


NICOR

 **HQIP**



NAD
NATIONAL AUDIT OF DEMENTIA

 **RC PSYCH**
ROYAL COLLEGE OF PSYCHIATRISTS

 **Royal College of Physicians** | **NACAP**

 **Quality Data Provider**
for commitment to patient safety through the **National Joint Registry** **2018/19**
CERTIFICATION FOR DATA SUBMISSION & QUALITY

 **TARN**
THE TRAUMA AUDIT & RESEARCH NETWORK

 **AMaT**
Audit Management and Tracking

Clinical Audit and Effectiveness ANNUAL REPORT 2021-22

Clinical Audit & Quality Informatics Department

Information for Improvement

NICE
National Institute for Health and Care Excellence



Content

Section	Page
• Forward – Deputy AMD for Clinical Audit & Effectiveness	3
• The Department	4
• Workforce (staff development)	5
• Training Programme	6
• Sharing the learning from Clinical Audit	7
• NHS Wales National Clinical Audit and Outcome Review Plan 2021-22 (Sample of 2021-22 national audit findings)	8
• Ward & Community Team real-time clinical audits	15
• NICE	16
• Learning from Mortality Reviews	17

Deputy AMD for Clinical Audit & Effectiveness

The National Clinical Audit and Review Outcome Plan confirms the National Clinical Audits and Outcomes that health boards are expected to participate in. This annual rolling program shows how findings from audits and reviews will be used to evaluate and improve healthcare quality and safety in Wales.

Clinical Audit is an integral part of the process for measuring the quality of services against set standards for comparison and identification of improvement opportunities.

Considering the challenges the Health Service is now facing across Wales being able to identify improvements and optimise efficiency has never been more important. When working in partnership with multiple disciplines, managers and policy makers the NCAROP enables objective assessment of the quality of healthcare to guide decision making.

The Clinical Audit and Quality Informatics Department champions education and engagement with the process at every level within the Health Board. There are clear lines of communication to ensure escalation to the Executive board and Medical Director as well as dissemination to all relevant departments.

The Mortality Review process, which continues to expand in scope and demand, is also being run by the Audit Department to great effect.

I wish to commend and recognise the hard work and dedication of our Clinical Audit and Quality Informatics Department who have produced all of this against a challenging backdrop of squeezed budgets, decreased staffing and increased demand. I also wish to thank the Clinical Audit Leads, the Medical Director and all those who have participated in the Audit process for their engagement and enthusiasm.



The Clinical Audit and Quality Informatics (CA&QI) Department is responsible for facilitating all clinical audit projects, incorporating both national, organisation and local priorities, throughout CTMUHB. It is an integral part of the Medical Directors Office which is accountable to the Executive Medical Director and Executive Board.

The 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.

Findings from national audits are presented quarterly to the Clinical Audit, NICE and Effectiveness Group (CANE) prior to inclusion in update reports to the Quality & Safety Committee. The Quality and Safety Committee is responsible for receiving assurances for all national audits.

A report is also provide annually for the organisation Audit Committee on clinical audit activity.

Clinical directorates hold bi-monthly Clinical Audit / Quality Assurance and Governance meetings at which they cover

standing quality agenda items which include clinical audit. The meetings are also used to plan how the directorates will implement the recommendations made as a result of national clinical audits.

The CA&QI department also manages the organisation's Mortality Review process, VTE/HAT monitoring, NICE Compliance, Ward Audits (including compliance with the Nurse Staffing Act) and provision of an informatics service from ward to board.



Workforce

Staff Development

Staff retention and development remains a key goal and through succession planning four staff have secured promotion and one has been supported in extending their secondment to the Medical Directors Office.

17 staff attended formal clinical audit training, with five successfully attaining accreditation.

3 staff have completed CMI Level 7 course.

A number of individuals with the team have also achieved:

- BSc in Computer Studies (1st)
- ILM Level 5 (NVQ) in Leadership and Management
- Won the prestigious Woodford TARN Audit Coordinator of the year Award

Investment in new posts, this year

0.5

WTE

For National Audit dashboard developments



No. of development opportunities(internal)

4

/1

External to department



No. National Audit Workshops attended

1

/4

Total staff Attendance



No. PDR identified courses supported

23

Qualified or Completed in 2021-22



Training Programme

Total clinicians
Trained 2021-22

Clinical
Audit

115

Ward &
Area
Audit

245

In addition to the standard package of training the following tailored group sessions were provided:



June 2021

Clinical audit session for
Pharmacy Technicians

September 2021

Clinical audit & AMaT training
session for F1 / F2 Doctors



December 2021

Clinical audit & AMaT session for
Pre-registration Pharmacists



November 2021 to March 2022
AMaT ward audit training for nursing staff



Workshop-based group training spread over 4 sessions has been provided that covered clinical audit techniques from inception to presentation. The core topics are;

- (1) Clinical audit overview;
- (2) Identifying your audit criteria;
- (3) Preparing an audit proforma and data collection;
- (4) Analysing audit results;
- (5) Preparing for presentation and sharing the findings (report writing and action planning).

Training sessions have been adapted for delivery using MS Teams in a condensed format and tailored to the needs of clinical teams. In addition to formalised training sessions, all clinical audit staff are able to provide clinical audit advice, support and training on an ad-hoc basis.

In addition, training sessions have been provided for clinicians on the use of the Audit Management and Tracking (AMaT) system. Demonstrations are a regular feature of clinical audit meetings, to ensure that clinical staff are able to register audits and upload audit information on the new system.

Sharing the learning from Clinical Audit

Since October 2021, a clinical audit newsletter is published on a quarterly basis to publicise key national audit findings, information on clinical audit services and to provide evidence of any associated improvement work.

Clinical Audit Newsletter



Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quarter 3

Oct - Dec 2021

Welcome to our new Senior Clinical Audit Facilitators



We are excited to announce our new appointments, as November 2021 saw our new Senior Facilitators take their posts. Debra Townley (Bridgend) and Sean Thomasson (Merthyr & Cynon) join Fiona Weston (Rhondda & Taff Ely) to make up our team of senior clinical audit facilitators.

Congratulations to Debra & Sean!

CANE Group established

Clinical Audit, NICE & Effectiveness (CANE) Group

The CANE Group was officially launched on 14th December at the inaugural meeting chaired by Mr Dai Morgan, Assistant Medical Director. Audit Leads from across the Health Board were invited to attend to set the direction for Clinical Audit for the months to come.



At the meeting the role and responsibilities of the CANE Group were set out, which include:-

- Review reports to Audit & Risk Committee and Quality & Safety Committee
- Support development of annual Clinical Audit Programme
- Identify Health Board priority clinical audit topics to register on the Clinical Audit Programme
- Monitor national clinical audit recommendations and action plans
- Receive summaries of national clinical audit reports and completed baseline assessments to agree recommendations and actions
- Receive completed local clinical audit reports and recommendations
- Review progress of Health Board and ILG Clinical Audit Programmes and escalate concerns to Audit and Risk and Quality and Safety Committee
- Receive NICE & Royal College Guidance compliance reports from the NICE Reference Group



ILG Clinical Audit & Effectiveness Leads were also introduced and the structure of the Clinical Audit Department was discussed. An update was provided on the features of AMaT (Audit Management and Tracking) software. Developments with NCEPOD studies, key national audit activity and the latest national audit publications were also outlined.

Updates from the Team

Accredited Clinical Audit Training

On 1st November 2022 virtual clinical audit training was delivered by Tracy Ruthven and Stephen Ashmore from the Clinical Audit Support Centre for our Team. The training covered all the essential elements of undertaking a clinical audit. For more information on the work of the Clinical Audit Support Centre visit the website: www.clinicalauditsupport.com



TARN Co-ordinator Success Story

We are pleased to announce that Nichola Jenkins, TARN Co-ordinator based in the POWH Clinical Audit Team has recently been appointed as chair of the South Wales Trauma Network TARN Co-ordinators' Forum. Encouraging conversations on this key national audit both within the network and across Wales.

Support for the Community Vaccination Centres



Over the Christmas period staff from the Clinical Audit Department ably supported the COVID-19 Booster campaign at our Community Vaccination Centres across the localities. Our staff were involved in welcoming members of the public to the centres, manning the reception desks and our clinical staff administered vaccinations.



New National Clinical Audit Reports

Quarter 3 was a busy period for national clinical audit reporting, with a high number of publications released covering broad subject area. Local action planning based on these reports will take place with audit facilitators and clinical teams during Quarter 4.

National audit reports released in October were predominantly in the field of maternity & child health and cardiac care:-

- National Pregnancy in Diabetes (NPID) Audit
- MBRRACE-UK Perinatal Mortality Surveillance Report 2019
- National Maternity and Perinatal Audit Clinical Report 2021
- National Perinatal Mortality Review Tool 3rd Annual Report
- National Heart Failure Audit (2021)
- National Audit of Cardiac Rhythm Management
- Myocardial Ischaemia National Audit Project (2021)

November publications:

- National Emergency Laparotomy Audit (NELA) – 7th Annual Report
- National Audit of Inpatient Falls Annual report 2021 - The Falls and Fragility Fracture Audit Programme (FFFAP)
- Ethnic and socio-economic inequalities in NHS maternity and perinatal care for women and their babies - National Maternity and Perinatal Audit (NMPA)

December publications:

- National Oesophago-Gastric Audit Annual Report 2021
- Sentinel Stroke National Audit Programme Annual Report 2020/21

Looking ahead

Development of Clinical Audit Forward Plans (2022/23) will take place from January with our audit leads and facilitators.

Standardised Clinical Audit meeting agenda template is planned for release in February 2022 to allow greater consistency.

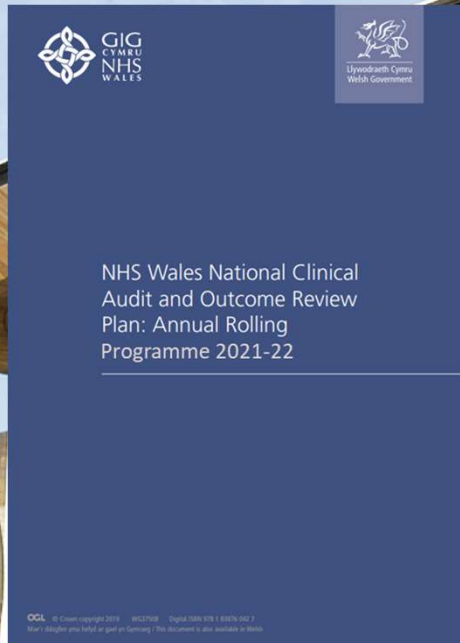
Relocation of the Clinical Audit offices at PCH to take place in January.

For further information on Clinical Audit contact **Natalie Morgan-Thomas**, Deputy Head & Lead Nurse for Clinical Effectiveness:
Natalie.Morgan-thomas@wales.nhs.uk



Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

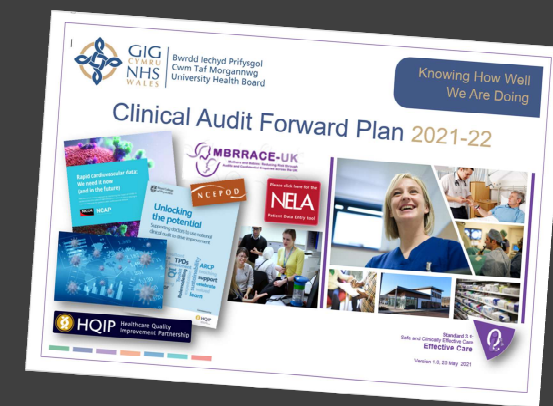
NHS Wales National Clinical Audit and Outcome Review Plan 2021-22



All organisations in Wales are required as part of their Quality Strategy to have an annual **Clinical Audit Forward Plan** in place to fully participate in all relevant national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.

The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan identifies all of the clinical audit projects from the National Clinical Audit and Outcome Review Plan for 2021-22 that must be undertaken by CTMUHB.

Clinical audit is a fundamental component of the



organisations quality assurance process, based on transparency and candour. Quality assurance provides a systematic approach to maintaining consistently high quality by constantly measuring and reporting on effectiveness, highlighting the need for improvement and enabling the sharing of good practice.

The CTMUHB Clinical Audit Forward Plan sets out a programme of prioritised continuous improvement activities, including clinical audit, and is designed to help to embed the above principles into the everyday working practice of individuals and clinical teams to improve clinical outcomes for patients, through focused and structured work. The plan for 2021-2022, was determined at both corporate, locality and directorate level based around priority categories established by the Healthcare Quality Improvement Programme (HQIP) and defined as:

1. External “must do” - Externally monitored audits that are driven by commissioning and quality improvement are treated as the priority and appropriate resources are provided to support these. Failure to participate or deliver on these externally driven audits may carry a penalty for the Health Board
2. Internal “must do” - Based on the classic criteria of high risk or high profile identified by health board management. They may include national initiatives with health board-wide relevance but no penalties exist for non-participation. Many of these projects will emanate from Health Board governance issues or high profile local initiatives.

The 10th annual National Clinical Audit and Outcomes Review Plan was delayed due to purdah and the transfer of responsibilities for the NHS Wales National Clinical Audit & Outcome Review Plan (NCA&ORP) from Welsh Government to Digital Health and Care Wales.

A key component of the work undertaken in 2021-22 was to align audit activity to the Integrated Locality Group structure. Clearly identified responsibilities and timeframes for completion of audit work and continuous monitoring of progress against the plan has ensured the improved compliance position for CTMUHB. The weekly national audit monitoring of compliance that was introduced in April 2019 and the implementation of the Clinical Audit & NICE Compliance Management system from April 2020 has ensured that the organisations compliance with all national audits has improved at a time of extreme pressure due to the pandemic.

Pages 10 to 14 of this report provide some examples of the national audits undertaken by the organisation as part of the CTMUHB Clinical Audit Forward Plan. A full list of national audits that the organisation participates in can be found in the published CTMUHB Clinical Audit Forward Plan 2021-22.





Improving patient outcomes

Achub bywydau
Gwellu canlyniadau
Cwneud gwahaniaeth

Saving lives
Improving outcomes.
Making a difference.

GIG CYMRU
NHS WALES

Rhwddwaith Trawm
De Cymru
South Wales
Trauma Network
TraumaNetwork@nhs.uk
01792 816688
SWT Trauma Network
Wales Trauma Network

Lesson Learnt Bulletin.. Issue 3
March 2021

On Thursday 18 March, SWTN held its quarterly Network Clinical Governance Day. The morning was taken up by a Case Quality Review et which cases from across the network were discussed. Below you will find key learning points that were drawn out by these cases. Please note that this CQR discussed cases from the period immediately after the network went live in September 2020.

Cases reach the CQR after discussion at local trauma morbidity and mortality meetings. In both forums our goal is to look for Opportunities for Care Improvement - aspects of the case where better care could have been delivered, perhaps under local circumstances. We break these CQRs down to look for active failures (actions or omissions) and latent failures (issues in the system that produced the incident). Latent failures might involve issues with training, supervision, equipment, policies, awareness, staffing or many other aspects of the system. Even if patient outcome was not affected in the case we discuss, latent failures persist in the system and could give rise to harm in the future. However, this also means that we can improve patient care by addressing them. Identified latent failures are taken up by local and network clinical governance bodies to ensure that remedial action is taken.

All involved in clinical care of trauma patients are encouraged to be part of this process. You can find out about your local trauma M&M from your health board's trauma lead. The next network CQR is on Thursday 17th June 2021 and you can find out how to take part by emailing TraumaNetwork@wales.nhs.uk

South Wales Trauma Network Transfer Pathways

When patients require acute transfer from a trauma unit or other hospital to the MTC, the SWTN acceptance policy ([link](#)) applies. A few points are worth emphasising:

- The trauma desk (based with Welsh Ambulance Service Trust) and the Trauma Team Leader (TTL) at the MTC have crucial roles in coordinating time-critical transfers, even for single system injuries. TUs should speak to the TTL via the trauma desk when they wish to discuss potential transfers. The TTL will then facilitate discussions with specialist teams at the MTC if required. Specialist teams should not be contacted directly for advice except in cases that are not time-critical.
- Specialist teams (consultants and registrars) at the MTC must be aware of the acceptance policy as well. If they receive calls that have bypassed the proper channels, it is important that they get the referring clinicians to speak to the trauma desk and TTL. This is the only way to ensure proper coordination of services and timely transportation.
- The network is undertaking a series of interactive workshops to raise awareness about the pathways. You can find more information at [South Wales Trauma Network Pathway Summary](#).
- It is important to ensure that discussions between the referring hospital and the TTL and specialists are conducted by clinicians with sufficient seniority. Specialists must consider not only the need for surgical intervention but the wider implications of their treatment decisions for patient treatment and prognosis. The TTL has a role in ensuring that referrers and specialists achieve a shared understanding of the case and of the plan.

24h

Complex Transfers for "Care With Treatment Closer to Home"

The network's "CWTC" policy recognises that some patients may have complex physical, mental and social needs that do not fit easily with the location of various specialist services. Exceptionally, it may be necessary to arrange for a recovering patient to be managed at a centre nearer to home despite having injuries that fall outside the normal scope of a receiving hospital. A recent difficult paediatric case demonstrated how this can work very well. The whole MDT, both at the MTC and at the receiving unit, went out of their way to make provision for a child with spinal injuries who needed to be closer to family. While complex, the collaboration between the teams was excellent. Arrangements like this are very unusual. Convening a large, pan-professional MDT at an early stage to build a shared picture of the issues that a case raises will facilitate making such transfers in a timely way.

[P02 SWTN Automatic repatriation policy review October 2020](#)

Every year across England and Wales, 12,500 people die as a result of a serious injury. It is the leading cause of death among children and young adults of 44 years and under. There is also significant amount of evidence available to show that patients who suffer a major trauma have a greater chance of survival and recovery if they are treated within a Major Trauma Network (MTN).

In March 2018, CTMUHB as part of the South Wales region was approved for the establishment of **Major Trauma Centres (MTC)** at the Princess of Wales and Prince Charles hospitals, with the aim of enhancing clinical care and patient experience through introduction of specialist teams

and a major trauma pathway. TARN is the national clinical audit for traumatic injury and forms part of the **National Clinical Audit and Outcome Review Plan** for Wales. CTMUHB participates in the TARN audit that informs the major trauma programme of work.

The team are responsible for ensuring that all TARN cases are identified and input onto TARN within 28 days of discharge from hospital.

Compliance with TARN quarterly reporting deadlines has not been achieved in 2021-22 compared to full compliance in 2020-21 due to the additional unplanned Major Trauma activity at the RGH.

A business case to secure an additional band 4 TARN Coordinator, has been submitted as part of the proposal to recognise RGH as a MTC.

National Paediatric Diabetes Audit (NPDA) Annual report 2019-20 (Published in June 2021)

The audit covers the health checks and outcomes for children and young people with diabetes who have attended PDUs (paediatric diabetes units) from 1 April 2019 to 31 March 2020.

Findings

There were a number of positive findings that included establishment of CTMUHB Diabetes Team to restructure service and standardise care across all three sites; participation in Diabetes QI project by the Royal College of Paediatrics and Child Health (RCPCH), which has emphasised a focused on the management of newly diagnosed patients and high completion rates noted for certain care processes e.g. blood pressure, urine, retinopathy and feet checks.

Actions:

- High number of patients with levels of HbA1c >69 and this number has been increasing. (New policy in development to address this matter)
- Inability to offer 4 Consultant led clinics a year for each patient and perform 4 HbA1c measurements a year. (Lead clinician from each ILG identified who is responsible for ensuring this is completed).
- High DNA rates (A new DNA policy has been developed and implemented).
- Lack of Psychology service provision for the patient group. (Funding approved for 1WTE post to provide a psychology service for paediatrics)



The National Audit of Care at the End of Life (NACEL)

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.

Round 3 of NACEL took place between April and October 2021, where members of the Palliative Care Team undertook detailed case note reviews, looking closely at the quality of care provided by clinical teams across Cwm Taf Morgannwg UHB (Acute, Community and Mental Health services) during April and May 2021.



National Audit of Care at the End of Life

Learning points

There were a number of key learning points identified that included:

Acute setting

Need for clear treatment plans, requirement for face-to-face Palliative Care team involvement in patient care and DNACPR documentation to include details of discussion with the patient and family members. The importance of Advanced Care Plans (ACP) developed in care homes with individuals and their family.

Community Setting

Difficult to find pertinent records, late recognition of dying phase and limited detail documented regarding discussions with family members.

Mental Health Setting

Care Decisions for Last Days of Life guidance to be used to enable individualised care.

Findings

The bespoke dashboards for NACEL Round 3 containing findings on key themes and the organisation's position against the national average are awaiting publication and the full report was released to the public in July 2022. Following the publication of the dashboards and audit report local improvement activity can begin.



The National Emergency Laparotomy Audit (NELA) was started in 2013 because studies showed this is one of the most risky types of emergency operation, lives could be saved, and quality of life for survivors enhanced by measuring and improving the care delivered.

NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy, through the provision of high quality comparative data from all providers of emergency laparotomy.

The Year 7 report published in November 2021 and highlighted the following key findings for CTMUHB:



Positive findings

- Post-operative critical care was maintained at levels comparable with the national average during this period, which included the peak of the COVID-19 pandemic.
- Risk adjust mortality rates were below the national average for Prince Charles Hospital and Princess of Wales Hospital, and comparable to the national average for Royal Glamorgan Hospital.

Concerns

- Timely administration of antibiotics.
- Lack of perioperative assessment by a consultant geriatrician for patients aged 80 and over or frail patients aged 65 years and over.

Recommendations

- The need for geriatric support in the management of frail and elderly surgical patients was a consistent message from across the acute hospital sites.
- A specialist emergency surgery nurse specialist to manage patients through the perioperative period was deemed necessary (Prince Charles Hospital).
- A lead clinician within the Emergency Department to support the initial management of emergency laparotomy patients was put forward to enhance care at the Princess of Wales Hospital.
- Electronic booking system for emergency surgery theatre lists also proposed for the Princess of Wales Hospital.

NJR is described as a global exemplar of an implantable medical device registry, which covers England, Wales, Northern Ireland, the Isle of Man and Guernsey continues to be the largest orthopaedic registry in the world, with an international reputation and holds over 3 million procedure records in order to provide timely warnings of issues relating to patient safety.

The registry's purpose is to record patient information and provide data on: the performance and longevity of replacement joint implants: the surgical outcomes for the hospitals where these operations are carried out; and on the performance outcomes of the surgeons who conduct the procedures.

Data Quality Award

Dr. Dom Hurford, Medical Director praised members of the Clinical Audit Team for their diligence and dedication to data quality, when the National Joint Registry awarded Cwm Taf Morgannwg UHB the Quality Data Provider status award for 2021/22 in August.

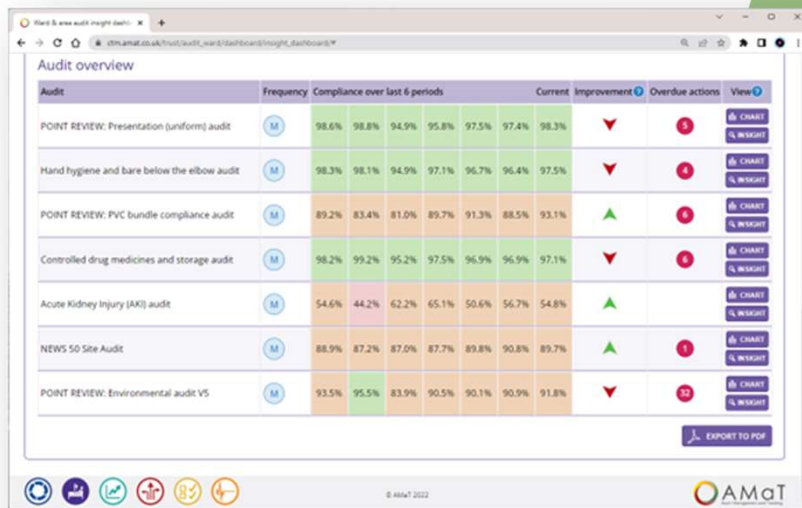
"I know that achieving compliance in order to win this award is no mean feat and is testament to the departmental effort of you all."

The award offers public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission.



Ward & Community Team real-time clinical audits

AMaT
Insight
Clinical
Dashboard



The screenshot shows a web browser window displaying the AMaT Insight Clinical Dashboard. The dashboard features a table titled 'Audit overview' with columns for Audit, Frequency, Compliance over last 6 periods, Current, Improvement, and Overdue actions. The table lists several audits with their respective compliance percentages and overdue counts.

Audit	Frequency	Compliance over last 6 periods					Current	Improvement	Overdue actions	View	
POINT REVIEW: Presentation (uniform) audit	M	98.6%	98.8%	94.9%	95.8%	97.5%	97.4%	98.3%	▼	3	CHART INSIGHT
Hand hygiene and bare below the elbow audit	M	98.3%	98.1%	94.9%	97.1%	96.7%	96.4%	97.5%	▼	4	CHART INSIGHT
POINT REVIEW: PVC bundle compliance audit	M	89.2%	83.4%	81.0%	89.7%	91.3%	88.5%	93.1%	▲	0	CHART INSIGHT
Controlled drug medicines and storage audit	M	98.2%	99.2%	95.2%	97.5%	96.9%	96.9%	97.1%	▼	0	CHART INSIGHT
Acute Kidney Injury (AKI) audit	M	54.6%	44.2%	62.2%	65.1%	50.6%	56.7%	54.8%	▲	0	CHART INSIGHT
NEWS 50 Site Audit	M	88.9%	87.2%	87.0%	87.7%	89.8%	90.8%	89.7%	▲	1	CHART INSIGHT
POINT REVIEW: Environmental audit VS	M	93.5%	95.5%	83.9%	90.5%	90.1%	90.9%	91.8%	▼	22	CHART INSIGHT

In April 2020 the ward and area audit module of the AMaT system was first deployed into the Maternity Unit at CTMUHB.

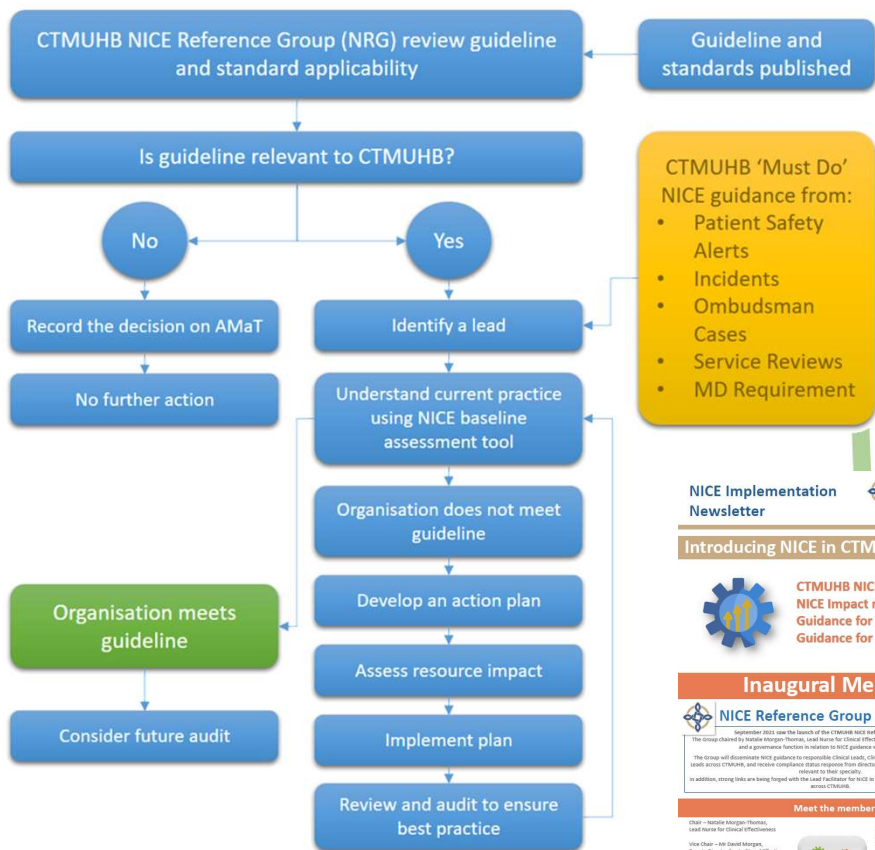
Following the success of the implementation within maternity a decision was made in April 2021 to extend the system rollout Health Board wide with a primary focus on 25b Nurse Staffing Act wards.

The rollout was completed as planned during 2021-22 and has provided significant assurance to the nursing unit around a number of key care metrics.

Some of the key metrics feed into the Health Board bi-monthly Quality Dashboard Report to the Quality and Safety Committee.



NICE Implementation Process Model



NICE
Implementation
Newsletter

NICE Implementation
Newsletter

Introducing NICE in CTMUHB



CTMUHB NICE Reference Group
NICE Impact reports
Guidance for consultation
Guidance for release

Inaugural Meeting

NICE Reference Group Established

September 2021, the launch of the CTMUHB NICE Reference Group (NRG). The group will disseminate NICE guidance to responsible Clinical Leads, Clinical Directors and Clinical Governance Leads across CTMUHB, and ensure compliance cases response from electronic notifications regarding NICE guidance relevant to their specialty.

Meet the members

Chair – Nicola Morgan-Thorpe, Lead Nurse for Clinical Effectiveness
Vice Chair – Aislinn Morgan, Deputy Director for Audit and Effectiveness
Aislinn Morgan, Head of Clinical Audit and Effectiveness
NICE Leads for Clinical Audit and Effectiveness
Mia Allen-Walker (Inpatient ICG)
Aislinn Morgan (Outpatient & T&F ICG)
Mia Allen-Walker (Emergency & Critical Care ICG)

Head of Governance
Chief Executive (Inpatient ICG)
Claire Applegate (Outpatient & T&F ICG)
Claire Applegate (Emergency & Critical Care ICG)

Angela Bell, Maternity Quality Manager
Bryony Tweeddale, Maternity Representative
Lauren Dwyer, Clinical Effectiveness Manager
Lisa Thompson, Senior Clinical Audit and Effectiveness Practitioner

Table with 2 columns: Topic, Date

Topic: Emergency response and management, diagnosis and initial management (updates), 24 November 2021

Topic: Primary prevention, secondary prevention, screening, testing and treatment, 30 November 2021

Topic: COVID-19 rapid guideline: management COVID-19 (updates), 1 December 2021

Topic: Prostate cancer (updates), 15 December 2021

Topic: Rehabilitation after traumatic injury, 22 January 2022

Topic: Mental wellbeing at work, 22 February 2022

Topic: Reproductive health: diagnosis and management (updates), 22 March 2022

In 2021 the organisation set out to develop and deliver an exemplar model to manage all NICE guidance and quality standards.

The following has been achieved in 2021-22:

- Appointed a Lead Nurse for Clinical Effectiveness (who has since qualified as a NICE Scholar)
- Established a NICE Reference Group to review and manage and monitor NICE compliance across the organisation
- Secure a system AMaT to enable the online recording of compliance against NICE guidelines and standards
- Appointed a NICE clinical lead in each of the 3 Integrated locality Groups
- Developed a NICE Newsletter to share best practice
- Working collaboratively across Wales with the NICE Implementation Facilitator for Wales through regular meetings and by helping to lead sub groups of the Welsh NICE Health Network
- Developed a pathway for the implementation of NICE guidelines and standards

Learning from Mortality Reviews

The introduction of Medical Examiners across NHS Wales has provided an opportunity to look at how mortality reviews can be conducted to identify themes and trends, maximise learning, prevent future harm and improve the experience of patients, families and NHS staff.

The Mortality Review Framework for Wales aims to provide a co-ordinated and systematic all Wales approach to the mortality review process to enable local and national implementation of learning, targeted clinical audit and quality improvement work.

Every stage of the mortality review process provides an opportunity for learning and recognizing notable practice. The learning captured is shared via a quarterly newsletter. Immediate make safe cases are instantly communicated to the directors of the ILG's and Directors of nursing if required. Going forward the mortality review module within DATIX will assist us with capturing this information in a more systematic way and each learning point will have an action plan assigned to it.

LEARNING FROM MORTALITY REVIEW Quarter 2 July - Sept 2021

360 cases of Good Practice

5 cases where Room for Improvement

Key Themes

Raising awareness - End of Life Care

From recent reviews at all levels of Mortality Review it has been noted that better end of life care may have achieved:

- Better patients care and less suffering
- Dying in dignity
- Dramatically reducing the burden & costs on unnecessary NHS/hospital intervention particularly speaking in this hard NHS days.

For training and support please email: CTM_SPTeducation@wales.nhs.uk or Rebecca Spicer-Thomas (CTM UHB - palliative care) - Rebecca.Spicer-Thomas@wales.nhs.uk

Quarter 1 MR Activity

Activity	Mentley & Cymdeirion	Rhondda & Taff	Regional
Referrals for Mortality Review	285	259	233
Referrals for Stage 2	72 (25%)	74 (29%)	12 (5%)
Stage 2 Complete	16	8	1

GENERAL LEARNING IDENTIFIED

- End of Life care
 - Obituary coverage for patients when documented "this for Obv" needs to be completed on baseline template
 - DISAC discussions could have taken place earlier in patient's episode of care
 - Interim/Unnecessary investigations for patients who have are being kept unnecessary for end of life care.
 - Appropriateness of transfer of patients to community hospitals in end of life - multiple episodes of death within 30 days of transfer this quarter
 - Interim decision pathways for patients
- Nursing
 - Reporting of fluid balance needs to be sub-optimal on numerous occasions. Not regularly reviewed but reviewing of output more extensive
 - There has been escalation to Stage 3
 - Discharge/Admission
 - Entry without notes in medical case notes. This is important from a medicolegal perspective
 - Communication
 - Family comments about communication from the Medical/Nursing teams
 - Delays in communication between specialist within the hospital
 - Referral to a patient has been referred to Stage 2 where cases were in the community as to which team were responsible for patients who subsequently received CRP
 - Ward
 - Unsettled patients noted by MR awaiting times for ambulance to arrive
 - Unavailability of ambulance to arrive patients for ambulance to arrive
 - Delays in coming able to allow patients to be transferred to the appropriate Department
 - Unsettled Care Homes
 - Unsettled patients with care requirements from Care Homes. Patients admitted and for nursing care only that should have been provided by Care Home
 - Family concerns over reactions of visiting due to COVID

RECOMMENDED

Stage 3

- Should CTD electronic notes systems have a clinical decision for DISAC/CRP when patient has a case but was not fully documented on system again with their system is currently
- Documentation of discussion between clinical teams to be improved. Clin of decision should be fully documented in the notes or understand the reasons for care decisions
- Increased number of patients admitted under the CRP/CRP system
- Should appropriate needs/requirements be met to be fully documented. It has been noted that COVID19 may be playing a part in this

For further information on Learning From Mortality Reviews please contact Natalie for Clinical Effectiveness: Natalie.Morgan-Thomas@wales.nhs.uk

In 2021-22 CTMUHB has led on:
The redevelopment of the Once for Wales (DATIX) Mortality Review Model and implementation of the module.

Quarterly Learning from MR Newsletters that identify key themes and trends, MR process performance and identified learning

Monthly Mortality Review (MR) training is undertaken by the Lead Nurse for Clinical Effectiveness and Medical Examiner. The aim to update clinicians on the new MR process nationally and locally within CTMUHB. In addition the training aims to provide clinicians with the knowledge on how to undertake a Hospital mortality review.

MR Learning Events planned for 2022-23



Clinical Audit and Effectiveness
Annual Report 2021-22



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



Clinical Audit &
Quality Informatics Department
part of the Medical Directors Office