) important to the patient were asked about? **%YES or NO BUT**	56%	**68%**
5	Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care? **%YES**	66%	**50%**
ORGANISATIONAL AUDIT		**National result**	**Your site**
Sites in organisational audit		142	**YES**
ORGANISATIONAL AUDIT INDICATOR		% OF SITES	**Your site**
6	Is there a lay member on the Trust board with a responsibility/role for End of Life Care?	49%	**No**
7	Did your Trust seek bereaved relatives' or friends' views during the last two financial years (i.e. from 1st April 2013 to 31st March 2015)?	80%	**Yes**
8A	Between 1st April 2014 and 31st March 2015 did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for **Medical staff**	63%	**Yes**
8B	Between 1st April 2014 and 31st March 2015 did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for **Nursing (registered) staff**	71%	**Yes**
8C	Between 1st April 2014 and 31st March 2015 did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for **Nursing non-registered) staff**	62%	**Yes**
8D	Between 1st April 2014 and 31st March 2015 did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for **Allied Health professional staff**	49%	**Yes**
9	Access to specialist palliative care for at least 9-5 Mon-Sun	37%	**Yes**
10	Does your trust have 1 or more End of Life Care Facilitators as of 1st May 2015?	59%	**Yes**

National Audit of Dementia

During 2015 the national audit of dementia requested a small number of Trusts to volunteer as pilot sites for the 2016 audit. The Trust was one of the pilot sites and tested the proposed methodology and data collection for the 2016 national audit project.

National Audit of Ophthalmology

The Trust was unable to participate in the first round of this audit due to access to the required data collection tool. In 2016 funding was secured from charitable funds to purchase the required software to enable us to participate in the data collection for this project.

National Joint Registry

A data validation exercise was undertaken by this audit during 2015 to check the quality of the data submitted and the accuracy of cases entered. The Trust participated in this exercise to ensure the robustness of the data submitted.

National Parkinsons Disease Audit

The 2015 UK Parkinson's Audit included data from 432 services across the UK on 8846 patients. 239 of these services were Neurology or Elderly care services, including data on 6202 patients. Dr Hussain the audit lead for this project will take forward the areas requiring improvement.

	Trust Response
Is a formal Activities of Daily Living assessment tool or check list used when Parkinson's patients are reviewed in this service? (clinic)	Not routinely available
Is the Parkinson's non-motor symptoms questionnaire or other form of checklist used to screen for non-motor symptoms when Parkinson's patients are assessed?	Not routinely available
Can patients in this service access a Parkinson's Nurse Specialist?	No

National Audit of Inpatient Falls

The National Audit of Inpatient Falls is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and managed by the Royal College of Physicians (RCP) as part of the Falls and Fragility Fracture Audit Programme (FFFAP).

	moderate/severe harm or death per 1,000 OBDs	**Falls per 1,000 OBDs**
Southport and Ormskirk	0.13	3.71

However there are areas which require improvement as the audit also collected data on whether patients had been assessed for all the risk factors of falls identified by NICE CG161 and whether there had been appropriate interventions to prevent falls:

Delirium	**BP**	**Medication**	**Vision**	**Mobility aid**	**Continence**	**Call bell**
60%	11.1%	53.6%	69.0%	40%	20%	85.7%

NAGCAE (National Advisory Group on Clinical Audit and Enquiries)

The head of audit and effectiveness has been appointed as the local clinical audit representative on the department of health advisory group for the national clinical audits.

Sharing Good Practice from Clinical Audit Projects

We had 2 posters shortlisted for the National Junior doctor audit completion which is organised annually by the clinical audit support centre. One of the posters focusing on temperature management of patients in theatre was awarded second place.

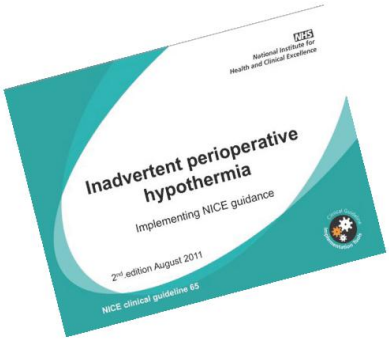
HQIP National Clinical Audit Tea Break

We participated in the National clinical audit tea break and had a stand in Ormskirk and Southport Hospital promoting clinical audit.

A clinical audit quiz was handed out to staff and the winner won a Lemon Drizzle Cake.

NHS trust

Keeping the audit cycle momentum as junior doctors move on – Perioperative Temperature Management



Aims and Objectives:

To measure local practice against the NICE (The National Institute for Health and Care Excellence) guidelines issued in April 2008 CG65 on the management of inadvertent perioperative hypothermia in adults.

This states that:

- Temperature monitoring is essential during surgery
- Both hypothermia and hyperthermia can complicate anaesthesia

Local Key Targets for best practice were set

Compliance Level	RAG rating
90-100%	
70-89%	
>69%	

3 Audit Cycles

2011 Audit Cycle 1 : 70 patients
2012 Audit Cycle 2 : 50 patients
2014 Audit Cycle 3 : 106 patients

- The initial project was undertaken by a middle grade anaesthetist under the supervision of the ***consultant anaesthetist.***
- The second audit was undertaken by a junior doctor and a consultant anaesthetist (different to the one who was the original sponsor for the project)
- The third audit was undertaken by 2 middle grade anaesthetists under the supervision of the ***consultant anaesthetist.***

Standards	2011	2012	2014
All patients should have their temp recorded prior to arrival in theatre	92.8%	98%	96.2%
All patients for elective surgery should have a core body temperature of 36.0°C or above.	63%	30%	92.5%
All patients should have their temp recorded intra-operatively	91.4%	0%	96.2%
All patients should have a post-operative temperature taken	100%	100%	100%
All patients should not be discharged from recovery until their temperature is above 36.0°C	100%	56%	100%
Assurance Level (% of standards achieving 90%)	80% (4/5)	40% (2/5)	100% (5/5)

Changes Made

After 2011

Audit results were presented and it was identified that there was a possible issue with equipment used to measure the temperature. An audit action plan was developed with 2 actions. Although both of these actions were completed they were not SMART actions and resulted in no change.

After 2012

Audit results were presented and it was noted that the audit results were much worse than 2011. A very detailed action plan was developed involving the theatre manager and consultant sponsor, with 8 actions for improvement. Initially the actions were once again not SMART, so they were reviewed to ensure actions would lead to a change and the appropriate ownership was assigned. It was agreed the root cause was ineffective thermometers in theatres, which lead to staff not trusting the temperatures indicated.

The changes made:

- Shared the results widely
- A business case was written to purchase new thermometers
- Purchase of new Tympanic thermometers (external ear) with theatre staff training on the appropriate use of these devices and the sources of error.
- Teaching and reminding the anaesthetists and anaesthetic assistants to measure and record temperature during surgery as per the NICE clinical guideline 65.

After 2014

Full assurance was achieved however the team developed another action plan for the 3 areas not quite reaching 100% , although the team were very pleased with the big improvement made since the previous audits.

Conclusions:

As junior doctors rotate round and often move hospital or department after just 6 months, it is important for audit projects to have a senior permanent member of staff as a sponsor to ensure the changes required can be implemented over the years.

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Dr Rebekka Konig, Dr A Al-Kayssi, Dr V Paulsen, Dr M Maity, Dr John Kirby, Sam Leese (clinical audit officer)
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NHS Trust

NICE Opioids in Palliative Care Audit

Rachael McDonald & Karen Groves

BACKGROUND

- Pain is a common symptom in advanced disease
- 2/3 people with cancer experience pain requiring a strong opioid

NICE GUIDANCE: RECOMMENDATIONS[1]

- Communication: address patients' concerns, give both verbal & written information
- Initiating opioids: if no renal or hepatic impairment offer titration with immediate release (IR) opioid or regular slow release (SR) opioid, with breakthrough dose as needed
- Constipation: prescribe laxatives regularly to avoid the development of constipation

1.National Institute for Health & Clinical Excellence. Opioids in palliative care: safe and effective prescribing of strong opioids for pain in palliative care of adults. 2012. London.

STANDARDS

1. Initial opioid regimes are prescribed according to NICE Guidance
2. Specialist palliative care service (SPCS) advice sought in renal or hepatic impairment
3. Laxatives are prescribed prophylactically unless contraindicated
4. Documentation that patients' concerns are addressed
5. Information given both orally and in writing
6. Patients are reviewed in a timely manner after initiation of opioids.

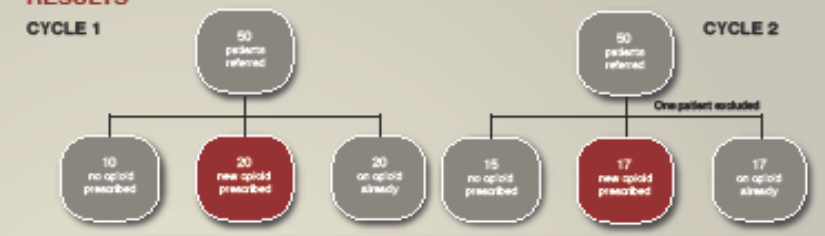
METHOD

- Prospective audit
- 50 hospital specialist palliative care referrals
- Cycle 1 Sep-Nov 2014; 2 Apr-Jun 2015
- Hospital notes prior to SPCS referral reviewed

INTERVENTION

- 25 junior doctor prescribers surveyed about their confidence in opioid prescribing before intervention
- Prescribers given 'Understanding opioids' leaflet & reminded about
  - NICE Guidance for prescribing opioids in palliative care
  - importance of involving SPCS where patients have renal or hepatic impairment
  - importance of having and documenting the conversation addressing concerns
  - documenting the giving of opioid leaflets to support the conversation
  - including review date
- Ward pharmacists prompted concurrent laxative prescribing
- Documentation drawers well stocked with opioid information leaflets

RESULTS



Initial opioid regimes are prescribed according to NICE Guidance
17/17 (100%) were prescribed opioid according to guidance
compared to 13/20 (95%) in cycle one
95% standard met → 100% standard met

In renal or hepatic impairment, SPCS advice is sought
1/1 (100%) SPCS consulted for advice
compared to 0/6 (0%) in cycle one
(4/6 had opioid switched when SPCS did become involved in view of renal impairment)
0% standard met → 100% standard met

Laxatives are prescribed prophylactically unless contraindicated
Laxatives prescribed prophylactically in 11/17 (65%)
compared to 12/20 (60%) in cycle one
60% standard met → 65% standard met

Documentation that patients' concerns are addressed
Documented in 4/17 (24%)
compared to 1/20 (5%) in cycle one
5% standard met → 24% standard met

Information given both orally and in writing
Documented that opioid information & leaflet given in 3/17 (18%)
compared to 0/20 (0%) in cycle one
0% standard met → 18% standard met

Patients are reviewed in a timely manner after initiation of opioids
9/17 (53%) had a planned review date
compared to 3/20 (15%) in cycle one
15% standard met → 53% standard met

SURVEY RESULTS

- 25 junior doctors (F1-CT2) surveyed following cycle 1 & before intervention
- 100% returned

	not at all confident	not very confident	confident	very confident
initiating opioids	4%	20%	64%	12%
dose titration & calculation	4%	44%	44%	8%
information & conversations	4%	0%	64%	32%
awareness of supporting leaflet	72% not aware		28% aware	

CONCLUSIONS

- Good adherence to NICE Guidance on appropriate initial prescribing
- Lack of early involvement of palliative care team in patients with renal / hepatic impairment improved in cycle 2
- Anticipatory laxative prescribing still inadequate
- Poor documentation surrounding addressing patient concerns, providing information and planning appropriate review date, improved in cycle 2
- Ongoing education clearly required

We also successfully had a project presented at the Faculty of Medical Leadership and Management Cambridge Quality Improvement Conference in November 2015 and it will be published shortly in BMJ Quality Improvement Reports.

Improving the Adequacy of Shoulder X-Rays at a District General Hospital: a Quality Improvement and Medical Student Leadership Training Project

Richards B[1], Saithna A[2]

[1]5th Year Medical Student, University of Liverpool, Liverpool, UK. [2]Consultant Orthopaedic Surgeon, Southport and Ormskirk Hospital NHS Trust, Merseyside, UK

Background

Radiographs are essential for accurate diagnosis of shoulder pathology. A high rate of suboptimal shoulder radiographs was identified during a service evaluation exercise at our institution. This inadequacy may lead to inaccurate diagnosis, the need for repeat imaging, increased radiation exposure, an increased workload, delays in the clinic and decreased patient satisfaction

AIM

The aim of this project was for the senior author to provide leadership training and mentorship to a SAMP (Specialist Attachment in Medical Practice) medical student in order for them to lead a quality improvement project directed towards reducing the rate of inadequate shoulder radiographs at Southport and Ormskirk Hospitals NHS Trust. The target of this was to improve clinic efficiency and reduce unnecessary work and cost for the radiology department.

The quantitative aim was to improve adequacy of radiographs of the shoulder to 64% to bring our service in line with other published data[1].

Methods

Three 30 minute leadership training sessions were conducted focusing on the basic leadership skills that a medical student would require to inspire, engage and gain the confidence of a group of experienced radiographers in order to effectively deliver a successful service improvement project.

Initial data collection/service evaluation to assess rate of inadequate shoulder radiographs was performed over three, 2 week periods.

Evaluation criteria were set for 3 frequently used views, AP, axillary and the Velpeau view based on standards for adequacy described in the literature.

The criteria were outlined on **posters** in the radiology department with **step-by step instructions** on how to capture an adequate image and were provided to radiographers as **PDF files** they could access via their smartphones. **Teaching sessions** were held where this information was re-iterated using PowerPoint and **practical sessions** using a skeleton in the x-ray suite to highlight anatomical landmarks. The AP view taught to the radiographers was the **Fulcrum view** outlined by Braunstein et al[1].

The audit cycle was closed by **data collection** that was then carried out to assess the impact of our intervention.

1. Braunstein V, Kirchhoff C, Ockert B, Sprecher CM, Korner M, Mutschler W, et al. Use of the fulcrum axis improves the accuracy of true anteroposterior radiographs of the shoulder. *J Bone Joint Surg Br.* 2009;91-B:1049-53

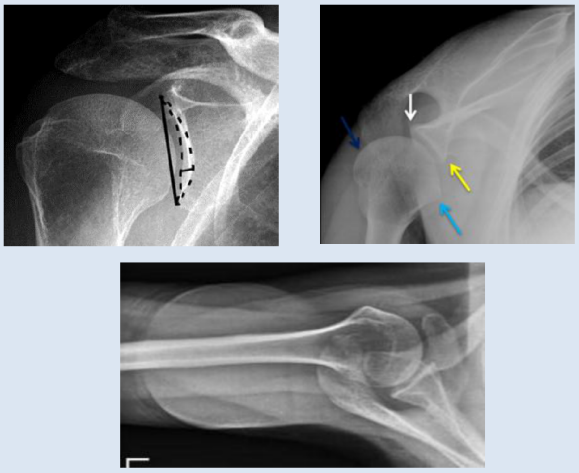


Figure 1: *Examples of adequate shoulder x-rays. Evaluation criteria were provided for each view along with step-by-step instructions on how to ensure an adequate image is taken.*

Results

Initial data collection:

36 patients required shoulder x-rays.

✗ 36 required an AP view, only 19.4% were adequate.

✗ 20 required an axillary view, only 60% were adequate.

Chi-Square Statistic: 23.8661. P <0.01

Second data collection, following intervention:

15 patients required shoulder x-rays.

✓ 15 required an AP view, 93% were adequate.

✓ 13 required an axillary view, 92% were adequate.

Chi-Square Statistic: 4.1462. P=0.042

Following discussion with the radiographers, the trust policy was changed to include the Fulcrum view as the 'default' AP view.

Key Messages

1. With appropriate leadership training and mentoring, medical students are able to make valuable contributions in the leadership of service improvement, project design and delivery.
2. Poor quality shoulder radiographs cost time and money and may result in missed diagnoses.
3. Simple interventions such as educating radiographers with best practice guidelines based on the literature result in quality improvement.

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Blow Your Own Trumpet

On the 3rd September 2015 the community business unit held an event for staff to raise the profile of clinical audit.

21 people attended the workshop. Evaluation forms were completed by 17 people. A response rate of 81%

Staff were asked to answer these questions using a numerical score where

1=Strongly Disagree and 5 = Strongly Agree

Question	Scoring					
	5	4	3.5	3	2	1
1. The venue was easy to access and suitable for the event	16 (94%)	1(6%)	0	0	0	0
2. I was more inclined to attend as food was provided	3 (18%)	3 (18%)	1(6%)	5 (30%)	2 (12%)	3 (18%)
3. The event has increased my understanding of how audit assists in improving patient care	11 (65%)	4 (24%)	0	1 (6%)	1 (6%)	0
4. The event has increased my understanding of how audit assists in improving services for patients	10 (59%)	5 (30%)	0	1 (6%)	1 (6%)	0

Audit of the Clinical Audit Policy

An audit was undertaken in November 2015 to demonstrate compliance with the management of clinical audit as detailed within the clinical audit policy (Clinical Corporate Policy No 82).

Overall the trust had 287 audits completed in the period April 14 to March 15. The 14 – 15 clinical audit forward plan was reviewed and 15% (43) of audits were randomly selected.

Results

	2012 / 2013 audit	2013 / 2014 audit	2014 / 2015 audit
Is the audit registered with the clinical audit department	100%	100%	100%
Is the source of the audit documented on the audit forward plan?	100%	100%	100%
Did the audit have a completed audit plan?	86%	90%	95%
Was the audit plan signed by the head (or assistant head of audit and effectiveness)?	69%	100% (where there was an audit project plan)	97.5% (Where there was an audit project plan)
Does the audit assess compliance against a set of criteria and or standards?	100%	100%	100%
Was the section on the audit plan completed indicating what standards where going to be used for the audit to be measured against.	100% (where there was an audit project plan)	100%	93%
Is there a completed presentation / report for the audit project?	87%	93%	100%
Did the audit sponsor and auditor produce an action plan?	72%	85%	90%
Did the action plan identify actions that are required to make improvements?	100%	100% (where there was an action plan)	100%

Assurance Level	Calculation of assurance
Full	To be used when 90%-100% of standard has achieved a score of 90% or above and rated Green
Significant	To be used when 65%-89% of standards have achieved a score of 90% or above and rated Green.
Limited	To be used when 35-64% of standards have achieved a score of 90% or above and rated green
Very Limited	To be used when 0-34% of standards have achieved a score or 90% or above and rated green.
Total number of standards	9
Number of standards 90% or above and rated green	9
% of standards 90% or above and rated green	100%
Assurance Level	Full

Community and Continued Care

	2014 / 15	2015 / 16
Number of Audits on Trust Audit Forward Plan	**58**	**44**
Number of projects no longer required	1 (2%)	1 (2%)
Number of projects carried over to 2016 / 2017	29 (50%)	9 (21%)
Number of projects completed	28 (48%)	34 (77%)

Integrated Governance & Nursing

	2014 / 15	2015 / 16
Number of Audits on Trust Audit Forward Plan	**39**	**20**
Number of projects no longer required	2 (5%)	
Number of projects carried over to 2016 / 2017	5 (13%)	1 (5%)
Number of projects completed	32 (82%)	19 (95%)

Planned Care

	2014 / 15	2015 / 16
Number of Audits on Trust Audit Forward Plan	**122**	**113**
Number of projects no longer required	6 (5%)	8 (7%)
Number of projects carried over to 2016 / 2017	35 (29%)	30 (27%)
Number of projects completed	81 (66%)	75 (66%)

Medical Directors CBU

	2014 / 15	2015 / 16
Number of Audits on Trust Audit Forward Plan	**47**	**28**
Number of projects no longer required	3 (6%)	
Number of projects carried over to 2016 / 2017	16 (34%)	10 (36%)
Number of projects completed	28 (60%)	18 (64%)

Urgent Care

	2014 / 15	2015 / 16
Number of Audits on Trust Audit Forward Plan	**84**	**69**
Number of projects no longer required	7 (8.3%)	2 (3%)
Number of projects carried over to 2016 / 2017	17 (20%)	21 (30%)
Number of projects completed	60 (72%)	46 (67%)

Women's and Children

	2014 / 15	2015 / 16
Number of Audits on Trust Audit Forward Plan	**83**	**76**
Number of projects no longer required	0	0
Number of projects carried over to 2016 / 2017	25 (30%)	17 (22%)
Number of projects completed	58 (70%)	59 (78%)