Internal Audit Report
For Leicestershire Partnership NHS Trust

Clinical Audit
(Report reference: 1213/LPT/16/R)
May 2013
Executive Summary

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<td>Discussion Draft Issued:</td>
<td>24/04/2013</td>
<td>Claire Rashid, Clinical Quality and Effectiveness – Trust Lead.</td>
<td>Mrs S Noyes, Acting Chief Executive</td>
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<tr>
<td></td>
<td></td>
<td>Jacque Burden, Clinical Governance Lead (AMH &amp; LD)</td>
<td>Dr P Cross, Acting Director of Finance, Performance and Information</td>
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<tr>
<td></td>
<td></td>
<td>Michelle Churchard-Smith, Deputy Clinical Director/Lead Nurse</td>
<td>Mr F Lusk, Director of Corporate Affairs/Trust Secretary</td>
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<td>06/05/2013</td>
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<td>Mrs B Johal, Head of Quality and Professional Practice</td>
</tr>
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<td>Client Approval Received:</td>
<td>13/05/2013</td>
<td></td>
<td>Mr C Parylo, Quality &amp; Effectiveness Co-ordinator</td>
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<tr>
<td>Final Report Issued:</td>
<td>14/05/2013</td>
<td></td>
<td>Ms J Raval, NICE &amp; Effectiveness Officer</td>
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<td>Mr C Burns, Chair, Audit Committee</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Mr N Bhayani, Non Executive Director, Audit Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mrs V Logan, Non Executive Director, Audit Committee</td>
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</tbody>
</table>

The co-operation and assistance of all staff involved is greatly acknowledged. This review was conducted by Sharon Harrison, Principal Auditor. Any query concerning the content of this review should be made to Hafiz Arif, Associate Director, Mental Health and Wellbeing on 01332 623700.
Executive Summary

Introduction & Background

Leicestershire Partnership Trust (“the Trust”) is committed to delivering effective Clinical Audit in all areas of clinical services. Clinical Audit contributes to the delivery of Corporate Objectives by supporting Clinical governance and quality improvement. The Trust’s objectives for clinical audit taken from the Trust’s Clinical Audit strategy for 2012-2015 are provided below:

- Harmonise Clinical Audit systems and processes to ensure a uniform approach across LPT
- Enable appropriate staff to have the necessary competency to support Clinical Audit
- Ensure organisational compliance with NHSLA Risk Management Standards
- Develop an annual clinical audit programme that improves the quality of care, from good to excellent
- Develop a robust system for reporting the outcomes of Clinical Audit activity
- Contribute to ensuring that the Trust is fully compliant with the requirements of the Health and Social Care Act 2008 (CQC)
- Demonstrate the benefits of Clinical Audit and share lessons learnt and good practice
- Encourage patient and public engagement in clinical audit
- Ensure that the audit service continues to modernise to meet the changing requirements of local and national Clinical Audit.

The Clinical Quality & Effectiveness – Trust Lead (CQEL) is responsible for managing the Clinical Audit forward plan. In conjunction with the Senior Clinical Quality Group (SCQG), Clinical Directors, Divisional Clinical Governance Leads and the Head of Quality and Professional Practice, the CQEL is responsible for ensuring that the clinical audit forward plan is relevant, supports service delivery and includes audits specified within national, regional and local guidelines.

The Quality and Effectiveness Co-ordinator (QEC) maintains a Trust wide clinical audit database which includes a log of proposal forms, completed reports and outcomes for all clinical audit activity. In addition a Clinical Audit Officer is assigned to each division to support Clinical Audit Leads with the delivery of clinical audit reports for priority level audits 1-4 for which definitions are provided below.

Priority Level one – External “Must do” audits

- Audits are externally monitored and assessed by the CQC and Commissioners. E.g. National Clinical Audit and Patient Outcomes Programme (NCAPOP), National Confidential Enquiries (NCE’s), National Commitments and Priorities published by the Care Quality Commission (CQC). Failure to participate in or deliver on these externally driven audits may carry a penalty for the Trust (either financial or in the form of a failed target or non-compliance- hence “must do” priority).

Priority Level two – Internal “Must do” audits

- Audits are based on high risk, high cost or high profile topics and may include national initiatives with Trust-wide relevance but no penalties exist for non-participation. Audits will relate to Trust governance issues or high profile local initiatives.

Priority Level three – Divisional Priorities

- Audits are identified by divisions and do not form part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and may be in response to persistent/local concerns or a trend analysis of complaints and adverse incidents.

Priority Level four – Clinician interest

- These audits are generated from innovative ideas by individual clinicians or professional groups.
The status of divisional work plans as at February 2013 is provided below:

**Key:**

- **Amber:** Delayed, with evidence of actions to get back on track.
- **Green:** Progressing to time, evidence of progress.
- **Blue:** Completed, evidence of compliance with standards or action plans to achieve compliance, or audits abandoned with approval of relevant groups.
- **White:** Audit not planned to start this quarter.

### Learning Disabilities

<table>
<thead>
<tr>
<th>Priority Level</th>
<th>Total</th>
<th>Red</th>
<th>Amber</th>
<th>Green</th>
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<td>7</td>
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<td>-</td>
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</tr>
<tr>
<td>Level 3 (Divisional Priority)</td>
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<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Level 4 (Clinician Interest)</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>1</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>48</strong></td>
<td><strong>1</strong> (2%)</td>
<td><strong>11</strong> (23%)</td>
<td><strong>26</strong> (54%)</td>
<td><strong>6</strong> (13%)</td>
<td><strong>4</strong> (8%)</td>
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### Adult Mental Health

<table>
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<tr>
<th>Priority Level</th>
<th>Total</th>
<th>Red</th>
<th>Amber</th>
<th>Green</th>
<th>Blue</th>
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</tr>
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<tr>
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<td>15</td>
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<tr>
<td>Level 2 (Internal – Must do)</td>
<td>38</td>
<td>1</td>
<td>9</td>
<td>18</td>
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<td>7</td>
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<tr>
<td>Level 3 (Divisional Priority)</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Level 4 (Clinician Interest)</td>
<td>27</td>
<td>-</td>
<td>7</td>
<td>10</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>95</strong></td>
<td><strong>2</strong> (2%)</td>
<td><strong>19</strong> (20%)</td>
<td><strong>47</strong> (50%)</td>
<td><strong>19</strong> (20%)</td>
<td><strong>8</strong> (8%)</td>
</tr>
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</table>

Discussions with the Clinical Audit Team identified that as governance structures have evolved and clinical audit processes become more embedded within the divisions, the identification of level 3 audits has improved resulting in an increased number to be included within the divisional plan for 2013/14.
Audit Objectives and Scope

Following agreement with the Head of Quality & Professional Practice and the Clinical Quality & Effectiveness Trust Lead our review has been conducted in the following two phases:

Phase 1:
- Our review has focussed on the development of Clinical Audit work plans for the Adult Mental Health and Learning Disabilities divisions. This includes an assessment of existing governance arrangements in place.

Phase 2:
- A high level review to assess the extent to which baseline assessments are undertaken both centrally and at Divisional level to determine which NICE guidelines are applicable to the Trust’s audit programme, and how these are monitored and reported.

As part of our review three level 3 and twelve level 4 audits were reviewed. Full details of the sample of audits reviewed is provided at Appendix A.

Areas of Good Practice

A brief summary of the areas of good practice identified during the course of the review is provided below, and more detailed findings can be found within the full report.

Phase 1

Development of 2012/13 Forward plans for AMH & LD divisions
- The Clinical Audit Plan was approved at the Senior Clinical Quality Group (SCQG) on 9th May 2012 and Quality Assurance Committee (QAC) on 19th June 2012.
- Standardised clinical audit programmes exist for the AMH and LD divisions.
- Progress against delivery of clinical audit work programmes are reported centrally to SCQG, Patient Safety and Experience Group (PSEG) and to the respective divisions’ Clinical Governance and Clinical Audit Groups.
- Clinical audit reports are presented to the Divisional Clinical Audit Groups for approval of action plans.
- Progress and findings against the AMH & LD divisional clinical audit programmes are regularly reported to and monitored by Divisional Clinical Audit Groups and Clinical Governance Groups.
- The Quality & Effectiveness Co-ordinator produces a bi-monthly progress report against the clinical audit work programme. They are presented at SCQG, PSEG and divisional clinical audit groups.

Review of Existing Governance Arrangements
- The Trust has a comprehensive Clinical Audit Policy which was revised in February 2013
- Training sessions/workshops have been held for Clinical Directors, Clinical Audit Leads and divisional clinical audit groups during 2012/13.
- The Clinical Audit Policy outlines the structure for responsibility and ownership of clinical audit within divisions.
- Roles and responsibilities in relation to clinical audit are clearly defined within Terms of Reference Divisional Clinical Governance Groups and Clinical Audit Groups for both the AMH and LD Divisions.
Phase 2 - NICE

- A policy exists for the Dissemination, implementation and monitoring of (NICE) guidance ensuring a consistent approach across the Trust.
- There is a designated NICE & Effectiveness Officer (NEO) with responsibility for overseeing and co-ordinating the Trust’s NICE guidance implementation procedure.
- Performance reports are regularly reported to Divisional Leads and SCQG.

Audit Opinion

Significant Assurance can be provided over the existing approach to developing the clinical audit work plans for the Learning Disabilities and Adult Mental Health Divisions and the extent to which baseline assessments for NICE guidelines are undertaken both centrally and at Divisional level.

Areas for Improvement

There were no High or Medium risk issues identified. Detailed findings in relation to the 6 low risk issues identified is provided within the detailed findings section of the report together with a summary of actions agreed to improve the existing control environment.

Summary Findings

A summary of the risk issues identified, and subsequent actions agreed, is as follows:

<table>
<thead>
<tr>
<th></th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed Actions</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Actions Agreed</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>6</td>
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</tbody>
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Follow-up

A follow-up exercise will be undertaken during 2013/14 to evaluate progress made in respect of issues raised. This will include obtaining documentary evidence to demonstrate that actions agreed as part of this review have been implemented.
The following sections of the report summarise the control environment established by the Trust in relation to Clinical Audit. Each section highlights areas of good practice identified by the review. Where relevant, any control weaknesses identified are outlined, including actions that have been agreed in order to address the associated risks. The matrix used for scoring risks is compliant with the ISO 31000 principles and generic guidelines on risk management. This risk matrix, along with definitions of different opinion levels, is provided at Appendix E.

**Phase 1: Development of 2012/13 Forward plan for AMH & LD divisions.**

The review confirmed that:

- The Trust’s Clinical Audit Plan was approved at the Senior Clinical Quality Group (SCQG) on 9th May 2012 and Quality Assurance Committee (QAC) on 19th June 2012. Priority Level 1 & 2 audits are taken from key regulatory and assurance requirements of the Trust, namely: the Quality Schedule, CQUIN, NICE priorities, NHS Litigation Authority standards, Serious Incident action plans and other nationally and locally agreed best practice.

- Prior to commencing a priority level three and four audit, Clinical Audit Leads are required to obtain approval from Divisional Clinical Audit Groups.

- The Quality & Effectiveness Co-ordinator has produced divisional annual audit forward plans for 2012-13 for all divisions. This document details each clinical audit project and its priority level; Level 1 (external ‘must do’), Level 2 (internal ‘must do’), Level 3 (divisional priority) and Level 4 (clinical interest).

- A review of minutes for the Divisional Clinical Audit Groups for the period April 2012–February 2013 confirmed that audits for inclusion with divisional clinical audit plans are discussed regularly and prioritised.

- Clinical audit reports are presented to the Divisional Clinical Audit Groups for approval of action plans.

- The distribution for results of audits undertaken is identified at the start of the project by the Clinical Audit Leads.

- Approved audit reports are sent to the Clinical Audit Team to be logged onto the Trusts Clinical Audit database.

- Progress and findings against the AMH and LD divisional clinical audit programmes are regularly reported to and monitored by Divisional Clinical Audit Groups and highlight reports are provided to Clinical Governance Groups.

- The Quality & Effectiveness Coordinator produces a bi-monthly progress reports for the clinical audit work programme which are presented at SCQG and the divisional clinical audit groups.
### Detailed Findings & Recommendations

<table>
<thead>
<tr>
<th>Ref</th>
<th>Findings</th>
<th>Risk and Score (Impact x Likelihood)</th>
<th>Agreed Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A sample of 15 Level 3 &amp; 4 audits were selected across the Learning Disabilities (LD) &amp; Adult Mental Health (AMH) Divisions. Testing was undertaken to ensure that Proposal forms/audit tools had been submitted and approved for those Level 3 and 4 audits added to divisional audit programmes during 2012/13. We identified one instance where evidence to support appropriate approval was not in place. <strong>Liver Function Test (monitoring of outpatients prescribed valproate)</strong></td>
<td><strong>Without appropriately prioritised audit programmes, clinical audit may not be an effective component of clinical governance.</strong>&lt;br&gt;2 x 2&lt;br&gt;Low</td>
<td>Proposal forms to be submitted to the Clinical Audit Team for all Level 4 (Clinician Led) audits and passed to the most appropriate Trust group for approval.&lt;br&gt;&lt;br&gt;<strong>Responsibility:</strong> Claire Rashid, Clinical Quality and Effectiveness - Trust Lead&lt;br&gt;&lt;br&gt;<strong>Implementation Date:</strong> May 2013</td>
</tr>
<tr>
<td>2</td>
<td>The Trust’s Clinical Audit Team currently use a RAG rated progress tracking system to report the various status of level 1 – 4 audits. Our review of the tracking system identified that the Red RAG rating (Definition: no progress towards completion) was being incorrectly used to report status of a number of audits. i.e. some progress had been made as opposed to no progress and therefore status was being incorrectly reported.</td>
<td><strong>Status of current audits incorrectly reported</strong>&lt;br&gt;2 x 2&lt;br&gt;Low</td>
<td>An exercise to be undertaken to ensure that the status of each Clinical Audit currently in progress is reported in line with the definitions of the existing progress tracking system.&lt;br&gt;&lt;br&gt;<strong>Responsibility:</strong> Claire Rashid, Clinical Quality and Effectiveness - Trust Lead&lt;br&gt;&lt;br&gt;<strong>Implementation Date:</strong> July 2013</td>
</tr>
<tr>
<td>Ref</td>
<td>Findings</td>
<td>Risk and Score (Impact x Likelihood)</td>
<td>Agreed Action</td>
</tr>
<tr>
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| 3   | **Adult Mental Health**  
For one level 4 audit (*Monitoring Renal function for patients on long-term lithium therapy*) target dates for key stages within the audit process were not specified within the audit proposal. | Lack of defined timescales for completion of key stages within the audit resulting in ineffective performance monitoring.  
2 x 2  
Low | Specific target dates for key stages within the audit process to be detailed within audit proposals to ensure performance can be monitored effectively.  
**Responsibility:** Claire Rashid, Clinical Quality and Effectiveness - Trust Lead  
**Implementation Date:** May 2013  
**Management Response:**  
Completed - Since this audit proposal form was written, the harmonised Clinical Audit Policy has been approved which includes a revised proposal form. The proposed dates for completion section now includes more specific information. |
Phase 1: Review of existing Governance Arrangements

Accountability Structure for Clinical Audit (included within Clinical Audit Policy)

- Trust Board
- Quality Assurance Committee (QAC)
- Senior Clinical Quality Group (SCQG) and other subgroups of QAC
- Adult Mental Health Services
  - Clinical Governance Group
  - Clinical Audit Group
- Learning Disability Services
  - Clinical Governance Group
  - Clinical Audit Group
- Families, Young People & Children Services
  - Clinical Governance Group
  - Clinical Audit Groups
- Community Health Services
  - Clinical Governance Group
  - Clinical Audit Group

*The results of clinical audit are disseminated to front line staff by Divisional Clinical Audit group representatives.*
Policy & Strategy

The review confirmed that:

- The Trust’s Clinical Audit Policy was revised and ratified by the Policy Group in February 2013.
- The policy sets out a framework for the conduct of clinical audit and the responsibilities for all staff. The policy has been circulated to all divisional Clinical Governance Leads.
- An introduction to clinical audit which is suitable for all LPT staff is available on the Clinical Audit web page on the Trust intranet.
- Clinical leads and staff engaging in clinical audit can access training/support through the Clinical Audit Team.
- Training sessions/workshops for Clinical Directors, Clinical Audit Leads and divisional clinical audit groups were delivered during 2012.
- A Clinical Audit & Quality Improvement event was held in March 2013 for all staff likely to be involved in clinical audit. The event was aimed at increasing quality improvement and audit knowledge, seeking out high quality evidence and engaging patients effectively.

Roles, Responsibilities & Accountability Structures.

The review confirmed that:

- The Trust’s revised Clinical Audit policy outlines the structure for responsibility and ownership of clinical audit within divisions as detailed in the diagram above.
- Roles and responsibilities in relation to clinical audit are clearly defined within Terms of Reference for Divisional Clinical Governance Groups and Clinical Audit Groups for both the AMH and LD divisions.
- Frequency of meetings held for all divisional clinical audit groups was in accordance with the respective TORs;
- Evidence provided confirmed that progress against the clinical audit forward plans is reported and discussed at Divisional Clinical Audit Groups and Clinical Governance groups;
Areas requiring action have been outlined below:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Findings</th>
<th>Risk and Score (Impact x Likelihood)</th>
<th>Agreed Action</th>
</tr>
</thead>
</table>
| 4   | Our review of minutes for the Divisional Clinical Governance Groups and Clinical Audit Groups for both the AMH & LD divisions identified instances where quorate requirements as specified in Terms of reference where not complied with. | The required quorum for transaction of business is not achieved resulting in the potential for decisions to be made without full representation of the group. 2 x 2 Low | Staff to be reminded of their responsibilities for attendance at Group meetings to ensure that quoracy is maintained at all times. Responsibility: Divisional Governance Leads  
Implementation Date: May 2013  
Management Comments: Divisional Governance Leads to raise this issue with the Chairs of Divisional Clinical Audit Groups. |
Phase 2
NICE (National Institute of Health and Clinical Excellence) Programme

The review confirmed that:

✓ A policy exists for the Dissemination, implementation & monitoring of (NICE) Guidance and other nationally agreed best practice. (due for update in February 2013) National “best practice” guidance enables staff to make evidence based decisions about treatment and healthcare. This ensures a consistent approach and a clearly identified process for the evaluation, dissemination, implementation, and monitoring of NICE and other good practice guidance across LPT.

✓ The Policy sets out duties / Roles & responsibilities for staff specifically
  
  - Executive Team
  - Medical Director
  - Head of Pharmacy
  - Divisional Directors
  - Divisional Governance Leads
  - Quality Assurance Committee
  - Senior Clinical Quality Group
  - Clinical Quality & Effectiveness – Trust Lead
  - NICE & Effectiveness Officer (NEO)

✓ The NEO has responsibility for overseeing and co-ordinating the Trust’s NICE guidance implementation procedure including identifying new NICE guidance published from the NICE website on a monthly basis. (Appendix B - D) and for supporting divisions with priority NICE audits.

✓ A Care Pathway event organised by the Deputy Medical Director was held in October 2012. The NEO was invited to exhibit at the event in order to provide an insight into how NICE guidance and associated recommendations feed into care pathways.

✓ A Clinical audit event was held on 21 March 2013 for all staff with an interest in Clinical Audit. A presentation was made by the NEO regarding the process within the Trust for implementation of NICE guidance.

✓ Bi-monthly reports are produced for Divisional Leads outlining performance and compliance exceptions.

✓ A quarterly position statement on NICE Clinical Guidelines & Technology Appraisals is presented to SCQG. This includes an exception report on any outstanding guidance from the former three organisations prior to transfer to LPT.

Areas requiring action have been outlined below:
### Detailed Findings & Recommendations

<table>
<thead>
<tr>
<th>Ref</th>
<th>Findings</th>
<th>Risk and Score (Impact x Likelihood)</th>
<th>Agreed Action</th>
<th>Management Comments</th>
</tr>
</thead>
</table>
| 5   | The existing policy for the Dissemination, implementation & monitoring of (NICE) Guidance is a comprehensive document and includes a flowchart demonstrating the process for dissemination of NICE guidance (Appendix B – D) however, the guidance does not explicitly detail the process for adding NICE audits to the Clinical Audit plan. We are aware that the policy is due to be reviewed in May 2013. | Lack of clarity regarding Clinical Audit priority status for NICE related audits. 2 x 1 Low | The flowchart included within the policy for the Dissemination, implementation & monitoring of (NICE) Guidance should be enhanced to demonstrate the link between NICE guidance and the Clinical Audit forward plan.  
**Responsibility:** Claire Rashid, Clinical Quality and Effectiveness - Trust Lead  
**Implementation Date:** June 2013 | This action will be addressed with the revision of the Dissemination, implementation & monitoring of (NICE) Guidance. The guidance will be reviewed by the end of June 2013 in readiness for consultation in July 2013.                                                                 |
| 6   | A NICE audit was recently completed in respect of Venous Thromboembolism (VTE) following the issue of NICE Clinical Guideline 92 on VTE. A review of the draft report produced identified anomalies with regard to the presentation of the findings within the report. For example the Trust developed an audit tool which consisted of both quantitative and qualitative questions. Our review of the results of the audit identified that a compliance rating had been applied to qualitative questions and due to their subjective nature this was distorting the results and therefore the Trust’s position was incorrectly rated as “red” in a number of instances. | Incorrect or irrelevant data capture resulting in the reporting of misleading or distorted results. 2 x 1 Low | Criterion included within Audit tools should be scrutinised prior to commencement of audits to ensure that relevant and meaningful information is being captured.  
**Responsibility:** Claire Rashid, Clinical Quality and Effectiveness - Trust Lead  
**Implementation Date:** May 2013 | Completed - It is agreed that certain criteria should not be rated as they do not relate to aspects of our practice and are descriptors of the patients included in the audit. This issue was subsequently recognised and was reflected in the revised report.                                                                 |
Learning Disabilities services

<table>
<thead>
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<th>Audit</th>
<th>Priority</th>
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<tbody>
<tr>
<td>Think family / whole family approach</td>
<td>3</td>
</tr>
<tr>
<td>Prescription and adaption of psychotherapy to patients with an intellectual disability suffering from depression</td>
<td>4</td>
</tr>
<tr>
<td>Medical documentation in the Leicestershire Learning Disability Service</td>
<td>4</td>
</tr>
<tr>
<td>Learning disability staff attitudes using a cultural sensitivity audit tool</td>
<td>4</td>
</tr>
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Adult Mental Health

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical assessment and investigation of patients on readmission</td>
<td>3</td>
</tr>
<tr>
<td>Stimulus dosing protocol seizure thresholds in patients receiving ECT</td>
<td>3</td>
</tr>
<tr>
<td>Identifying illicit drugs use in patients admitted to a mental health unit</td>
<td>4</td>
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<tr>
<td>Availability of physical examination equipment on psychiatric wards</td>
<td>4</td>
</tr>
<tr>
<td>Metabolic screening on admission in AMH inpatient wards</td>
<td>4</td>
</tr>
<tr>
<td>Medical reports for mental health tribunals for inpatients</td>
<td>4</td>
</tr>
<tr>
<td>Monitoring renal function for patients on long-term lithium therapy</td>
<td>4</td>
</tr>
<tr>
<td>Content of clinic letters</td>
<td>4</td>
</tr>
<tr>
<td>Are long discharge letters being sent to the GP within 10 of discharge from Bosworth Ward?</td>
<td>4</td>
</tr>
<tr>
<td>Hypnotic prescribing for insomnia in psychiatric patients</td>
<td>4</td>
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AMH & LD – Trust Wide Reviews

<table>
<thead>
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<th>Audit Title</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of physical examination equipment on psychiatric wards</td>
<td>4</td>
</tr>
<tr>
<td>Hypnotic prescribing for insomnia in psychiatric patients</td>
<td>4</td>
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</tbody>
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Appendix B

NICE Guidance, Relevance, Compliance & Dissemination

National Institute for Health & Clinical Excellence (NICE) and Technology Appraisals (TAs) published each month

Clinical Quality & Effectiveness Lead (CQEL) & NICE & Effectiveness Officer (NEO) will assess relevance of the NICE guidance each month

All clearly non-relevant guidance not disseminated and reasons recorded by the NEO

DCGL & HOPh to confirm non-relevance of guidance to services to NEO with a rationale

NEO to send out the guidance & BAT to the nominated lead(s) for each division

Completed BAT to be returned to NEO & DCGL in a month (4 weeks)

All Relevant guidance will be disseminated by the NEO to the Divisional Clinical Governance Leads (DCGL) & Head of Pharmacy (HOPh) to respond within 2 weeks

For relevant guidance the DCGL will nominate a lead and will confirm name of individual who will complete the baseline assessment tool (BAT) to NEO for each division

DCGL to disseminate relevant guidance to the nominated lead(s) and to confirm & provide evidence of dissemination of guidance to NEO

Abbreviations
CQEL – Clinical Quality & Effectiveness Lead
NEO – NICE & Effectiveness Officer
DCGL – Divisional Clinical Governance Leads
HOPh – Head of Pharmacy
BAT – Baseline Assessment Tool
Exceptions, Assurance, & Reporting to Divisional Clinical Audit & Effectiveness Groups, Senior Clinical Quality Group, Quality Assurance Committee and Commissioners

- NICE & Effectiveness Officer (NEO)
- Report exceptions in evidence of dissemination of guidance, action planning, implementation or audit to the following groups/committee
  - Divisional Clinical Audit & Effectiveness Groups
  - Commissioner’s Assurance
  - Senior Clinical Quality Group
    - Risks
    - Quality Assurance Committee
Financial Decisions in relation to Cost Implications

Medical Director  Divisional Director  Head of Pharmacy

Divisional Assessment/Recommendation on financial implications using NICE cost assessment template where appropriate

Divisional assessment and recommendations on financial implications sent to the NICE & Effectiveness Officer

Business Development Group for Decision

Finance & Performance Report Providing assurance

Divisional action via contracts teams to discuss & agree with Commissioners
# Appendix E Risk Matrix & Opinion Levels

## Audit Opinions

**Full Assurance** can be provided that the system of internal control has been effectively designed to meet the system's objectives, and controls are consistently applied in all areas reviewed.

**Significant Assurance** can be provided that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk.

**Limited Assurance** can be provided as weaknesses in the design or inconsistent application of controls put the achievement of the system's objectives at risk in the areas reviewed.

**No Assurance** can be provided as weaknesses in control, or consistent non-compliance with key controls, could result [have resulted] in failure to achieve the system's objectives in the areas reviewed.

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