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#CAAW25

CLINICAL AUDIT AWARENESS WEEK 2025

CELEBRATING OUR CLINICAL AUDIT HEROES!

PATIENT SAFETY

12:30-13:45

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CAAW25 programme

Date	Mon 2 June	Tues 3 June	Weds 4 June	Thurs 5 June	Fri 6 June
Topic	Patient Safety	Patient & Public Involvement	Healthcare Inequalities	Influencing Change	Efficiencies
Key speakers	Hester Wain (NHSE)	Kim Rezel (HQIP)	Danny Keenan (HQIP)	Sam Riley (NHSE)	Dr Theresa Barnes (RCP)

All online, 12:30-13:45

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Today's agenda

1. Introduction

2. Key speaker

3. Clinical Audit Hero winner announced

4. Winner presentation

5. Q&A

6. Evaluation

7. Close and celebrate #CAAW25!

#CAAW25

Introduction

2024.

Bold & Ambitious

2025.

Value & Impact

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#CAAW25 - Patient Safety

National Clinical Audit

National Emergency Laparotomy Audit (NELA) - Focuses on the care of patients undergoing **emergency bowel surgery**—a high-risk procedure often performed in acute hospital settings – Impact: improvements in survival rates and consistency of care across acute trusts in England and Wales.

National Clinical Audit of Psychosis (NCAP) – Focuses on evaluating the care provided to individuals experiencing a first episode of psychosis, particularly through **Early Intervention in Psychosis (EIP)** services – Impacts: preventing deterioration and harm, reduces medication-related risks, safer home environments and relapse prevention and reduces variability and unsafe practices in mental health care

Pulmonary Rehabilitation Audit – focuses on evaluating the quality, accessibility, and outcomes of pulmonary rehabilitation (PR) services for people with **Chronic Obstructive Pulmonary Disease (COPD)** across community and outpatient settings in England and Wales – **Impact:** Reduces hospital admissions and improves quality of life, identifies gaps in service provision that could lead to deterioration or preventable harm & supports safe transitions from hospital to community care through structured rehabilitation pathways.

CVDPREVENT – focuses on identifying patients with undiagnosed or undertreated high risk conditions such as: **Atrial Fibrillation, Hypertension, High Cholesterol, Diabetes and Chronic Kidney Disease** – **Impact:** Reduces complications, medication related harm, missed interventions and helps identify and address disparities of care – safe and equitable care

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Local Clinical Audit

Sepsis Screening and Management Audit - Reviewing timely identification and treatment of sepsis - **Impact**: Improved early intervention and reduced mortality.

Equity in Access to Cardiology Services Audit - Identifying disparities in access to timely diagnosis and treatment (e.g. for heart failure, angina, or arrhythmias) - **Impact:** Improved early intervention preventing complications, admissions and reduced mortality.

Patient Involvement in Discharge Planning Audit - Ensuring patients understand their medications, follow-up appointments, and warning signs to watch for. **Impact:** reducing re-admission rates and post discharge complications - medication errors and avoidable harm after hospital stays.

Adherence to NICE Guidelines for Stroke Rehabilitation - Ensuring patients receive **evidence-based interventions** that reduce disability and improve recovery. **Impact:** reduced long term disability, falls or complications like aspiration pneumonia

Digital Documentation and Handover Audit - Ensuring **accurate, timely, and complete clinical records**, which are essential for continuity of care. **Impact:** reducing handover errors – a leading cause of preventable harm

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CAAW - Patient Safety

- PSIRF and Clinical Audit working hand in hand
- Harness power of patient experience
- Importance of audit and making it easy
- Collaborative working for Patients involvement QI projects
- Highlights that audit can improve patients experience & journey
- The power of using clinical audit to improve patient care
- Be bold and innovative when considering projects
- How important it is to develop links with Trust patient safety teams
- Thinking wider from a system perspective
- How audit can fit into PSIRF. There is so much focus on PSIRF and good to know how we can fit in
- Thinking carefully about how we can link our efforts to the patient experience
- Compassionate involvement
- The importance of clinical audit as well as looking at the system & human factors in incidents

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#CAAW25 - Patient Safety

Considerations for Clinical Audit

Effective Clinical Audit for Patient Safety (1.)

We plan and deliver health & care both ***safely and with efficacy***

Clinical Audit effectively utilised to measure & improve on delivering **clinically effective** care can **prevent avoidable harm**

Clinical Audits effectively utilised in response to **Patient Safety** can reduce or eliminate a risk, address concerns or even ***prevent recurrence*** where harm has occurred

An **evidence based QI process** that supports teams to understand when, where and why **evidence based health & care** is not being delivered – **consistently** & as **standardised** practice

Clinical Audit outcomes drive **evidence based improvements** that **reduce variability**, **standardise care** and enhance **patient safety**

Considerations

2. Involving patients and their families/carers

3. Health Inequalities

4. Influencing Change

5. Efficiencies

Value & Impact - Patient Safety

Improved Recognition and Response to Deterioration

Safer Surgical and Procedural Care

Reduction in Hospital-Acquired Harm

Enhanced End-of-Life and Compassionate Care

Faster Learning from Adverse Events

Improved Multidisciplinary Team (MDT) Working Across Systems

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Healthcare Quality Improvement Partnership (HQIP)

- **Tina Strack**

  Associate Director, National Clinical Audit and Patient Outcomes Programme (NCAPOP)

  HQIP

Find out more about all #CAAW25 activities and releases – scan the QR code or go to:
www.hqip.org.uk/clinical-audit-awareness-week

Key speaker

Patient safety healthcare inequalities reduction

Hester Wain (she/her), #CallMe "Hes" or "Hester"

Head of Patient Safety Policy, NHSE hester.wain@nhs.net

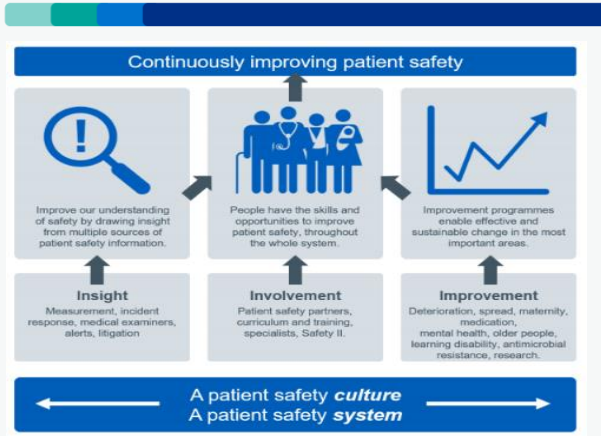
Empower, engage, inspire
Ally
NHS England
LGBTQIA+ staff network

MENOPAUSE NETWORK

Mental Health First Aider®
MHFA England

Global Majority Ally

Our patient safety commitment



"We are committed to identifying whether and how current patient safety culture and mechanisms contribute to health inequalities, including by engaging with patient, staff and other stakeholder groups."

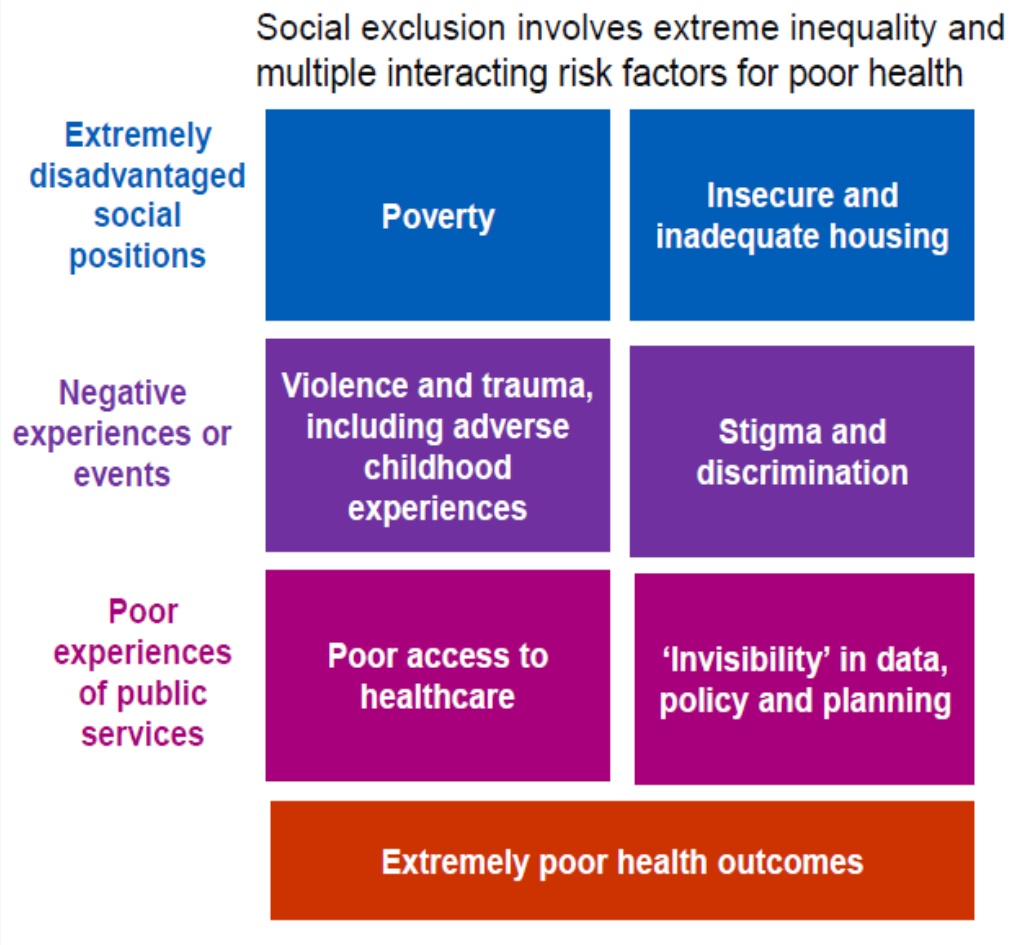
Marginalised groups

Protected characteristics

1. Age
2. Disability
3. Gender Reassignment
4. Marriage & Civil Partnership
5. Pregnancy and Maternity
6. Race and ethnicity
7. Religion and belief
8. Sex
9. Sexual orientation

Inclusion health groups

People experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery, looked-after children and young people; carers of patients; people or families on a low income; people with poor literacy (language skills) or health literacy; people living in remote locations, rural, coastal and island locations; refugees, asylum seekers; *Armed Forces personnel, veterans and their families, and other socially excluded groups.



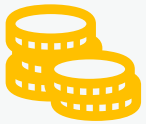
*Armed Forces Bill (2021)

Why healthcare inequalities matter

Health outcomes - inequalities lead to worse outcomes for marginalised groups

Fairness and justice - everyone should have an equitable opportunity to be healthy

Trust in the system - inequity erodes trust in healthcare staff, providers and institutions



Economic impact - health disparities are costly, which leads to pressure on care systems

Public health - when parts of the population are left behind, it affects the whole of society

Black women were **3.7x** more likely to die than white women (**34 women** per 100,000 giving birth)

Asian women were **1.8x** more likely to die than white women (**16 women** per 100,000 giving birth)

Trans and non-binary

30% of trans and non-binary respondents did not access any NHS or private support during their pregnancy or pregnancies.

54% of trans and non-binary respondents who freebirthed* would have found it helpful to have a midwife to support them during labour and giving birth

80% of trans and non-binary respondents who freebirthed were not confident to access maternity services if they needed to.

This was particularly stark for Black children who were 10 times more likely to be referred to CAMHS via social services (rather than through the GP) relative to White British children.

Nearly 1 in 5 (19%) of people told us they require a communication support professional, such as a BSL interpreter, lipspeaker or notetaker to be to be present during an appointment. 67% of sign language users and 62% of people needing another type of communication support professional have been denied this at some point.

- Still Ignored the fight for Accessible Healthcare (2025)
- MBRRACE-UK - Saving Lives, Improving Mothers' Care (2022)
- Trans and Non-Binary Experiences of Maternity Service, LGBT Foundation (2022)
- Ethnic Inequalities in Healthcare: A Rapid Evidence Review - NHS Race and Health Observatory (2022)

Patient safety healthcare inequalities

Health inequalities are preventable, unfair and unjust differences in healthcare status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill-health occurs.

Healthcare inequalities include unequal access, experiences and outcomes within health and care systems. When these inequalities cause or increase the risk of harm to patients in healthcare, they are considered patient safety healthcare inequalities.

5 principles to reduce patient safety healthcare inequalities

Principle 1:

Communication and information

Principle 2:

Training and resources

Principle 3:

Accurate and complete diversity data

Principle 4:

Diverse co-production

Principle 5:

Research

[NHS England » Patient safety healthcare inequalities reduction framework]

The most important aspect of this framework is the experiences that informed it, stories of suffering and loss that were bravely shared so we could learn and improve patient safety. These personal stories are available online.

With special thanks to:

- **Oliver McGowan's family**
- **Ayeesha**
- **Seni Lewis' family**
- **James**
- **Deaf parent**
- **Sean**
- **Fizzah Ali**
- **Jaspreet Kaur**
- **Angela Thomas**
- **Kye Gbangbola**

Benefits

To patients and families:

1. Fewer people harmed, especially those from marginalised communities
2. Fewer complaints, as culturally sensitive communication improves
3. People feel more able to raise concerns with staff
4. People feel safer and listened to within healthcare, with less discrimination, so are more likely to seek help earlier
5. People are involved in the co-production and delivery of improvements, so that these are tailored to needs of the people who require them

To staff:

1. Increased confidence and understanding of patient safety healthcare inequalities reduction via access to free, online training
2. Increased confidence and understanding of how to access translation and interpretation services 24/7
3. Accurate collection of diversity data, leading to better understanding of where and how to target resources
4. Increased staff diversity leading to more improvement and innovation

The impact of co-design

- Khudeja and Priscilla, our patient safety partners (PSPs) , have been part of the Patient safety healthcare inequalities reduction group from the start
- They have directly contributed to patient stories and case studies that enable the inclusion of patient safety stories of people from diverse ethnicities
- They have ensured that we accurately reflect the breadth of diversity of communities that access and support our NHS within this framework
- Priscilla has presented on the promotion of inequalities reduction and inclusion of patient safety partners to the initial development work on “Worry and Concern” that has morphed into Martha’s Rule
- Khudeja has presented the Patient safety healthcare inequalities reduction plan at NHS Confed 2024
- Khudeja and Priscilla have both been involved in discussions on Interpretation and Translation Services with the Healthcare Inequalities Improvement Programme
- Khudeja and Priscilla have produced a podcast on PSP involvement in inequalities reduction https://on.soundcloud.com/1CDUa62DbWpY4t79A with over 1,700 hits!
- Khudeja has further supported and added amendments to the final shaping of the framework, ensuring the use of plain English

What you can do to reduce inequalities

Inclusion

- ✓ Provide resources in multiple languages and formats
- ✓ Promote translation and interpretation services

Insight

- ✓ Collect data to understand patient diversity
- ✓ Record patient diversity data for incidents in LFPSE
- ✓ Review local population to identify marginalised groups
- ✓ Review NHS staff survey data in relation to WDES and WRES - Model Health System

Involvement

- ✓ Identify 2 or more patient safety partners (PSPs)
- ✓ Talk to community groups, patient safety partners, marginalised groups, equality, diversity and inclusion lead(s), and staff diversity networks
- ✓ Tell stories from service user, patients and families from local communities
- ✓ Enable diverse staff teams, as this has a positive impact on patient care, and enhances our ability to improve and innovate, and results in better productivity and staff engagement (Kline 2018)

Improvement

- ✓ Train staff on unconscious bias, patient safety syllabus and healthcare inequalities
- ✓ Promote the benefits of accurate collection and use of diversity data

Understanding your local population

Local Authority – Public Health teams

- Produce a Joint Strategic Needs Assessment which includes demographic information based on Census (which includes protected characteristics data) as well as using the GP registered population.
- Public health teams also conducted health needs assessments in various areas such as older people, mental health, physical health, carers needs, etc. which provides used information on the local population needs.

ICS – Health information team

- Can provide GP level demographic breakdown of the population registered with GPs with breakdown of protected characteristics (where recorded).
- GP profiles developed by the OHID can be access via https://fingertips.phe.org.uk/profile/general-practice

Census 2021 data at Local authority level as well as at lower geographies such as super output areas including maps

- Can be accessed via – CENSUS 2021 Statistics for England and Wales. Office for National Statistics https://www.ons.gov.uk/census/maps/ OR via https://www.ons.gov.uk/datasets/TS007/editions/2021/versions/3

Office for Health Improvement and Disparities produces various health profiles which can be accessed via

- https://fingertips.phe.org.uk/
- You can drill down to a Local authority or an ICS level for most datasets which includes comparative and trend data and some profiles also breakdown the data with regard to health inequalities

NHS England

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Thank you

NHS
RACE & HEALTH OBSERVATORY
Breaking barriers for better health

NHS
The Royal Wolverhampton NHS Trust

NHS
North Bristol NHS Trust

Mid and South Essex Integrated Care System

NHS
Resolution

NCEPOD

NICE National Institute for Health and Care Excellence

CareQuality Commission

Health Innovation Network

NHS
Hampshire and Isle of Wight

LOCAL CARE DIRECT

NHS England — NHS England – North West

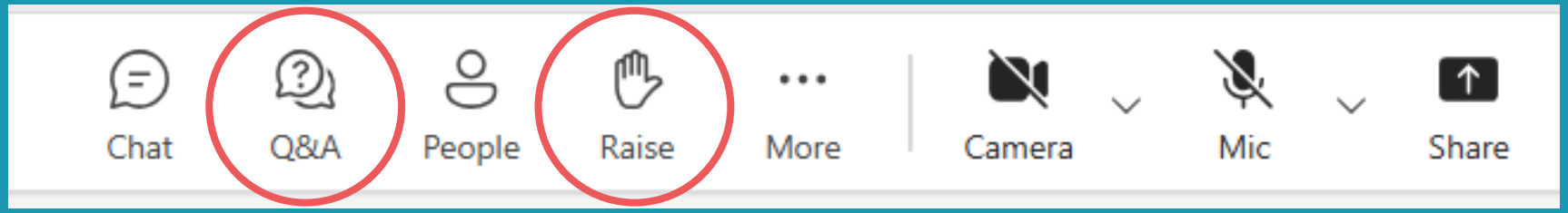
North West London Integrated Care System
Working together for better health and care

NHS
University Hospitals Bristol and Weston NHS Foundation Trust

NHS England — NHS England – London

Q&A for our Key Speaker

Raise your hand and when selected, we will enable your mic and camera so you can take yourself off mute and ask your question



Submit a written question via Q&A

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Our Clinical Audit Hero winners…

Patient Safety Hero

Runner-up

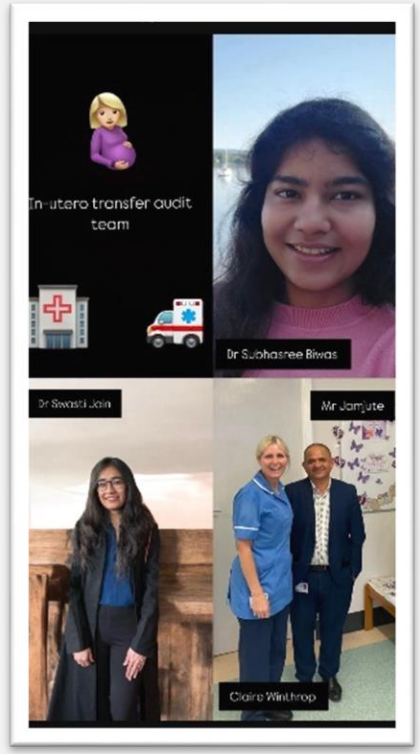
Mosab Elbasuny
Core Psychiatry Trainee
Liaison Psychiatry Team
Torbay Hospital, Devon Partnership Trust

Project: Safety Planning Audit in Liaison Psychiatry 2023-2024

Patient Safety Hero

Runner-up

Dr Swasti Jain, Dr Subhasree Biswas, Mr Pradumna Jamjute, Claire Winthrop
Obstetrics and Gynaecology
West Cumberland Hospital, Whitehaven, North Cumbria Integrated Care NHS Trust



Project: In-utero transfer

Patient Safety Hero

Winner

Sarah Willis
Advanced Neonatal Occupational Therapist
Coventry and Warwickshire Partnership Trust

Project: Neonatal Occupational Therapy to Improve Positioning Practices

Winner presentation

Coventry and Warwickshire Neonatal
Allied Health Professionals Integrated Service

NHS
Coventry and Warwickshire Partnership
NHS Trust

Neonatal Occupational Therapy: Impact on neonatal positioning

Sarah Willis
Advanced Neonatal Occupational Therapist

Clinical Audit Heroes Awards 2025

People at our heart

Context

- George Eliot Hospital agreed funding to provide Occupational Therapy (OT) into a SCBU that previously had none.
- The role of OTs in neonatal care is poorly understood and valued nationally.
- Understanding around developmental positioning was highlighted as lacking in the unit, confirmed by audit.
- Quality improvement methodology was integral to scope, implement and monitor change in practice for neonatal positioning. Considering sustainable change to improve care for neonatal babies.
- Focus on prevention!

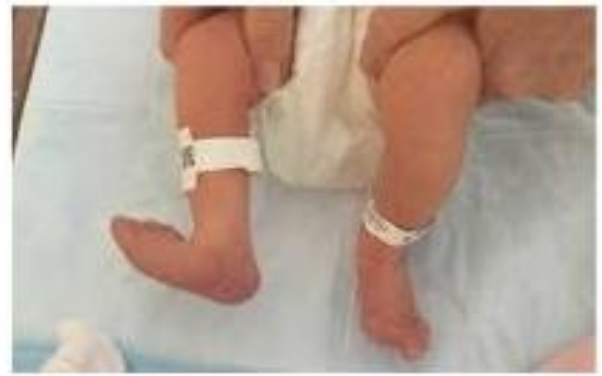
PEST(L)

Political	Economic	Social	Technological	Legal
NHS LTP – Right Specialist, Right Time Ockenden (2020, 2022) "Staff working and training together (MDT focus)" NCCR Review (2019) "enhanced provision to improve neonatal outcomes" GIRFT (2022) "a call to embed AHPs, into all neonatal units, to help improve outcomes"	Isolated Role – difficult to integrate, not many others to look to or model off Funding for Role - external Additional costs as a result – resources, positioning equipment, assessment kit, physical space	Babies surviving at younger gestations with more complex needs Existing staff's understanding of the Role Patient expectations and Role of Families in decision making Staff Morale/Moral Injury associated with change of practice	Access to online info about what could/should be delivered at a gold standard Tools to measure/monitor Ability to launder positioning equipment	Litigation Letby court case and spotlight on neonatal services

When positioning goes wrong.....

Stress and pain

Reduced perception of midline which affects balance



Externally rotated hips and feet

Tight shoulder girdle which can restrict movement

Poor posture

Increased cervical lordosis

Plagiocephaly/ Brachycephaly/ Scaphocephaly

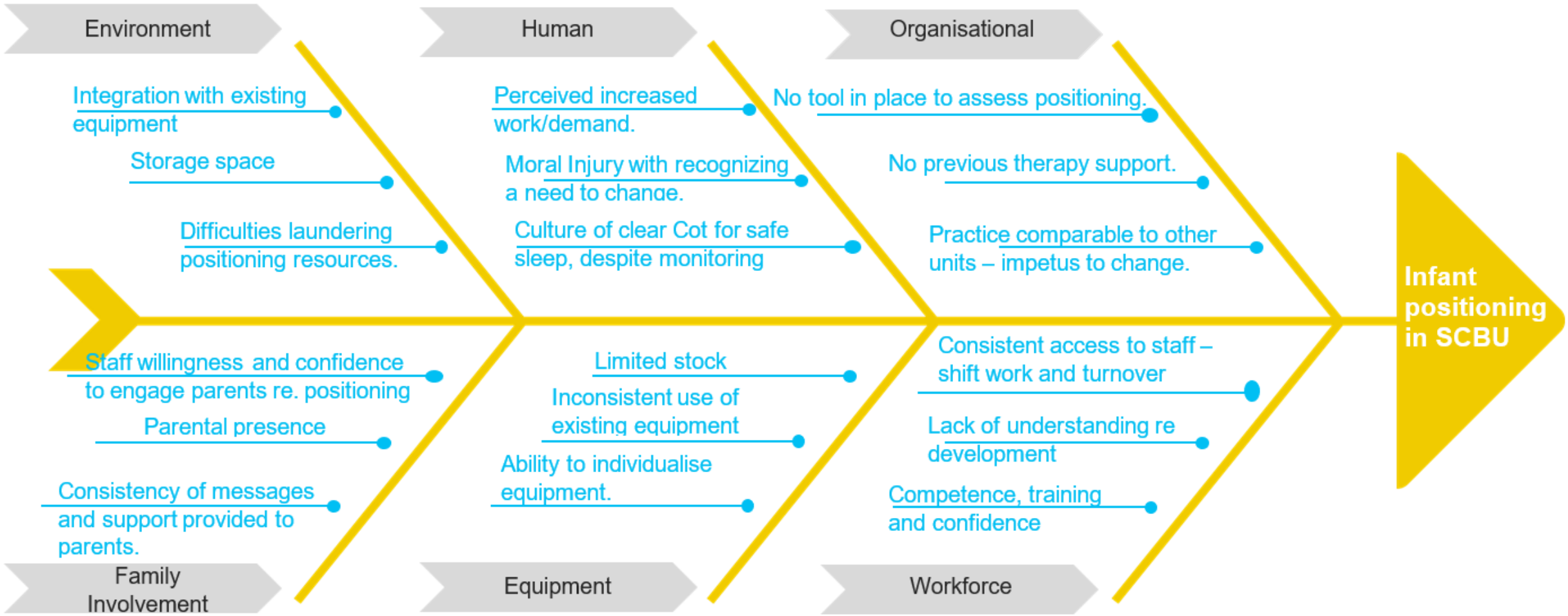
Asymmetry

Poor head control

Delayed visual and auditory skills

Skin Breakdown

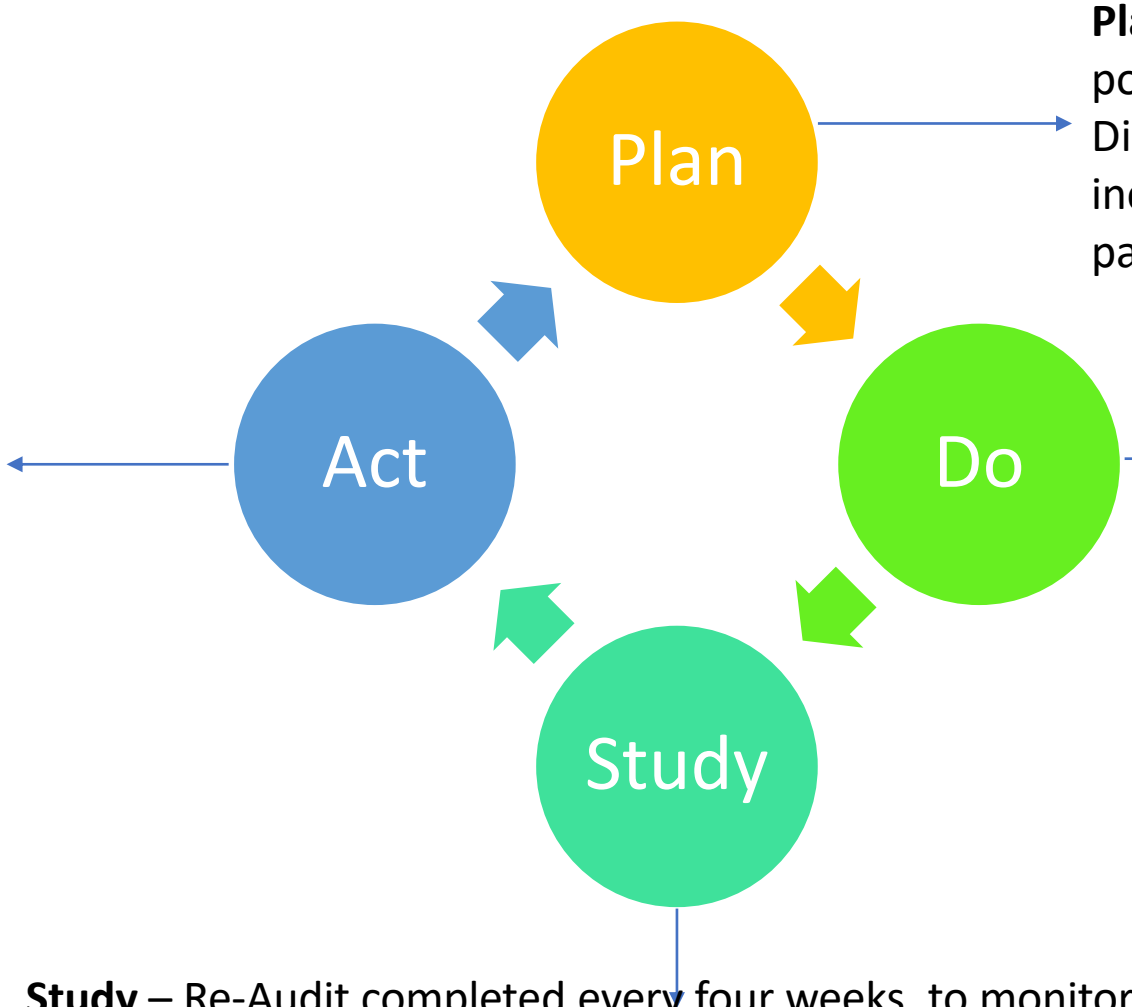
FISHBONE DIAGRAM



Ishikawa, K (1968) Guide to Quality Control, JUSE, Tokyo

PDSA

Act – Key questions developed such as: Are positioning scores improving?
Are staff taking individual ownership of enhanced positioning their patients without OT prompting?
If not, why not?
Implemented action plan and started cycle again

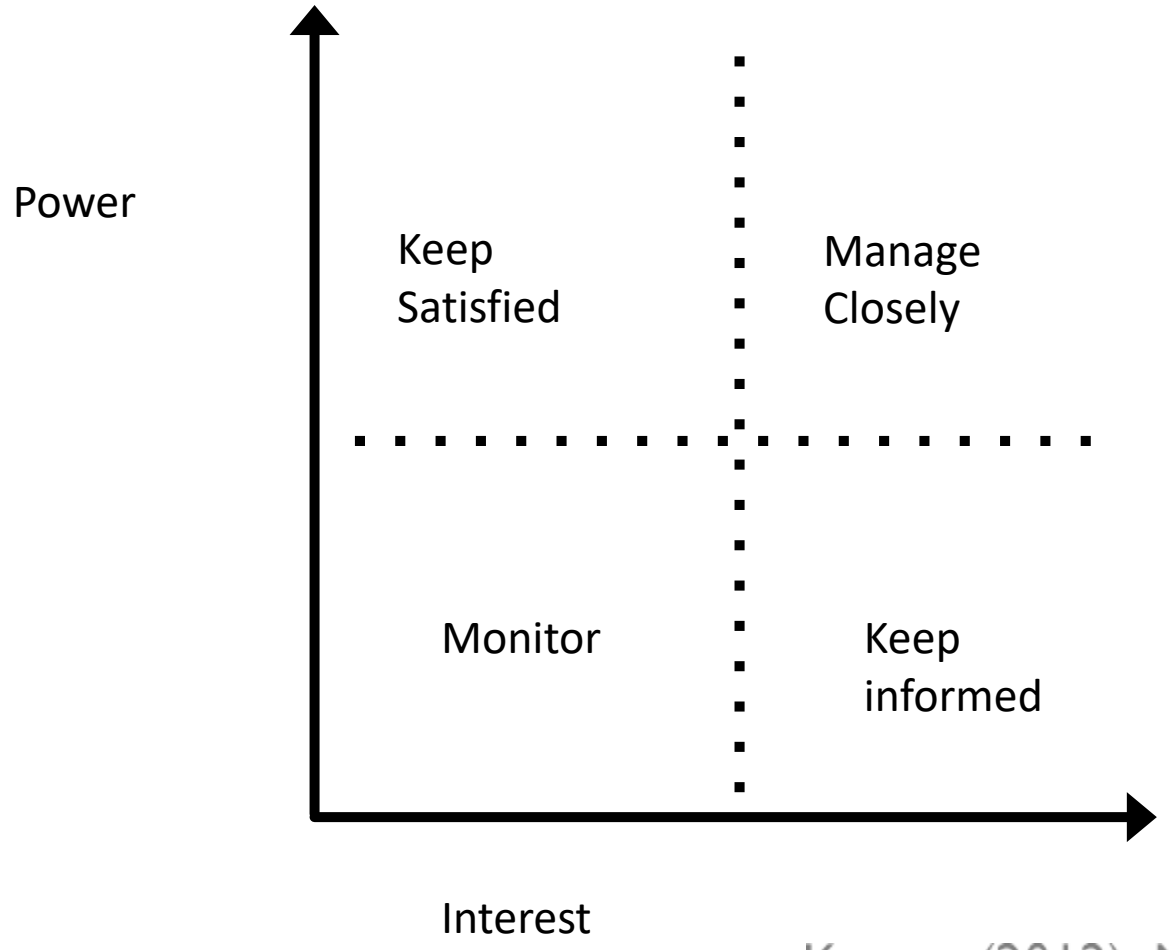


Plan – Reviewed and audited current positioning practices and equipment. Discussed with key stakeholders including ward staff, MDT and parents.

Do –
-Introduced cot side demonstration of enhanced neonatal positioning.
-Established examples of good practice that can be shared.
-Offered support to reposition and demonstrate alternative techniques.
-Training for care navigation staff.
-Engaged parents as stakeholders

Study – Re-Audit completed every four weeks, to monitor if improvement is occurring and considered the effectiveness of my approach. Analysed trends in data and created targeted action plans (education, demonstrations etc). Kept stakeholders engaged and shared data trends to key stakeholders for continued compliance

Stakeholder Analysis



Kantor (2012), NHS England and NHS improvement (2021)

Challenges


Readiness
Time
Impatience
Reality
Moral Injury
Leadership

Outcome

- Positioning audit completed monthly using Hunter tool (which is used network wide)
- For 8 months 100% of babies were scoring as needing major repositioning
- On month 9 = first month where **all** babies scored as needing only minor adjustments only
- 100% minor adjustments only scoring maintained

Feedback

- “I’ve worked in neonates for years and years and it wasn’t until I worked with you that I understood positioning”

- “when they told me I was poorly and she needed to come so early I was reassured she would have good medical care but no one could reassure me about her development and how to support this so it was such a relief to meet you, I really don’t know how we could do it without you. “

- “he was looking so comfy and well positioned when I arrived and I just knew you must have done that.” I was pleased to be able to explain that I didn’t need to reposition her baby which is why it’s so great to hear how comfy he looks as it shows that across the team we are are understanding the purpose of some of my positioning!

QI-1285 Neonatal Occupational Therapy to Improve Positioning Practices

Project Lead: Sarah Willis, *Advanced Neonatal Occupational Therapist*

Feb 2024

NHS Coventry and Warwickshire Partnership NHS Trust

NHS George Eliot Hospital NHS Trust

Project Aim: To evaluate the effectiveness of Neonatal therapeutic input and collaborative working in George Eliot Hospital (GEH).

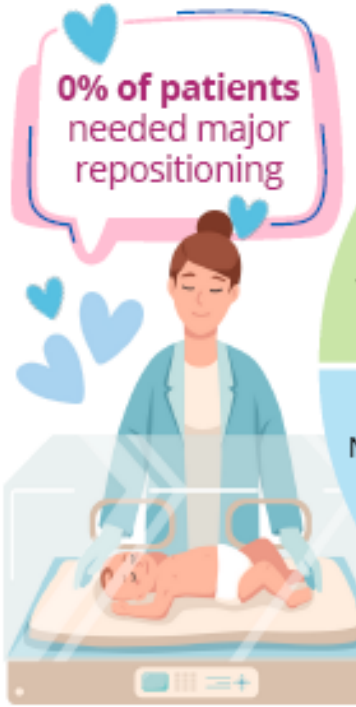
Summary: The *'Theory of Moral Injury'* (led by Čartolovni et al) was established during the pandemic following observations around inflicting human suffering during life saving treatment. This research is increasingly being applied to Neonatal care, acknowledging the pain caused to save tiny babies lives, the quality of life that child may be left with and effect of the families long term. A new role was created in the Special Care Baby Unit (SCBU), where there was previously no therapeutic input for neonatal patients. George Eliot Hospital (GEH), recognised and funded the role, with the scope of the full service open to improvement. This project on positioning practices will be used to determine service needs, as well as increase collaborative working with other regional units via a Trust SLA.

QI Tools Used:

- **PDSA** (Plan, Do, Study, Act) Cycle
- **Stakeholder Analysis**
- **Fishbone Diagram**
- **PESTLE** (Political, Economic, Social, Technological, Legal) Framework

Outcomes Achieved:

- Positioning audits completed monthly using the Hunter Tool (recognised network wide), demonstrated a **reduction** in neonatal patients needing major repositioning vs minor adjustments only; in month 1-8 **100% of neonatal patients** needed major repositioning **vs 0% of patients** needing major repositioning in month 9.
- This trend was maintained; no subsequent months have shown 100% of babies needing major repositioning.
- Staff reported increased confidence in delivering therapeutic positioning independently, reducing reliance on specialist intervention.
- Families were educated on positioning principles, **empowering** them to contribute to their child's care. This fostered **trust** and **engagement**, **improving** the overall care experience.



Next Steps:

CWPT have recently been successful in securing a bid to host the new Local Maternity and Neonatal System (LMNS) wide Neonatal Therapy service which now offers input and support to 3 units in Coventry & Warwickshire, where there was previously no service.

The Improvement Team

People at our heart

Thank you for listening

Questions?

Coventry and Warwickshire Neonatal
Allied Health Professionals Integrated Service

NHS
Coventry and Warwickshire Partnership
NHS Trust

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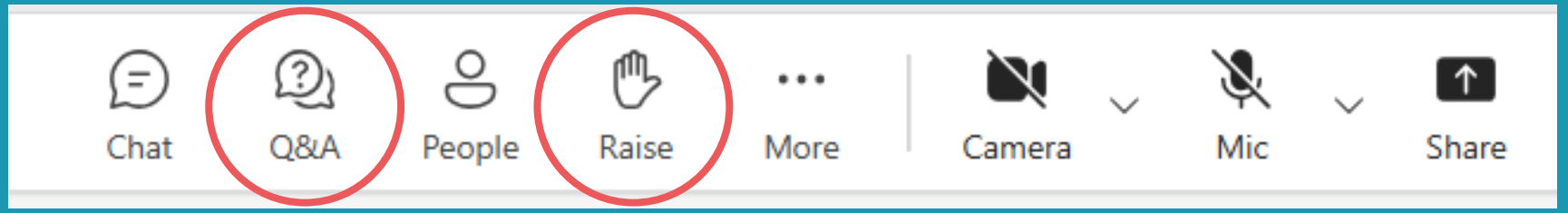
Q&A for our Winner

Raise your hand and when selected, we will enable your mic and camera so you can take yourself off mute and ask your question



Submit a written question via Q&A

Evaluation and close

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How was this event?

46

#CAAW25 - Patient Safety

Take away challenges

How will this Clinical Audit add **value**? How will it support **patient safety**?

What metrics will be utilised to evidence **impact** on improving **patient safety** overtime?

What do we already have that we can utilise differently?

- Are we maximising the impact of participation in current Clinical Audits across pathways & systems?
- How can we make better use of real time integrated data to drive improvements across pathways & systems?

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National Quality Improvement (Inc. Clinical Audit) Network
N-QI-CAN

#CAAW25

Join tomorrow's lunch and learn!

Date	Mon 2 June	Tues 3 June	Weds 4 June	Thurs 5 June	Fri 6 June
Topic	Patient Safety	Patient & Public Involvement	Healthcare Inequalities	Influencing Change	Efficiencies
Register					

All online, 12:30-13:45

Upcoming Clinical Audit Awareness Week activities

- **JOIN A LIVE Q&A on HQIP's X account (handle: @HQIP) TODAY (2 June) from 2.00pm – 2.30pm**
  Balancing learning in clinical audit and quality improvement with patient safety
  With HQIP's Clinical Fellow, Dr Ollie Burton
- **SIGN UP for tomorrow's Lunch & Learn on Tue 3 June, 12.30pm – 1.45pm**
  Patient & Public Involvement (PPI)
  With key speaker: HQIP's Head of Patient Engagement, Kim Rezel, and N-QI-CAN
- **WATCH A NEW video release (or the podcast version) – available on HQIP's website now!**
  Improving sepsis care through clinical audit
  With HQIP's Chair, Celia Ingham Clark & Clinical Fellow, Dr Ollie Burton
- **READ a new patient safety case study – available on HQIP's website now!**
  Sepsis Audit 2023–2024 – Haywood Community Hospital
- Find out more about all #CAAW25 activities and releases (event recordings, resources, case studies, etc)
  Scan the QR code or go to: www.hqip.org.uk/clinical-audit-awareness-week
- For those on social media, please share your **#CAAW25** updates!

#CAAW25

Share CAAW activity with us

N-QI-CAN

- future.nhs.uk/NQICAN
- nqican.org.uk
- nqi.can1@nhs.net

HQIP

- @HQIP
- hqip.org.uk
- communications@hqip.org.uk
- Healthcare Quality Improvement Partnership