Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	13 February 2024
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Interim Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Ian Bebb, Clinical Audit Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To provide the Quality, Safety and Experience Committee with examples of clinical audits and the impact of these activities on quality and safety within the Health Board.

Cefndir / Background

The Health Board develops an annual Clinical Audit Programme which is carried out by the operational Services. This programme consists of a list of key clinical audit projects that have been prioritised in line with Health Board (Service specific or otherwise) aims and objectives. This programme also includes all projects mandated by Welsh Government (NCAORP) and other national bodies. National benchmarking is possible through this mechanism.

Asesiad / Assessment

Clinical Audit Programme 2023/24

The Clinical Audit Programme for 2023/24 has a total of 45 different clinical audit projects from 13 different service areas (committee/group) representing an increase from previous years. NCAORP projects are automatically included in addition, bringing the total to 75. The Clinical Audit Department (CAD) are continuing to work with services to expand this programme as well as to ensure projects are completed and focused on quality improvement.

Shared Learning

The CAD is continuing to run the Whole Hospital Audit Meetings (WHAM). WHAM events are held every quarter and alternate between site specific (4) and Health Board wide events. The most recent event was held on 7th December 2023 and focused on Health Board specific clinical audits. The following projects were presented:

- The Quality of Service of Emergency Appendectomy in Children under 18 years of age at Bronglais General Hospital
- Compliance with Pre-operative Fasting Guidance for Emergency Orthopaedic &Trauma Patients (Re-Audit)
- Use of Prophylactics Antibiotics in Elective General Surgical Operations
- Audit of Cannulation Referrals to Anaesthetics Department
- Provision of `Last done` Details on Laboratory Antibiotic Requests
- Clinical and Pathological Reporting for Colorectal Cancer
- Pain Management in Adults presenting to A&E
- Quality of Discharge Summaries on Gynae Ward
- Telemetry Re-Audit
- PET-CT Scan in the Management of Breast Cancer
- Breast Pain Clinic Audit

The CAD continues to support the Enabling Quality Improvement in Practice (EQIiP) programme by attending event days and giving presentations on the links between QI and Clinical Audit and how they can complement each other in particular how clinical audit activity can inform improvement activities.

Clinical Audit Activity

The below figures represent an overall snapshot of audit activity at time of writing this report. Clinical audits have a number of distinct stages of completion and are not considered complete until the action plan/improvement work has been completed. There is naturally an extended time frame for these projects to be *fully* completed (as opposed to data collection or the submission of an action plan) which is reflected in the results. This is however a more meaningful and complete measure of the impact of clinical audit.

	2022-2023	2023-2024
Total No. of Projects	62	106
In progress	43	93
Improvement implementation stage	23 (53%)	30 (32%)
Fully completed	19 (31%)	13 (12%)

**NCAORP projects are not included in the above figures due to the extended time frames for these types of projects*

National Clinical Audits

Below are some examples of the impact of the Health Board's participation in the NCAORP. These are mandatory audits and the Health Board participates in 32-36 of these annually (depending on which ones are running).

National Hip Fracture Database (NHFD) *(2023 report)*

The NHFD is a clinically led web-based audit of hip fracture care and secondary prevention in England, Wales and Northern Ireland. The NHFD's 15th annual report emphasises the importance of quality improvement with five specific improvement focuses, and in

particular reports on two key performance indicators(KPIs) that are designed to examine the very first and final stages of each patient's care.
Unfortunately, the pandemic had a negative effect on the health of older people in general, and this placed an additional strain on hospital and community services, leading to an increase in the number of people who fell and broke their hip in 2022.

The September 2023 report has reflected the improvements that have been embedded for patients admitted to hospital with hip and femoral fractures. HDdUHB hospital sites have achieved top quartile in several standards. The audit findings have shown that:

- 100% of patient's in Bronglais Hospital (BGH) have had a nutritional risk assessment (94.8% nationally)
- 100% of patients in Withybush hospital had a subtrochanteric fracture treated with an Intramedullary nail - provides the strongest mechanical fixation of any shaft fracture (89.6% nationally)
- All hospital sites had achieved higher than average (59.0% nationally) for General Anaesthetic and Nerve Block given to patients. GGH 93%, WGH 68.3%, BGH 96.6%

The chart below shows the KPIs for hip fractures only. It does not include other femoral or peri-prosthetic fractures.

Name	KPI 0 %	KPI 1 %	KPI 2 %	KPI 3 %	KPI 4 %	KPI 5 %	KPI 6 %	KPI 7 %
Withybush General Hospital	5.2	0.3	68.5	74.8	73.3	46.8	72.3	1.4
West Wales General hospital	5.8	70.3	67.2	65.3	73.9	75	72.2	40.7
Bronglais General Hospital	3.9	99.3	37.7	80.4	79	97.8	75	72.4

*1 January 2022 – 31 December 2022 data

Below average | Average | Above average

KPI 0 - Admission to ortho ward	KPI 1 - Prompt orthogeri assessment	KPI 2 - Prompt surgery
KPI 3 - Nice compliant surgery	KPI 4 - Prompt mobilisation	KPI 5 - Not delirious post-op
KPI 6 - Return to original residence	KPI 7 - Medication	

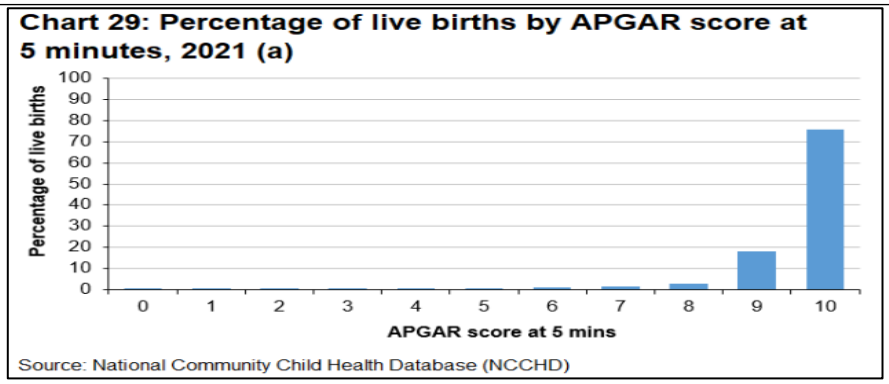
The NHFD team have been proactive in making improvements to the service in response to these findings. The team have regular meetings on all sites to discuss KPI's and overall performance and monthly performance figures are shared with all members of the team. Improvements have been made through shared learning across all sites to improve poor performance identified.

Work has been underway to improve Prompt Orthogeriatric Assessment as it was identified that Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) were not meeting this target. Compliance has since improved for Glangwili and Withybush due to the Orthogeritrican post being filled for both sites.

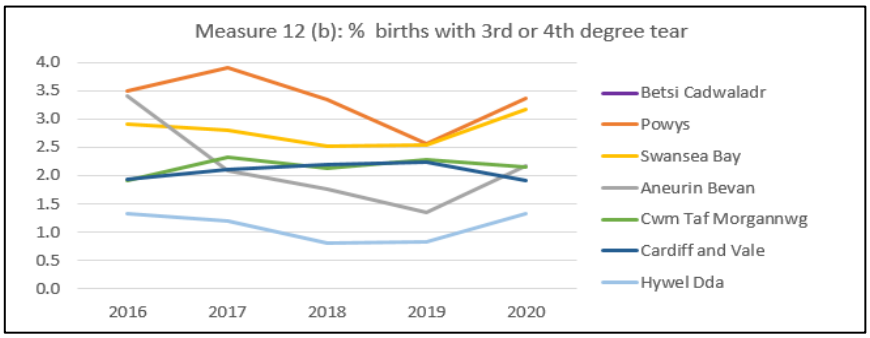
National Maternity and Perinatal Audit (NMPA) *(2022 report)*

The National Maternity and Perinatal Audit aims to improve the treatment of mothers and babies during their stay in a maternity unit by evaluating a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.

- Post-partum haemorrhage blood loss rates within HDUHB are below the national rates for Wales; post-partum haemorrhages of 1.5 litres or more is 2.3% and post-partum haemorrhages of more than 2.5 litres is 0.3%.
- Babies with an APGAR score (observations to risk assess baby's condition at birth recorded at 1, 5 and 10 minutes of age) of less than 7 within the Health Board is consistently lower than the national average with a rate of 0.2% compared to 2% across Wales.



- HDUHB demonstrates the lowest rate of mothers with perineal trauma in Wales over 5 consecutive years.



The Health Board is waiting on several new systems of data collection to be implemented across Wales; one such system is Digital Maternity Cymru (DMC), which will support health boards to provide comparable data around the audit which will allow further analysis on aspects of the maternity and perinatal data.

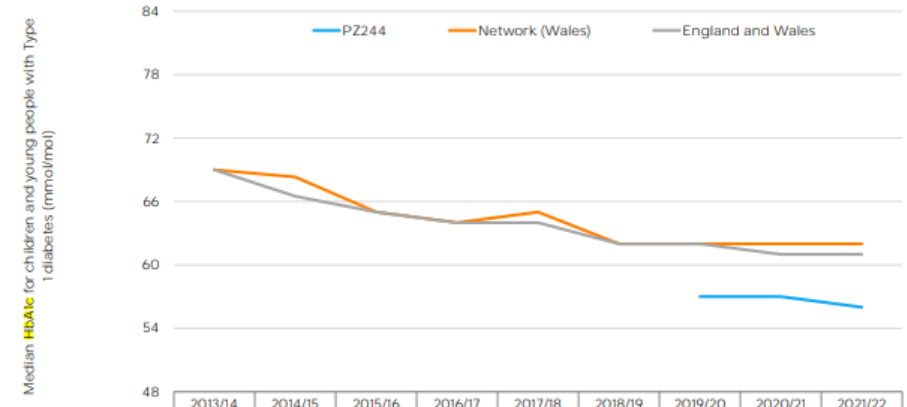
The service have noted recommendations from the audit report and are introducing new support systems for patients, updating local guidance and communicating up-to-date guidance and advice to staff.

National Paediatric Diabetes Audit (NPDA) *(2023 report)*

The National Paediatric Diabetes Audit aims to compare the care and outcomes of all children and young people with diabetes receiving care from the Paediatric Diabetes Unit (PDU) in England and Wales. It collects data submitted by PDUs around the completion of NICE recommended health checks for people with Type 1 and Type 2 diabetes, and their outcomes.

HDUHB was the top paediatric unit in Wales with the best HBA1C for 2021-22 and in the top 4-paediatric units for 2022-23.

Figure 18: Median HbA1c for children and young people with Type 1 diabetes



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
PZ244							57.0	57.0	56.0
Network (Wales)	69.0	68.3	65.0	64.0	65.0	62.0	62.0	62.0	62.0
England and Wales	69.0	66.5	65.0	64.0	64.0	62.0	62.0	61.0	61.0

**PZ244 indicates HDUHB data*

Improvements in care outcome processes and psychology provision have been recorded. In order to maintain the improvements in psychology provision, the service hope to secure ongoing funding for wider multidisciplinary team members. The service are introducing regular reviews and the appointment of additional staff on a permanent basis.

National Pregnancy in Diabetes Audit (NPID) *(2023 report)*

The National Pregnancy in Diabetes (NPID) Audit measures the quality of pre-gestational diabetes care against NICE guideline based criteria and the outcomes of pre-gestational diabetic pregnancy.

There have been notable improvements in glucose levels and pregnancy outcomes for Type 1 Diabetes Mellitus (DM). There were fewer diabetic ketoacidosis events, reductions in preterm births, reductions in large for gestational age babies and neonatal unit admissions. There were also significant reductions in the serious adverse outcomes that are most important for women living with Type 1 DM such as birth defects and baby deaths. These successes have been attributed to the increased use of continuous glucose monitoring (CGM) technology. HDUHB has adopted widespread use of CGM technology and has higher numbers of women hitting HBA1C targets before and during pregnancy because of this.

Hywel Dda data compared with England and Wales 2020 - 2022

	England	Wales	Hywel Dda UHB
% with HbA1c < 48 mmol/mol in early pregnancy	30.7	26	35.3
% with HbA1c < 43 mmol/mol in late pregnancy	43	36	46.2
% taking 5mg Folic acid	30.8	35.2	33.3
% with first contact before 10 weeks gestation	68.3	71.4	88.9
% of deliveries large for gestational age	36.1	41.1	35.7
% of deliveries admitted to neonatal care	39.3	43.6	42.9
% of live deliveries that were preterm	32.4	36.2	28.6

HDUHB figures for neonatal outcomes were encouraging with figures that were better than the England and Wales averages. For these outcomes to improve further, HDUHB will need to

improve prenatal care (increase prescription of Folic Acid and reduce HBA1C) and reduce HBA1C levels during pregnancy.
The service is conducting research into pregnancy specific technology and are reviewing the provision of pre-conception care services with the hope of appointing additional staff.

National Adult Asthma *(2023 report)*

The National Respiratory Audit Programme (NRAP) for England and Wales aims to improve the quality of care, services, and clinical outcomes for people with respiratory disease (including Asthma and COPD). The adult asthma continuous clinical audit collects information on adults admitted to hospital in England and Wales with asthma attacks.

- In GGH, respiratory specialist review carried out within 24 hours has increased to 83% in 2021-22 (54% in 2019-20). The national average in 21-22 is 51%. In 2021-22, GGH was above the national interquartile range and within the range for PPH.
- In PPH, systemic steroids administered within one hour of arrival to hospital has increased to 42% in 2021-22 (25% in 2019-20). This was somewhat better and above the national interquartile range from PPH where most adult asthma admissions come direct to AMAU under the medical team as there is no A&E department. There is still significant scope for improvement in this but this potentially illustrates a benefit of these patients being assessed and seen in a medical department by medical doctors rather than waiting in an emergency department and being seen by A&E teams.
- In 2021-22, key elements of the BTS discharge bundle were delivered to 100% of patients admitted to BGH with PPH and WGH being within the national interquartile range.
- In 2021-22, 100% of current smokers in GGH and 87% in PPH had evidence of their tobacco dependency being addressed.

The service has noted the recommendations from the report and aim to initiate an acute asthma care bundle to be implemented on each acute admission site. The Clinical Lead has begun enquiries into the individual service models across the 4 sites with reference to their individual outcome data in order to try and reduce variation in practice and improve the services.

Health Board Clinical Audits

Below are some examples of Health Board audits that have been undertaken and the impact they have had on our patients and the organisation. The source and driver for these audits is hugely varied and can arise from professional interest, identified risks, governance concerns, complaints etc. as well as identified areas for improvement. Some of the auditors involved in these projects are very passionate about making improvements in the quality of care that we provide. We encourage all audits to have multiple audit cycles or “re-audits”. The below are all examples of such – showing a continued commitment to improvement over time.

Audit on Discharge Summary in Same Day Emergency Care (SDEC) Re-audit

This re-audit was undertaken to assess the compliance of patient discharge summaries which should be completed and sent to the GP within 24 hours of patient discharge. Delaying the information transfer may put patients at risk. A presentation on the discharge summary results and guidelines was given to staff in Same Day Emergency Care. Changes that have been made since the initial audit included appointing more staff, attempting to complete a discharge summary on the same day of a patient attendance and to include the diagnosis and medication details (dose, route, duration, addition and removal cause, supply etc).

Following implementation, they found that:

- 69% of discharge summaries had been completed within 24 hours (43% previously)
- 99% of discharge summaries had clear follow up instructions (96% previously)
- 88% of the discharge summaries contained clear diagnosis (79% previously)

A re-audit is planned for September 2024 to be able to indicate any further improvements that may have been made.

An Audit of Compliance with the Royal College of Pathologists Dataset for Colorectal Cancer Clinical and Pathological Reporting

This audit and re-audit were undertaken to assess adherence to communication guidelines between departments of General Surgery and Histopathology and to audit Histopathological service at HDUHB. The audit aimed to determine the adequacy of clinical information provided by the surgical team, whilst assessing the quality of sampling. In addition, this audit intended to ensure core data items have been included in the pathology report.

The re-audit demonstrated that 19 out of 31 criteria were achieved, which was an increase of 4 additional criteria when compared to the initial audit round. Significant improvements were seen in “clinical details” criteria, for example, Figure 1 highlights that preoperative stage was provided in 50% of patients (14% previously). Furthermore, neo-adjuvant therapy information were provided in 20% of cases (8% previously). Additionally, site of tumour stayed consistent and was provided in 100% of cases, in both audit and re-audit.

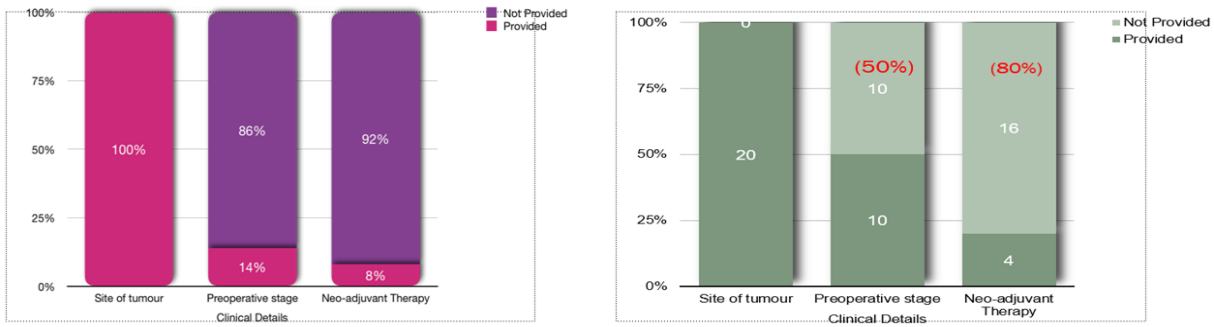


Figure 1: Bar chart highlighting difference in clinical details criteria between audit and re-audit.

Following the completion of this audit, changes were implemented and information was disseminated through teaching sessions. These sessions highlighted the importance of being compliant to the Royal college guidance. Following completion of both audit and re-audit, improvements have been presented at General Surgery speciality meeting and at Cellular Pathology Department in GGH.

The findings from this audit will be utilised to provide further clinical details to the histopathologists especially site, pre-operative radiological stage and presence/absence of neoadjuvant therapy. Furthermore, the auditors have decided to conduct another re-audit, to be able to indicate any further improvements that may have been made.

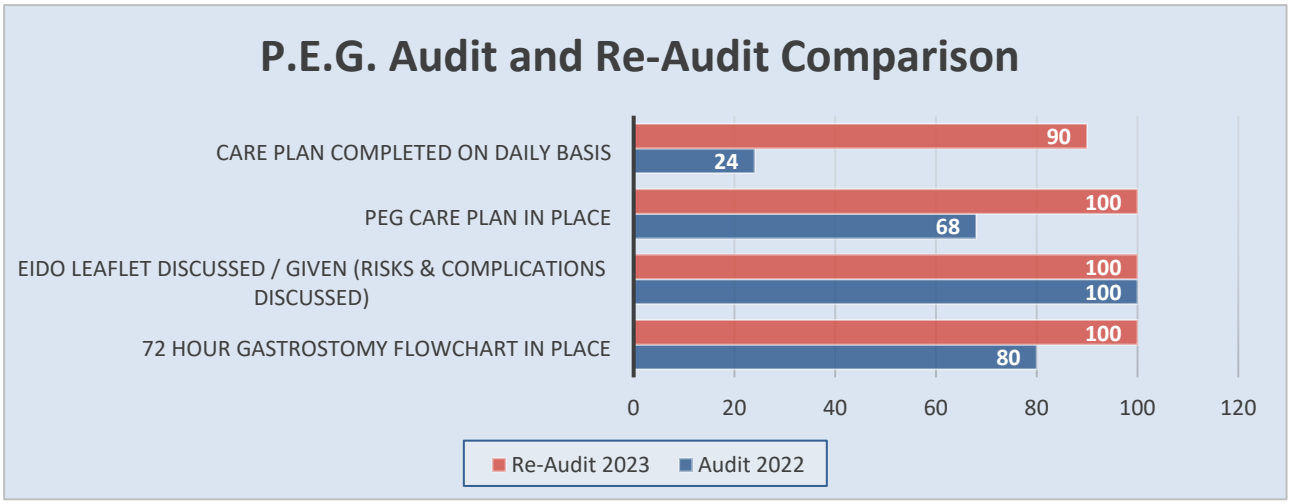
Percutaneous Endoscopic Gastrostomy Care (P.E.G) Audit

This audit was undertaken across the 4 main sites of HDUHB by the Nutrition and Dietetics team and presented at a Health Board Whole Hospital Audit Meeting (WHAM) on the 9th March 2023.

There are 60-70 PEG placements annually in the Health Board. This audit was undertaken to improve the quality of service, reduce risk taking behaviours, ensure safe practice was followed post-gastrostomy insertion procedure and assess patterns or trends of complications post-gastrostomy insertion procedure.

Criteria	Target	Results
72 hour gastrostomy flowchart in place	100%	**80%**
Prophylactic anti-biotics provided	100%	**92%**
EIDO Leaflet discussed / given (risks & complications discussed)	100%	**100%**
PEG care plan in place	100%	**68%**
Care plan completed on daily basis	100%	**24%**

Though the audit found that not all of the documentation was being completed as advised there was no evidence of patients being at risk. Following these results, the service aimed to ensure that the 72 hour post-gastrostomy flowcharts and care plans are given to each patient by providing copies to the ward upon admission/PEG placement. Also, each ward are to be given a laminated copy.



A planned re-audit of P.E.G was undertaken in December 2023 and following implementation of the above actions, a number of improvements were demonstrated. As displayed in the above graph, 100% of patients had the 72 hour gastrostomy flowchart and the PEG care plans in place. 90% of the care plans were also completed daily which is a marked improvement from 24% in the initial audit. EIDO leaflets provided also maintained 100% compliance.
The re-audit showed that although 100% of care plans were in place, 10% were not completed daily. The CNS nutrition team are updating PEG care-plans to ensure they are user friendly for staff to aid in compliance.

The re-audit is due to be presented at the next WHAM on the 6th March 2024.

Oxygen Prescription Audit

This audit was undertaken in 2022 in response to a lack of awareness and understanding among junior doctors regarding the requirement to prescribe

oxygen according to the target saturation range. The objective was to equip junior doctors with the knowledge to identify various indications for different desirable oxygen saturation ranges and improve accuracy of oxygen prescription.

The audit stated that an oxygen target saturation range should be prescribed for all patients who are admitted to hospital. The results showed that only 41% (67/162) of inpatients had oxygen prescribed on their drug chart across eight of the wards that were included. Based on these findings, teaching sessions were implemented for all junior doctors to highlight the importance of oxygen prescribing.

The planned re-audit of Oxygen Prescription took place in February 2023 with the results showing a significant improvement at 70% (113/161). Furthermore, the findings were presented in the WHAM June 2023 to emphasise this key practice point and disseminate the findings.

Hywel Dda Inpatient Smoking Audit - 2022

A previous smoking cessation audit was undertaken in 2018 which included the four main sites. The last re-audit included did not include GGH as WNCR was not in use at that time.

The audit aimed to identify how often smoking status is recorded on hospital inpatient and outpatient charts, what smoking cessation treatments are offered and delivered, and to assess the success rates.

If smokers are not identified routinely then they are not offered access to nicotine replacement to prevent withdrawal often leading to discomfort or aggression whilst in hospital. Access to support prevents relapse on discharge but also prevents withdrawal during a hospital stay. Without this support 50% of those who have remained abstinent whilst in hospital will relapse within 2 days of discharge.

The results of this audit showed improvements compared to the 2018 audit:

- Offer of specialist support up to 96% in 2022 from 22.4% in 2018.
- Offer of nicotine replacement therapy in 2022 was 75% compared to 9% in 2018

Following the results, the service have identified the need to recruit 4 x Band 5 roles, 1 per site, to help with CURE model introduced into secondary care by Welsh Government. These positions were filled as of May 2023. The re-audit was presented at WHAM in September 2023. Plans for re-audit are currently being discussed.

DNACPR - All Wales Audit (Secondary Care)

The All Wales DNACPR policy '"Sharing and Involving" A Clinical Policy For Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults in Wales' was launched in 2015 and has been re-audited within the Health board annually thereafter (exception 2021)
.
Previously, one site was identified by the RRAILS group as underperforming; targeted work was put in place to combat this and results have improved sufficiently. In 2022 the audit was repeated retrospectively using a modified audit tool.

A key success for the 2022 audit is that the forms are being filed in the appropriate areas, being visible in the notes and accessible when needed.

Areas of improvement have been documented in the following areas:

- increase in recording of clinical summaries
- recorded discussions with the patient
- recorded reasons for not discussing
- forms signed by a doctor
- forms signed by a nurse
- forms with a GMC/NMC number recorded
- forms signed by senior responsible doctor
- forms with senior GMC number recorded

Results have been presented to the HDUHB RADAR group, associated site groups plus to a wider audience at the December Whole Health Board Audit Meeting. As always, this information will feed into training sessions throughout the Health Board.

Recommendations are to revert to using the All Wales audit tool for the 2023 audit. The Clinical Audit Department will coordinate the usage of AMaT, an Audit Management and Tracking system where prospective data will be uploaded directly to an electronic audit tool by auditors. A DNACPR task and finish group is being established which will identify and oversee necessary DNACPR improvement work.

This will benefit our patients by ensuring that the multi-professional clinical teams are implementing the policy and in turn, the form is duly completed. This will reduce inappropriate resuscitations due to poor documentation and in turn reduce the number of complaints.

Summary

The above projects represent a small cross section of audits from around the Health Board and is by no means an exhaustive list. There is a focus on re-audit and those that have had a demonstrable impact and we hope that this gives an indication of the positive impact of clinical audit. The examples together with clinical audit activity figures above will give a snapshot into the role clinical audit plays.

There are many other audits, both national and local that are highlighting the need for improvement. Some of these projects highlight the need for previously unanticipated improvements, governance issues, risks etc. that would not have been known had the audits not been undertaken. There are also projects that deliver assurance because all standards are being maintained at a satisfactory level. The potential for audit is therefore one for quality improvement, identifying concerns as well as providing assurance. It remains the goal of the Clinical Audit Department and the Health Board to maximise this functionality as much as possible.

Argymhelliad / Recommendation

- Note the above as examples of how clinical audit projects have had a positive impact on quality, safety and patient experience
- Note the continued commitment to quality improvement through the use of re-audit
- Take assurance from the continued shared learning through Whole Hospital Audit Meetings
- Note the variety of uses for clinical audit and how this can and is benefiting the Health Board

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.17 Shape and Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	n/a
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services
Amcanion Cynllunio Planning Objectives	2b Employer of choice
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	National Clinical Audit and Outcome Review Programme 2023/24 Hywel Dda UHB Forward Clinical Audit Programme 2022/23, 2023/24
Rhestr Termau: Glossary of Terms:	NCAORP – National Clinical Audit and Outcome Review Programme CAD – Clinical Audit Department
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod:	Mandy Davies, Assistant Director of Nursing and Quality Improvement Sharon Daniel, Interim Director of Nursing

Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	The principals of audit imply that quality/patient care will be impacted. However, the impact of the audits held within this report are positive examples of improvement activities and are individually called out.
Gweithlu: Workforce:	Workforce engagement in Clinical Audit provides an understanding of the impact of quality of service and clinical care delivery and is a key driver for appraisal for medical staff and professional practice development in all clinical disciplines.
Risg: Risk:	Audit specific risks are contained within service/specialty specific risk registers. This includes non-participation with mandatory national audits.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	There is the potential for reputational impact when the Health Board does not participate in mandatory audit projects. None of the criteria in the impact assessment apply.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable