Bundle Audit & Risk Assurance Committee 27 August 2019

4.8 WAO Review of Operational Quality & Safety Arrangements Update

Presenter: WAO/Mandy Rayani/Dr Philip Kloer

SBAR WAO Review of Operational Quality & Safety Arrangements ARAC August 2019

WAO Review of Operational Quality & Safety Arrangements: Final Report (with Mgmt Response)

5.1 Clinical Audit Update

Presenter: Mandy Rayani/Dr Philip Kloer

SBAR Clinical Audit Update ARAC August 2019

Clinical Audit Annual Report 2018/2019

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	WAO Review of Operational Quality and Safety Arrangements
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality and Patient Experience / Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sian Passey, Assistant Director of Nursing, Assurance and Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to present to the Audit & Risk Assurance Committee the management response to the Wales Audit Office (WAO) report following the review of the operational quality and safety arrangements and the management response to the recommendations made by the WAO.

Cefndir / Background

As part of the WAO 2018 audit plan for the Health Board, WAO included local work to review the Health Board's operational quality and safety arrangements. This review commenced in September 2018 and asked the following question: Are the Health Board's operational quality and safety arrangements and structures effective?

In undertaking this work, WAO examined arrangements and structures at a directorate and corporate level. The arrangements and structures at a committee level were also considered.

Asesiad / Assessment

The WAO found that the Health Board has some good quality and safety arrangements at a directorate level, supported by developing corporate arrangements, however these are not yet consistent, and the flow of assurance from directorates to the Board is not as effective as it could be. The final report (provided as an annex to this paper) made eight recommendations:

Recommendations	
R1	To improve consistency, the Health Board should introduce a standardised approach to the quality and safety arrangements within the operational directorates. The standardisation should apply to structures, core membership, frequency of meetings and core agenda items for discussion. The county director arrangements must include consideration of primary care quality and safety matters.

R2	To ensure a multidisciplinary approach is taken to considering quality and safety matters, the Health Board should encourage and support attendance by relevant medical staff at meetings across the structures.
R3	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should: a) Merge the Mental Health and Learning Disabilities Quality, Safety and Experience Sub-Committee with the Operational QSESC; b) Ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee. c) Align all directorate level governance committees so they report directly to the Operational QSESC. d) Introduce a standardised report template for all directorates to submit to the Operational QSESC, with a summarised version submitted to the QSEAC.
R4	To improve the focus of the Operational QSESC, the sub-committee should incorporate within its activities assurance that learning from risks and action plans is being shared across directorates. Risks that should be discussed should include severe and high risks, as well as risks that are affecting a number of directorates.
R5	To improve quality and safety assurance flows to the QSEAC, the Health Board should: a) Support and encourage attendance at the Improving Experience sub-committee and Effective Clinical Practice sub-committee; and b) Revisit the scope of the Effective Clinical Practice sub-committee.
R6	To support effective use of limited corporate team resources, the Health Board should consider bringing together county and hospital directorate governance arrangements in line with the arrangements now in place for the Executive Performance Reviews. This can be done at specific intervals during the year.
R7	To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.
R8	To ensure that quality and safety is considered from both a professional and operational perspective, the Medical Director and Director of Clinical Strategy needs to ensure that the Associate Medical Director (AMD) for Quality and Safety in the new medical directorate structure works closely with the two new operational AMD posts for primary and secondary care.

A meeting to consider the recommendations, and the Health Board response to the recommendations, was held with the Director of Nursing, Quality and Patient Experience, Medical Director and Director of Strategy, the Executive Director of Therapies and Health Science and the Board Secretary attending. The report has also been presented to the Quality, Safety & Experience Assurance Committee (QSEAC). The management response (appendix 1 of the annex) has been formulated, taking into account the discussions at the meetings.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to:

- Receive the WAO report following the review of operational quality and safety arrangements;
- Receive assurance that the findings of WAO have been considered and appropriate actions have been identified to address the recommendations; and
- Support the management response to the recommendations.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2. Safe Care 3. Effective Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Associate Medical Director (AMD) Operational Quality, Safety and Experience Sub-Committee (OQSEC) Quality, Safety and Experience Assurance Committee (QSEAC) Wales Audit Office (WAO)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Nursing, Quality and Patient Experience Medical Director and Director of Strategy Executive Director of Therapies and Health Science Board Secretary Assistant Director of Nursing, Assurance and Safeguarding

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Requirement to implement changes to strengthen Governance arrangements in relation to quality Governance committee arrangements
Gweithlu: **Workforce:**	Staff released to attend meetings – recommendations should streamline and enhance Governance arrangements
Risg: **Risk:**	Risks to concerns not being escalated adequately if arrangements are not in place
Cyfreithiol: **Legal:**	N/A
Enw Da: **Reputational:**	Need strong Governance arrangements to ensure there is appropriate escalation of risks
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	All reports to new committee structure will complete EQiA as this becomes established

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Review of operational quality and safety arrangements – **Hywel Dda University Health Board**

Audit year: 2018

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This document has been prepared as part of work performed in accordance with statutory functions.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

The team who delivered the work comprised Anne Beegan and Phil Jones.

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The Health Board now has some good quality and safety arrangements at a directorate level, supported by developing corporate arrangements but these are not yet consistent, and the flow of assurance from directorates to the Board.is not as effective as it could be

Summary report

Introduction

1 In our 2017 Structured Assessment report for Hywel Dda University Health Board (the Health Board), we identified that the operational directorate teams at that time needed to mature, and that the operational structures needed to be further developed, to support the Health Board's governance arrangement, particularly in relation to quality and safety.

2 We also identified that improvements were needed to ensure that the Board received the necessary assurances from its committees, in particular, from its Quality, Safety and Experience Assurance Committee (QSEAC), Work was underway to reconfigure the QSEAC and its supporting structures at that time, with the aim to improve assurance flows.

3 In our 2018 Structured Assessment report we further identified that the Health Board continues to strengthen governance and management arrangements, but there is recognition that there remain some weaknesses in quality and safety governance arrangements. We identified that work has taken place to revisit and refine the QSEAC supporting structures, but agendas remain long, duplication exists between sub-groups and many issues discussed are best placed at an operational level.

4 As part of our 2018 audit plan for the Health Board, we included local work to review the Health Board's operational quality and safety arrangements. This review commenced in September 2018 and asked the following question: **Are the Health Board's operational quality and safety arrangements and structures effective?**

5 In undertaking this work, we have examined arrangements and structures at a directorate[1] and corporate level. We have also examined the arrangements and structures at a committee level. This has included QSEAC and its supporting sub-committees, in particular, the Operational Quality, Safety and Experience Sub-Committee (Operational QSESC).

6 Our work has included interviews with all directorate senior management teams as well as senior leads for quality and safety across the Health Board. We have also reviewed documentation including minutes of meetings, committee papers, organisational structures and risk registers. We have observed the QSEAC and the Operational QSESC.

[1] We have reviewed ten directorates. These are the four hospital directorates (Bronglais, Glangwili, Prince Philip and Withybush), the three county directorates (Carmarthenshire, Ceredigion and Pembrokeshire), and the three Health Board wide directorates (Mental Health and Learning Disabilities, Scheduled Care, Women and Children).

Summary of findings

7 We conclude that the Health Board now has some good quality and safety arrangements at a directorate level, supported by developing corporate arrangements but these are not yet consistent, and the flow of assurance from directorates to the Board is not as effective as it could be.

8 In reaching this conclusion we have found that:

- Some directorate level arrangements are good, but they are not sufficiently consistent;
- Corporate quality and safety arrangements are developing but capacity within the clinical audit and patient experience teams is an issue and shared learning is not as prominent as it could be;
- The operational quality, safety and experience sub-committee is evolving with scope to take greater assurance from directorates and to focus more on key risks, but attendance is problematic; and
- The functioning of QSEAC is improving but work is needed to address attendance at two of its other sub-committees and improve the quality of papers.

9 We explore these findings in more detail later in this report.

Recommendations

10 In undertaking this work, we have identified a number of recommendations. These are set out in Exhibit 1 below.

Exhibit 1: Recommendations

Recommendations	
R1	To improve consistency, the Health Board should introduce a standardised approach to the quality and safety arrangements within the operational directorates. The standardisation should apply to structures, core membership, frequency of meetings and core agenda items for discussion. The county director arrangements must include consideration of primary care quality and safety matters.
R2	To ensure a multidisciplinary approach is taken to considering quality and safety matters, the Health Board should encourage and support attendance by relevant medical staff at meetings across the structures.
R3	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should: a) Merge the Mental Health and Learning Disabilities Quality, Safety and Experience Sub-Committee with the Operational QSESC;

Recommendations	
	b) Ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee. c) Align all directorate level governance committees so they report directly to the Operational QSESC. d) Introduce a standardised report template for all directorates to submit to the Operational QSESC, with a summarised version submitted to the QSEAC.
R4	To improve the focus of the Operational QSESC, the sub-committee should incorporate within its activities assurance that learning from risks and action plans is being shared across directorates. Risks that should be discussed should include severe and high risks, as well as risks that are affecting a number of directorates.
R5	To improve quality and safety assurance flows to the QSEAC, the Health Board should: a) Support and encourage attendance at the Improving Experience sub-committee and Effective Clinical Practice sub-committee; and b) Revisit the scope of the Effective Clinical Practice sub-committee.
R6	To support effective use of limited corporate team resources, the Health Board should consider bringing together county and hospital directorate governance arrangements in line with the arrangements now in place for the Executive Performance Reviews. This can be done at specific intervals during the year.
R7	To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.
R8	To ensure that quality and safety is considered from both a professional and operational perspective, the Medical Director and Director of Clinical Strategy needs to ensure that the Associate Medical Director (AMD) for Quality and Safety in the new medical directorate structure works closely with the two new operational AMD posts for primary and secondary care.

Detailed report

Some directorate level arrangements are good, but they are not sufficiently consistently

11 Our work has identified that each of the directorates discuss quality and safety matters, but there is variation in the local quality and safety structures and the depth of the discussion.

12 Six of the directorates have separate governance meetings focusing solely on quality and safety. These meetings are at the highest level within the respective directorates and run alongside the routine business meetings which focus on finance and performance. With the exception of the Prince Philip directorate, meetings are on a monthly basis and cover a wide range of quality and safety aspects. Prince Philip directorate hold governance meetings twice a month.

13 Three of the directorates include quality and safety matters as part of the monthly business or management team meetings. These meetings are also on a monthly basis, but discussion is generally limited to concerns, complaints and risks.

14 For the Mental Health and Learning Disabilities Directorate, directorate level quality and safety is the focus of a dedicated sub-committee reporting directly to the QSEAC. This means that discussions for this directorate take place at a much higher level within the Health Board. This is an historical arrangement as a result of previous concerns, which are no longer evident. The agendas cover a wide range of quality and safety matters, but frequency of meetings is limited to every two months.

15 The arrangements across the directorates are set out in Exhibit 2.

Exhibit 2: Directorate arrangements for quality and safety

Directorate	Committee	Sole focus on quality and safety	Frequency
Bronglais	Hospital Management Committee	No	Monthly
Carmarthenshire	County Management Team	No	Monthly
Ceredigion	County Management Team	No	Monthly
Glangwili	Governance	Yes	Monthly
Mental Health & Learning Disabilities	Sub-committee of QSEAC	Yes	Every 2 months
Pembrokeshire	Governance	Yes	Monthly
Prince Philip	Governance	Yes	Twice a month
Scheduled Care	Governance	Yes	Monthly
Withybush	Governance	Yes	Monthly

Directorate	Committee	Sole focus on quality and safety	Frequency
Women & Children	Governance	Yes	Monthly

Source: Wales Audit Office analysis of interviews and documentation

16 In the six directorates with separate governance meetings, there is a good range of agenda items. As well as concerns, complaints and risks, agenda items include:

- compliance with Welsh Health Circulars;
- Healthcare Inspectorate Wales reports;
- results of audits, both internal and external;
- Royal College reports;
- results of Community Health Council visits;
- serious incidents;
- mortality reviews; and
- patient experience.

17 The range of discussion however is not consistent or standardised across the six directorate governance meetings.

18 In the three directorates where quality and safety is considered as part of wider business meetings, the relevant directorates are reliant on supporting assurance groups which sit below the directorate level. Reports from these groups however are not always available for the management team meetings. This is particularly the case for the Ceredigion directorate.

19 Across all of the county directorates, there is limited focus on the quality and safety aspects of primary care provision within the governance and management meetings. The quality and safety of primary care is instead managed through the central primary care team reporting directly to the Director of Primary Care, Community and Long-Term Care.

20 Over the last six months, the Health Board has been developing a quality and safety dashboard. Initially developed for the QSEAC, it is the intention to develop underpinning dashboards for each of the directorates. Our work has identified that the directorate dashboards are not yet in place, although the directorates are drawing on the relevant sources of information. There is however a bespoke dashboard available to support the Women and Children's Directorate, focusing predominantly on maternity services.

21 The directorate heads of nursing and general managers are largely driving the quality and safety agendas. Where quality and safety forms part of the routine business meetings, membership is largely based on the core directorate team. For directorates with governance meetings, membership is larger and more multidisciplinary. Representation from nursing and therapy professions is good,

and there is regular attendance by corporate teams including patient experience, clinical audit and redress.

22 Clinical directors and cluster leads are members of all quality and safety structures, but medical representation at meetings is generally limited with frequent part attendance or apologies sent. Directorates identified challenges engaging medics in the quality and safety agenda, including concerns, complaints and incidents largely because of time constraints around clinical commitments.

23 All directorates have their own professional nursing forums to bring together lead nurses from across the underpinning departments to consider quality and safety. These forums feed into the quality and safety discussions in the directorates and the senior nursing team meetings across the Health Board with the Director of Nursing, Quality and Patient Experience.

Corporate quality and safety arrangements are developing but capacity within the clinical audit and patient experience teams is an issue and shared learning is not as prominent as it could be

24 The Health Board has corporate teams in place to support key aspects of quality and safety, including concerns, complaints, serious incidents, patient experience and clinical audit. These teams report directly to the Director of Nursing, Quality and Patient Experience.

25 These corporate teams have previously worked in isolation. The Community Health Council, in particular, has raised concerns over the variability in the management of issues, and the differing approaches within each team. Through the senior nursing team meetings, these corporate teams have become more connected over the last twelve months, with approaches starting to become more consistent.

26 Capacity within some of the corporate teams however is an issue. The Audit and Risk Assurance Committee (ARAC) is sighted of the capacity constraints within the clinical audit team, and the Health Board's own benchmark indicates that patient experience capacity is the lowest in Wales. Although the Board supported a new patient experience framework in December 2018, funds have only recently been made available to support the rollout of the 'Friends and Family Test' system.

27 In July 2018, the Board approved the Health Board's Quality Improvement Strategic Framework. This places greater emphasis on sharing the learning from improvement activities. All of the corporate teams focus on learning; however, capacity is such that attention is drawn to supporting the directorates respond to incidents and events as they arise, restricting the ability of the corporate teams to share learning more widely to prevent the issues reoccurring. The Health Board formally launched the Quality Improvement Strategic Framework in March 2019 which should start to help promote the learning agenda more widely.

28 The number of directorates within the Health Board also places demands on the corporate teams' capacity, particularly in relation to attending governance meetings. The bringing together of some of the quality and safety arrangements within directorates, such as county and hospital directorates, may help alleviate the capacity constraints on the corporate teams. This would align with the approach taken within the Executive Performance Reviews which is increasingly considering the performance of county and hospital directorates on a joint basis.

29 Quality and safety is also the professional responsibility of the Medical Director and Director of Clinical Strategy. Amendments are currently being made to the Medical Directorate structure with a proposed new Associate Medical Director (AMD) lead for quality and safety. In addition, there are two new operational AMD posts for primary and secondary care, which are designed to provide day-to-day support to the directorates on medical related issues. It will be important for these posts to work together to make sure that quality and safety is not managed in isolation but collectively across operational and professional domains.

The operational quality, safety and experience sub-committee is evolving with scope to provide greater assurance from directorates and to focus more on key risks, but attendance is problematic

30 In July 2018, the Primary and Community Quality, Safety and Experience Sub-Committee merged with the Acute Quality, Safety and Experience Sub-Committee to become the Operational Quality, Safety and Experience Sub-Committee (QSESC).

31 The new Operational QSESC has met on six occasions and is still evolving. It meets on a bi-monthly basis and reports directly to the Quality, Safety and Experience Assurance Committee. It is one of eight sub-committees reporting to QSEAC, with plans to also merge the Mental Health and Learning Disabilities QSESC into the Operational QSESC once the current sub-committee is fully embedded.

32 The Operational QSESC however is not yet working effectively. Membership is large at 24 as it seeks to include representation from all directorates and corporate teams, but attendance by members is a problem. For the three meetings held between September 2018 and January 2019, significant numbers of members were not represented. There is however attendance from a wider group of staff outside those identified on the terms of reference (exhibit 3).

Exhibit 3: attendance at Operational QSESC

	Number of members (or representatives) in attendance	Number of members not present or represented	Total number of staff in attendance included members (or representatives)
September 2018	12	12	17
November 2018	12	12	20
January 2019	11	13	15

Source: Wales Audit Office analysis of documentation

33 The sub-committee aims to seek assurance from the directorates that actions are being taken to address quality and safety issues through exception reporting. However, directorates are not always present at the meetings to report back or there are frequently no issues to report. The sub-committee also seeks to monitor the management of operational risks but the number of risks that need to be considered has meant that this has become unmanageable within the time available in meetings.

34 Risks and action plans to address quality and safety issues however are increasingly being considered as part of the Executive Performance Reviews (EPRs) with the directorates, posing a risk of duplication between the EPRs and the business of the sub-committee. Risks and action plans are also being considered by relevant operational forums.

35 To reduce the risk of duplication, the sub-committee should focus its attention on taking assurance that learning from risks and action plans is being shared across directorates. This should include severe and high risks, as well as risks that are affecting a number of directorates.

36 Not all of the directorates however are represented at the sub-committee, with Mental Health and Learning Disabilities the focus of the separate sub-committee reporting to QSEAC.

37 Primary care is also not a key feature of the sub-committee despite its scope. Our work has identified that primary care quality and safety matters appear to be largely reported and managed through operational structures to the Director of Primary Care, Community and Long-Term Care, with limited scrutiny and assurance through any of the Board's committee structures. This is of particular concern given the recent changes to the GP indemnity scheme which requires health boards to have a much greater understanding of the level of quality and safety risks that they are carrying in primary care.

38 Like the directorate structures, there is some medical representation on the sub-committee but this is largely because they are chairs or representatives of sub-groups, for example, the Rapid Response to Acute Illness Learning Set (RRAILS) sub-group. Attendance can also be limited to part of the meetings due to other clinical commitments.

39 The sub-committee has a number of groups from which it takes assurances. Good assurances are taken from the Medical Devices Group and the Mental Capacity Act & Consent Group. Assurance is also taken from the Nutrition and Hydration Group although it is acknowledged that this group is only focused on inpatient care. Attendance at the Organ Donation Group and RRAILS Group however have been problematic resulting in cancelled meetings. Although assurances are taken from these groups, these are not as frequent as they should be.

40 As well as duplication with the EPRs, there is also some duplication between the sub-committee and QSEAC in relation to agenda item discussions. Some of this is on purpose by way of having initial discussions ahead of a more focused discussion at QSEAC, but this is not always a case.

41 The sub-committee however is not yet able to provide assurance to the QSEAC that operational quality and safety issues are being managed. There is currently no formal standardised reporting from the directorates to the sub-committee with reliance placed predominantly on exception reporting. Consequently, there is a gap between the QSEAC and the directorate teams.

42 The sub-committee has the potential to address this by seeking standardised assurances from all directorates, or combined directorates, on a range of quality and safety issues, by means of a standardised report. These can then be summarised to provide collective assurance to the QSEAC and ultimately the Board.

The functioning of QSEAC is improving but work is needed to address attendance at two of its other sub-committees and to improve the quality of papers

43 Historically, the attendance at the QSEAC has been large, agendas have been long, and the committee members have been unable to take assurance on a number of agenda items either due to the quality of the papers presented, or cancellations of sub-committee meetings.

44 Our recent observations of the committee during 2019 have identified that the functioning of the QSEAC has however started to improve. The committee attendance has now been refined to only include those who need to be there, and accounting officers are now called in to the meeting for specific agenda items as and when required. This has helped address the large attendance levels which largely consisted of representation from corporate teams.

45 The committee however still struggles to take assurance from a number of its sub-committees. This includes the operational QSESC, due to the reasons set out in paragraphs 32-42, but also the Effective Clinical Practice sub-committee and the Improving Experience sub-committee. Both of these sub-committees have struggled with attendance making it difficult to fully explore many of the agenda items for these meetings. On a number of occasions, these meetings have also had to be cancelled because of low attendance rates. The Effective Clinical Practice sub-committee has also struggled with a lack of clarity on its role. The Medical Director and Director of Clinical Strategy has recently taken over the chair of this committee to improve its effectiveness.

46 QSEAC papers also continue to be large with some concerns remaining that there is too much detail, which detracts attention away from the key issues and mitigating actions being taken. Some papers also focus too much on performance matters which are the separate consideration of the Business Planning and Performance Assurance Committee. This can in part be due to the authors not always being able to provide the right focus for the QSEAC.

47 The committee has undertaken a recent self-assessment exercise which reflects the issues raised through our work. An action plan is being put in place to take forward many of the improvement areas raised.

Appendix 1

Action plan

Exhibit 4: management response to recommendations

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	To improve consistency, the Health Board should introduce a standardised approach to the quality and safety arrangements within the operational directorates. The standardisation should apply to structures, core membership, frequency of meetings and core agenda items for discussion. The county director arrangements must include consideration of primary care quality and safety matters.	Improved consistency across directorates, which also includes primary care where relevant.	Yes	Yes	Options for standardising the approach to quality and safety arrangements have been agreed. This includes templates for terms of reference, agendas for meetings and standardised reporting. Templates will be developed in collaboration with the Corporate Governance Team. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, specialist, primary and acute services, with cross-organisational groups reporting to OQSEC. Quality and safety matters are included in the county directors meetings and this will be monitored.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	To ensure a multidisciplinary approach is taken to considering quality and safety matters, the Health Board should encourage and support attendance by relevant medical staff at meetings across the structures.	Increased multi-disciplinary focus, drawing on the expertise of all professions.	Yes	Yes	A restructure of the Associate and Deputy Medical Directors has been undertaken. This new structure includes the appointment of a new Associate Medical Director for Quality and Safety and the proposal to strengthen quality medical lead roles throughout the services.	October 2019	Medical Director and Director of Strategy
R3a	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should merge the Mental Health and Learning Disabilities Quality, Safety and Experience Sub-Committee with the Operational QSESC.	Improved use of staff time. Improved shared learning.	Yes	Yes	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, both specialist, primary and acute services, with cross-organisational groups reporting to OQSEC. Transition arrangements for changes to Mental Health and Learning Disabilities quality report arrangements will be developed and worked through with the triumvirate team. Any specific exceptions requiring escalating to QSEAC escalated via OQSEAC, and appropriate staff asked to attend QSEAC as appropriate.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary Director of Therapies and Health Sciences Clinical Director for Mental health and Learning Disabilities

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3b	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee.	Improved consistency across directorates.	Yes	Partial	There is a Mental Health and Learning Disabilities directorate level governance committee. Work will be undertaken to strengthen and standardise the reporting arrangements to OQSEC (as recommendation 1)	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary
R3c	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should align all directorate level governance committees, so they report directly to the Operational QSESC.	Improved flow of assurance from directorates to QSEAC and the Board.	Yes	Yes	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, both specialist, primary and acute services, with cross-organisational groups reporting to OQSEC.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary
R3d	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should introduce a standardised report template for all directorates to submit to the Operational QSESC, with a summarised version submitted to the QSEAC	Improved flow of assurance from directorates to QSEAC and the Board.	Yes	Yes	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports (see recommendation 1).	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	To improve the focus of the Operational QSESC, the sub-committee should incorporate within its activities assurance that learning from risks and action plans is being shared across directorates. Risks that should be discussed should include severe and high risks, as well as risks that are affecting a number of directorates.	Improved effectiveness of meetings. Reduced duplication with Executive Performance Reviews.	Yes	Yes	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports (see recommendation 1). Agreement that risks and learning will be, embedded into the standard reporting templates. The templates will also advise on how learning from risks and action plans are being shared across Directorate and other areas. Deep dives are currently being discussed at each OQSESC meeting and will continue, these will support in-depth conversation required. The Risk Registers are to be used to inform these. A Listening and Learning Group is being established to facilitate shared learning across the organisation. Reporting arrangements for the group will be finalised and endorsed through QSEAC.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary Director of Therapies and Health Science. Director of Nursing, Quality and Patient Experience
R5a	To improve quality and safety assurance flows to the QSEAC, the Health Board should support and encourage attendance at the Improving Experience sub-committee and	Improved flow of assurance from sub-committees to QSEAC and the Board.	Yes	Yes	The appointments of a new AMD for Quality and Safety and the enhanced roles of clinical leads will support the wider medical engagement at sub-committees. The terms of reference for both the Improving Experience sub-committee and Effective Clinical Practice sub-committee	October 2019	Medical Director and Director of Strategy Director of Nursing, Quality and Patient

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	Effective Clinical Practice sub-committee; and				have been reviewed, including membership, with the aim of focussing membership and attendance at meetings.		Experience/Medical Director and Director of Clinical Strategy.
R5b	To improve quality and safety assurance flows to the QSEAC, the Health Board should revisit the scope of the Effective Clinical Practice sub-committee.	Improved effectiveness. Improved flow of assurance from sub-committee to QSEAC and the Board.	Yes	Yes	The terms of reference for the Effective Clinical Practice sub-committee have been reviewed including membership; with a paper to be submitted to the Audit & Risk Assurance Committee.	Complete	Medical Director and Director of Strategy
R6	To support effective use of limited corporate team resources, the Health Board should consider bringing together county and hospital directorate governance arrangements in line with the arrangements now in place for the Executive Performance Reviews. This can be done at specific intervals during the year.	Improved whole-system focus on quality and safety. Improved shared learning. Effective use of limited corporate team resources.	Yes	Yes	Whilst this recommendation is accepted the approach and arrangements to facilitate this will require further consideration with the Director of Operations and chairs of the various quality meetings. Meeting to be held to work through the arrangements and options to enable effective join up of governance meetings periodically throughout the year.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R7	To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.	Improved consistency across directorates.	Yes	Yes	Task and finish group established which is jointly chaired by Director of Nursing and Director of Planning. The work of the task and finish group has been expedited. A project plan is in place including agreement of the priority indicators to be populated and rolled out to directorates.	April 2020	Director of Nursing, Quality and Patient Experience
R8	To ensure that quality and safety is considered from both a professional and operational perspective, the Medical Director and Director of Clinical Strategy needs to ensure that the Associate Medical Director (AMD) for Quality and Safety in the new medical directorate structure works closely with the two new operational AMD posts for primary and secondary care.	Improved shared learning. Improved whole-system focus on quality and safety.	Yes	Yes	The appointments of a new AMD for Quality and Safety and clinical leads will work closely with the two new operational AMD posts for primary and secondary care. There will also be close working relationships with Assistant Director of Nursing for Quality and Assurance and Head of Goverance for Quality and Assurance	October 2020	Medical Director and Director of Strategy

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	27 August 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mandy Rayani, Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Ian Bebb, Clinical Audit Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is:

- To share with the Audit & Risk Assurance Committee the Annual Clinical Audit Report for 2018-19;
- To provide an update on the outstanding recommendations from the audit tracker 1428 from the Internal Audit report of the Clinical Audit Function;
- To provide an update on the Health Board's participation with the National Ophthalmology Audit.

Cefndir / Background

The Audit & Risk Assurance Committee (ARAC) requested that a formal clinical audit report be produced; showing overall compliance levels and reporting on the progress of both the mandatory national audits and the Health Board's newly instated Forward Clinical Audit Programme. ARAC also requested a sample of audit outcomes, in order to demonstrate work that has been undertaken as a result of these projects.

The 2013/14 Internal Audit report of the Clinical Audit function outlined 5 recommendations. Of the 5, 4 were fully completed on time. The remaining recommendation consisted of 30 separate elements that came from an independent review, many of which would need to be developed and implemented over time. 28/30 (93%) of these recommendations were met, with the intention that the remaining elements would be completed in line with a formal clinical audit report.

ARAC also requested an update on the Health Board's participation in the National Ophthalmology Audit which is currently (and historically) non-compliant. This non-compliance has been widely reported and discussed within the Health Board including ARAC, ECPSC, QSEAC and Scheduled Care Quality, Safety & Experience meetings. The Service has been unable to provide the administrative and electronic support required for participation in this audit. It was believed that implementation of the Medisoft system would enable this; however, the Service has reported that it has not delivered the desired solution.

Asesiad / Assessment

Annual Clinical Audit Report 2018-19

The Clinical Audit Department has produced the Annual Clinical Audit Report for 2018-19. Within this report is included:

- Participation rates for mandatory national audits (RAG rated)
- Completion rates and other analysis of the forward programme
- Samples of national audit outcomes
- Action plans for forward programme audits (including nationals)
- Activity date for non-programme audits
- An executive summary

The report effectively finalises the remaining recommendations from the Internal Audit report, which has been marked as complete.

National Ophthalmology Audit

The Health Board has remained non-compliant with this national audit. The Service Delivery Manager has completed a risk assessment in line with new Health Board processes. Balancing this participation requirement with the quality of the service being assessed through other factors such as Incident reporting, Referral to Treatment targets, action planning and other work in progress, the Service has classified non-participation as a low risk.

The Service has also presented an independent paper to QSEAC in June 2019. This paper included a variety of updates for the Committee, as well as information on the national audit, with an intended participation in line with the electronic record in quarter 4 of 2019-20.

The ECPSC discussed this audit in May 2019 and asked that the Service take a paper to the Operational Quality, Safety & Experience Sub Committee. ECPSC has reconsidered this request in light of the paper received by QSEAC, to avoid duplication.

From August 2019, the above audit has been classified as non-mandatory for all Health Boards in Wales (and England). The reason for this will be multifactorial. Any continued participation is voluntary and a charge will be applied to contribute should the audit continue in the future. This would need to be carefully considered against other expenditure, and the Service's position from June 2019 will need to be reconsidered.

The Clinical Audit Department is working with the Scheduled Care directorate to encourage the Ophthalmology Service to participate in the Forward Clinical Audit Programme. Whilst it is believed that the Service does have a suite of audit projects it undertakes, it is the intention that where appropriate, these be captured formally by the programme, including outcomes.

Wales Audit Office

The action plan from the recent WAO report "Review of operational quality and safety arrangements – Hywel Dda University Health Board", June 2019, highlighted the need to review the scope and role of ECPSC. This has been undertaken, and has resulted in strengthened arrangements being put in place, under the direction of the Medical Director & Director of Clinical Strategy.

Other work, relevant to clinical audit, was identified throughout the report. Although capacity constraints within the Clinical Audit Department (and wider function) remain an issue, continuous improvements to governance structures, links with other quality & safety initiatives and other work with operational teams is being undertaken to mitigate this. Progress is slower than intended as a result of these capacity issues; however, this report demonstrates that a number of improvements have been made, with plans for further improvements.

See 3.6, 5.1, 5.2, 5.11 and 6.2 within the Annual Clinical Audit Report 2018-19 for more details.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to:

- Review and discuss the annual Clinical Audit Report 2018-19;
- Note the update against the audit tracker recommendations that have now been completed;
- Note the update on the National Ophthalmology Audit, which is no longer a mandatory national project.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.3 In carrying out this work the Audit & Risk Assurance Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness. 5.9 Provide assurance with regard to the systems and processes in place for clinical audit, and consider recommendations from the Effective Clinical Practice Sub-Committee on suggested areas of activity for review by internal audit. 5.21 The Audit & Risk Assurance Committee and the Quality, Safety & Experience Assurance Committee both have a role in seeking and providing assurance on Clinical Audit in the organisation. The Audit & Risk Assurance Committee will seek assurance on the overall plan, its fitness for purpose and its delivery. The Quality, Safety & Experience Assurance Committee will seek more detail on the clinical outcomes and improvements made as a result of clinical audit. The Internal audit function will also have a role in providing assurance on the Annual Clinical Audit Plan.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Nursing Quality and Patient Experience (NQPE 29 CRR123)

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation 3.5 Record Keeping
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Hywel Dda Internal Audit Report: Review of Clinical Audit, March 2015 Palmer Report, July 2014 http://gov.wales/docs/dhss/publications/140716dataen.pdf National Clinical Audit and Outcome Review Programme 2018/19 Clinical Audit SBAR to ARAC, January 2019, March 2019 Clinical Audit Update QSEAC, October 2018 Ophthalmology Service SBAR to QSEAC, June 2019 Clinical Audit SBAR to ECPSC March 2019 Executive Team Performance reviews 2018/19 Hywel Dda UHB Forward Clinical Audit Programme 2018/19 WAO Report: Review of operational quality and safety arrangements – Hywel Dda University Health Board Annual Clinical Audit Report 2018-19
Rhestr Termau: Glossary of Terms:	ARAC – Audit & Risk Assurance Committee CAD – Clinical Audit Department ECPSC – Effective Clinical Practice Sub-Committee NCAORP – National Clinical Audit and Outcome Review Plan QSEAC – Quality, Safety & Experience Assurance Committee WAO – Wales Audit Office
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Clinical Audit Manager Assistant Director of Nursing, Quality Improvement and Service Transformation Director of Nursing, Quality & Patient Experience Effective Clinical Practice Sub-Committee Clinical Lead for Clinical Audit

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	None. The CAD has made cost savings in line with the financial plan for the Health Board.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Failure to participate in clinical audit and to conduct it effectively could lead to concerns not being identified and subsequent improvements in services not being made.
Gweithlu: **Workforce:**	Key projects highlighted in the report will identify impact on workforce but the workforce impact is not applicable to this report.
Risg: **Risk:**	Potentially failure to conduct particular audits appropriately will lead to risk and/or legal implications. Further implications possible if audit discovers sub-standard care and no improvements are undertaken. There is a reputational impact for the Health Board in non-compliance and participation with the NCAORP which is publicly reported. There may be other implications from Welsh Government if the Health Board does not participate in the mandatory projects outlined. There is a risk that we cannot be assured of clinical standards or outcomes with the failure to participate fully in audit.
Cyfreithiol: **Legal:**	See above
Enw Da: **Reputational:**	There is a reputational impact for the Health Board in non-compliance and participation with the National Clinical Audits which are publicly reported.
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	There is some variability in participation for National Audit across the organisation which means that practice cannot be compared locally or nationally and inequality of care may not be identified. This does not have a direct impact on equality - only that it is more difficult to measure. The situation is improving.

Hywel Dda University Health Board

Annual Clinical Audit Report 2018/19

Report completed by:
Ian Bebb, Clinical Audit Manager

July 2019

Approved by:
Effective Clinical Practice Sub-Committee
July 2019

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Foreword by Clinical Lead for Clinical Audit – Dr Ceri Brown, Consultant Anaesthetist

The practice of good Clinical Governance in Hywel Dda is shown in this report. As Professionals, all staff are encouraged to gather data on the work they perform with the aim of making improvements, however small, to improve the clinical services they provide.

As you will see, the amount of clinical audit activity across Hywel Dda in all specialties is extensive, and the results of this activity, in the form of recommendations for action, show that our clinical colleagues are committed to service improvement.

Clinical audit activity is generated from national and local sources. The National Clinical Audit and Outcomes Review Plan (NCAORP) in Wales, Royal Colleges, National Institute for Health and Care Excellence (NICE) and the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) and specialist groups, are the main drivers nationally. Locally audits are generated by clinicians and departments in relation to local need and perceived risk to patients in Hywel Dda. The range of individual topics is impressive and there are many positive outcomes from the audits.

Looking at the way the Health Board supports clinical audit, the report describes the structure of the clinical audit department and its plans for the future, including the establishment of a Clinical Audit Scrutiny Panel to provide internal governance and strategic direction for performing clinical audit.

Finally, I am grateful for the work of the staff of the clinical audit department for the work they have performed to support clinical audit in the past year, and to Ian Bebb, the Clinical Audit Manager, for producing this report.

Dr Ceri Brown

Dr Ceri Brown

Anesthetydd Ymgynghorol / Consultant Anaesthetist
CCM Effeitholrwydd Clinigol / AMD Clinical effectiveness

1. EXECUTIVE SUMMARY

The 2018-19 Annual Clinical Audit Report summarises the audit activity for the 2018-19 financial year. This will include participation with the mandatory national programme as well as activity for local and other audit activity.

1.1. Clinical Audit Activity

1.1.1. National Clinical Audit and Outcome Review Plan (NCAORP)
Overall the Health Board has participated in 32 of the 34 applicable mandatory national audits. 6 of these projects experienced some challenges with participation and the level of challenge and reasons for this varied for each project. The remaining 2 projects were not participated due to capacity within the services which had to be balanced against other priorities.

A total of 25 improvement plans were submitted to Welsh Government detailing plans for meeting audit recommendations across a wide variety of audit and outcome review topics.

1.1.2. Forward Clinical Audit Programme (FCAP)
The Health Board chose to adopt a formal approach to a clinical audit programme for 2018-19. A total of 50 projects were submitted and met the criteria for the programme and the final status for these projects were as follows:

- 60% of projects had been undertaken (32% complete with improvement plans)
- 36% of projects had not been started (12% now planned for 2019-20)
- 4% projects were not completed (2% valid discontinuation and 2% incomplete)

1.1.3. Other audit activity
A variety of other audit activity was undertaken within the Health Board. This is composed of projects from many different specialties and reflects local priorities, other national projects as well as smaller scale projects with more specific benefits or designed based on educational outcomes. A total of 306 projects were being undertaken during 2018/19 with a final status as follows:

- 51% of projects had been completed
- 39% of projects were being carried out
- 10% of projects were not completed (1% valid discontinuation and 9% incomplete)

1.2. Wales Audit Office

The action plan from the recent WAO report *"Review of operational quality and safety arrangements – Hywel Dda University Health Board", June 2019,* highlighted the need to review the scope and role of ECP-SC. This has already been undertaken in 2018-19.

Other work, relevant to clinical audit was identified throughout the report. Although capacity constraints within the Clinical Audit Department (and wider function) remain an issue, continuous improvements to governance structures, links with other quality & safety initiatives and other work with operational teams is being undertaken to mitigate this. Progress is slower than intended as a result, however this report demonstrates that a number of improvements have been made with plans for further improvements.

See 3.6, 5.1, 5.2, 5.11 and 6.2 for more details.

1.3. Key achievements

- The Health Board has implemented a board wide forward clinical audit programme, the key aim of which is to ensure that Health Board priority projects are appropriately carried out and effectively resourced.
- A number of process and infrastructure improvements have been made regarding the FCAP and including the NCAORP. More NCAORP projects are now being discussed and analysed through regular or ad hoc meetings including the Stroke (SSNAP), Cardiology Programme, National Hip Fracture, Emergency Laparotomy (NELA), Diabetes and Major Trauma audits.
- An increase in the number of assurance forms (action plans) for NCAORP projects as well as the scrutiny applied to these.
- An increase in overall completion rates for “local” audit projects.
- The profile of clinical audit has been raised within the organisation.
- Further embedding of NCAORP concerns within Directorate risk registers and an increase in compliance with the risk assessment process.

1.4. Key areas for improvement

- The Health Board has not been able to achieve its goal of participation in all NCAORP projects. Whilst the number of these projects has not changed they still remained non-compliant for the entire period.
- Participation levels for some of the other NCAORP projects has varied somewhat with some areas seeing significant gains and some others in sharp decline. Achieving satisfactory participation remains a challenge for the Health Board especially given the challenges already facing the Services.
- Further work will be required to ensure that NCAORP improvement plans are being met in full. Whilst future plans for Welsh Government to develop this process remain a possibility it is essential that the Health Board act appropriately in lieu of this.
- The amount of support available for clinical audit within the Health Board has fallen.
- Delays to the implementation of the Clinical Audit Scrutiny Panel due to a lack of administrative support as well as concerns raised regarding the work plan of the Effective Clinical Practice Sub-Committee need to be addressed.

1.5. Future work

- Develop an effective mechanism to monitor NCAORP action plans and feedback to the relevant governance groups and through Executive Team Performance Reviews.
- Ensure more clinical audit (particularly NCAORP) is embedded appropriately within directorate risk assessment processes and that non-participation is addressed through these channels.
- Develop additional and appropriate means of escalation within governance structures to encourage support and governance for key projects.
- Set up of the Clinical Audit Scrutiny Panel to effectively monitor the NCAORP and the new processes introduced in 2018-19.
- Encourage and support increased completion rates for the 2019-20 FCAP.
- Build on successes of audit participation compliance by focusing on audit outcomes.
- Encourage and develop further integration between clinical audit and other quality and safety work streams.

Section 1

2. INTRODUCTION TO CLINICAL AUDIT

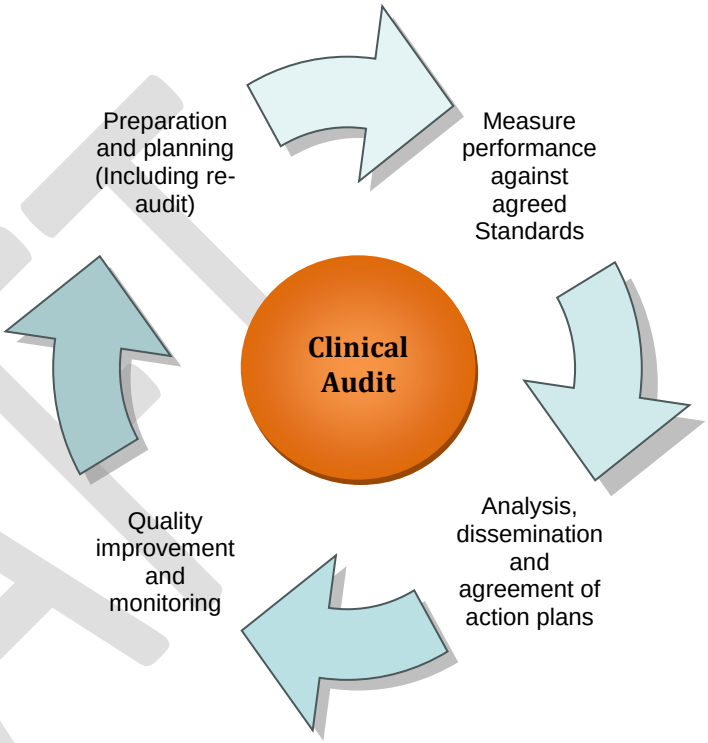
Clinical Audit
The Health Board adheres to the widely accepted definition of clinical audit endorsed by the National Institute for Health and Care Excellence (NICE):

> "*Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery"*
>
> *(Principles of Best Practice in Clinical Audit, NICE, 2011)*

Clinical audit is essentially all about checking whether best practice is being followed and making improvements if there are shortfalls in the delivery of care. A good clinical audit will identify (or confirm) problems and should lead to effective changes being implemented that result in improved patient care.

Clinical Audit Cycle

Clinical audit is often described as a cyclical process. It is a systematic process involving a number of key stages that form a continuous loop. Completing all stages of the cycle fully is often referred to as "closing the loop". The cycle suggests that as the process continues, each cycle or loop aspires to a higher level of quality of care.



Purpose of this report

The purpose of this report is to provide a statement on the activities and arrangements in place for Clinical Audit within Hywel Dda University Health Board for the financial year 2018/19.

3. BACKGROUND

The Health Board's approach and commitment to clinical audit is a key component in quality improvement and patient safety. Clinical Audit is also a valuable tool in the provision of assurance, whether to the Board, the clinical teams involved, the wider Health Board or to the Public. It is essential that there is a robust system of procedures and monitoring mechanisms in place to ensure that clinical audit is being carried out effectively, maximising the use of resources and leading to improvements in quality of care.

As part of the Clinical Audit Function and in line with the NHS Wales Audit Committee standards via the Audit and Risk Assurance Committee (ARAC), the Clinical Audit Department (CAD) is required to produce an annual audit report. This report will summarise clinical audit activity, highlight changes to the clinical audit function and show overall audit compliance for the year.

The Health Board needs to support effective clinical audit that leads to improvements in the quality of care that we provide and clinical audit will form a key evidence base for the Health Board's recently developed Quality Improvement Strategic Framework and Quality Improvement Goals.

One of the key aspects to successful clinical audit lies within the structure of the clinical audit process – how audit topics are selected and how audits are planned, implemented and evaluated. Getting this process right is not easy. By providing a structured approach to emulate and guidelines on what to do as a framework, the effectiveness of clinical audit can be greatly improved and we can succeed in creating a more stable and supportive environment in which the organisation can focus on improving the quality of care.

The overall success of clinical audit is also largely determined by the commitment and enthusiasm of the Services/Directorates/Individual staff to undertake these projects. This is of course in itself determined by the time/capacity that staff within the services have available to commit to such projects and can be a key barrier for quality improvement. Time invested in clinical audit must be as effective as possible and balanced against both clinical and other priorities, targets and challenges that the services adhere to.

The intention is to integrate clinical audit as much as possible within the services, improving the effectiveness of the projects as well as providing streamlined and reliable evidence and data for the services themselves. Where this is not possible then participation in audit must be carefully considered and balanced against other needs.

There are various forms of quality improvement activity and clinical audit is one such method that benchmarks current performance against standards of best practice. This report focuses on clinical audit and a small number of national outcome reviews.

3.1. Health Board Forward Clinical Audit Programme

The Health Board has implemented a Board-wide Forward Clinical Audit Programme (FCAP) – a prioritised summary of planned clinical audit activity which is regularly updated and scrutinised in accordance with Health Board strategy and policy. The aim of this programme is to focus available clinical audit resources (within services and the CAD) towards a small number of core projects focusing on high priorities or key risks. Each project should provide direction for definable improvements in the quality of services we provide as well as provide a level of assurance to the Health Board that services are either meeting required standards or improvement work is being carried out.

A forward programme is also a requirement outlined in the NHS Wales Audit Committee Handbook.

A forward programme will consist of projects related to these key elements:

- The Health Board's 10 Strategic Objectives
- Mandatory national audits
- Risks articulated in the risk registers
- Directorate, Department or Committee priorities that have been clearly agreed and outlined prior to inclusion as audits on the programme

The Operational teams, through the existing governance framework are asked to develop forward plans for clinical audit and have overall accountability for the development and implementation of recommendations.

The CAD take into consideration high priority and/or risk associated audits which are identified throughout the year by the governance framework.

The CAD recognises that this is a new approach to clinical audit and some allowance for this should be factored in to any appraisal of the finalised programme. It is also accepted that embedding of this programme has taken significant engagement work. As a result some areas are not represented whether through choice or insufficient capacity to engage fully.

3.2. National Clinical Audit and Outcome Review Plan

The Welsh Government's National Clinical Audit and Outcome Review Plan (NCAORP) is one of the core mechanisms for assessing the quality of healthcare in Wales and is a means for the Health Board to compare its current practice with the best provided elsewhere in Wales; driving forward improvements in quality and safety. The plan compiles a list of mandatory national clinical audit projects that the Health Board must participate in (where those services are provided).

All projects within this national programme are automatically included in the Health Board's Forward Clinical Audit Programme.

3.3. Other Clinical Audit Activity

Whilst the focus of the Health Board and the resources of the CAD will be targeted towards the Forward Clinical Audit Programme there is still the opportunity for other clinical audit projects to be undertaken.

Other clinical audit projects can come from a variety of sources such as important projects put forward by the services that do not quite meet the criteria for the programme or from an individual clinician who is interested in improving a specific area of care, or with a personal interest etc.

To satisfy governance arrangements, there is still a requirement that all clinical audit undertaken within the Health Board be registered with the CAD.

3.4. National Enquiries into Patient Outcomes and Death (NCEPOD)

The National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD) purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public; by reviewing the management of patients, by undertaking confidential surveys

and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

The Clinical Audit Facilitators are the Local Reporters for the Health Board; acting as a link between the staff at NCEPOD and local specialties. Dr Ceri Brown, Consultant Anaesthetist at Withybush General Hospital is the NCEPOD Ambassador who supports both NCEPOD Local Reporters and fellow clinicians working alongside NCEPOD.

3.5. National Institute for Health and Care Excellence (NICE)

National Audits, which form a key component of the Health Board's clinical audit programme, often include recommendations from NICE guidance. Other NICE guidance related audits should form a key part of the FCAP.

3.6. Wales Audit Office

As part of the WAO 2018 audit plan for the Health Board, WAO included local work to review the Health Board's operational quality and safety arrangements. This review commenced in September 2018 and asked the following question: Are the Health Board's operational quality and safety arrangements and structures effective?

The review has called out capacity constraints within the Clinical Audit Department as an issue. It has also recommended that arrangements be made to support and encourage attendance at the ECP-SC as well as a revisit of the scope of this committee which has been identified as a barrier to this committee's ability in providing effective levels of assurance.

Whilst there are currently no formal plans to increase capacity of the Clinical Audit Department the strength and role of ECP-SC has been improved. More details on this can be found in Section 3; 5.1 and 5.2 below.

The report also raised concerns over the isolated approach of various streams of quality and safety related activity and the work of the respective corporate teams. Developments to address this are already underway and the links between clinical audit and quality improvement are being strengthened through the work of the Quality Improvement Strategic Framework (5.11 below).

"Review of operational quality and safety arrangements – Hywel Dda University Health Board", June 2019 by Wales Audit Office.

Section 2

4. SUMMARY OF CLINICAL AUDIT ACTIVITY

4.1. National Clinical Audit and Outcome Review Programme 2018/19

National Clinical Audit is a tool for benchmarking services with other Health Boards and Trusts in England and Wales as well as internally between sites. Participation in National Clinical Audit should be a key driver for improvement and the action plan a key driver for turning recommendations into practice.

The 2018/19 NCAORP contains a list of 34 audits, registries and databases that the Health Board was required to participate in during the year. 6 additional audits were included on the plan but were not applicable to this Health Board. The plan consisted of a range of projects across many specialties. Projects applicable to this Health Board:

- **Acute**
  - National Joint Registry
  - National Laparotomy Audit (NELA)
  - Case Mix Programme (ICNARC)
  - Major Trauma Audit (TARN)
  - National Ophthalmology Audit
- **Long Term Conditions**
  - National Diabetes Audit (Primary Care)
  - National Diabetes Foot care
  - National Diabetes Inpatient Audit*
  - National Pregnancy in Diabetes
  - National Diabetes Paediatric
  - National COPD Audit Programme
  - National Asthma Audit
  - Pulmonary Rehabilitation
  - National Audit of Chronic Obstructive Pulmonary Disease (Primary Care)
  - National Early Inflammatory Arthritis
  - All Wales Audiology Audit
- **Older People**
  - SSNAP (Stroke)
  - National Audit of Inpatient Falls
  - National Hip Fracture Database
  - Fracture Liaison Service Database
  - National Audit of Dementia
  - National Audit of Breast Cancer in Older People
- **Heart**
  - National Heart Failure
  - Cardiac Rhythm Management
  - Myocardial Ischaemia National Audit Project (MINAP)
  - Cardiac Rehabilitation
- **Cancer**
  - National Bowel Cancer
  - National Lung Cancer
  - National Oesophago-gastric Cancer
  - National Prostate Cancer
- **Women's and Children's Health**
  - National Neonatal Audit Programme

- National Maternity and Perinatal

- **Other**
  - Epilepsy 12 Children and Young People
  - National Audit of Psychosis
  - Chronic Kidney Disease (Primary Care)*
  - National Audit for Care at the End of Life (NACEL)

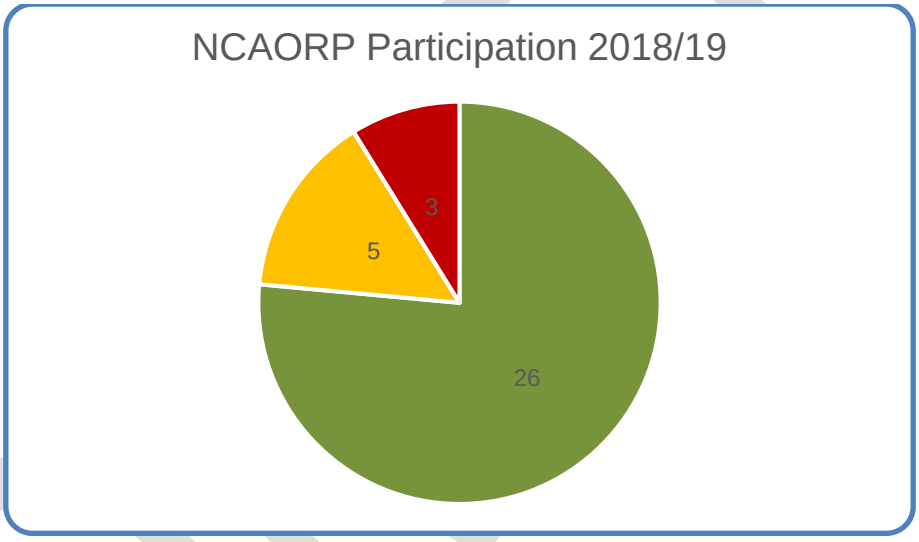
**no data collection during 2018/19*

Due to the different set up, providers, reporting timeframes and other factors of the multitude of national audits the information below is based on the latest available information and is an estimate of the contribution from the Health Board for 2018/19.

More information on NCAORP projects can be found in Section 4.

Participation levels have been RAG rated and are grouped in figure 1 below:

Figure 1: Participation RAG indicators for 2018/19



RAG Indicator Key:
Green - Reasonable participation across all relevant sites
Amber - Partial participation (i.e. not all sites and/or low case ascertainment)
Red - No participation from any site

4.1.1. National Clinical Audit Outcomes

The below is a small illustrative sample of audit outcomes from the Health Board's participation with the NCAORP. Further details as well as the most recent action plans can be found in Appendix A.

Audit Title	Key Information and Benefits
National Audit of Inpatient Falls	• Roll out of RCP clinical practice tool to standardise assessments of lying and standard blood pressure • A re-enforcement of individual patient medication reviews on admission to hospital to identify medications that can contribute to falls • Development of a new post falls medical assessment tool

	• Implementation of continence assessments through nursing assessment process • Further checks introduced on 2 hourly basis as part of intentional rounding
National Hip Fracture Database	• Employment of Orthogeriatrician to support KPIs for audit • Improvements made for patients operated on over the weekend with an increase of input from Therapies Staff • Trauma database set up to improve patient flow and ensure that patients are treated in turn/by clinical urgency • Improvements have been made to the provision of Fascia Blocks, Time to Orthogeriatric review and Falls Assessments • Introduction of regular Physiotherapy exercise classes for inpatients which has increased patient morale • Daily site bed meetings to patients are admitted to Orthopaedic ward when possible
National Ophthalmology Audit	• Journal clubs and speciality audit meetings provide a forum to discuss the implementation of new systems and to discuss all audit data • Information is given to patients at their outpatient appointment regarding their care and treatment • A cataract pathway is completed for each patient having surgery to act as a record of their care
National Audit of Dementia	• Additional staff recruited in old age psychiatry to improve support to hospital sites • Additional mental capacity assessors recruited to undertake and support timely assessments of patients' mental capacity and facilitate early diagnosis of dementia
National COPD Audit Programme	• A lead nurse for NIV has been appointed • Smoking cessation specialists and counsellors are now available in all 4 hospitals • An opt out smoking cessation referral system commenced for pre assessment clinics • Level 3 smoking cessation services available in community pharmacies across the Health Board • Introduction of testing of pulmonary rehabilitation utilising video conferencing in a hub and spoke model to increase through put and start offering service in Ceredigion
National Cardiac Audit Programme	• Hywel Dda and ABM UHBs initiated the pilot 'Treat and Repatriate Service' which has seen a reduction in wait from an average of 10 days to 4 days for patients. A business case is in development to sustain this service / pathway. • Cardiac Audit Group is being developed to share best practice and support development of improvement plans
National Maternity and Perinatal Audit	• Monthly data is collected and distributed via the Maternity Clinical Dashboard and discussed at the Labour Ward Forum and monthly Directorate QSEAC

	• Admission to high dependency and intensive care units is included on the Maternity Trigger list and Datix reported and investigated
National Paediatric Diabetes Audit	• Employment of a psychologist one day per week to support services • Reallocation of families to nurses to more evenly spread capacity
National Pregnancy in Diabetes Audit	• We are utilising CGM technology in antenatal clinics to improve blood glucose levels during pregnancy and reduce HbA1c
National Diabetes Primary Care Audit	• A single point of referral system to the Self-management service has been established • Implementation of a lay led diabetes self-management programme as well as delivering the more complex XPERT education programme to improve access to programmes and throughput • Funding has been agreed for the Directed and 4 National Enhanced Services
National COPD Primary Care Audit	• An on line spirometry course is now available for those not yet accredited improving accurate diagnosis • COPD and Asthma templates are being trialled in the Llanelli cluster to improve the capture and assessment of relevant patient data
National Emergency Laparotomy Audit	• Improvements have been made in resolving the discrepancies between CT scans and Operative findings • The Health Board has committed to being part of the Emergency Laparotomy Cymru (ELC) improvement work
Maternal, Newborn and Infant clinical Outcome Review Programme (MBRRACE)	• A National perinatal mortality review tool has been implemented • Initiation of a senior nurse to scope population requirements around Obesity and Smoking data. • Training updates for midwifery and obstetric medical staff have commenced in relation to post mortem counselling. • We have initiated a new developmental Bereavement midwife role to support the Bereavement Midwife in meeting the training and counselling needs of staff and patients

4.2. NCEPOD activity 2018/19

A total of 2 NCEPOD studies were participated in during 2018/19. This encompasses the entire NCEPOD programme (i.e. 100% compliance). There was also activity for MBRRACE.

- NCEPOD Medical and Surgical Programme - Pulmonary Embolism
- NCEPOD Medical and Surgical Programme - Bowel Obstruction
- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)

Further details and NCEPOD action plans can be found in Appendix A.

4.3. Forward Clinical Audit Programme 2018/19

A total of 98 local projects were submitted for inclusion in the Forward Clinical Audit Programme (FCAP). 48 of these projects did not meet the criteria for the programme and were removed either by the CAD or through Committee/Group agreement. The 34 NCAORP projects also form part of the FCAP but are not included in the analysis below due to differing reporting structures. Further information on the FCAP can be found in Section 4.

A number of specialties/services did not submit a programme for 2018/19. Engagement with the programme has been variable across the organisation and the reasons for this are multi factorial. Reasons include:

- Insufficient resources to carry out clinical audit projects in addition to other quality improvement activities
- Projects not meeting the criteria for the programme
- Insufficient resources to engage fully with the development of the programme

Figures 2 - 4 below are in reference to the projects that were submitted to the programme and were not subject to exclusion:

Project Status	***Description***
Complete	Project was completed and action plan submitted
Awaiting Report/Action Plan	Data collection was completed and the CAD is awaiting the submission of an action plan or the report (in the case of national projects)
In progress	Project is underway and will also be included in the 2019/20 programme
Discontinued	Project was stopped for valid reasons (e.g. policy superseded, audit no longer relevant etc.)
Incomplete	Project was not completed and without sufficient rationale provided
Roll Over to 2019/20	Project was not conducted but decision has been made to carry the project over to 2019/20
Not started	Project was not conducted and the audit has not been selected for roll over at this time though may be added later
Unknown	Insufficient available information to determine status or type of project but sufficient rationale to be included in the programme. No decision as to roll over of project.

Figure 2: National vs Local projects on FCAP

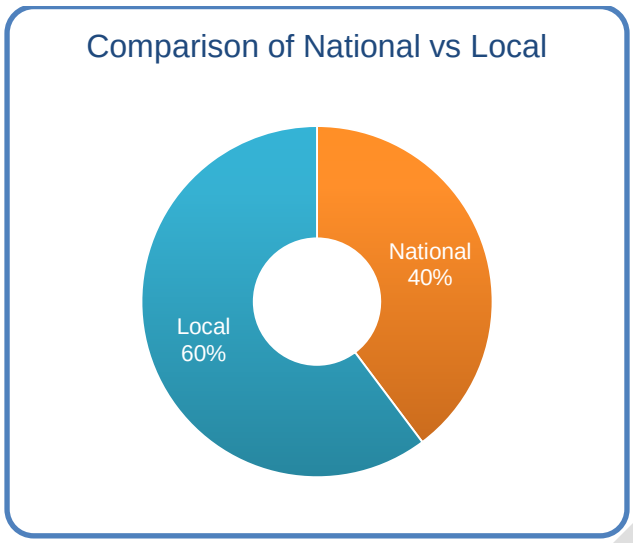


Figure 3: Project status at year end

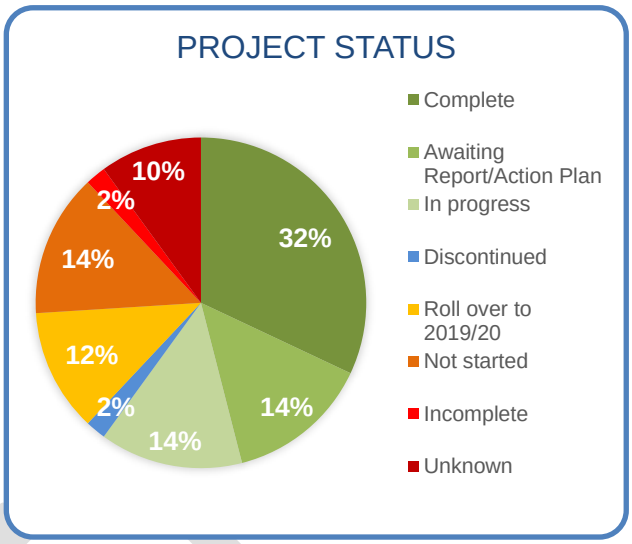
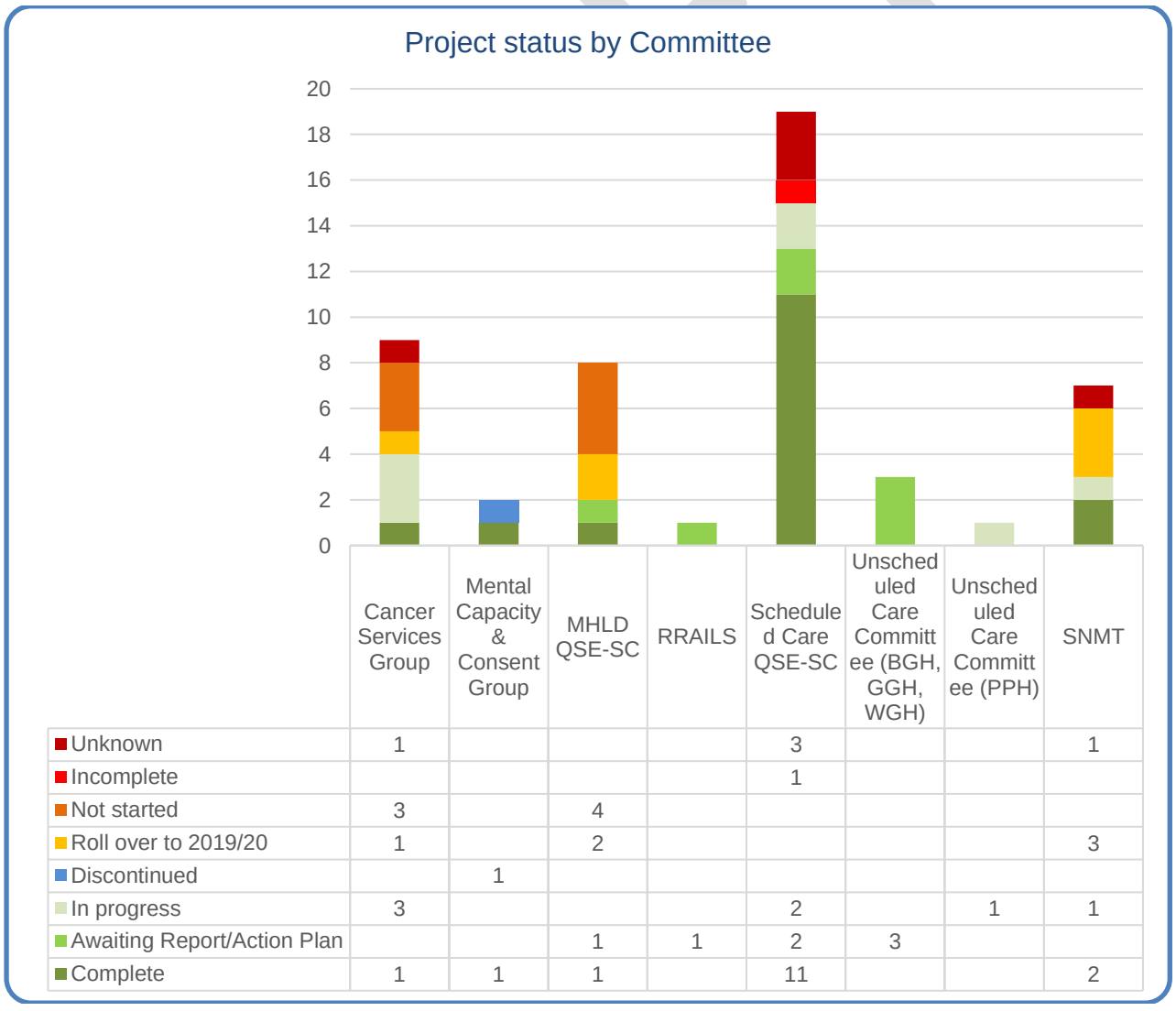


Figure 4: Breakdown of project totals and status



	Cancer Services Group	Mental Capacity & Consent Group	MHLD QSE-SC	RRAILS	Scheduled Care QSE-SC	Unscheduled Care Committee (BGH, GGH, WGH)	Unscheduled Care Committee (PPH)	SNMT
Unknown	1				3			1
Incomplete					1			
Not started	3		4					
Roll over to 2019/20	1		2					3
Discontinued		1						
In progress	3				2		1	1
Awaiting Report/Action Plan			1	1	2	3		
Complete	1	1	1		11			2

4.3.1. FCAP AUDIT OUTCOMES

The below is an illustrative sample of audit outcomes from the FCAP. Further details, all audit action plans as well as the complete programme can be found in Appendix B.

Audit Title	Key Information and Benefits
Audit of patients undergoing immediate breast reconstruction using Ti-loop	• Assurance that services are compliant with all audit standards.
Consent Form Audit	• Director of Operations has sent letters have to individual clinicians to address any significant concerns with compliance. • Consent training is being given to all relevant Health Board staff. • Re-audits show continued improvements with each audit round
Restrictive Physical Interventions (RPI)/ Positive Behaviour Management (PBM)	• Training is now given at preceptorship for newly qualified staff and during all RPI training courses. • Improvements have made in DATIX investigations ensuring that incidents are investigated fully and that increased learning is undertaken.
WGH Orthopaedic ERAS compliance with 1000 lives recommendations	• Assurance that services are compliant with all audit standards.
Compliance to BOAST Guidelines for ankle fractures	• A series of educational lectures have been introduced to increase training and awareness which include “hands on” sessions.
Efficacy of acute pain management	• Assurance that WHO ladder is being implemented and that no further issues are being identified.
Diagnosis of Suspected Scaphoid Fractures	• We are now providing more information to Ortho/A&E doctors about the availability of further imaging modalities as well as guidance on when to use them. • Through a quarterly presentation and teaching session awareness about the importance of not missing Scaphoid fractures
Operative notes in THR (re-audit)	• Assurance that services are compliant with all audit standards.
Orthopaedic Elective day cases (re-audit) 2018	• Presented to Junior Doctors in teaching sessions. • Ongoing work with the DSU to increase knowledge and awareness of ward staff.
Medicines Management Nursing Audit	• Immediate actions taken within a number of areas to increase compliance with audit standards. • Various long term improvements being rolled out after presentation at SNMT regarding the secure storage of controlled drugs etc. • Annual re-audit developed.
PEG Audit	• Ongoing ward based teaching by the CNS Nutrition in response to any Datix reports and requests by staff and ward managers

4.4. Non-programme activity for 2018/19

A total of 306 projects were being carried out in addition to the forward programme. The figures below detail information on all projects that have been registered with the CAD and reflect projects in various forms of completion. See Appendix C for a list of all projects.

Figure 6: Total clinical audit activity

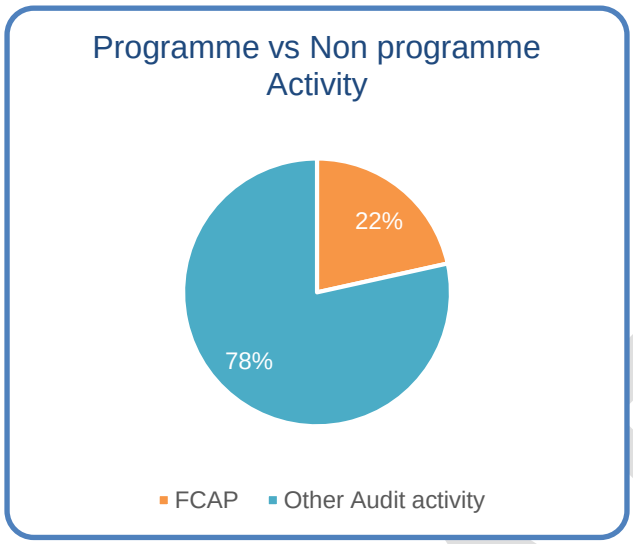


Figure 7: Non programme activity

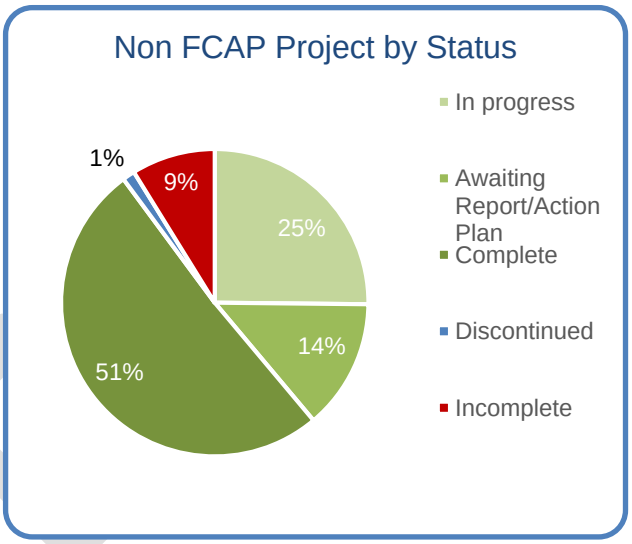
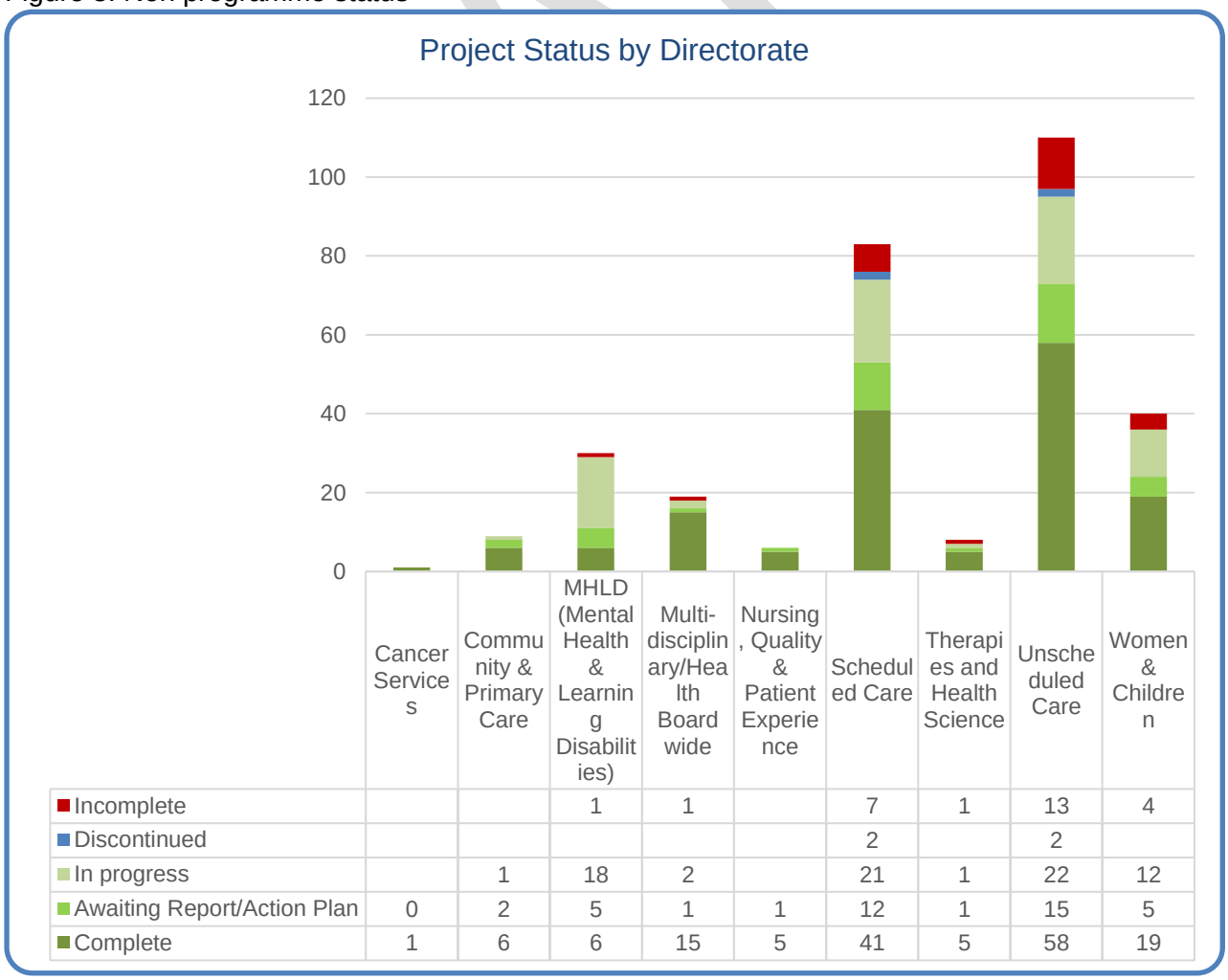


Figure 8: Non programme status



	Cancer Services	Community & Primary Care	MHLD (Mental Health & Learning Disabilities)	Multi-disciplinary/Health Board wide	Nursing, Quality & Patient Experience	Scheduled Care	Therapies and Health Science	Unscheduled Care	Women & Children
Incomplete			1	1		7	1	13	4
Discontinued						2		2	
In progress		1	18	2		21	1	22	12
Awaiting Report/Action Plan	0	2	5	1	1	12	1	15	5
Complete	1	6	6	15	5	41	5	58	19

Section 3

5. AT A GLANCE

5.1. Effective Clinical Practice Sub-Committee

The Effective Clinical Practice Sub-Committee (ECP-SC) reports to the Board's Quality, Safety, Experience and Assurance Committee (QSEAC) and is responsible for providing assurance to the Board that clinical effectiveness (including clinical audit) issues are being appropriately addressed.

The ECP-SC met 4 times in 2018/19. The meetings included a workshop to discuss the future direction of the sub-committee and a review of the ToR and membership. The attendance at ECP-SC has been flagged as a cause for concern and the minutes of the meetings as well as the resulting workshop and revisions to the ToR have reflected this. It has been noted that the Medical Director is revising the Medical Directorate structure and within this will be included job planning for the Chair of ECP-SC and some of the contributory groups.

The above work has aligned with the Wales Audit Office Report, June 2019 and the recommendations made. Recommendation 5 of this report called out the need for the above steps which have already been undertaken and now further work can continue.

5.2. Clinical Audit Scrutiny Panel

The Health Board identified a need to set up a sub-group of ECP-SC in order to provide further scrutiny and support for clinical audit activity and in line with WAO recommendations. The setup of this group has been delayed due to the revision of the ECP-SC. It has now been agreed that this group will take the form of a scrutiny panel.

The purpose of this new panel will be:

"To provide assurance that a robust clinical audit function is in place, supporting the organisation's strategic direction, priorities and identified risks as well as national priorities, with strong links to the quality, safety and experience sub-committees who will provide assurance with regard to the dissemination and implementation of actions arising from clinical audits and service evaluations."

The group is still establishing effective administrative support before it can meet. It is due to meet for the first time in 2019/20.

5.3. Clinical Audit Support Committees

As part of the infrastructure to support clinical audit within the Health Board, Clinical Audit Support Committees (CASC) were established representing each County (geographically) and Mental Health (four groups). The function and purpose of these committees is to ensure that through clinical audit, healthcare staff are encouraged to help improve the quality and safety of the care within the services provided.

Memberships of these committees are made up of the Chair, as well as representatives from a number of service areas.

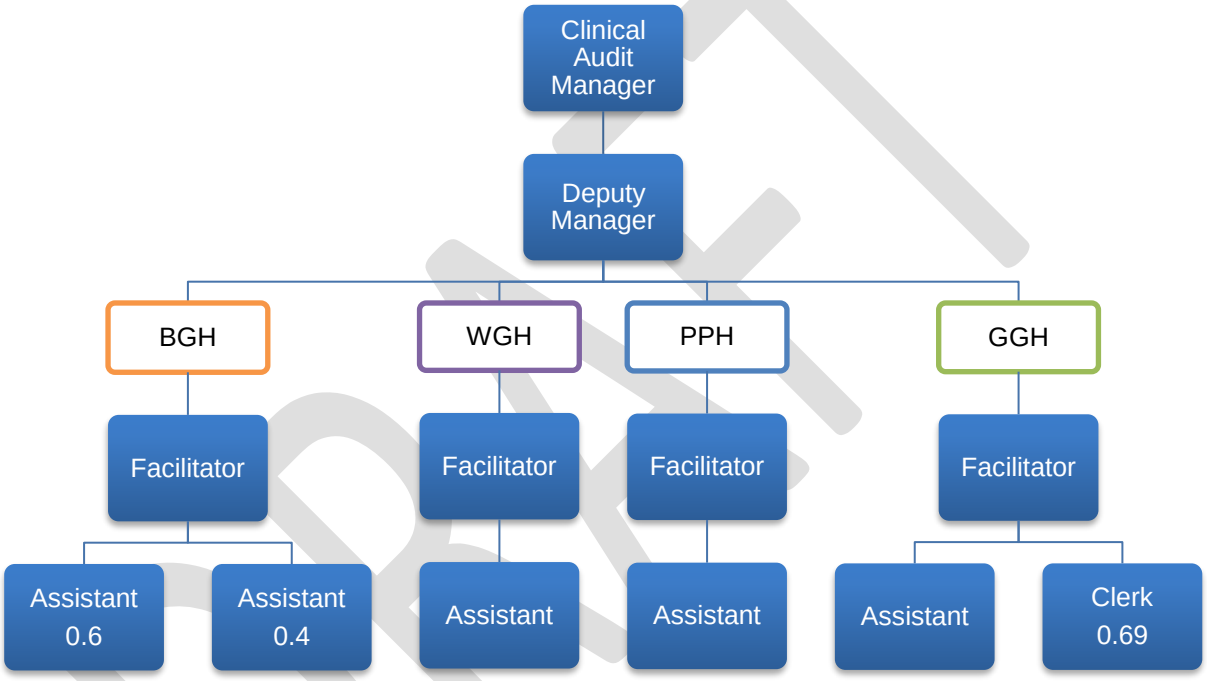
The role and ToR of these groups will be discussed further after the implementation of the Clinical Audit Scrutiny Panel.

5.4. Clinical Audit Policy

This policy has been through a number of minor revisions in 2018/19 and updated in line with new structures and GDPR requirements. The policy is due for further review in 2019/20.

5.5. Clinical Audit Department

The CAD has experienced a number of staff changes during 2018/19. It has also undergone a slight restructure in recent years to accommodate the new Health Board financial strategy. Throughout the year varying staffing levels have been experienced. The structure below indicates the permanent structure that is now representative of the Department.



5.6. Shared Learning

All audits undertaken require an action plan to be submitted to the CAD. The CAD issue reminders for these plans and have formal follow up procedures. A re-audit should be carried out to show that changes have resulted in the intended improvements. It is the intention that with a reduced number of projects on the forward programme that the CAD can increase support for services to ensure that this is done for all programme audits.

5.7. Whole Hospital Audit Meetings

As part of the audit process, healthcare professionals are encouraged to present their audit findings to a multidisciplinary audience. These presentations are open for discussion, providing an educational learning tool for the clinical teams. The Whole Hospital Audit Meetings (WHAM) are supported and coordinated by the CAD on each site. WHAMs are considered protected time to maximise the learning opportunity. However there is no protected time for Nursing, Clinical Support, Therapy staff or Managers to attend.

The audit meetings are an example of good practice that has highlighted many areas of excellent working as well as areas which can be improved upon. The CAD is essential to the dissemination of audit results throughout the organisation, for action within designated areas and to provide a link to other healthcare professionals and management teams who may be able to use the data to improve practice.

In 2018/19 a total of 19 events have been held with a total of 77 audits (local and national) presented and learning shared. Presentations shared at these events, as well as agendas, event feedback information and other audit outcome information is available on the clinical audit website:

http://howis.wales.nhs.uk/sitesplus/862/page/43470

5.8. Other

A number of the services also have regular meetings to discuss the national audit results. This allows them to act proactively on current performance and address concerns raised throughout the year before a report is ever produced. There has been a notable improvement in the number of formal meetings held within the last 12 months.

Ultimately the services themselves may provide further evidence to indicate that they are safe, efficient and of adequate quality. This is done through a variety of means such as quality dashboards, performance reviews, QI projects and target reporting.

5.9. Education and Training

Training raises the profile of clinical audit and builds capacity and capability of all staff involved. This is a driver for quality improvement. Training has been given when required and has included information stands and presentations for Junior Doctor Induction programmes on a regular basis. Specific Departmental training has also been provided in some cases.

The clinical audit training programme has been delivered in conjunction with the prioritisation and development of the Forward Clinical Audit programme, the National Audit Programme (NCAORP) and in line with other assurance requirements.

In 2018/19 a total of 13 training sessions were delivered by the CAD which included, nursing, physiotherapy, junior doctors and medical staff.

5.10. Hywel Dda HUB

The CAD contributes to Hwyl Hub – the Health Board Innovation Hub setup in July 2018. The Hub's aim is to encourage, inspire and support innovation within the Health Board through virtual and physical forums, events and project based support. The Clinical Audit Manager sits on the Hwyl Hub as a core member and one of the contributing Hub "Gurus".

5.11. Quality Improvement Strategic Framework

Clinical audit will form a key evidence base for a number of the Quality Improvement Goals 2018-2021 set by the Health Board:

- No avoidable deaths
- Protect patients from avoidable harm
- Reduce unwarranted variation and increase reliability

Evidence for these will be obtained by participation in the NCAORP and ensuring that the Health Board takes robust, clinically lead actions in response to these projects. Evidence will also be obtained from local audit outcomes. Many of the processes outlined in this report are designed to help achieve this.

The Clinical Audit Department is also supporting the Quality Improvement Collaborative and attending the sessions for 2019. The Department is committed to supporting any audits that arise from this collaborative and including them on the FCAP which in turn will be supporting the Annual Quality Priorities for the Health Board. This will also include encouragement of the submission of projects for the collaborative following NCAORP recommendations.

5.12. Links with other governance groups

The CAD provides updates to a number of governance groups within the Health Board. In 2018/19 it has provided updates and contributions to the meetings and reports below:

- Executive Team Performance Reviews
- Business Planning and Assurance Committee
- Audit and Risk Assurance Committee
- Quality, Safety, Experience and Assurance Committee
- Women & Children, MHLD, Scheduled and Unscheduled Care Q&S
- Senior Nursing and Midwifery Team meetings
- Governance, Leadership and Accountability Report
- Annual Quality Statement
- Internal Audit Reports
- Together for Health report
- QI collaborative

5.13. Health and Care Standards in Wales

The Health and Care Standards in Wales, Welsh Government [April 2015] provide a framework for gaining and providing assurance to patients, public and others on our ability as a Health Board to fulfil our aims and objectives for the delivery of safe, high quality health services. The use of clinical audit within the Health Board directly impacts on Standard 3 of the Health and Care Standards: Effective Care. The principle of effective care is that people receive the right care and support as locally as possible and are enabled to contribute to making that care successful.

5.14. Clinical Audit Awareness Week

The CAD once again joined the rest of the country for Clinical Audit Awareness week which ran from 19th - 23rd November 2018. This was the 6th annual Clinical Audit Awareness Week, organised by the Healthcare Quality Improvement Partnership (HQIP), to enable Trusts, Health Boards, audit providers and others to celebrate the best in clinical audit and encourage collaboration in improving patient care. During the week the CAD had informational stands throughout the four main sites and staff were encouraged to visit their local CAD for informal advice. Photographs and further information about site specific activities can be found on the Intranet.

http://howis.wales.nhs.uk/sitesplus/862/page/73682

Outstanding Auditors from the Health Board were nominated for the CAAW Hall of Fame. Congratulations go to Gwyn Jones, Elderly Trauma Advanced Nurse Practitioner from Bronglais General Hospital who was accepted in to the Hall of Fame.

6. RECOMMENDATIONS/GOALS FOR COMING YEAR

6.1. Forward Clinical Audit Programme 2019/20

The 2018/19 programme likely does not reflect the true priorities of the Health Board and is a probably a reflection of the setup of this new initiative by the Health Board. It is the intention that the FCAP will be refined for 2019/20. The number of initial submissions to the programme has decreased since the previous year. This is both expected and perhaps desirable in some ways. Whilst the intention is to have every service area contribute a robust programme of clinical audits it is prudent to allow these programmes to be properly developed by the services. The forward programme continues to be a challenge for the Health Board and it will take time and perseverance to reach its full potential.

The CAD in conjunction with the Services will develop a more effective reporting, support and escalation process for key clinical audit projects.

The CAD will continue to liaise with individuals, groups and committees to increase engagement and help ensure that all services have the opportunity to contribute to the programme. This has and will continue to include all Health Professionals.

6.2. National Clinical Audit Outcomes

It will be in the intention of the CAD to further develop the mechanisms by which national clinical audit action plans are monitored. Through the new Clinical Audit Scrutiny Panel, national audit outcomes and action plans will be presented and monitored with the intention that non-compliance or slow progress is reported via the Executive Team Performance Reviews and to the Effective Clinical Practice Sub-Committee. It has also been identified that there are gaps in the Welsh Government process regarding the reporting of national audit outcomes and so the Health Board will ensure that these gaps are addressed internally in addition to the existing national process.

Working with the Quality Improvement Team, the CAD will encourage the use of the new collaborative to support improvement work following NCAORP outcomes.

6.3. Local Audit

In discussion with some of the services there is clearly a need and desire that all clinical audit activity should be reviewed and outcomes considered. Work will be undertaken with these services to encourage the use of governance forums to review all clinical audit outcome data, regardless of its source.

6.4. Re-audit

The CAD will use available resources to further encourage the use of re-audit. This will focus primarily on the FCAP but will be encouraged for all audits. The intention being to present regular progression to show improvements over time as well as identify when audit cycles can be postponed or stopped when suitable levels of quality and assurance are both achieved and maintained.

Section 4

7. MAIN REPORT AND APPENDICES

7.1. Interpreting the Report

This report is a summary of audit activity for 2018/19 and is accurate at time of writing. Information contained within the report is based on documentation received and knowledge obtained by the CAD. It is acknowledged that other audit activity may exist within the Health Board that is not registered with the CAD. Though it is the aim of the CAD to capture all clinical audit information as per HB policy, it can only report on the activity that it is aware of. This also applies to information on project completion and implementation.

This report contains within it information on the quality of clinical services, however, it is not the intention of this report to form an opinion on the quality of the services that it features. All information held within this report must be taken within the context of the provider services. Further information or clarity should be sought from auditors and service leads if necessary for further interpretation or assessment of services.

7.2. Action Plans for Improvement

For every clinical audit undertaken it is required that an action plan be produced. Continuous audits that have no fixed end date will require that an action plan be produced at the end of each review period which must be specified at the onset. The project lead is ultimately responsible for the completion of the audit cycle and implementation of actions.

7.3. Sustaining Improvement

Re-audit is an important stage in the clinical audit cycle. It determines whether agreed actions have been implemented according to the action plan and whether or not these actions have had the desired effect (or indeed the opposite effect). Where non-compliance of any standard is discovered and therefore an action plan produced, a re-audit should be undertaken within an appropriate time frame. If practice is compliant with all standards or, in the rare case that all identified non-compliance is deemed to be an acceptable risk without intervention, then a re-audit should still be scheduled but with a larger timeframe.

8. APPENDIX A: NATIONAL CLINICAL AUDIT AND OUTCOME REVIEW PLAN

The information below contains summaries of National Audits that the Health Board has participated in. The information is based on the last available report for national audits that were either included within the 2018/19 plan or reported on during this time period, providing an idea of the work undertaken following the publication of a national audit report.

Each national audit summarised below includes information on the last report publication, the latest reported case ascertainment, the assurance form submitted to Welsh Government (action plan) as well as an indicator, RAG rated for 2018/19 participation:

Green 	Amber 	Red 	Did not run 	TBC 

The action plans detailed below describe the actions already taken or in the process of being developed to address the key findings and recommendations with timescale and details of named lead.

Further mechanisms for capturing the implementation of NCAORP recommendations are being developed in line with the new committee structures (see 6.2 above).

8.1. National Clinical Audit and Outcome Review Plan - Scheduled Care

National Joint Registry
Last report Date: October 2018
Last reported case ascertainment: 100%
Last Assurance Form Submission: n/a (assurance forms only requested if a hospital is flagged as an outlier)

Case Mix Audit Programme
Last report Date: December 2018
Last reported case ascertainment: 100%
Last Assurance Form Submission: Not yet reported through standard process

National Early Inflammatory Arthritis
Last report Date: Not reported
Last reported case ascertainment: Not reported
Last Assurance Form Submission: n/a

Fracture Liaison Service
Last report Date: December 2018
Last reported case ascertainment: 0%
Last Assurance Form Submission: none

All Wales Audiology Audit
Last report Date: September 2018
Last reported case ascertainment: 100%
Last Assurance Form Submission: Not yet reported through standard process

National Emergency Laparotomy Audit (NELA)
Last report Date: November 2018 (for Dec 2016-Nov 2017)
Last reported case ascertainment: BGH = 128.3% GGH = 141.9% WGH = 67.7%
Last Assurance Form Submission: February 2019

Action	Timescale	Clinical Lead
Bronglais General Hospital:		
There are already 3 full time consultant surgeons (after appointment of 2 new surgeons) working at BGH. There will be a change in consultant rota as on call for a week	From March 2019	
BGH team have been taking a part in ELC (Cymru) meetings, sharing experience and learning from other sites, in terms of quality improvement. Recently, there was an ELC (Cymru) team visit to BGH to discuss about BGH NELA data, including run charts		
Recently BGH team presented local Laparotomy data, including timeliness of antibiotics in acute admission in hospital multi-disciplinary meeting, in view of updating local Laparotomy pathway	April 2019	
Discrepancy between CT report and operative findings have been discussed between local radiologists and surgeon (NELA surgical lead). However, report from 2016/17 is slightly improved from local audit on same topic		
Glangwili General Hospital:		
Local multidisciplinary team identified and signed up to Emergency Laparotomy Cymru (ELC)	July 2018- July 2019	Mr Rao/Dr Smithson
Local introduction of an Emergency Laparotomy booking form/checklist	March 2019	Dr Smithson/Mr Rao
Work towards formulation of All Wales Emergency Laparotomy Care Pathway	1 Year (July 2019)	ELC team
Improve quality of data collection through real time data input at the point of care	Ongoing	Lisa Churchill
Improve the timing of antibiotic and pre-operative lactate measurements/review of sepsis guidelines	September 2019	Dr Smithson
Raise the profile of NELA - Education/Audit meetings/WHAM	Ongoing	ELC team
Withybush General Hospital:		
Establish a Task and Finish Health Board group for implementation and full compliance across HDUHB with Emergency Laparotomy Pathway	March 2019	HB NELA Lead
Set up Health Board NELA Cluster to facilitate quality improvement – to meet quarterly, again to raise the profile and importance of NELA	April 2019	HB NELA Lead
To re-establish a local level NELA collaborative group, set-up quarterly meetings, include representatives from all relevant specialties, cascade information on development and	March 2019	NELA Leads

improvements, and assist with local quality improvement and to raise the profile of NELA at a local level		
To establish an Emergency Laparotomy Pathway	March 2019	NELA Leads
To develop a fast track referral pathway to elderly medicine	To be discussed at a local level	NELA Leads
Committed to being part of the Emergency Laparotomy Cymru (ELC) improvement work	Ongoing	NELA Team

National Audit of Inpatient Falls (NAIF)
Last report Date: November 2017
Last reported case ascertainment: 100%
Last Assurance Form Submission: June 2018

Action	Timescale	Clinical Lead
Falls Multi-Disciplinary Working Group National audit on in-patient falls report discussed as agenda item on the Adult Inpatient Falls Reduction Improvement Group on 9th March 2018. Further discussion to be initiated at the site/Directorate Quality Safety Improvement and Experience Assurance Group Document circulated by chair of Adult Inpatient Falls Reduction Improvement Group 15th March 2018 to be placed on the agenda of the above meetings Recommended best practice actions identified for improvement in reduction of inpatient falls to be included in current local action plan	July 2018 Completed September 2018	Assistant Director Operational Nursing & Quality Acute Services
NICE QS 86 Quality Statements 4-6 Initiate audit against the NICE QS 86 Quality statements 4-6 as part of the Quality Improvement Action Plan	December 2018	Assistant Director Operational Nursing & Quality Acute Services
Lying and Standing Blood Pressure RCP Clinical practice tool to standardise practice piloted on each acute hospital site in 2017. Initiate roll out plan to all ward inpatient areas	December 2018	Assistant Director Operational Nursing & Quality Acute Services
Medication Review		Clinical Leads:

To re-enforce current practice of individual patient medication review on admission to hospital as part of the medical assessment of the patient. This includes identifying medications which could contribute to falls. Pilot in progress on one hospital site involving daily review of patient medication chart by a pharmacist who would apply a yellow falling stars symbol alongside the prescribed medication to alert prescribers to the risk of falls A medical assessment form has been developed as part of the standardisation of post falls procedures. This will prompt medical staff to undertake a medication review. Assessment form currently being piloted across all acute hospital sites with a view to roll-out across hospital sites in the health Board	December 2018	Dr A Hayden Consultant Physician/ Dr W Backen Consultant Orthogeriatrician
Visual Impairment To initiate a pilot of the RCP Clinical Practice Tool on each acute hospital site. Develop implementation plan for roll-out.	March 2019	Assistant Director Operational Nursing & Quality Acute Services
Walking Aids Mobility Aids currently included in preventing falls and post fall care in inpatient areas policy. To initiate audit review process of mobility aids - availability and usage	March 2019	Assistant Director Operational Nursing & Quality Acute Services
Continence Care Plan Continence assessment is currently undertaken as part of the nursing assessment process on admission to hospital Patient need and management of continence is incorporated into a nursing care plan Continence status is recorded on an intentional rounding chart every two hours	Implemented	Assistant Director Operational Nursing & Quality Acute Services
Call Bells Accessibility is currently checked and recorded on intentional rounding form every two hours. Incorporate an audit review process within the current monthly quality assurance audit framework undertaken by Senior Nurse Managers	September 2018	Assistant Director Operational Nursing & Quality Acute Services
Development in Delirium Pathway Multi-agency regional Dementia Working Group developing Dementia Strategy and Delirium Pathway	March 2019	Sandra Morgan Assistant Director of Therapies

National Hip Fracture Database (NHFD)
Last report Date: November 2018
Last reported case ascertainment: BGH– 105.0% GGH – 92.5% WGH – 104.5%
Last Assurance Form Submission: March 2019

Action	Timescale	Clinical Lead
Glangwili General Hospital: Employment of Orthogeriatrician to improve key indicator 1 and medical care.	Immediate	Mr R Williams
Improved orthopaedic consultant theatre supervision (goal 90%).	March 2019	
Improved delirium assessment (4AT) and treatment pathway (goal 95%).	March 2019	
Develop a system to improve 120 day follow-up.	March 2019	
Improve assessment by physiotherapist day 1 (goal 95%).	March 2019	
Improve fascia iliac block pre-theatre to decrease delirium and pain (goal 90%).	May 2019	
Improve mobilisation day after surgery (85%).	May 2019	
The admission of patients to an Orthopaedic ward is a key objective and daily site bed meetings ensure this occurs when possible.	Ongoing	
Bronglais General Hospital: Middle Grade has been appointed to support the Orthogeriatrician, awaiting Visa clearance.	2-3 months	
The system of therapy input for patients operated on over the weekend has changed slightly. The on call Physio contacts the Orthopaedic on call junior to ensure that the Fractured Neck of Femur patients are assessed and mobilised as soon as possible.	Complete	Annette Snell
The County Director and Site General Manager are addressing the lack of provision of Community Beds with the relevant parties.	Ongoing	
Whereas a weekend trauma list hasn't yet been set up, a database has been created to record all trauma patients waiting for surgery. This is held by the Theatre team and populated by the junior doctors. This has helped create a better flow of the patients and ensures that patients are treated in turn/clinical urgency.	Complete & ongoing	

A newly developed (in-house) clerking proforma has been created and is now in use. This was created by the T&O junior doctors. Improvements have been made to the provision of Fascia Blocks, Time to Orthogeriatric review and Falls Assessments Pre-Alert system being set up with WAST New NHFD proforma being drawn up (HB wide), pilot in process Introduction of regular Physiotherapy exercise classes for inpatients which has increased patient morale. Patient Experience Diaries – to help improve quality of patient care. The admission of patients to an Orthopaedic ward is a key objective and daily site bed meetings ensure this occurs when possible.	Complete Complete & ongoing, monitoring continues March 2019 June 2019 Complete Ongoing Complete & ongoing	 Gwyn Jones Phil Kloer, Medical Director General Management team, Bronglais Hospital Gwyn Jones
Withybush General Hospital: New NHFD proforma being drawn up (HB wide), pilot in process The admission of patients to an Orthopaedic ward is a key objective and daily site bed meetings ensure this occurs when possible Recruitment of an ANP to support all trauma patients Training of T&O junior medical staff in delirium assessment Improvements in increasing mobilisation of patients all patients receive 20 minutes of rehabilitation daily (regularly audited throughout the year) Working towards achieving CSB standards Application of a post-operative checklist for junior doctors is reinforced by middle grade and Consultant staff Perioperative Medical assessment- poor results were due to Orthogeriatrician working across two sites. This has now ceased, therefore an improvement in results will occur	 June 2019 Ongoing Ongoing Ongoing Ongoing Immediate	 Dr Phil Kloer, Medical Director General Management team, Withybush Hospital GM, Withybush Hospital Physiotherapy service Mr S Isopescu Dr W Backen

National Ophthalmology Audit
Last report Date: August 2018
Last reported case ascertainment: 0%
Last Assurance Form Submission: November 2018

Action	Timescale	Clinical Lead
Medi sight software is currently being installed within the Health Board, it is hoped that this will be implemented within October and data entry can commence when staff are proficient in using it. To date it has been installed in the pre assessment clinics. Works are underway within Theatres and other clinical areas. We are currently working with Opticians in the local community to give them shared access to the data also which will help streamline services.		Gordon Wragg
Journal clubs and speciality audit meetings provide a forum to discuss the implementation of new systems and to discuss audit data		Huw Jenkins
Information is given to patients at their outpatient appointment regarding their care and treatment.		Sam Evans
A cataract pathway is completed for each patient having surgery to act as a record of their care.		Sam Evans

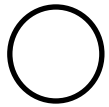
8.2. National Clinical Audit and Outcome Review Plan - Unscheduled Care

National Audit of Dementia
Last report Date: June 2017
Last reported case ascertainment: 100%
Last Assurance Form Submission: October 2017

Action	Timescale	Clinical Lead
Additional staff recruited in old age psychiatry to improve support to DGH site	Already done	Mark Chandler
Additional mental capacity assessors recruited to undertake and support timely assessments of patients' mental capacity and to facilitate early diagnosis of dementia	Already done	Chris Sayer
Plans for teaching and training for staff to raise awareness about dementia and early recognition of the special needs of these patients	During next 12 months	Chris Sayer

National Audit of the Care at End of Life (NACEL)
Last report Date: new audit - No report published
Last reported case ascertainment: n/a
Last Assurance Form Submission: n/a

National Diabetes Inpatient Audit (NADIA)
Last report Date: March 2018
Last reported case ascertainment: 100%
Last Assurance Form Submission: June 2018



Action	Timescale	Clinical Lead
Continued Thinkglucose work and meetings	ongoing	Carol Cottrell
Development of training animations & roll out	Summer 2018	Sam Rice
Secure Thinkglucose coordinator role	End 2018	Carol Cottrell

National Diabetic Foot care audit (NDFA)
Last report Date: March 2018
Last reported case ascertainment: Not reported
Last Assurance Form Submission: June 2018

Action	Timescale	Clinical Lead
<u>Diabetic foot training</u> Think glucose programme for HCP Nursing HCSW	Ongoing rolling programme commenced last 3 years	Chris Cottrell/ Joanne Morris lead Petra Gibbard Jones – Llanelli Catherine Llewellyn Carmarthen Steve Bishop Pembrokeshire Rhiannon Roberts Ceredigion
Pressure damage workshops incorporating inspection and risk assessment for diabetic, oedematous feet for in- patients	Ongoing programme commenced December 2017	Jane James TVN /Joanne Morris Podiatry leads on four sites of Hywel Dda Martyn Williams Carms and Llanelli Rhiannon Roberts Ceredigion. Alice James Pembrokeshire.
New documentation changes for Fundamentals for Care to be implemented for all inpatients clerked in all wards to have a foot inspection and diabetic assessment, with referral in-patient pathway	Sept 2018	Judith Bowen , Helen Humphries Jane James Joanne Morris
Putting feet first training for Primary care HCP's for referral in primary care to specialist services	Commenced 2017 poor uptake by GP surgeries.	Joanne Morris
<u>Pathways</u>		Joanne Morris

Urgent referral pathway: open access now on all sites to improve access, we don't have 7 day working, but can refer in weekdays within 24 hours usually. MDT T&O/vascular/endocrinology TBC and in discussion. New Joint health board Limb at risk pathway update ABMU/HDHB primary to secondary care and specialist services.	Ongoing Launch expected October 2018	 'Limb at risk' project GP ABMU/Hywel Dda health board. Joanne Morris Rhiannon Roberts Podiatry
New services New vascular assessment clinics to assess Peripheral arterial disease in primary and secondary care addressing the prevention agenda. Care aims training to enable clinicians to empower diabetic patients to self-manage and self-refer to specialist services.	Commenced August 2017 July 2018	Joanne Morris Rhiannon Robert Martyn Williams Joanne Morris

National Adult Asthma Audit
Last report Date: new audit – No report published yet
Last reported case ascertainment: n/a
Last Assurance Form Submission: n/a

National COPD Audit Programme
Last report Date: April 2018
Last reported case ascertainment: BGH 100% GGH 60% PPH 54% WGH 12% *(figures disputed by HB)*
Last Assurance Form Submission: August 2018

Action	Timescale	Clinical Lead
Local NIV guidelines in draft format	Completed for review at next RPDG Sept 2018	Prof Lewis
Lead nurse for NIV appointed	completed	Prof Lewis
Smoking cessation specialist now available in all 4 hospitals	completed	Prof Lewis
Opt out smoking cessation referral system commenced for pre assessment clinics	Ongoing next review September 2018	Prof Lewis
To plan next inpatient oxygen Audit	September 2018	Dr Carol Llewellyn Jones
Continue to advertise for more respiratory consultants to improve access to specialist respiratory care within 24 hours	Ongoing review September 2018	Dr Carol Llewellyn Jones
Smoking cessation counsellors now in all 4 hospital sites	completed	Prof Lewis
Level 3 smoking cessation services available in community pharmacies across the health board	Ongoing next review September 2018	Prof Lewis
Introduction of testing of pulmonary rehabilitation utilising video conferencing in a hub and spoke model to increase through put and start offering service in Ceredigion	Third programme completed ongoing	Prof Lewis
Business case developed to support further role out of this model for pulmonary rehabilitation	Completed awaiting outcome	Prof Lewis
Continue to promote the use of the COPD discharge bundle across all 4 hospital sites.	Ongoing review September 2018	Dr Carol Llewellyn Jones
Further training planned to promote and support the use of the discharge bundle	Planned for 2019	Dr Carol Llewellyn Jones

Pulmonary Rehabilitation
Last report Date: new audit – April 2018
Last reported case ascertainment: 100%
Last Assurance Form Submission: January 2019

Action	Timescale	Clinical Lead
85% of appropriate patients are enrolled on pulmonary rehabilitation within 90 days of referral Unfortunately there is no realistic prospect of this target being achieved without significant investment in the service. HDdUHB is currently in targeted financial interventions and all requests for additional resourcing of the pulmonary rehab programme have been unsuccessful to date. A business case for funding for a Virtual Pulmonary Rehabilitation service ("VIPAR") was submitted in July 2018 following on from an SBAR submitted to HDdUHB in December 2017for a VIPAR service. The Director of Therapies and Health Science is looking to support the strengthening of the business case to address this area of unmet need, with a longer term plan to align a hub and spoke model with other areas of service delivery to make this sustainable.	12 months. 1st July 2019	Signed by Prof. K Lewis 1/11/18
70% of patients commencing PR complete the course (completion defined as 75% attendance and discharge assessment performed) Completion rates in Pembrokeshire already exceed this target. Completion rates in Carmarthenshire are close to target and likely to be improved by the introduction of "taster sessions" for PR where potential candidates get the opportunity to learn more about the commitment required to complete PR before enrolling.	12 months. 1st July 2019	Signed by Prof. K Lewis 1/11/18
85% of patients who commence PR will have practice walking tests performed. The requirement to perform practice walking tests is incorporated into the HDUHB Standard Operating Procedures for the Incremental Shuttle Walking Test and the Six Minute Walking Test.	12 months. 1st July 2019	Signed by Prof. K Lewis 1/11/18

National Cardiac Audit Programme *(combines MINAP, Heart Failure, Cardiac Rhythm Management and others)*

National Heart Failure
Last reported case ascertainment: Not reported

Myocardial Infraction National Audit Programme (MINAP)
Last reported case ascertainment: BRG - 96.36% PPH – 62.82% GGH – 65.99% WYB – 98.68%

Cardiac Rhythm Management
Last reported case ascertainment: 100%

Last report Date: November 2018 (NCAP report)
Last Assurance Form Submission: April 2019

Action	Timescale	Clinical Lead
Recommendation 3: Patients with a suspected heart attack should call an ambulance rather than take themselves to hospital Review current processes in place intended to raise public and patient awareness concerning the need to dial 999 and not attend local A&E when experiencing chest pain. Identify necessary improvement and action plan to support this.	July 2019	Paul Smith (Service Delivery Manager)
Recommendation 5: Medical directors and their clinical leads should have clinical pathways that ensure the rapid detection of higher-risk heart attacks Health Board-wide clinical pathway in place for the identification and management of higher-risk heart attack patients; NICE guidance CG95 followed.		
Recommendation 8: Commissioners and clinical leads should ensure that patients who are at high risk for surgical aortic valve replacement are considered for transcatheter aortic valve implantation (TAVI) Health Board-wide clinical pathway in place for the identification and management of patients deemed appropriate for TAVI; Recent WHSC guidance for commissioning TAVI sent to relevant professionals.		

Recommendation 12: Hospital providers and directors of nursing should review their pathways for patients with heart failure and where this is a primary diagnosis these patients should ideally be cared for on a cardiology ward with access to heart failure specialist teams Health Board-wide clinical pathway in place for the identification and management of Heart Failure patients; Health Board to review local clinical pathway for Heart Failure patients and align with recommendations of the All Wales Heart Failure Patient Pathway Workshop held in February 2019; Need to clarify role of Pro BNP in screen for Heart Failure. Discussions to be had with Health Board chemical pathology.	August 2019 August 2019	Paul Smith (Service Delivery Manager) Dr Adrian Raybould (Clinical Lead)
Recommendation 13: Commissioners should ensure that access to specialist follow-up and to cardiac rehabilitation services is available to all patients following a heart attack as well as to patients admitted with heart failure All 3 County Cardiac Rehabilitation services provide menu-based Cardiac Rehabilitation to patients following heart attached and to patients referred with Heart Failure; All 3 County Cardiac Rehabilitation services submit data to NACR; All patients admitted with heart failure are followed up by a Heart Failure Specialist Nurse; Decision needed following on-going discussions regarding identifying a Health Board lead for Heart Failure.	June 2019	Dr Adrian Raybould (Clinical Lead) Paul Smith (Service Delivery Manager)
Recommendation 14: Commissioners should expect and clinicians should provide an evidence-based 'bundle-of-care' for patients with heart attacks. The NCAP will work to facilitate this. Health Board to review local clinical pathway for NSTEMI patients and align with recommendations of the All Wales NSTEMI/ACS Patient Pathway Workshop held in January 2019; Explore development of a 'bundle-of-care' for heart attack patients.	August 2019 August 2019	Dr Adrian Raybould (Clinical Lead) Paul Smith (Service Delivery Manager)
Recommendation 15: Medical directors and clinical leads should review their local patient flow data to ensure that the time taken from presentation and diagnosis to angiography and revascularisation for patients with lower-risk heart attacks is as efficient as possible Hywel Dda and Abertawe Bro Morganwg Health Boards recently reviewed data and performance with respect to this patient group and on 7th January 2019 initiated the pilot 'Treat and Repatriate Service' which has seen a reduction in wait from an average of 10 days to 4 days for patients. A business case is currently in development to sustain this service / pathway.	May 2019	Dr Adrian Raybould (Clinical Lead) Paul Smith (Service Delivery Manager)

Recommendation 16: To allow timely assessment of performance and to ensure that every hospital is assessed correctly, hospital management teams must ensure that accurate data are provided to the national audit programme on time Service Delivery Manager for Cardiology is currently reviewing processes concerning local compliance with national cardiac audits. This will involve scoping of current levels of case ascertainment for all mandatory cardiac audits and the needed actions / resource to achieve improvement. Health Board Cardiac Audit Group to be developed to share best practice and support development of an improvement action plan. Risk assessment and management plans for areas of concern to be completed and local Cardiac Audit Group to be established to support improved compliance.	May 2019 May 2019 April 2019	Paul Smith (Service Delivery Manager) Paul Smith (Service Delivery Manager) Paul Smith (Service Delivery Manager)

Cardiac Rehabilitation
Last report Date: November 2018
Last reported case ascertainment: Not reported (estimate 100%)
Last Assurance Form Submission: Not yet reported through standard process

Major Trauma Audit (TARN)
Last report Date: March 2019
Last reported case ascertainment: GGH 2.9% – 3.5% BRG 100% WGH 17.7% - 22%
Last Assurance Form Submission: Not yet reported through standard process

Sentinel Stroke National Audit Programme (SSNAP)
Last report Date: November 2016
Last reported case ascertainment: 90%+
Last Assurance Form Submission: January 2017

Action	Timescale	Clinical Lead
IPC Training commenced on all 4 sites. Health Board documentation currently going through approval process.	March 2017	Site Stroke Specialist Nurses
Psychology service: Stroke Plan (linked to IMTP) prioritising investment required to meet this significant service demand for our population. Awaiting Executive Team feedback with regards to funding. Other Therapy staff and ESD: As above, awaiting decision of Executive Team. NB. Current deficit impacting on clinical performance and without allocation of funding resource the clinical service will not have a significant improvement.	April 2017 (decisions reached) September-March (recruitment and new service implementation)	Dr Granville Morris, Health Board Clinical Lead for Stroke

8.3. National Clinical Audit and Outcome Review Plan – Cancer Services

National Bowel Cancer
Last report Date: December 2018
Last reported case ascertainment: BGH = 111% GGH & PPH = 91% WGH =104%
Last Assurance Form Submission: February 2019

Action	Timescale	Clinical Lead
Develop Colorectal Services at Bronglais Hospital. This will be an incremental approach over a 2 year period to ensure supporting staff are effectively trained and there is all the necessary equipment. It is envisaged that this will commence with right hemicolectomy and progress to more complex surgery as the team gains experience and confidence		Jegadish Matthias (Cancer Lead) Mark Henwood (Director of Scheduled Care) Ken Harries (Clinical Lead for Surgery)
Targeted Peer review of MDT planned for later this year to address some concerns expressed by a clinician regarding decision making		Targeted Peer review of MDT planned for later this year to address some concerns expressed by a clinician regarding decision making
Stoma rates are now within expected range (flagged as an outlier in report)		

National Oesophago-gastric Cancer
Last report Date: April 2018
Last reported case ascertainment: 61 - 70% (amber)
Last Assurance Form Submission: January 2019

Action	Timescale	Clinical Lead
Key Finding 1 - Ensure no barriers to data collection/uploading. First in HB. Discuss with Cancer Services.	Jan 2019	Mr Mark Henwood
Key Finding 2 – Implementation of Single Cancer Pathway	April 2019	Mr Mark Henwood
Key Finding 3 - Implementation of Single Cancer Pathway	April 2019	Mr Mark Henwood

Key Finding 4 – Ensure complete information is submitted to NOGCA. Discussion with Cancer Services.	Jan 2019	Mr Mark Henwood
Key Finding 5 – Ensure all patients considered for radical treatment receive appropriate staging investigation	Jan 2019	Mr Mark Henwood
Key Finding 8 – Encourage use of nCRT and enter patients into NeoAEGIS	Jan 2019	Mr Mark Henwood
Key Finding 11 – Ensure patients receive appropriate palliative treatment	Jan 2019	Mr Mark Henwood

National Prostate Cancer
Last report Date: February 2019
Last reported case ascertainment: 84 – 100%
Last Assurance Form Submission: In progress

National Lung Cancer
Last report Date: April 2019
Last reported case ascertainment: Not reported
Last Assurance Form Submission: In progress

National Audit of Breast Cancer in Older People
Last report Date: June 2018
Last reported case ascertainment: 100%
Last Assurance Form Submission: September 2018

Action	Timescale	Clinical Lead
All patients over the age of 70 years will have a medical assessment questionnaire completed	1 year	Mrs Saira Khawaja
TNM staging will be completed for all patients in each local MDT and rechecked	1 year	Mrs Saira Khawaja/ Mr William Maxwell

8.4. National Clinical Audit and Outcome Review Plan – Women and Children

National Neonatal Audit Programme

Last report Date: September 2017 (2016 Data)
Last reported case ascertainment: 96%
Last Assurance Form Submission: December 2017

Action	Timescale	Clinical Lead
Appointment of secretary has improved data entry on BadgerNet. Feedback sessions are provided to doctors and nurses to ensure accuracy and completeness.	6 months	Dr Prem Pitchaikani
Organise educational sessions for midwives, Obs, doctors, nurses	6 months	Dr Prem Pitchaikani
Highlight current guidance on use of antenatal steroids + Mg So4 in MDT meetings such as perinatal and antenatal meeting.	6 months	Dr Prem Pitchaikani
Ensure nurses and doctors have up to date knowledge on importance of breast feeding especially for preterm babies.	6 months	Dr Prem Pitchaikani

National Maternity & Perinatal Audit

Last report Date: January 2019
Last reported case ascertainment: 100%
Last Assurance Form Submission: April 2019

Action	Timescale	Clinical Lead
Data is collected monthly via the Health Board Maternity Clinical Dashboard and circulated for review and discussion at the Health Board Labour Ward Forum and monthly Directorate QSEAC	Current	Julie Jenkins, Head of Midwifery
Admission to high dependency and intensive care units is included on the Maternity Trigger list and Datix reported and investigated	Current	Julie Jenkins, Head of Midwifery

National Paediatric Diabetes
Last report Date: July 2018 (2016-17 data)
Last reported case ascertainment: 100%
Last Assurance Form Submission: January 2019

Action	Timescale	Clinical Lead
Employed psychologist one day per week	Started	Dr Simon Fountain-Polley
Finance agreed to increase additional dietetic input 0.6 WTE	In progress	Dr Simon Fountain-Polley
Reallocation of families to nurses to more evenly spread capacity	Achieved	Dr Simon Fountain-Polley
Additional PDSN time introduced into IMTP 2019-20	In progress	Dr Simon Fountain-Polley

National Pregnancy in Diabetes
Last report Date: October 2017 (2016 data)
Last reported case ascertainment: 100%
Last Assurance Form Submission: December 2017

Action	Timescale	Clinical Lead
Developing neonatal transitional care service	2019	Paediatrics
Utilise CGM technology in antenatal clinic to try and improve BG levels during pregnancy and reduce HbA1c	Recently started	Dr Lisa Forrest
Recruit to Diabetes Specialist midwife role – develop pathways of referral, education, links to primary care	2018	Obstetrics
Education to primary care regarding pre- conception	2018	Dr Lisa Forrest
Developing neonatal transitional care service	2019	Paediatrics

National Epilepsy 12 Children and Young People
Last report Date: January 2019
Last reported case ascertainment: 100%
Last Assurance Form Submission: In progress

8.5. National Clinical Audit and Outcome Review Plan – Mental Health and Learning Disabilities

National Audit of Psychosis
Last report Date: July 2018 (2016-17 data)
Last reported case ascertainment: 100%
Last Assurance Form Submission: Not yet reported through standard process

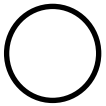
8.6. National Clinical Audit and Outcome Review Plan – Primary Care

National Diabetes – Primary Care
Last report Date: March 2018 (2016-17 data)
Last reported case ascertainment: 100%
Last Assurance Form Submission: June 2018

Action	Timescale	Clinical Lead
Referrals to structured education – 1. A single point of referral system to the Self-management service has been established	completed	Mark Barnard
2. Numbers of programmes established on a yearly basis and more added if needed.	yearly	Mark Barnard
3. Implemented a lay led diabetes self-management programme as well as delivering the more complex XPERT education programme to improve access to programmes and throughput	Completed and rollout ongoing	Mark Barnard
4. Working with primary care to identify lists of people with Type 2 Diabetes	ongoing	Mark Barnard
5. Working with the All Wales Lead for structured education to define a Self-Management pathway for people with Type 2 Diabetes	ongoing	Mark Barnard
6. Identified team for Hywel Dda to be trained in DAFNE for people with Type 1 Diabetes	Completed waiting for training dates	Mark Barnard
Support the implementation of the Direct and local enhanced service for Type 2 diabetes – 1. LES has been superseded by the DES and 4 NES's	In place	Mark Barnard
2. Funding has been sourced for the DES and 4 NES's	completed	Mark Barnard
3. Reporting template agreed	completed	Mark Barnard
4. New integrated diabetes service delivery across the care pathway under discussion	Discussions ongoing plan to be completed by March 2019	Mark Barnard
Plans for Clusters to take the lead on Diabetes Care using a peer reviews system to compare the delivery of all 8 care processes and identify where practices/clusters require additional support	Jan 2019	Mark Barnard

Chronic Kidney Disorder - Primary Care

Last report Date: December 2017
Last reported case ascertainment: 50 – 75%
Last Assurance Form Submission: May 2018



Action	Timescale	Clinical Lead
Encouraging clusters to act on the data via cluster meetings	ongoing	Mark Barnard
Senior clinical staff undertaking Practice governance visits and data will be discussed during these (in addition to other NCAORP audits)	ongoing	Mark Barnard
The national audits will be highlighted in the monthly GMS newsletter sent to all practices	Done. Repeat in June 2018	Mark Barnard

Chronic Obstructive Pulmonary Disease (COPD) – Primary Care

Last report Date: April 2018
Last reported case ascertainment:
Last Assurance Form Submission: August 2018

Action	Timescale	Clinical Lead
COPD and Asthma templates are being trialled in the Llanelli cluster. If these capture all relevant data required for COPD including READ codes , MRC, spirometry to roll out across primary care	April 2019	Claire Hurlin & Mark Barnard
On line spirometry course now available and ARTP fees will be paid. To offer out this course to those not yet accredited in primary care This will improve accurate diagnosis.	April 2019	Claire Hurlin & Mark Barnard
Improve the use of pocket medic COPD films and referrals to self-management courses to skill people with COPD in their care. This would improve understanding of symptoms and appropriate access to health care. Work in progress with primary care on best way to refer people into these services.	April 2019	Claire Hurlin & Mark Barnard

8.7. NCEPOD and MBRRACE reports released during 2018/19

Medical & Surgical Review Programme: Acute Heart Failure Report 2018

Report Date: November 2018
Case ascertainment: 100%

Action	Timescale	Clinical Lead
Discuss with pathology the opportunity to have BNP and serum natriuretic peptide measurement, estimated costs and funding approval	March 19	Adrian Raybould

National Confidential Inquiry into Suicide and Safety – Annual Report 2018

Report Date: October 2018
Case ascertainment: Not reported

Action	Timescale	Clinical Lead
NCISH Quality Safety standards benchmarked against This was carried out following the 2016 quality & safety standards provided by NCISH. There have no further specific action plans released since this date.	Completed	Head of Nursing
Internal thematic review This is completed on an annual basis.	Completed annually	Head of Nursing
Internal thematic review of actions and subsequent action plan identified There is an overarching action plan which has identified 6 core work streams being progressed.	Completed	Head of Nursing
Contributions to local, regional and national Groups. There will be action plans arising from attendance at these meetings which will be managed locally.	Attendance is ongoing	Head of Nursing

MBRRACE-UK Perinatal Mortality Surveillance Report 2018
Report Date: June 2018
Case ascertainment: 100%

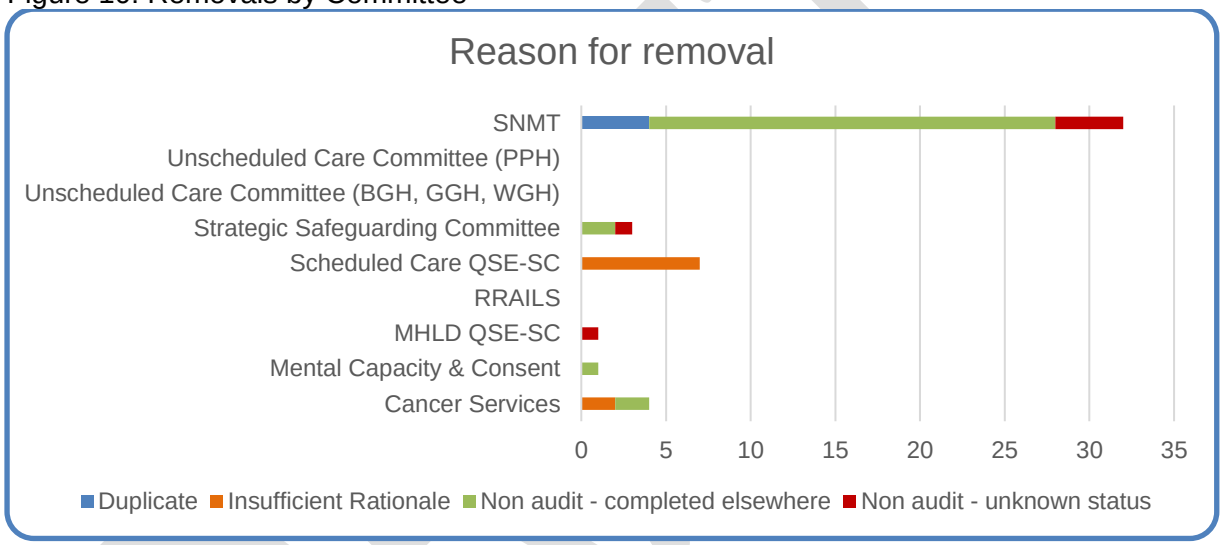
Action	Timescale	Clinical Lead
National PMRT has been implemented	April 2018 and will be ongoing.	Sharon Thomas. Clinical Risk Governance Midwife.
Met with Public Health Team initiated a band 7 Nurse to scope HB population requirements around Obesity and Smoking data.	April-December 2018	Cate Langley Consultant Midwife Public Health Lead.
Training updates for midwifery and obstetric medical staff have commenced in relation to post mortem counselling. We have initiated a new Band 6 developmental Bereavement midwife role to support the Band 7 bereavement midwife in meeting the training and counselling needs.	April-December 2018 Developmental role will start in November 2018.	Nicola Rees Practice development midwife. Heulwen Harden Bereavement midwife.

9. APPENDIX B: FORWARD CLINICAL AUDIT PROGRAMME 2018/19

Figure 10 below provides the reasons and associated number of projects that were excluded from the programme. These projects do not feature in the overall analysis of the programme and are subject to the following key:

Reason for removal	*Description*
Duplicate	Duplicate project submitted in error and already included elsewhere in the programme
Insufficient Rationale	Project does not meet the required rationale for the programme. No further information available as to the status of the project.
Non audit – completed elsewhere	Project is not an audit but confirmation has been received that this project was carried out by the service.
Non audit – unknown status	Project is not an audit. No further information available as to the status of the project.

Figure 10: Removals by Committee



9.1. Future work for the programme

Although the FCAP for 2018/19 has now been finalised the projects themselves will still be subject to the standard clinical audit procedures for the Health Board. This will include the 3 and 6 month follow up procedures followed by all audits. In addition to this the CAD will ask that all FCAP audits be reviewed by the originating governance committee to ensure that actions are appropriately implemented. The CAD will also look at further escalation mechanisms where appropriate (see 6.1 above).

This work will build with each progression of the programme as it is important to firmly embed any of these new processes before further developments in order to provide a supportive environment in which the Services are able to participate.

9.2. Forward Clinical Audit Programme completed projects *by Committee* 2018/19

The following projects have completed the data collection stage and the auditors have submitted an action plan to the CAD. These plans are followed up by the CAD to allow auditors the opportunity to update the plans with outcomes etc. These action plans are assigned one of the following audit statuses *(shown on the far left hand column in the table below)*:

Audit Status	***Description***
1.Complete (3 months f/up)	Action plan submitted and awaiting 1st follow up
2.Complete (6 months f/up)	Action plan submitted and awaiting 2nd follow up
3.Complete - Implemented	Action plan followed up with evidence of implementation
4.Complete – Not implemented	Action plan followed up but without further evidence of the implementation of actions submitted to the CAD

	Title	Reason for Inclusion	Standards	Location	Lead	Proposed Action	Action Taken
Cancer Services Senior MDT							
3	Audit of patients undergoing immediate breast reconstruction using Ti-loop			HB	Dr Asma Munir	None: audit completed 100% compliance	
Mental Capacity Act and Consent Group							
1	Consent Form Audit	WRP required audit. Key objective of MCA & Consent Group to improve quality of consent processes and ensure they are compliant with consent law.	All Wales Policy for Consent to Examination or Treatment	HB	Madeleine Peters	Report issues and actions to MCA & Consent Group and Operational QSEAC Audit findings to be presented at each of the WHAMs, to provide the opportunity to discuss the findings and potential improvements in practice. Director of Operations to write to individuals who had particularly poor	Report taken to MCA & Consent Group on 6/9/18. Scheduled to go to Operational QSE Sub-Committee on 13/11/18.Carol Cotterell will then report it to QSEAC. Presentations given or booked into all 4 WHAMs during October/November Letters sent out 24/10/18

						results to inform them of the concerns. Continue with consent training for nurses to ensure pre-theatre consent are more robust.	 Training has commenced. Likely to take at least 2 years to complete.
MHLD Quality, Safety & Experience Sub Committee							
1	Restrictive Physical Interventions (RPI)/ Positive Behaviour Management (PBM)	National Work stream and Quality Indicator for National benchmarking. Required for QSEAC.	NICE Guidelines 25,42,82	MHLD	Sian Hall	Service users post incident support questionnaires are not being completed. Only 5% were completed in 2018. Service users are being searched on adult mental health wards especially Low Secure Unit & Psychiatric Intensive Care. Monitor staff training figures and provide information to managers to ensure all staff are up to ensure compliance with mandatory training. Ward managers should consider the key areas requiring improvements in recording and discuss with their teams. PAMOVA and CEAD staff are available to attend team meetings to help facilitate such discussions.	Training given at preceptorship for newly qualified staff and during all RPI training courses. Included in Datix report. Datix investigators not to sign off until completed or investigated fully. Datix changed so that Datix remains open until SU questionnaires completed. Search Policy task & finish group are finalising review Quarterly training figures presented at the MHLD QSESC meeting and other UHB meetings and as requested to ward managers. On-going
Scheduled Care Quality, Safety & Experience Sub Committee							
3	WGH Orthopaedic ERAS compliance with	1000 Lives Plus	1000 Lives Wales	WGH	Dawn Ferris	Complete Audit / Develop poster 100% Compliance	Audit complete & Poster developed

	1000 lives recommendations						
3	Compliance to BOAST Guidelines for ankle fractures	Review of practice	British Orthopaedic 2014 Association Trauma	WGH	Mr Nitin Deshmukh	Non-specific need for improvement identified. Audit broadly meets standards	BOAST Recommendations for weight bearing following ankle fracture fixation contravenes local guidelines
1	Non Invasive Ventilation in HDU / ITU	Review of practice	NCEPOD NIV Published report	WGH	Dr Veronica Mihai	To provide these findings to respiratory team so that service improvement activity can be done as a joint process New documentation sheet was suggested To improve training for the staff involved in providing NIV	Needs further discussion in common forum Educating Lecture was conducted and planning to have more lectures and hands on sessions
1	Audit on Management of new onset atrial fibrillation in the Intensive Care Unit of WGH	Review of practice	RCOA Best Practice recommendation in managing AF	WGH	Dr W A D P Wickramaarachchi	Discuss treatment options for our ITU Presentation in departmental audit meeting Introduce a sticker for follow-up management	Completed Completed
3	Efficacy of acute pain management	Review of practice	British Orthopaedic Association standards for Trauma	WGH	Dr Hans Vargas	Adequate pain relief to be prescribed as per WHO ladder Feedback to ward staff Next audit to follow up for 48 hours Re-audit	We are following the WHO ladder The Acute Pain team fed back to Ward staff There is no need to re-audit at the moment – if there are any issues we will re-audit
1	Annual Phototherapy Standard Units	National Standards / Identified risk / departmental priority	British Association of Dermatologists	2 Sites - GGH WGH	Debora Harry	To ensure phototherapy referral forms are completed fully.	This matter will be discussed in the next dermatology team meeting, to ensure everyone in

			Standards for Phototherapy				the team is aware they need to complete the referral forms fully.
						To ensure a PASI assessment is completed and the score is documented PRIOR to treatment.	This matter will be discussed in the next dermatology team meeting, to ensure everyone carries out a PASI assessment in clinic and phototherapy and documents the score.
						To ensure a DLQI score is recorded on the referral form by the referring clinician and before commencing phototherapy.	This matter will be discussed in our next dermatology team meeting, to ensure everyone records the DLQI on the referral forms and also pre - phototherapy.
						No MPD or MED performed at GGH or WGH.	Catherine & Emma visiting UHW, Cardiff 4/6/19 to observe SR B Gambles MED clinic. Catherine & Emma will then set up MED clinics at GGH & WGH & teach the rest of the phototherapy team how to use the MED machine.
						To ensure discharge advice PIL given to every patient on discharge from phototherapy at GGH & WGH.	Discussion to be held with the phototherapy team regarding this. Everyone to give the discharge PIL'S out on discharge.
1	Diagnosis of Suspected Scaphoid Fractures	Complaint, Missed Scaphoid Fracture	Guideline for the Management of Suspected Scaphoid Fractures in the Emergency Department	BGH	Dr Elabbadi	Provide more information to Ortho/A&E doctors about the availability of further imaging modalities and when to use them Raise the awareness about the importance of not missing Scaphoid	To be included in the presentation on Scaphoid Fractures to Junior Ortho/A&E every 4 months

			(September 2013)			fractures and having a regular session in the junior Ortho/A&E teaching Re-audit	Presentation on Scaphoid Fractures to Junior Ortho/A&E every 4 months
4	Operative Consent (re-audit)	Review of practice	RCS Consent guidelines in good surgical Practice, BOA Operation Guidelines.	BGH		Continue to evaluate risks & complications on consent forms Continue to evaluate consent discussion documentation in notes	Will collect Data Will collect Data
3	Operative notes in THR (re-audit)	Very common elective procedure. Financial cost. In addition having detailed operative notes helps to reduce the risk of litigation.	British Orthopaedic Association standards THR a guide to best practice	BGH	Mr Omar	In view of persistent progressive improvement on repeated audits and maintaining excellent results, this audit not to be repeated in near future.	
3	Orthopaedic Elective day cases (re-audit) 2018	Review of practice	British Orthopaedic Association standards	BGH	Mr Omar	Increase Junior doctor awareness of importance of documentation (included in Departmental induction) Feedback findings to Ward Clerk and DSU staff. Feedback findings to Orthopaedic Seniors	Presented to Junior Doctors in teaching sessions. Audit presentation emailed to DSU sister and fed back results and action plan. DSU Sister will feedback to staff and Ward Clerk. Completed during Departmental meeting.
1	ASA Grade of hip fractures	Anthony Johansen, Clinical Lead for the NHFD queried the percentage of 2017 BGH patients with high ASA Grades (4 and above) so this audit is being undertaken to	American Society of Anaesthesiologists	BGH	Dr Snell	Include preadmission mobility, weight, new diagnosis and grade of aortic stenosis to ensure additional information or ASA grading in next round of audit.	Incorporated into audit planning. Planning of audit in progress. Accountabilities for data collection assigned.

		provide assurance of the quality of our NHFD Data.				Re-audit 2018 NHFD audit data (provisional data suggests 30 day mortality for 2018 is 0.8%).	Data collection to commence 2019.
Senior Nursing and Midwifery Team							
1	Medicines Management Nursing Audit	HIW Inspections, Complaints, Datix Incidents	HB Medicines policy, MARRS policy	HB	Mandy James	Heads of Nursing requested to update SNMT of the compliance against immediate actions from the audit. Review value/refresh approach to embedding red tabard system HB wide aimed at reducing interruptions during medication administration Re audit every 6 months Ensure completion and ongoing management of signature list for all clinical areas Disseminate poster with information around correct disposal bins for use in clinical areas. Ensure correct recording of Control Drug wastage in the CD register. Ensure all treatment room doors or cupboards within the rooms must be locked at all times.	
1	PEG Audit	Quality Standards	HDUHB	HB		Annual audit of all patients who have a PEG inserted in HDUHB Ward based teaching with nursing staff on PEG care and the use of the HDUHB PEG care plan.	All patients who have a PEG placed from January 2019 to be included in the next audit period CNS Nutrition team will undertake ward based teaching in response to any Datix reports and also where requested by staff and ward managers [on going]

9.3. Forward Clinical Audit Programme Table 2018/19

The table below represents the Forward Clinical Audit Programme in its entirety after the programme had undergone appropriate validation (e.g. removal of non-audit projects etc.)

Title	Standards	Location	Status
Cancer Services			
Audit of patients undergoing immediate breast reconstruction using Ti-loop		Health Board Wide	Complete
Management of suspected neutropenic sepsis patients known to AOS	NICE	Health Board Wide	In progress
Audit of breast cancer patients over the age of 70		Health Board Wide	In progress
Active Surveillance audit	BAUS	3 sites: WGH, GGH, PPH	In progress
Management of patients presenting acutely with previously undiagnosed malignancy known to AOS	NICE	Health Board Wide	Not started
Biological treatment guidelines	BAD	2 Sites - PPH GGH	Not started
Excision margins of skin cancer	BAD	2 Sites - PPH GGH	Not started
Management of suspected malignant spinal cord compression patients known to AOS	NICE	Health Board Wide	Roll over to 2019/20
Prostate Fusion Biopsy Prospective Audit	BAUS	Health Board Wide	Unknown
Mental Capacity Act and Consent Group			
Consent Form Audit	All Wales Policy for Consent to Examination or Treatment	Health Board Wide	Complete
Audit of Form 4: Treatment in Best Interests	Mental Capacity Act	Health Board Wide	Discontinued
MHLD Quality, Safety & Experience Sub Committee			
Care Treatment Plan (CTP) Audit	Welsh government code of practice, Mental health measure 2010	MHLD	Awaiting Report/Action Plan
Restrictive Physical Interventions (RPI)/ Positive Behaviour Management (PBM)	NICE Guidelines 25,42,82	MHLD	Complete
National CISH (2016) Quality/Safety standards audit	National Inquiry Suicide & Homicide 2016. Quality Safety Standards.	MHLD	Not started
Mental Health Act Documentation Audit	Mental Heath Act	MHLD	Not started
Mental Capacity Act Documentation Audit	Mental Capacity Act	MHLD	Not started
Inpatient standard for OAMH ward audit re-audit	RCP Guidelines	MHLD	Not started
Post discharge follow up audit	National Inquiry Suicide & Homicide 2016	MHLD	Roll over to 2019/20

Substance misuse audit	Co-occurring disorders framework	MHLD	Roll over to 2019/20
RRAILS			
Compliance in documenting on the All Wales DNACPR Forms	All Wales DNACPR policy and Form	Health Board Wide	Awaiting Report/Action Plan
Scheduled Care Quality, Safety & Experience Sub Committee			
Medical Record Keeping	Royal College of Physicians	Withybush	Awaiting Report/Action Plan
OOH MRI requests and clinical validity	Hywel Dda Out of Hours MRI Policy	Glangwili	Awaiting Report/Action Plan
Compliance to BOAST Guidelines for ankle fractures	British Orthopaedic 2014 Association Trauma	Withybush	Complete
Non Invasive Ventilation in HDU / ITU	NCEPOD NIV Published report	Withybush	Complete
Audit on Management of new onset atrial fibrillation in the Intensive Care Unit of WGH	RCOA Best Practice recommendation in managing AF	Withybush	Complete
Efficacy of acute pain management	British Orthopaedic Association standards for Trauma	Withybush	Complete
Annual Phototherapy Standard Units	British Association of Dermatologists Standards for Phototherapy	2 Sites - GGH WGH	Complete
Diagnosis of Suspected Scaphoid Fractures	Guideline for the Management of Suspected Scaphoid Fractures in the Emergency Department (September 2013)	Bronglais	Complete
Operative Consent (re-audit)	RCS Consent guidelines in good surgical Practice, BOA Operation Guidelines.	Bronglais	Complete
Operative notes in THR (re-audit)	British Orthopaedic Association standards THR a guide to best practice	Bronglais	Complete
Orthopaedic Elective day cases (re-audit) 2018	Britsh Orthopaedic Association standards	Bronglais	Complete
ASA Grade of hip fractures	American Society of Anesthesiologists	Bronglais	Complete
WGH Orthopaedic ERAS compliance with 1000 lives recommendations	1000 Lives Wales	Withybush	Complete
Audit of deaths following HDU admission after elective surgery CG50	NICE CG50, Track & Trigger guidelines, Fluid Oxygenation practice, ICNARC	Withybush	In progress
Compliance to BOAST Guidelines for distal radius fractures	BOAST	Withybush	In progress
Review of the quality of care provided to patients receiving acute Non Invasive Ventilation	Nice Guidelines	Withybush	Incomplete
NICE guidelines for the prescribing of biologics	NICE	Health Board Wide	Unknown
Retinal Detachment Dataset	Royal College Informatics and Audit Committee	Glangwili	Unknown

Macular hole dataset	Royal College Informatics and Audit Committee	Glangwili	Unknown
Senior Nursing and Midwifery Team			
Medicines Management Nursing Audit	HB Medicines policy, MARRS policy	Health Board Wide	Complete
PEG Audit	HDUHB	Health Board Wide	Complete
Fasting		Health Board Wide	In progress
Briefing / Debriefing Audit	NatSIPPS / LocSIPPs	Health Board Wide	Roll over to 2019/20
WHO Checklist	NatSIPPS / LocSIPPs	Health Board Wide	Roll over to 2019/20
Stop Before you Block		Health Board Wide	Roll over to 2019/20
Residual Drugs		Health Board Wide	Unknown
Unscheduled Care Committee (BGH, GGH, WGH)			
Royal College of Emergency Medicine Feverish Child	Royal College of Emergency Medicine Guidelines	3 sites: WGH, GGH, PPH	Awaiting Report/Action Plan
Royal College of Emergency Medicine Vital Signs in Adults	Royal College of Emergency Medicine Guidelines	3 sites: WGH, GGH, PPH	Awaiting Report/Action Plan
Royal College of Emergency Medicine VTE Risk in Lower Limb Immobilisation	Royal College of Emergency Medicine Guidelines	3 sites: WGH, GGH, PPH	Awaiting Report/Action Plan
Unscheduled Care Committee (PPH)			
BTS Adult Non-Invasive Ventilation (NIV) Audit	BTS	2 Sites - PPH BGH	In progress

10. APPENDIX C: NON-PROGRAMME ACTIVITY 2018/19

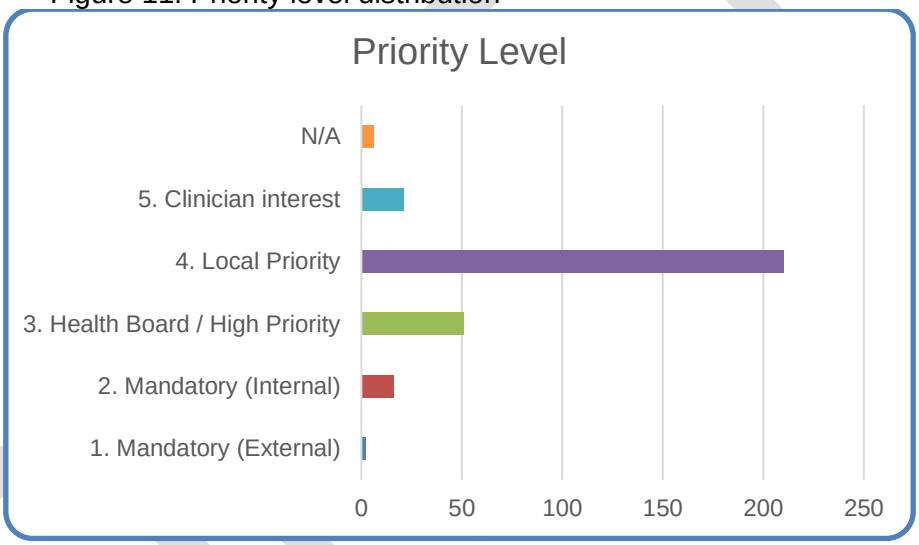
10.1. Prioritisation of Clinical Audit

The Health Board has developed a framework for the prioritisation of clinical audit. All audit projects should contribute to the overall priorities of the Health Board with a clear aim to improving the quality of care that is provided.

A 5 point priority level system for prioritising all audit activity has been adopted. Priority levels are set through discussions with senior staff and the information provided on clinical audit documentation. The decision is then made by the applicable CASC.

- Priority 1 - External 'must do' audits
- Priority 2 - Internal 'must do' audits
- Priority 3/4 - Local Priorities
- Priority 5 - Professional interest/CPD requirement
- N/A - Predates the priority system

Figure 11: Priority level distribution



It would be expected that higher priority level projects would feature on the FCAP. In the above analysis the higher priority projects are all older projects (registered pre April 2018) and the majority of these priority 1 & 2 projects have been completed.

Project Status Key:

Project Status	***Description***
Complete - Implemented	Action plan followed up with evidence of implementation
Complete (6 months f/up or 3 months f/up)	Action plan submitted and awaiting 1st or 2nd follow up by CAD
Complete (OLD)	Action plan submitted but audit predates the f/up process
Complete – Not implemented	Action plan followed up but without further evidence of the implementation of actions submitted to the CAD
Awaiting Report or Action Plan	Data collection was completed and the CAD is awaiting a report or the submission of an action plan
In progress	Project is underway
Discontinued	Project was stopped for valid reasons (e.g. policy superseded, audit no longer relevant etc.)
Incomplete	Project was not completed and without sufficient rationale provided

10.2. Non-programme clinical audit activity *by Directorate* 2018/19

Reference	Title	Specialty	Lead	Start date	Priority Level	Status at year end
Cancer Services						
P252 [B338, G369, W1746]	An Audit of the Management of a New Cancer Diagnosis made during an Acute Admission within Hywel Dda University Health Board	Cancer Services/Oncology	Robert Bowen	01/12/2016	4	Complete not implemented
Community and Primary Care						
G362 [B332, P299, W1728]	End Of Life Care Board Acute Hospital Audit - Deaths Within Acute Hospitals In Wales Of Adults Over 18 Years With A Length Of Stay Longer Than 4 Hours, Omitting Deaths Following Acute Trauma & Suicide	Palliative Medicine	Dr Rebecca Croft	24/10/2016	3	Awaiting action plan
H15	Care Decisions Audit	Palliative Medicine	Pamela Beynon	28/03/2019	3	Awaiting action plan
W1820	Quality of End of Life Care	Palliative Medicine	Dr Annette Edwards	10/11/2017	3	Complete implemented
W1826	Management of Hypercalcaemia in Malignancy	Palliative Medicine	Annette Edwards	04/12/2017	4	Complete for 6 month follow up
W1837	Quality of Palliative Care Discharges	Palliative Medicine	Dr Annette Edwards	17/01/2018	4	Complete implemented
W1845	Domiciliary Dental Care Audit	Community Dental	Philip Summer	19/03/2018	4	Complete implemented
W1868	A retrospective audit on provision of conscious sedation in CDSHUHB	Community Dental	Aisha Tahir	30/10/2018	4	Complete implemented
W1871	Quality of deaths in Sunderland Ward	Palliative Medicine	Dr Annette Edwards	13/11/2018	4	Complete implemented
W1874	Quality of Palliative Care Discharges Re-Audit	Palliative Medicine	Dr Robert Jones	12/12/2018	4	In progress
Mental Health and Learning Disabilities						
S667	Lithium Initiation and monitoring	MHLD Adult MH Services		18/05/2015	4	Complete for 3 month follow up
S675	MH&LD CTP Audit Pilot, Localities and Teams self auditing for monthly CTP Audit	MHLD Other	Elizabeth Ryan-Davies	06/07/2015	N/A	Complete (OLD)
S688	An Audit of Physical Health Monitoring of patients on Antipsychotics Medications	MHLD Adult Psychology	Dr Zain Noor	12/02/2016	4	Complete for 3 month follow up
S692	Antipsychotics in Dementia	MHLD Adult MH Services	Dr Kiran Kumar	26/04/2016	4	Complete not implemented
S693	Re audit of Prescribing antipsychotic Medication for people with Dementia	MHLD OAMHS	Dr Graham O'Connor	21/04/2016	4	Complete for 3 month follow up

S695	Points of Ligature Audit	MHLD Other	Stuart Jones	06/06/2016	2	In progress
S696	Re audit of Motor Driving Advice in Mental Health	MHLD Adult MH Services	Dr Anand Ganesan	14/06/2016	4	In progress
S697	Topin 11 - Prescribing antipsychotic medication for people with dementia	MHLD Pharmacy	Catrin Fischetti	14/06/2016	3	In progress
S699	Points of Ligature (Mental Health and Learning Disability In-patient Wards)	MHLD Adult MH Services	Stuart Jones	12/07/2016	3	In progress
S700	Care Treatment Planning audit - Monthly audit	MHLD Adult MH Services	Liz Caroll	12/07/2016	3	In progress
S701	Audit of completion of Discharge Summaries from acute adult mental health services.	MHLD CAMHS	Dr Teresa Magee	28/07/2016	4	In progress
S702	Does The Use Of An Acute Psychiatric Assessment Clerking Proforma Improve Standards Of Key Information Capture During Initial Psychiatric Assessment In Secondary Care	MHLD CAMHS	Dr R Davies & Dr M Qamruddin	21/10/2016	4	Complete for 3 month follow up
S703	Polypharmacy in Older Adults	MHLD Adult MH Services	Dr Akshey Nair / Dafydd Rees	17/01/2017	4	Complete for 3 month follow up
S704	Pre-Requisite Blood Tests and ECG before Prescribing Antipsychotics	MHLD Adult MH Services	Dr Wiecko	17/01/2017	4	Awaiting action plan
S706	Audit of Resources & Infrastructure to Support Effective CBT	MHLD Adult Psychology	Dr Evelyn Gibson	13/03/2017	4	In progress
S707	Audit of Completion of Discharge Summaries from Acute Adult Mental Health Services	MHLD Adult MH Community Teams (Carmarthenshire)	Dr Teresa Magee	13/03/2017	4	In progress
S708	Clinical Record Keeping Of Mental Health ACT Assessments	MHLD Adult MH Community Teams (Carmarthenshire)	Dr.A.Gane San	03/04/2017	4	Awaiting action plan
S709	Readmissions to Mental Health Units Hywel Dda 2016/17 – Re-audit	MHLD OAMHS	Dr Helmut Hardt	01/05/2017	4	In progress
S710	Depression in Children	MHLD CAMHS	Dr Looyd	23/05/2017	4	Awaiting action plan
S711	Prescribing Antipsychotics in people with a diagnosis of Dementia presenting with Behavioural and psychological disturbances [BPSD] : Current Practice Vs Nice Guidance	MHLD OAMHS	Dr.Graham O Conner	05/04/2017	4	Awaiting action plan
S712	Audit of Referrals to Old Age Psychiatry	MHLD OAMHS	DR Srivarshini Sarvabhowma	01/05/2017	N/A	Incomplete
S714	Restrictive Physical Interventions / Practice used in Mental Health	MHLD Adult MH Crisis Resolution and Home Treatment Teams	Martin Morris	11/05/2017	3	In progress
S715	Physical Health Monitoring For Patients Prescribed Antipsychotics	MHLD Adult Psychology	Dr C Moyle	12/07/2017	4	In progress
S716	CTP (Care Treatment Plan) Baseline Audit	MHLD CAMHS	Nadine Morgan	12/07/2017	4	In progress
S717	Standards for Inpatient Older Adults Mental Health Services	MHLD OT MH	Nicky Thomas	12/07/2017	4	In progress

S718	An Audit of Prescription of Antipsychotics in Dementia Patients	MHLD OAMHS	Dr Sabyasachi Mandal	11/01/2018	4	Complete for 3 month follow up
S720	ECT Health Record Audit	MHLD CAMHS	Liz Davies	18/12/2018	4	In progress
S722	Metabolic Side Effects of Antipsychotic Drugs	MHLD Adult MH Community Teams (Ceredigion)	Dr Harish Reddy	19/02/2019	3	In progress
S723	Monitoring of Patients in Clozapine Clinic	MHLD Adult MH Community Teams (Carmarthenshire)	Janet Edge	01/11/2018	3	In progress
S724	Physical Health Monitoring for Older Adults on Antipsychotics for Dementia	MHLD Older Adult Psychology	Dr S Mandal	15/03/2019	4	Awaiting action plan
Multi-disciplinary/ Health Board Wide						
B327	Audit to assess adherence to Health Board guideline when prescribing antibiotics for treating respiratory infections at Bronglais General Hospital	Pharmacy	Cerith Morgan	14/09/2016	4	Complete implemented
B335	Are we complying with Intensive Care Society Guidelines on Standard Medication Concentrations in Critical Care Areas?	Pharmacy	Emma Nurse	05/12/2016	5	Complete for 3 month follow up
B382	Audit to Assess Adherence to Health Board Antibiotic Guidelines when Prescribing Co-Amoxiclav to Non-Admitted Patients Presenting to Accident and Emergency	Pharmacy	Meryl Davies	02/08/2017	4	Complete implemented
G308	Occupational Therapy Fractured NOF	Occupational Health	Helen Davies	16/02/2016	3	Complete not implemented
G341	Antibiotic prescribing audit in GGH	Pharmacy	Nerys Price	12/07/2016	3	Complete not implemented
G387 [B393, P321, W1828]	Board Wide Audit of Form 4 - Treatment in Best Interests (For people who lack capacity to consent form)	Clinical Governance	Madeleine Peters	27/11/2017	2	Complete implemented
G441 [B383, P305, W1774]	Board Wide Consent Form Audit (of all Wales and Hywel Dda Consent Forms)	Clinical Governance	Madeline Peters	27/06/2017	2	Complete implemented
G454	Antibiotic Prescribing Audit in GGH, Post Introduction of New Medication Chart	Pharmacy	Nerys Price	05/09/2017	3	Complete implemented
G481 [B401, P331, W1847]	HB Wide Audit to determine if Consent form 1 is being inappropriately used for perople who lack capacity to consent for themselves, instead of form 4: Treatment in Best Interests.	Clinical Governance	Madeleine Peters	20/03/2018	2	Complete implemented
G500	An Audit of Antibiotic Prescribing in Obstetric Infections at Glangwili General Hospital	Pharmacy	Rhiannon Smyth	31/10/2018	4	Complete for 3 month follow up
G503	Review of the Symptom Triggered Alcohol Detoxification Procedure in Practice	Pharmacy	Teleri Gruffudd	14/01/2019	4	In progress
P222	Antimicrobial Prescribing in Secondary Care in Wales 2015	Pharmacy	Dr Emrys Williams	28/04/2016	3	Complete implemented
P312	An Audit to Assess the Prescribing of Meropenem, a Restricted Antibiotic, according to the Hywel Dda University Health Board Guidelines in PPH	Pharmacy	Rosslyn Sharpe	28/07/2017	4	Complete implemented

W1772 [B381, G434, P297]	What percentage of admissions to the Admissions Unit is due to a medicines related event	Pharmacy	Dianne Burnett	30/03/2017	4	Complete implemented
W1776	An audit of the incidence of polypharmacy on medical wards in Withybush General Hospital	Pharmacy	Dr Sarah Davidson	14/06/2017	4	Awaiting report/presentation
W1803	An audit to assess the prescribing of Non-Vitamin K Oral Anticoagulants (NOACS) within Withybush General Hospital	Pharmacy	Joanna Rees	23/08/2017	5	Incomplete
W1825	Transfer of information on medication changes on discharge from hospital to primary care	Pharmacy	Kelly Rowe	20/11/2017	4	Complete implemented
W1850 [G484, P332]	HDUHB Carbapenem usage in secondary care	Pharmacy	Sophie Glyn-Williams	27/03/2018	3	Complete not implemented
W1869	Antibiotic Usage in Withybush Inpatients - October 2018	Pharmacy	Sophie Glynn-Williams	02/11/2018	4	In progress
Nursing, Quality and Patient Experience						
G460 [P255]	Patients Admission to Hospital with Urinary Tract Infection (September, October and November 2016)	Infection Control	Sharon Daniels	09/10/2017	4	Complete implemented
P326 [B398, G472, W1838]	Medicines Management Nursing Audit	Nursing	Mrs Mandy James	17/01/2018	2	Complete implemented
P336	Is Hypoglycaemia Management Within the Clinical Setting Compliant with The Health Board Algorithm?	Nursing	Melanie Richards	27/04/2018	5	Complete for 6 month follow up
W1793	The Nursing home documentation audit (tissue viability)	Community Nursing (DNs, Health Visitors, School Nurses, Acute Care at Home)	Vicki Broad	11/07/2017	3	Complete implemented
W1807	Fundamentals of Care in Nursing Homes	Community Nursing (DNs, Health Visitors, School Nurses, Acute Care at Home)	Penny Lamb	09/10/2017	4	Awaiting action plan
W1808	Effectiveness of older persons assessment and liaison clinic - Newport surgery	Community Nursing (DNs, Health Visitors, School Nurses, Acute Care at Home)	Dr Angela Puffett	20/10/2017	4	Complete not implemented
Scheduled Care						
B280	MRSA Screening for Surgical and Orthopaedic Patients	General Surgery	Dr Snell	27/06/2016	3	Complete for 3 month follow up
B334	Diagnosis and Management of Gallstone Disease Re-audit	General Surgery	Mr Taha Lazim	05/12/2016	4	Incomplete
B339, W1740	National Audit of Small Bowel Obstruction	General Surgery	Mr Mathias	21/12/2016	3	Incomplete

B341	Correlation Comparison of CT abdomen reporting and emergency laparotomy findings for acute abdomen.	General Surgery	Dr Liaquat Khan	07/02/2017	5	Complete for 3 month follow up
B368	Management of Acute Pancreatitis in BGH - Re-audit 2017	General Surgery	Mr Taha Lazim	09/06/2017	4	Complete for 3 month follow up
B377	DVT Prophylaxis in Elective Joint Replacements	Trauma & Orthopaedics	Mr Mohamed Omar Ali	12/07/2017	4	Complete for 6 month follow up
B404	The Use Of Antibiotic Prophylaxis In Elective Laparoscopic Cholecystectomy	General Surgery	Mr Jared Butt	03/04/2018	4	Complete for 3 month follow up
B411	Are we meeting NICE guidelines for providing information to glaucoma patients	Ophthalmology	Sister Mia Lewis	29/08/2017	3	In progress
B414	Intravitreal Injection Safety Audit	Ophthalmology	Mr Riz Cheema	25/09/2018	5	Awaiting action plan
B415	Rate of "Negative" Emergency Appendicectomy in Bronglais General Hospital Re-Audit	General Surgery	Dr Samy Mohamed	28/02/2019	4	Awaiting action plan
G330	Surgery Cancellation for Medical Reason	Anaesthetics	Gordon Milne	06/06/2016	3	In progress
G353	Preoperative Investigations	Anaesthetics	Dr Gordon Milne	28/09/2016	3	In progress
G356	National Epistaxis Audit 2016	ENT	Robert McLeod	10/10/2016	4	Incomplete
G379	Assessing the impact of changing the standard clerking pro-forma on the probability of Doctors taking a smoking history on admission, prescribing Nicotine replacement and signposting to Smoking Cessation Services.	ENT	Rohit Singh	25/10/2017	4	Incomplete
G399	OAKS-2: A Student-Driven Audit of Kidney Injury Following Major Gastrointestinal Surgery	General Surgery	Mr Williams Beasley	22/03/2017	4	Incomplete
G418	Screening For Diabetic Foot Problems Within 24 Hours OF Hospital Ward Admission	Trauma & Orthopaedics	Tracy Ashbridge	15/05/2017	4	Complete implemented
G431 [B378, P292, W1854]	Improving Donor Identification and Consent Rates for Deceased Organ Donation	Critical Care	Kathy Rumbelow	01/04/2017	1	Complete not implemented
G443	Audit On Care Of Adult Tracheostomy	ENT	Mr Vinod Prabhu	12/07/2017	4	Complete implemented
G452	Patterns of Referrals to Ophthalmic Casualty Clinic	Ophthalmology	Mr Waleed Tantawy	14/08/2017	4	Awaiting action plan
G458	PANDORA - Hypoxic Respiratory Failure Prevalence & Management	Anaesthetics	Igor Otahal	04/10/2017	4	Awaiting action plan
G459	WHO Surgical Safety check list - Evaluation of current practice	Anaesthetics	Dr Igor Otahal	09/10/2017	4	Incomplete
G461	Audit of Unplanned Admission after Paediatric Day Case Anaesthesia in the UK (PAPAYA National Audit)	Anaesthetics	Dr Alun Thomas	12/09/2017	4	Awaiting action plan
G470	Ileus Management International (IMAGINE)	General Surgery	Mr Pawan Dhruva Rao	28/12/2017	4	In progress
G478	The Indications for CRRT in ICU, GGH	Anaesthetics	Dr Igor Otahal	20/03/2018	4	In progress

G483 [P337]	The BAHNO Head & Neck Cancer Surveillance Audit 2018	ENT	Yasmine Kamhieh	21/03/2018	3	Awaiting action plan
G488 [P335]	RICOCHET Audit: Receipt of Curative Resection Or Palliative Care for Hepatopancreaticobiliary Tumours	General Surgery	Mr Brendan O'Riordan	23/04/2018	3	In progress
G490	Perioperative Analgesia Prescription Practice for Post LSCS	Anaesthetics	Dr Alun Rees	22/05/2018	4	In progress
G498	Outcome of Patients Admitted to ICU with Severe Acute Pancreatitis	Anaesthetics	Dr Peter Havalda	04/10/2018	4	In progress
G504	Wound Infection in Colorectal Surgery (WICS)	General Surgery	Mr Andrew Deans & Mr Pawan Dhruva Rao	30/01/2019	4	Awaiting action plan
G510	Respiratory Complication after Abdominal Surgery {RECON}	Anaesthetics	Dr Peter Havalda / Dr G Milne	04/03/2019	4	In progress
G516	Tranexamic Acid in Hip Fracture Surgery	Trauma & Orthopaedics	Mr Fanarof	25/04/2019	3	In progress
M1	Audit on OOH Discharge from ITU (Multi site PPH & GGH)	Anaesthetics	: Dr Subhamay Ghosh	11/07/2018	4	Awaiting action plan
M2	Hypothermia: Prevention and Management in Adults having Surgery (BGH, GGH,PPH)	Anaesthetics	Dr Jacek Zeber & Dr Subhamay Ghosh	25/07/2018	2	Awaiting action plan
M4	An Audit of End of Life documentation in Intensive Care Unit	Anaesthetics	Dr Subhamay Ghosh	12/10/2018	4	In progress
M5	Mastectomy Decision Audit	Breast	Mrs Saira Khawaja	11/12/2018	5	In progress
M8	Re-Audit: Tocilizumab IV/SC For The Treatment of Rheumatoid Arthritis – Are We Complying With The Current NICE Guidelines?	Rheumatology	Dr Tanzeel Ijaz	14/02/2019	5	Awaiting action plan
P213	The iBRA study - A National Audit of the Practice and Outcomes of Implant Breast Reconstruction	Breast		07/03/2016	3	Incomplete
P250	TeaM – A National Audit of the Practice and Outcomes of Therapeutic Mammaplasty.	Breast	Mrs S Khawaja	28/10/2016	2	Complete implemented
P270	Audit of Safe Prescription of Methotrexate in Skin Disease	Dermatology	Dr Ahmed Al-Rusan	20/04/2017	4	Complete implemented
P317	Audit of M3 Mammograms	Breast	Dr Anita Huws	16/10/2017	5	Complete implemented
P318	Osteoporosis Treatment Management	Rheumatology	Dr Sarah Jayne Evans	16/10/2017	5	Complete implemented
P319 [G464, W1811]	Measuring Vit D level in Melanoma Patients	Dermatology	Hanadi Qeyam	20/10/2017	5	Complete not implemented
P338	Re-audit of Wire Localisation with DBT	Breast	Mrs Saira Khawaja	14/12/2018	5	In progress
W1426	Prolonged-release oxycodone/naloxone reduces opioid-induced constipation and improves quality of life in laxative-refractory patients: Results of an observational study	Anaesthetics		18/12/2013	N/A	Complete implemented

W1445	Pilot evaluation of an alternative definition for Ventilator Associated Pneumonia	Anaesthetics		25/03/2014	N/A	Complete implemented
W1477	NICE CG74: Surgical Site Infections in Colorectal Surgeries	General Surgery	Mr Umughele	29/04/2016	4	Complete not implemented
W1669	Quality of Care for Elderly Non-Hip Fracture Patients	Trauma & Orthopaedics	Dr W Backen	04/04/2016	4	Discontinued
W1701	Operation Notes: a prospective audit on documentation quality	General Surgery	Mr J Mathias	19/08/2015	4	Complete implemented
W1716	Consent documentation within T&O department at Withybush General Hospital	Trauma & Orthopaedics	Mr Appan	04/08/2016	4	Discontinued
W1718	Operation Notes Audit	General Surgery	Mr K Serafelmidis	15/09/2016	4	Complete implemented
W1721	All Wales Audit of ANCA positive associated vasculitis according to BSR guidance	Rheumatology	Julie Barber	13/09/2016	4	Complete not implemented
W1729	Re-audit of patient blood management in adults undergoing scheduled surgery	Anaesthetics	Dr. Sunita Agarwal	31/10/2016	4	Complete not implemented
W1749	The use of CT/MRI in Occult Hip Fracture	Trauma & Orthopaedics	Mr Yaqoob	19/01/2017	4	Complete not implemented
W1751	Re-audit of efficacy protocol following joint arthroplasty	Anaesthetics	Dawn Ferris	26/01/2017	4	Complete not implemented
W1761	Compliance with Pre-Operative Fasting for Emergency Orthopaedic and Trauma Patients	Theatres	Helen George	16/02/2017	3	Complete implemented
W1771	Compliance with Anaesthesia Sprint Audit of Practice (ASAP) Re-audit	Anaesthetics	Dr Rob Jones	30/03/2017	4	Complete not implemented
W1777	If diabetic patients are in the first third of the theatre list	General Surgery	Sian Davies	14/06/2017	4	Complete not implemented
W1778	Splenectomy Audit	General Surgery	Otumeluke Umughele	14/06/2017	4	Complete not implemented
W1782	Incidence of Acute Kidney Injury in Elective patient post-operative period	Trauma & Orthopaedics	Mr Appan	14/06/2017	4	Complete implemented
W1787	Operation Note keeping within Dept. of T&O	Trauma & Orthopaedics	Mr Deshnukh	29/06/2017	4	Complete not implemented
W1788	Is there a scope to improve? How do we compare to national #NoF standards	Trauma & Orthopaedics	Mr Deshmukh	29/06/2017	4	Complete not implemented
W1794	Sprint National Anaesthesia Project (SNAP-2)	Anaesthetics	DrSunita Agarwal	10/07/2017	1	Awaiting report/presentation
W1814	Audit of deaths following HDU admission after elective surgery CG50	Anaesthetics	Dr Ceri Brown	24/10/2017	4	Complete for 6 month follow up
W1816	Diagnosis and management of gallstone disease	General Surgery	Mr O Umughele	17/01/2018	4	Complete not implemented

W1818	Audit of performance following implementation of the Early Inflammatory Arthritis (EIA) Initiative in the Rheumatology Department at Hywel Dda Health Board in July 2017	Rheumatology	Amanda Coulson	26/10/2017	4	Complete implemented
W1819	Consent in fractured neck of femur: Are we doing it correctly?	Trauma & Orthopaedics	Mr S Isopescu	09/11/2017	4	Complete not implemented
W1822	Increasing the knowledge and awareness on Compartment Syndrome within the Day Surgery setting	Trauma & Orthopaedics	Mr Nitin Deshmukh	19/12/2017	4	Complete implemented
W1824	Bio similar audit: Comparing the efficacy of enbrel and benepali All Wales audit	Rheumatology	Professor Ernest Choy	17/11/2017	3	Complete implemented
W1839	Diagnosis and management of acute pilonidal abscess and sinus disease	General Surgery	Mr Umughele	25/01/2018	4	Complete not implemented
W1844	Re-audit of increasing the knowledge and awareness on Compartment Syndrome within the Day Surgery Setting	General Surgery	Mr Nitin Deshmukh	06/02/2018	4	Complete not implemented
W1846	Auditing compliance of distal radial fracture management with BOAST (British Orthopaedic Association Standards for Trauma) guidelines	Trauma & Orthopaedics	Mr N Deshmukh	19/03/2018	4	Complete implemented
W1849	Operation Notes Audit (2nd Cycle)	General Surgery	Mr K Serafeimidis	20/03/2018	4	Complete implemented
W1859	Re-audit of Acute Kidney Injury (AKI) Incidence and Management in Elective T&O Patients	Trauma & Orthopaedics	Mr Sadai Appan	30/08/2018	4	Complete implemented
W1860	Standardising Foot and Ankle X-rays	Trauma & Orthopaedics	Mr Stefan Isopescu	04/09/2018	4	In progress
W1861	Are Foot and Ankle Radiographs Requests Appropriate?	Trauma & Orthopaedics	Mr Stefan Isopescu	04/09/2018	4	In progress
W1862	Clinical Handover in Critical Care Unit	Anaesthetics	Dr Sunita Agarwal	06/09/2018	4	In progress
W1863	Retrospective audit of colorectal outcomes	General Surgery	Mr J Mathias	20/09/2018	4	In progress
W1865	Percentage of breast cancer patients receiving treatment as per agreed MDT meeting	Breast	Mr William Maxwell	04/10/2018	4	Awaiting action plan
W1876	Comparison of actual documented risks consented for ankle ORIF vs risks that should be consented for according to BOA Guidance	Trauma & Orthopaedics	Mr Deshmukh	28/01/2019	4	In progress
W1878	Auditing Acute Kidney Injury in Over 65's in Acute Trauma Admissions of Patient's Requiring Operative Management	Trauma & Orthopaedics	Mr S Appan	04/02/2019	4	In progress
W1879	An audit looking at Surgical Note Documentation on a Consultant Ward Round	General Surgery	Mr Jegadish Mathias	04/02/2019	4	In progress
W1880	The Effectiveness of Temporal Artery Biopsy Service at WGH	General Surgery	Mr Costas Serafeimidis	22/02/2019	4	In progress
W999	NICE CG50: Continual audit of deaths following HDU admission after elective surgery	Anaesthetics		26/01/2010	N/A	Complete implemented
	Therapies and Health Science					
G421 [B234, P289]	Audit into the use of Nasogastric Bridles as introduced into the HB in December 2013 (HB Policy # 300)	Dietetics/Nutrition	Dr Mark Narain	18/05/2017	3	In progress
G455 [B412, P316, W1805]	The Safe Use of Hand Control Mittens to Retain Nasogastric Feeding Tubes in 2017 - 2018	Dietetics/Nutrition	Karen Thomas	12/09/2017	4	Complete implemented

H8	Vascular assessment of lower limb by the New Vascular Podiatry Service - HB	Podiatry	Joanne Morris	12/10/2018	3	Complete for 6 month follow up
W1655	Clinical Documentation Re-audit 2016	Physiotherapy	John Davies	14/03/2017	4	Incomplete
W1775	Physiotherapy Hip Fracture Sprint Audit	Physiotherapy	Claire Curran	20/06/2017	3	Awaiting action plan
W1786	The safe use of hand control mittens to retain nasogastric feeding tubes in adults 2018-2019	Dietetics/Nutrition	Karen Thomas	06/07/2018	4	Complete implemented
W1802	Pulmonary Rehab Audit (Pembrokeshire) To meet Q.5.9 of BTS Quality Standards for Pulmonary Rehab in Adults	Physiotherapy	Jane Douglas	16/08/2017	4	Complete for 6 month follow up
W1829	Clinical Notes Audit	Physiotherapy	Rosie Barker	21/12/2017	4	Complete for 6 month follow up
Unscheduled Care - Bronglais						
B269	Management of Paracetamol Overdoses in Adults in the ED	Emergency Department	Dr Martin Sawyer	10/02/2016	3	Complete for 3 month follow up
B272	Confirmation of Death Post Cardiac Arrest Audit	Care of the Elderly	Dr Annette Snell	28/09/2016	4	Complete for 3 month follow up
B318	Audit of BTS Discharge Bundles for Acute Exacerbation of COPD	Respiratory	Dr Lalit Pandya	28/09/2016	2	In progress
B371	SAMBA Society of Acute Medicine Benchmark Audit	Integrated Medicine	Dr Boswell	22/06/2017	4	Complete for 6 month follow up
B388	Management of DKA Re-audit 2017	Care of the Elderly	Dr Nadeem Abbas	04/10/2017	4	Awaiting report/presentation
B392	DVT Management in MAU	Integrated Medicine	Dr Graham Boswel	27/03/2018	3	Complete for 6 month follow up
B399	NIV Use In Acute Care Setting	Respiratory	Dr Kaled Hatashe	27/02/2018	3	Complete for 3 month follow up
Unscheduled Care - Glangwili						
G335	Chest Pain of Recent Onset	Cardiology	Dr Eiry Edmunds	27/06/2016	4	Incomplete
G336	Acute Upper Gastrointestinal Bleeding	Gastroenterology	Dr Dafydd Bowen	29/06/2016	4	Incomplete
G381	Evaluating the Quality of Medical Certificates of Cause of Death	Care of the Elderly	Dr Abhaya Gupta	24/10/2017	4	Complete for 6 month follow up
G384	Management of Back Pain in Patients Presenting to the Emergency Department	Emergency Department	Nigel Waghorne	20/11/2017	4	Complete implemented

G385	Weekend Handover Re-Audit	Care of the Elderly	Dr Richard Vaughan	21/11/2017	3	Awaiting action plan
G386	Managing Sepsis in Acute Medical Admission	Care of the Elderly	Dr Tazeen Muneer & Dr Anil Narayanan	27/11/2017	4	Complete not implemented
G393	CT Scanning for Suspected Strokes Attending A&E	Emergency Department	Nigel Waghorne	03/11/2017	4	Complete not implemented
G398	Fascia-iliaca Compartment Block for Pain Relief in Patients with NOF Fractures	Emergency Department	Rhys Williams	16/03/2017	4	In progress
G402	Hospital Acquired Thrombosis Risk Assessment & Prevention	Haematology	Hywel Rhys Williams	07/04/2017	4	Complete for 3 month follow up
G407	A Baseline Audit to Measure compliance against NICE Guidance on the treatment of Anti coagulation in Stroke Prevention – Stroke Prevention in AF Pilot Project for Welsh Government	Cardiology	Dr Lena Izzat	27/04/2017	4	Complete for 3 month follow up
G408	National Parkinsons Audit 2017/2018	Care of the Elderly	Dr Surendra Gupta	27/04/2017	4	Complete implemented
G419	Are Patients With Atrial Fibrillation Who Develop Ischaemic Stroke Appropriately Anti-coagulated Prior To The Event	Integrated Medicine	PS Sridhar	15/05/2017	4	Incomplete
G420	Does Filing Only The Current Admission Notes And Relevant Documents Improve Documentation, Filing And Usibility.	Care of the Elderly	P S Sridhar	15/05/2017	4	Incomplete
G425	Management Of Suspected Scaphoid Fractures In A&E	Emergency Department	Dr Nigel Waghorne	25/05/2017	4	Complete not implemented
G429	ECG's In NON Traumatic Chest Pain	Emergency Department	Dr Nigel Waghorne	05/06/2017	4	Complete not implemented
G436	Suicide & Self Harm In The Emergency Department	Emergency Department	Dr Adam Crewe	09/06/2017	4	Complete not implemented
G439	Gastrointestinal Bleed (Re-Audit)	Gastroenterology	Dr Ashish Kumar	19/06/2017	4	Complete for 6 month follow up
G447	Treatment for Hypoglycaemia in Hospital	Care of the Elderly	Helen Davies	19/07/2017	4	Incomplete
G456	Are We Using Safety Checklist For Radiology Interventional Procedures	Radiology	Dr Aparna Pai	28/09/2017	4	Complete for 6 month follow up
G457	Evaluation of Accuracy of Radiological Staging in Endometrial Cancer	Radiology	Dr Jurgen Brand	29/09/2017	5	Complete implemented
G462	Outcome of Urgent Lower Gastrointestinal GI Scoping	Gastroenterology	Dr Dafydd Bowen	17/10/2017	5	In progress
G463	Management of Decompensated Chronic Liver Disease	Gastroenterology	Dr Dafydd Bowen	23/10/2017	4	In progress
G466	VTE Propylaxis: How are we doing?	Care of the Elderly	Dr Eiry Edmunds	19/12/2017	3	Incomplete
G468	Mortality Audit in Acute Stroke Unit & Gwenllian	Care of the Elderly	Dr P S Sridhar	21/12/2017	4	In progress
G474	Death Verification Audit	Care of the Elderly	Dr Sridhar	20/03/2018	4	In progress

G476	Medical Record Keeping Standards in CDU	Cardiology	Dr Eiry Edmunds	20/03/2018	4	Complete for 6 month follow up
G482	Thrombolysis Audit	Care of the Elderly	Dr Sridhar	19/03/2018	4	In progress
G485	Prescription of Therapeutic Oxygen in A&E dept. Glangwili General Hospital in Accordance with BTS Guidelines Section 11	Emergency Department	Taimoor Ahsan Jafri	09/04/2018	3	Complete implemented
G489	Adequacy of Urgent Suspected Cancer Referrals	Radiology	Dr Aparna Pai	02/05/2018	4	Complete implemented
G494	Compliance to Modified WHO Checklist for Radiological Intervention Procedures	Radiology	Dr Aparna Pai	10/08/2018	4	Complete not implemented
G495	Local Assessment & Management of Delirium	Integrated Medicine	Dr N Coles	10/08/2018	4	In progress
G496	Compliance in Filling Out the Admission Proforma	Integrated Medicine	Dr Tazeen Muneer	07/09/2018	4	Complete implemented
G497	A Review of Safe Sharps Disposal Unit (SSDU) Placements in GGH Medical Wards	Haematology	Dr Ahmed Salamat	18/09/2018	4	In progress
G499	Re-Audit on Completion of Admission Proforma in CDU	Integrated Medicine	Dr Anil Narayanan	07/07/2018	5	Complete for 3 month follow up
G501	Audit of Compliance of Prescription Charts with All Wales Prescription Writing Standards	Care of the Elderly	Dr P Sridhar	06/11/2018	4	Awaiting action plan
G502	Medical Record Keeping	Care of the Elderly	Dr Sridhar	08/01/2019	4	In progress
G506	Turn-over Time and Reporting Discrepancy of Polytrauma CT	Radiology	Dr Jurgen Brand	07/02/2019	4	In progress
G509	Iron Deficiency Anaemia (IDA)	Gastroenterology	Dr Aashish Kumar	18/02/2019	4	In progress
G511	Audit to Assess Waiting Time for Cardioversion in People with New Persistent Atrial Fibrillation. Also, to Establish a New Pathway to Minimize the Time till DC Cardioversion.	Cardiology	Dr Eiry Edmunds	01/03/2019	3	Complete implemented
G512	Compliance Rate with Adult DKA Care Bundle	Endocrinology/Diabetes	Arif Khan	06/03/2019	3	In progress
G513	Acute Upper Gastrointestinal Bleed Re-Audit	Gastroenterology	Dr Bowen	27/03/2019	4	Awaiting action plan
Unscheduled Care - Health Board Wide/Multi Site						
H10	Eosinophic Oesophagitis Audit	Gastroenterology	Dr Paul Rastall	24/01/2019	4	In progress
H11	Completion of Outpatient Outcome Forms	Gastroenterology	Dr Paul Rastall / Leah Williams (Improvement & Transformation)	24/01/2019	4	Complete for 3 month follow up
H3	Appropriate Vitamin D Testing	Care of the Elderly	Dr A Gupta	21/06/2018	4	In progress
	Unscheduled Care - Multi-Site					
M7	Audit of appropriate use of Octaplex for reversing warfarin and DOACS	Haematology	Dr Rhian Fuge	08/02/2019	4	Awaiting action plan
G343 [B308, W1646]	College of Emergency Medicine (CEM) Consultant Sign Off 2016-2017	Emergency Department	Dr Samit Purkayastha	19/01/2016	2	Complete not implemented

G344 [B307, W1647]	College of Emergency Medicine (CEM) Moderate & Acute Severe Asthma - Adult and Paediatric 2016-2017	Emergency Department	Dr Samit Purkayastha	19/01/2016	2	Complete not implemented
G345 [B309, W1648]	College of Emergency Medicine (CEM) Severe Sepsis & Septic Shock in Adults 2016-2017	Emergency Department	Dr Samit Purkayastha	19/01/2016	2	Complete not implemented
G400 [B361, P256, W1793]	The New All Wales (Adult) DNACPR Form & Policy Re-Audit	Resuscitation	Sian Hall	30/03/2017	2	Complete implemented
G440 [B372, P304, W1783]	Arrhythmia Care Coordinator	Cardiology	Carys Jones	20/06/2017	4	In progress
G444 [B386, W1790]	CEM Neck of Femur Study 2017-2018	Emergency Department	Dr Nigel Waghorne	13/07/2017	2	Awaiting report/presentation
G445 [B387, W1791]	CEM Procedural Sedation in Adults 2017-2018	Emergency Department	Dr Nigel Waghorne	14/07/2017	2	Awaiting report/presentation
G446 {B385, W1792]	CEM Pain in Children Study 2017-2018	Emergency Department	Dr Nigel Waghorne	14/07/2017	2	Awaiting report/presentation
G467 [B396, P325, W1832]	Reviewing Management of Primary Biliary cholangitis in Accordance with EASL PBC Management	Gastroenterology	Dr Dafydd Bowen	20/12/2017	4	In progress
P245 [G352]	An Audit of Endobronchial Ultrasound (EBUS) Lymph Node Biopsy in Suspected Patients with Suspected Lung Cancer with Mediastinal Involvement	Respiratory	Dr R Ghosal	20/09/2016	4	Complete not implemented
P308 [W1795]	Benefits of GLP-1 in Diabetes and adherence to NICE Guidelines	Endocrinology/Diabetes	Dr A Mallipedhi	11/07/2017	4	Complete not implemented
P324 [B395, G471, W1831]	BTS National Audit on Smoking Cessation in Secondary Care 2017-2018	Respiratory	Professor Keir Lewis	12/01/2018	3	Complete for 6 month follow up
Unscheduled Care – Prince Philip						
P242	The Prescribing of Thromboprophylaxis on Patient Admission	Emergency Department	Dr L Izzat	16/08/2016	4	Complete not implemented
P243	An Audit of the Prescribing of Inhalers According to Hywel Dda University Health Board Guidelines for Asthma and Chronic Obstructive Pulmonary Disorder (COPD)	Emergency Department	Marie Treharne	16/08/2016	4	Complete not implemented
P251	The Management of Pre-Operative Anaemia	Haematology	Dr Rhian Fuge	31/10/2016	4	Complete not implemented
P269	BTS National Adult Bronchoscopy Audit	Respiratory	Dr Robin Ghosal	23/03/2017	3	Complete not implemented
P291	Has the Introduction of THE THINK GLUCOSE Insulin Administration Record Improved the Quality of Insulin Prescribing?	Cardiology	A Mallipedhi	22/05/2017	4	Complete not implemented
P307	All Wales Delirium Re-Audit 2017	Care of the Elderly	Andrew Haden	10/07/2017	3	Complete not implemented
P315	Integrated Care Nurse Led Transfusion Pathway Audit	Pathology	Dr Rhian Fuge	01/09/2017	4	Complete implemented

P327	Out of Hours request form for chest and abdomen radiographs	Radiology	Dr A Richards	12/02/2018	4	Complete not implemented
P328	Neurovascular Clinic Re-Audit	Care of the Elderly	Dr S Kumar	19/02/2018	3	Complete not implemented
P333	Re-Audit of Out of Hours Chest and Abdomen Radiographs (Out of Hours/OOH = 17.00-08.45 and weekends)	Radiology	Dr Andrew Richards	19/04/2018	4	Incomplete
P334	Percutaneous CT-Guided Lung Biopsy	Radiology	Dr Andrew Richards	19/04/2018	4	Complete not implemented
P339	Lactate & Sepsis Audit	Care of the Elderly	Dr Mark Sheehan	14/01/2019	4	Awaiting action plan
P340	Chronic Pancreatitis Audit	Gastroenterology	Dr Ian Rees	21/02/2019	5	In progress
P341	DNACPR in Palliative Care	Haematology	Dr Helen Fielding	21/02/2019	4	In progress
Unscheduled Care - Withybush						
W1628	Incidence and Common Trends of Extravasation of contrast media in CT	Radiology	Mr Sean Jones	11/11/2015	4	Incomplete
W1657	BTS National Emergency Oxygen Audit 2016	Respiratory	Dr Saba Kebede	26/02/2016	2	Incomplete
W1704	Prevalence of B12 deficiency in patients referred to memory clinic	Care of the Elderly	Dr C M James	03/06/2016	4	Incomplete
W1709	Re-audit of the management of febrile patients with neutropenia secondary to bone marrow disease	Haematology	Dr Sumant Kundu	30/08/2016	4	Complete implemented
W1726	NHS Benchmarking Audit: Older people in Acute settings	Care of the Elderly	Angela Puffett	24/10/2016	3	Complete implemented
W1735	Constipation Comparison Audit	Integrated Medicine	Dr Will Backen	13/12/2016	4	Incomplete
W1737	Steroid Card Audit	Integrated Medicine	Dr Sarah Davidson	30/11/2016	4	Complete not implemented
W1738	Acute Kidney Injury - Prevention, detection and management in adults.	Integrated Medicine	Yamin Rashid	06/12/2016	3	Incomplete
W1739	COPD Care bundle	Respiratory	Dr Yamin Rashid	06/12/2016	4	Complete not implemented
W1762	Verification of death by Doctors	Integrated Medicine	Rob Jones	23/02/2017	3	Complete not implemented
W1766	Relevance of First TROP-T Result in the Eradication of Chest Pain in ED	Emergency Department	Dr Samit Purkayastha	16/03/2017	4	Complete not implemented
W1769	Re-audit Blood Culture	Integrated Medicine	Dr Kingsuk Mukherji	26/06/2017	4	Complete implemented
W1770	CTPA Re-audit	Integrated Medicine	Dr Yamin Rashid	27/03/2017	3	Complete not implemented
W1801	Wales Delirium Audit	Care of the Elderly	Angela Puffet	26/07/2017	4	Complete implemented
W1809	To assess justification of SPECT - CT Performed after whole body bone scan	Radiology	Sarah Stace	20/10/2017	5	Complete implemented
W1810	Benchmarking Audit - Older people in acute settings	Care of the Elderly	Dr Angela Puffett	23/10/2017	3	Complete implemented

W1817	Lower Limb Thromboprophylaxis Re-audit	Emergency Department	Antony Mathew	26/10/2017	4	Complete for 6 month follow up
W1821	An audit study of the diagnostic quality of radiographer approved postero-anterior erect chest x-rays based on anatomical image criteria	Radiology	Barry Denton	23/11/2017	4	Awaiting action plan
W1834	A retrospective study of obinutuzumab in combination with chlorambucil for untreated chronic lymphocytic leukaemia at WGH	Haematology	Dr Sumant Kundu	25/01/2018	4	Complete implemented
W1840	Audit to assess compliance with protocol for the medical assessment and management of patients admitted with hip fractures	Integrated Medicine	Dr Will Backen	25/01/2018	4	Discontinued
W1841	Hyponatraemia Management	Integrated Medicine	Dr Paul Underwood	31/01/2018	4	Incomplete
W1842	Chronic Heart Failure	Cardiology	Dr Kingsuk Mukherji	15/02/2018	4	In progress
W1851	An audit of bone marrow sampling and yield at WGH	Haematology	Dr Sumant Kundu	03/05/2018	5	Awaiting report/presentation
W1853	An audit to assess whether WGH is upholding national guidelines and adhering to the All Wales Transfusion Record when prescribing and giving blood transfusion	Haematology	Dr Bartlett	22/05/2018	4	Complete for 3 month follow up
W1855	Radiography for knee trauma re-audit: Compliance with the Ottawa knee rule	Emergency Department	Dr Samit Purkayastha	28/06/2018	4	Awaiting action plan
W1857	Community Acquired Pneumonia	Microbiology	Dr Emrys Williams	31/07/2018	4	In progress
W1866	Patients presenting to A&E Minors with a fall - can we prevent admission with interventions of their care?	Care of the Elderly	Dr Nagasayi	04/10/2018	4	Awaiting report/presentation
W1870	Management of first presentation of TIA	Integrated Medicine	Dr Yamin Rashid	06/11/2018	4	Discontinued
W1872	Quality of Discharge Summary for the Elderly	Care of the Elderly	Dr Subramaniam Nagasayi	26/11/2018	4	Complete for 3 month follow up
W1873	Compliance to Decompensated Cirrhosis Care Bundle in First 24 Hours	Integrated Medicine	Dr Rana Haider	06/12/2018	4	Awaiting action plan
W1875	National Audit Meningitis Management (NAMM)	Care of the Elderly	Prof. Ken Woodhouse	13/12/2018	4	Awaiting report/presentation
W1877	Revalidation of GAPs Score	Emergency Department	Dr A Mathew	29/01/2019	4	In progress
Women and Children						
B182	Diagnosis and management of Coeliac disease in childhood	Paediatrics		04/02/2015	N/A	Complete implemented
B391	Induction of Labour	Obstetrics & Gynaecology	Dr G Datta	17/11/2017	4	Complete for 3 month follow up

B402 [G479]	In-utero Transfer in Hywel Dda Maternity Unit	Obstetrics & Gynaecology	Dr Selvi Premkumar	09/03/2018	3	In progress
B405	Clinical Outcomes Analysis of Tension Free Vaginal Tape Obturator (TVTO)	Obstetrics & Gynaecology	Mr Said Awad	30/04/2018	3	Awaiting action plan
B409	Consent Counselling Audit	Obstetrics & Gynaecology	Dr Henan Al-Hussein	01/10/2018	3	Awaiting report/presentation
B410	Audit on Ectopic Pregnancy	Obstetrics & Gynaecology	Mrs Aruni Nan	25/09/2018	4	Complete for 3 month follow up
B413	Management Of Miscarriage - Are We Following NICE Guidelines Audit	Obstetrics & Gynaecology	Dr Mazar Abul-Gasim	24/09/2018	4	Incomplete
G333	Paediatric Prescribing audit	Paediatrics	Dr Toni Williams	22/06/2016	4	Complete implemented
G334	OUTCOME OF TWIN PREGNANCIES	Obstetrics & Gynaecology	Dr Islam Abdelrehman	22/06/2016	4	Awaiting action plan
G383	Neonatal Sepsis (Re-audit of G297)	Paediatrics	Dr Prem Kumar Pitchaikani	13/11/2017	3	Incomplete
G401 [P302, W1693]	Quality Standard Assessment of Diagnosis & Management of Attention Deficit Hyperactive Disorder in Children in Hywel Dda UHB	Paediatrics	Dr Martin Simmonds	06/04/2017	4	Complete for 6 month follow up
G427 [B369]	BASHH National Clinical Audit 2017. Management of Syphilis	Sexual Health/GUM	Dr Madhusree Ghosh	25/05/2017	4	Complete implemented
G448 [B389, P309, W1798]	Antenatal Corticosteroids Audit	Obstetrics & Gynaecology	Dr Selvi Premkumar	19/07/2017	4	Complete not implemented
G449 [P310, W1796]	Amniocentesis	Obstetrics & Gynaecology	Richard Husicka	20/07/2017	4	In progress
G465	Fetal Fibronectin in Clinical Practice	Obstetrics & Gynaecology	Manal Elbadrawy	08/12/2017	4	Awaiting action plan
G473	Postperative Outcomes of Laparoscopic Hysterectomy	Obstetrics & Gynaecology	Dr Islam Abdelrahman	22/01/2018	4	Complete implemented
G475	VBAC Counselling Re-audit	Obstetrics & Gynaecology	Dr Ganeshelvi Premkumar	20/03/2018	4	Complete for 3 month follow up
G477	External Cephalic Version	Obstetrics & Gynaecology	Dr Nicola Piskorowskyj	20/03/2018	4	Complete for 3 month follow up
G486	Febrile Neutropenia Annual audit	Paediatrics	Marcus Andrews	23/04/2018	5	Complete not implemented
G487	Febrile Neutropenia Re-audit	Paediatrics	Marcus Andrews	23/04/2018	5	In progress

G491	TransOrburatorTape (TOT) audit	Obstetrics & Gynaecology	Islam Abdelrahman/Manal Elbadrawy	09/07/2018	4	Complete implemented
G492	Paediatric Prescribing Re-audit	Paediatrics	Dr Richard Richmond	11/07/2018	5	Complete implemented
G493	Audit on Documented Risk Assessment of VTE at Antenatal Booking	Obstetrics & Gynaecology	Ms Piskorowsky	11/07/2018	5	Complete implemented
G505	Induction of Labour Audit	Obstetrics & Gynaecology	Dr Roopam Goel	06/02/2019	4	In progress
G507	Management of Heavy Menstrual Bleeding (HMB)	Obstetrics & Gynaecology	Mr L R Shankar	11/02/2019	4	In progress
G508	Post Natal Readmissions	Obstetrics & Gynaecology	Mr Shankar	15/02/2019	4	In progress
H12	Effects of High Dose in Reducing the Incidence of Pre-Eclampsia	Obstetrics & Gynaecology	Dr Ceiros Jones/Mr L Shankar	05/02/2019	4	In progress
H2	Screening and Management of Small for Gestational Age Babies (SGA)	Obstetrics & Gynaecology	Dr Selvi Prem Kumar	29/05/2018	3	In progress
M3	Inhalers and Asthma Action Plans in Children with Asthma	Paediatrics	Dr V Narayan	20/09/2018	4	In progress
W1663	Colposcopy Service Audit 2015	Colposcopy	Sue Bojanowski-Rees	29/03/2016	4	Incomplete
W1664	TVT Re-audit	Obstetrics & Gynaecology	Christine Link	23/03/2016	4	Awaiting action plan
W1719	Non-attendance at out patient clinics in the Department of Child Health, Pembrokeshire	Child Health	Martin Simmonds	06/09/2016	4	Complete not implemented
W1720	ADHD prescribing and monitoring in children and young people	Paediatrics	Martin Simmonds	06/09/2016	4	Complete not implemented
W1727	Delivery of Botulinum Toxin injection to children with spasticity in Pembrokeshire - Efficiency, Management and Cost Effectiveness.	Paediatrics	Dr Jayasinghe	25/10/2016	4	Complete not implemented
W1736 [B336, G432, P254]	Perinatal Outcomes Audit	Obstetrics & Gynaecology	Dr C Overton	23/11/2016	4	Complete not implemented
W1781	Novasure Endometrial Ablation	Obstetrics & Gynaecology	Mr Debashish Sanyal	14/06/2017	4	Complete implemented
W1797	Re-audit: Obesity in children with ASD	Child Health	Dr Alice Setti	14/07/2017	4	Incomplete
W1835	Follow up in Trisomy 21 children in Pembrokeshire	Paediatrics	Dr M Simmonds	17/01/2018	4	In progress
W1858	Management of Gestational Diabetes at WGH	Obstetrics & Gynaecology	Dr Talar Amin	31/07/2018	4	In progress
W1867	Novasure Ablation Outcome Audit	Obstetrics & Gynaecology	Mr Sanyal	17/10/2018	4	In progress