CLINICAL AUDIT & EFFECTIVENESS DEPARTMENT ANNUAL REPORT 2020-2022

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APPENDICES

1. Introduction

The Annual Clinical Audit and Effectiveness Report aims to provide an overview of clinical audit activity undertaken within the Health Board for both the 2020/21 and 2021/22 periods, as reported to the Clinical Audit and Effectiveness team.

The Health Board has a relatively small team to support the Welsh Government mandated national topics and other work streams, including facilitation of the mortality reviews process (Appendix 1.).

For the report period, the Health Board adopted the National Clinical Audit and Outcomes Review Advisory Committee (NCA&ORAC) list published annually by Welsh Government as its only forward Clinical Audit Plan. The list includes national audits/registries and outcome reviews that relate to a wide range of services. Health Boards are mandated to participate in all topics relating to the services they deliver.

As a sub-group of the Quality Safety Governance Group and Quality and Safety Committee, the Clinical Outcomes and Effectiveness Group (COEG), was established in September 2020. Monthly meetings have provided a platform for the escalation of issues and monitoring of activities.

A revised approach to the prioritisation of local audit and improvement activities has been detailed in the updated version of the Clinical Audit and Effectiveness Policy, accommodating mandated national topics, corporate, Service Delivery Group and service and directorate level priorities along with necessary ad-hoc activities.

The Health Board adopts the Healthcare Quality Improvement Partnership (HQiP) definition for clinical audit, supporting the view that it is a quality improvement process, not simply data collection:

"a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes."

2. Clinical Audit and Effectiveness Department

For the report period following a year-long absence that resulted in retirement of the post-holder, staff resource fell from 10 to 9.4wte. In addition, the overarching Clinical Effectiveness and Governance Manager post remains vacant following retirement of the post holder in April 2019. Gaps and the associated risks have been noted on the Executive Medical Director's Risk Register.

With the arrival of Microsoft 365 and the need to find new ways of working during the worst of the pandemic, a Digital Officer role was introduced to the team in April 2021 (Appendix 1).

The department prioritises support for any mandated national audits and outcome registries that it has responsibility for, along with any special projects initiated in response to requests from the Executive team.

2. Clinical Audit and Effectiveness Department (contd.)

The team also facilitates the existing Health Board's Mortality Review Process and more recently Learning from Deaths Process to support the local receipt, review and reporting of required actions resulting from recommendations emerging from the new Medical Examiners Service.

2.1 Objectives and Opportunities for Improvement

The introduction of the new Digital Officer role within the team has already resulted in extensive use of SharePoint in support of the Clinical Outcomes and Effectiveness Group and Consent to Treatment Committee meetings.

A successful bid to Health Technology Wales has secured the Audit Management and Tracking (AMaT) system for a two-year period licence fee free. The web-based system will replace the existing Microsoft 365 and SharePoint approaches in use to; record, review and approve audit project proposals, house audit plans and responses to new and refreshed NICE and other national guidance in addition to required Welsh Government assurance responses to published national audit/registry reports.

The potential for AMaT is wide ranging and colleagues across from Nursing, Risk and Assurance, Medicines Management and Information Governance have been identified to progress use within their own areas.

3. Clinical Audit & Effectiveness Policy

The revised Clinical Audit & Effectiveness Policy outlines the Executive Medical Director's new approach towards the prioritisation of audit and improvement activities.

In addition to the list of mandated national audit/registry topics, the Executive Medical Director has identified a number of Priority Topics for the Health Board; Consent, End of Life Care, No Not Attempt Resuscitation, WHO Surgical Checklist, Antimicrobial Stewardship and Use of Chaperones.

As part of the revised hierarchy approach, Service Delivery Groups and Departments are now asked to participate in planning a small number of projects deemed as necessary in addition to the priorities outlined above.

It is anticipated that the combination of topics identified from these levels will meet both the needs of the Health Board and doctors and health professionals in training. However, it is recognised that emergent, necessary topics are likely to be flagged up in-year (Fig 1.).

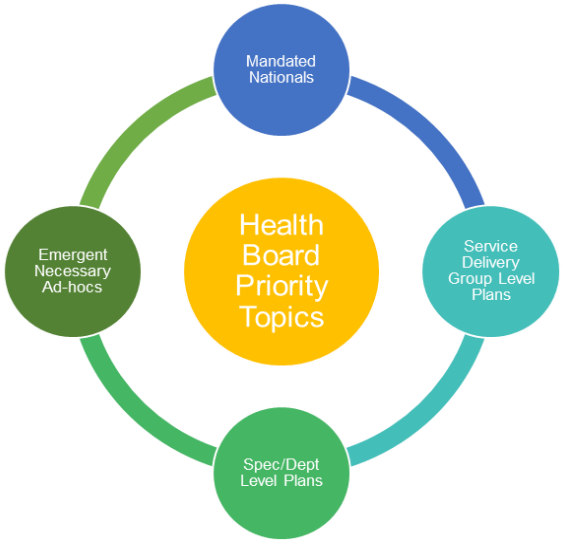


Fig 1. Hierarchy of Audit Priorities

4. Clinical Audit Activity

4.1 Current National Clinical Audit Priorities - NHS Wales National Clinical Audit and Outcome Review Advisory Committee Plan and Assurance Process

On behalf of Welsh Government (WG) the National Clinical Audit and Outcome Review (NCA&OR) list of mandated national clinical audits and outcome reviews is normally issued on an annual basis. This has of course been interrupted by the pandemic and therefore the current programme has not been refreshed for some time (Appendix 2).

All health boards and trusts that provide the relevant services must participate in these projects. The majority are on-going and require continuous data collection. They can be limited to NHS Wales, or run UK-wide. The list, which had for a number of years been adopted as the only Health Board Forward Clinical Audit Plan, includes the Clinical Outcomes Review Programme, formerly known as Confidential Enquiries, which cover Medical and Surgical, Mental Health and Women and Child Health topics.

The WG's Healthcare Policy Division has developed a two-stage assurance form to capture details on improvement plans resulting from national audit reports and the progress made. Turnaround times are challenging and compounded by the need to ensure that responses are quality checked and in some instances, amalgamated into a single Health Board response.

The Clinical Outcomes and Effectiveness Group monitors participation in mandated topics and compliance with the WG assurance process.

4.2 Service Delivery Group Clinical Audit Activity

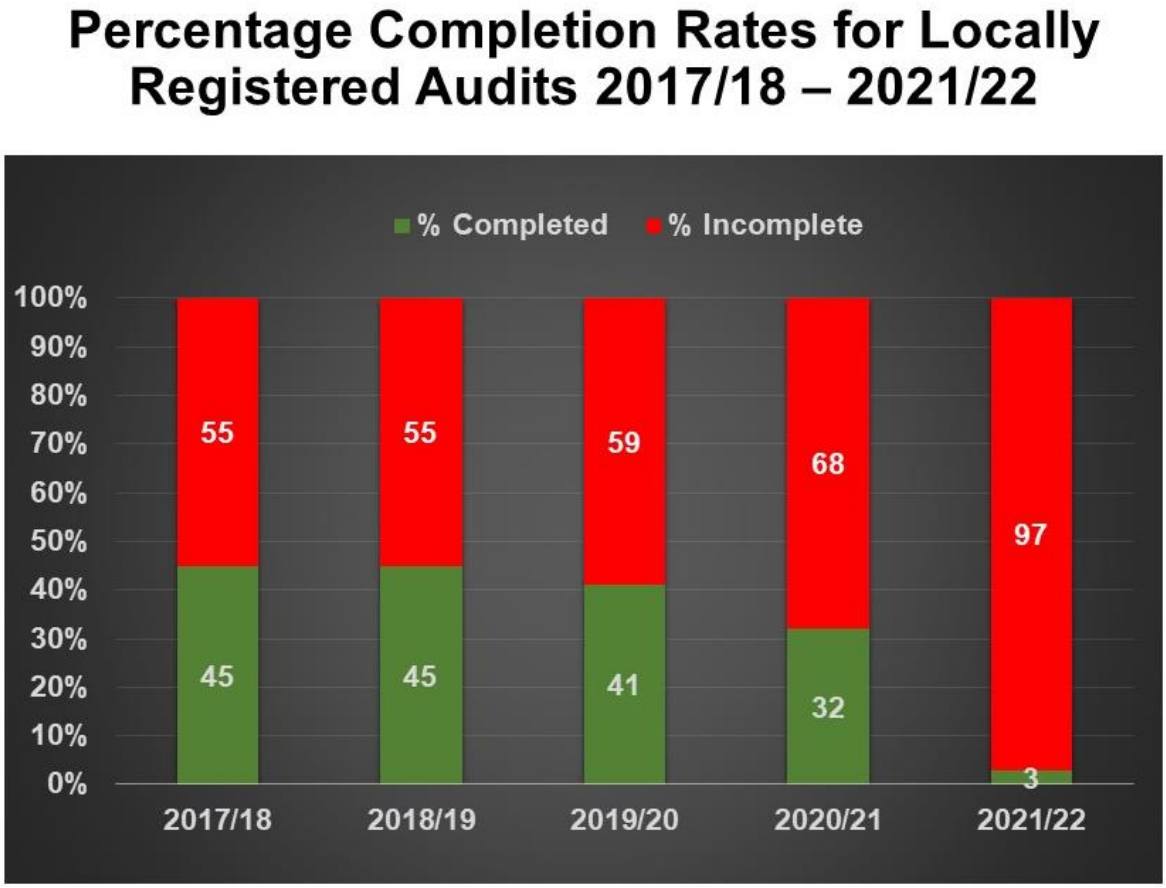
Audit proposals and outcomes for the report period were collected electronically via a SharePoint site.

The total number of locally initiated projects for 2020/21 increased for the first time in five years. Despite the pandemic, the number of proposals rose significantly from 168 in the previous audit year to 240.

At the close of the 2020/21 audit year, 14% of registered projects had been reported as completed. To date, this now stands at 38%.

The total number of locally initiated projects for 2021/22 fell substantially to 57 approved projects. However, it should be noted that this is in part to the revised Policy released in September 2021 which is intended to direct Departments and Services towards undertaking audits in the 2022/23 year that are more focused on quality, risks and assurance needed based on the priorities of the Service Group and Health Board. To date, only 2 topics (3%) are complete for the 2021/22 period.

Historically, submission of summary of outcomes and actions to the Clinical Audit & Effectiveness Department has been poor, with a high of 45% in recent years achieved via the team actively chasing results and action plans (Graph 1.).



Graph 1. Percentage Completion Rates for Locally Registered Audits 207/18 – 2021/22

A reduction in staffing and additional workload has impacted the capacity of the Clinical Audit & Effectiveness team in proactively chasing completion and outcomes of registered projects. Via the Audit Plans, the responsibility for ensuring timely completion of projects and submission of findings will lie with the departments and Service Delivery Groups, monitored via COEG.

Comparative data on the volume of completed topics and brief summaries are listed in Appendix 3.

5. Audit Plans

In line with the revised Clinical Audit & Effectiveness Policy, the team issued requests for Service Delivery Group Level and Departmental Level Audit Plans to key personnel to outline their requirements in addition to the national mandated audits/registry topics and the Health Board Priority Topics (Appendix 4.). Progress and outcomes with these plans will be monitored by the Service Delivery Groups and the Clinical Outcomes & Effectiveness Group.

Plans and any ad-hoc proposals will be managed and monitored through the AMaT system. Ad-hoc proposals will be considered by designated audit leads, who will be asked to indicate if there is a need for the topic at the point in time in place of planned activities.

6. Information, Education and Training

Formal training requests from the team are rare and with the development of Healthcare Quality Improvement Partnership (HQiP) and other e-learning packages, not necessary to support an individual's training needs. However, advice continues to be provided regarding specific queries and projects as required.

7. Exhibitions and Events

The Health Boards own audit and quality improvement exhibition ceased in 2015 due to issues with venues and in particular, poor attendance on the day. However, for the 2021/22 audit year the Chief Registrar for Morriston was successful in securing support and funding for a regional Quality Improvement event, held in June 2021.

The event will be repeated in 2022.

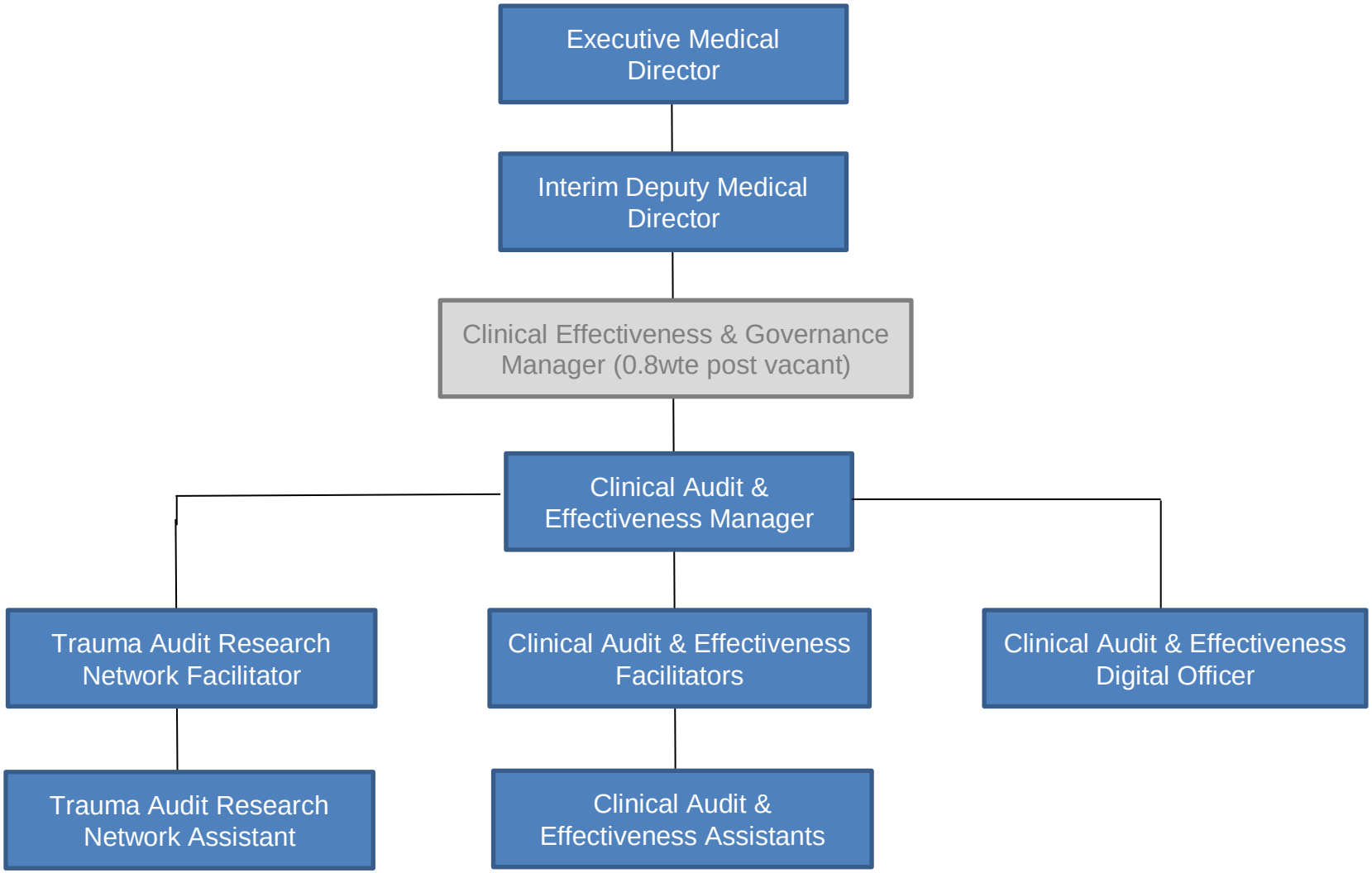
8. Reporting and Monitoring

The Clinical Outcomes and Effectiveness Group (COEG) reported on a monthly basis to the Quality and Safety Governance Group (QSGG) via membership of the Interim Deputy Medical Director. QSGG in turn reported upwards to the Quality Safety Committee.

Current terms of reference for COEG are attached as Appendix 5.

In 2022, a restructure of the Health Board Quality and Safety forums has resulted in the replacement of existing structures with the new Quality, Safety and Patient Services Group and a number of subgroups. One of these subgroups is the Patient Outcomes and Clinical Effectiveness Group, which COEG will report to moving forward.

Appendix 1. The Clinical Audit & Effectiveness Department Organisational Chart



Appendix 2 – Current National Clinical Audit Priorities - NHS Wales National Clinical Audit and Outcome Review Advisory Committee Plan

Acute	Audit website homepage
National Joint Registry	www.njrcentre.org.uk
National Emergency laparotomy Audit	www.nela.org.uk
Case Mix Programme (CMP)	www.icnarc.org
Major Trauma Audit #	https://www.tarn.ac.uk/

Long Term Conditions	Audit website homepage
National Diabetes Audit **Note this covers the following areas** • National Diabetes Foot Care Audit • National Diabetes Inpatient Audit (NaDia) • • National Pregnancy in Diabetes Audit • National Core Diabetes Audit • National Diabetes Transition Audit	General: https://digital.nhs.uk Foot care: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-foot-care-audit NaDia: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-inpatient-audit Pregnancy: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-pregnancy-in-diabetes-audit Core: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit Transition: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-transition-audit
National Diabetes Paediatric Audit (NPDA)	www.rcpch.ac.uk/npda
National Asthma and COPD Audit Programme (NACAP) **Note this covers the following areas** • COPD • Adult Asthma • Children and Young People Asthma • Pulmonary Rehabilitation	https://www.rcplondon.ac.uk/projects/national-copd-audit-programme https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-copd https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult-asthma https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-children-and-young https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-pulmonary-rehabilitation-workstream
Renal Registry (Renal Replacement Therapy)	https://www.renalreg.org/
National Early Inflammatory Arthritis Audit	https://www.rheumatology.org.uk/Practice-Quality/Audits/NEIA-Audit
All Wales Audiology Audit	

Older People	Audit website homepage
Stroke Audit (SSNAP)	www.strokeaudit.org
Falls and Fragility Fractures Audit Programme Including: • Inpatient Falls • National Hip Fracture Database • Fracture Liaison Service Database	https://www.rcplondon.ac.uk/projects/falls-and-fragility-fracture-audit-programme-fffap
National Dementia Audit	www.nationalauditofdementia.org.uk

End of Life	Audit website homepage
National Audit for Care at the End of Life (NACEL)	https://www.nhsbenchmarking.nhs.uk/nacel

Heart	Audit website homepage
National Cardiac Audit Programme (NCAP) • National Heart Failure Audit • Cardiac Rhythm Management • National Adult Cardiac Surgery Audit • National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) • National Congenital Heart Disease Audit • Myocardial Ischaemia National Audit Project (MINAP) • National Vascular Registry Audit (includes Carotid Endarterectomy Audit)	https://www.nicor.org.uk/ https://www.nicor.org.uk/national-cardiac-audit-programme/heart-failure-heart-failure-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/cardiac-rhythm-management-arrhythmia-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/adult-cardiac-surgery-surgery-audit/ https://www.nicor.org.uk/adult-percutaneous-coronary-interventions-angioplasty-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/congenital-heart-disease-in-children-and-adults-congenital-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/myocardial-ischaemia-minap-heart-attack-audit/ www.vsqip.org.uk
Cardiac Rehabilitation Audit	http://www.cardiacrehabilitation.org.uk/

Cancer	Audit website homepage
National Lung Cancer Audit	https://www.rcplondon.ac.uk/projects/national-lung-cancer-audit
National Prostate Cancer Audit	www.npca.org.uk
National Gastrointestinal Cancer Audit Programme	https://www.nogca.org.uk/
National Audit of Breast Cancer in Older People (NABCOP)	https://www.nabcop.org.uk/

Women's and Children's Health	Audit website homepage
Paediatric Intensive Care (PICaNet)	www.picanet.org.uk
National Neonatal Audit Programme Audit	www.rcpch.ac.uk/nnap
National Maternity and Perinatal Audit	http://www.maternityaudit.org.uk/pages/home
Perinatal Mortality Review Tool	https://www.npeu.ox.ac.uk/pmrt

Other	Audit website homepage
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	https://www.rcpch.ac.uk/work-we-do/quality-improvement-patient-safety/epilepsy12-audit
National Clinical Audit of Psychosis	https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis

Clinical Outcomes Review Programme

Clinical Outcomes Review Programme	**Programme website homepage**
Medical and Surgical Programme	http://www.ncepod.org.uk/ - Dysphagia in Parkinson's Disease - Physical Healthcare of Inpatients in Mental Health Hospitals - In Hospital Management of Out of Hospital Cardiac Arrests
Mental Health Programme	http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci
Child Health Clinical Outcome Review Programme	http://www.ncepod.org.uk/ National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Maternal, Newborn and Infant Clinical Outcome Review Programme	https://www.npeu.ox.ac.uk/mbrrace-uk

Appendix 3 – Summary of Service Delivery Group Audit Activities and Outcomes

Primary & Community Care – Projects Summary

Projects by Specialty	Registered		Completed in	
	20/21	21/22	20/21	21/22
Occupational Therapy	-	4	-	0
Orthopaedics	1	-	0	-
Specialist Palliative Care Therapy Team	-	1	-	0
Total registered/complete	**1**	**5**	**0**	**0**

Comparison

↑ in the number of topics approved - from 1 in 2020/21 to 5 in 2021/22

Eventual completion rate 17/18 - 60%

Eventual completion rate 18/19 - 63%

Current completion rate 19/20 – 29%

Current completion rate 20/21 - 0%

Current completion rate 21/22 - 0%

Mental Health & Learning Disabilities – Projects Summary

Projects by Specialty	Registered		Completed in	
	20/21	21/22	20/21	21/22
Cardiff and Bridgend Community Learning Disability Teams	-	1	-	0
Forensic Psychiatry	2	1	3*	0
Intellectual Disability Psychiatry	-	1	-	0
Liaison Psychiatry	1	-	0	-
Mental Health and Learning Disabilities	10	7	10*	1*
Old Age Psychiatry	1	-	1	-
Older People Mental Health Services	1	2	1	0
Occupational Therapy	-	1	-	0
Pharmacy CCH	1	-	1	-
Total registered/completed	**16**	**13**	**16**	**1**
Total completed from previous audit years			**2***	**1***

Comparison

↓ in the number of topics approved - from 16 in 20/21 to 13 in 21/22

Eventual completion rate 17/18 - 50%

Eventual completion rate 18/19 - 33%

Current completion rate 19/20 – 100%

Current completion rate 20/21 – 93%

Current completion rate 21/22 – 0%

Mental Health & Learning Disabilities - Completed Projects 20/21 – 21/22

Specialty	Title	Brief Summary
Forensic Psychiatry	High Dose Antipsychotic Prescribing in a Medium Secure Forensic Unit (Caswell Clinic)	Regular storage place on each ward where ECGs are stored and readily available. Encouraging regular review of Antipsychotic prescribing, particularly at CTP. Stopping PRN Antipsychotic that is no longer being used is an easy way to improve the numbers of PRN Antipsychotic medication prescribed. A specific metabolic syndrome monitoring and prescribing clinic within Caswell where Psychiatrists could refer patients to. This could be Nursing Practitioner or GP led A review of the diets in Caswell and the impact this has on the development of metabolic syndrome
Forensic Psychiatry	Lithium Monitoring: safer prescribing and monitoring	Very small sample. Difficult data collection as some patients not started on lithium at Caswell Clinic. Need to monitor calcium. Form to complete when initiating lithium and to guide monitoring
Mental Health & Learning Disabilities	Risk Assessment at Point of Discharge	Discussed with MDT at monthly business meeting and following action points agreed: Perinatal specific risk assessment developed. Word document so more contemporaneous (team still don't have access to electronic records despite multiple escalations). Ensure standard included in all staff member's induction.

Specialty	Title	Brief Summary
Mental Health & Learning Disabilities - Completed Projects 20/21 – 21/22 (Contd.)		
Mental Health & Learning Disabilities	Quality Audit of Mental Health Measure - Care and Treatment Plans in Mental Health/Learning Disabilities	Areas Indicating Improvement: CTP Present and in date. Needs and strengths. Views of SU included – significant improvement. Care outcomes identified – improved in all areas. Relapse signatures and crisis planning, still room to grow. Discharge planning – some improvement from last audit but still work to do areas with learning identified: risk assessments – unfortunately we performed significantly worse in this audit. Slight drop in CTPS having been completed within the last 12 months.
Mental Health & Learning Disabilities	Physical Health Monitoring of Patients on Antipsychotics	Live physical health monitoring database developed with; demographics recorded: patient name, NHS no., hospital no., antipsychotic prescribed, address, date of last physical health check completed, if due physical health check date blood and ECG forms sent to patient, date results reviewed etc. Service adopted the template in HB guidance for recording results but also adapted to include any actions after each review. Addition to guidance included that was specific to the service as it covers both patients in primary and secondary care.
Mental Health & Learning Disabilities	Vitamin D Prescribing for People With Intellectual Disability on Anti-Epileptic Drugs	Reinforce standards. Circulate information leaflet on 'bone health in adults with ID on AEDs'
Mental Health and Learning Disabilities	POMH-UK: Improving The Quality of Prescribing Valproate in Mental Health Services	Generally good compliance with pre-treatment and on treatment monitoring parameters. (FBC, LFT, BMI). Reasons for initiating valproate treatment should be documented in the clinical records. 10/35 no reason documented. Reason for 'off label' use not documented in notes N=4. Patients should have an annual review including therapeutic benefit, adverse effects and medication adherence. 10/30 no documented review. Females < 55 there should be documented evidence that the conditions of the pregnancy prevention programme, are fulfilled. Completed for 2/9. The current protocol for prescribing & monitoring valproate for patients with bipolar disorder should be followed in all CMHT and inpatient areas. Data set was small N = 35, N = 4 or 2 in some subsets. Need to have greater engagement with data collection.
Mental Health and Learning Disabilities	POMH-UK:Topic 17b Use of LAI Antipsychotics in Relapse Prevention	Data collection Oct '19, N=33, small sample size. Good compliance with care plan, patient involvement, signature signs/ symptoms of relapse, and crisis plan. Improvement in having clinical plan for response to default from treatment, but still only 29%. Medication review 80%, but assessment of side effects 20%, less than 2017. Need to improve review process – documentation. New Community charts may help. Database – record of last review, physical health monitoring?
Mental Health and Learning Disabilities	Discharge Audit DU Wide	Given the broader scope of this audit it has been difficult to draw direct comparisons with the results from 2018. The performance of services across the Service Group has been inconsistent with some areas having improved since 2018 and several appearing to have performed more poorly. Many of the findings in keeping with the recent CTP audit. The audit also indicated some challenges with the current audit tool and proforma.
Mental Health and Learning Disabilities	POMH-UK:Topic 18b: The Use of Clozapine	Need to improve: General physical exam (documentation) – CV system. Documentation and discussion of off license use. Annual review by senior clinician - ?Need to be Consultant. Some patients clozapine treatment not documented in GP record (Previous audit QI carried out). Patients started as inpatients, plan regarding smoking on discharge? System in place, no patients in sample. Data collection – sample size of new and early treatment
Mental Health and Learning Disabilities	Self-harm audit	To implement new mental health triage form for use in the emergency department. Mental Health toolkit introduced to improve the assessment done by ED staff. Better provision for overnight assessments by mental health still needed from Mental Health Services – e.g. 24-hour Liaison Psychiatry Service or Junior doctor cover overnight. Better documentation of communication between ED and Mental Health Professionals out-of-hours
Old Age Psychiatry	Antipsychotic Review in Local Care Homes - Neath Port Talbot	Up to the mark according to audit standards and in following NICE guidance. We follow up all patients on anti-psychotic medication in our care home. It's also important for us while doing the anti-psychotic review, that we are understanding the side effects, risks like metabolic syndrome and to take clinical decision whether to continue or stop medication. It needs clinical medical leadership to review all the patients on medication 6 weeks to 3 months' time in order to maintain the good medical practice.

Specialty	Title	Brief Summary
Mental Health & Learning Disabilities - Completed Projects 20/21 – 21/22 (Contd.)		
Older People Mental Health Services	Monitoring for Chronic Kidney Disease In Dementia Inpatient Wards in Swansea	Despite the ongoing high percentage of dementia inpatients with low eGFR, there were no patients with eGFR below 30 in the 2nd cycle in comparison to the 1st cycle, suggesting better monitoring, more stability of the stage of CKD and slower progression. No referrals to nephrology department were required in the 2nd cycle, suggesting better monitoring for CKD on dementia inpatient wards, with better stability of the stage of CKD. There has been evidence of reduction in medication burden for most groups of medications in dementia inpatient wards, with a more favourable outcome on kidney health. In terms of psychotropic prescribing, the 2nd cycle showed prescribing Memantine more than antipsychotics, in comparison to the 1st cycle, which reduces risk of CV complications with a favourable effect on cognition as well as renal functions. However, it is to be noted that Memantine dose requires adjustment according to degree of renal impairment.
Pharmacy CCH	Physical Health Monitoring of Patients Prescribed Antipsychotics Within Abertawe Medical Partnership	Many patients were not monitored during the audit period, which increases their risk of harm from side effects. The CMHT need to clarify whether patients are open to CMHT or fully discharged. Most antipsychotics prescribed for licensed or recognised off-label indications, but a significant amount were prescribed for personality disorders, which is less evidence based

**** Audit results from older time periods not summarised***

Neath & Singleton - Projects Summary

Projects by Specialty	Registered		Completed in	
	20/21	21/22	20/21	21/22
Anaesthetics	1	1	0	0
Audiology	2	-	1	-
Breast Care	1	-	0	-
Colposcopy	1	-	0	-
Community Paediatrics	4	5	1	0
Dermatology	1	-	0	-
Gynae Oncology	5	3	2	0
Haematology	-	1	-	1
Hepatology	-	1	-	0
Maternity	6	-	2	-
Medicine	12	3	3	0
Neonatal Intensive Care Unit	1	1	1	0
Obs and Gynae	18	1	8	0
Oncology	3	1	0	0
Ophtalmology	5	-	3	-
Ortho geriatrics	1	-	0	-
Paediatrics	2	2	1	0
Palliative Care	9	2	7	0
Pharmacy	3	2	0	0
Respiratory	-	1	-	0
Rheumatology	1	-	1	-
Sexual Health	2	-	0	-
Wales Fertility Institute	8	-	6	-
Total registered/completed	**86**	**24**	**36**	**1**

Comparison

↓ in the number of topics approved - from 86 in 2020/21 to 24 in 2021/22

Eventual completion rate 17/18 - 52%

Eventual completion rate 18/19 - 43%

Current completion rate 19/20 - 28%

Current completion rate 20/21 - 42%

Current completion rate 21/22 - 4%

Neath Port Talbot & Singleton - Completed Projects 20/21 – 21/22		
Specialty	**Title**	**Brief Summary**
Audiology	Cost-effectiveness Analysis of Hearing Aids Capable of Remote Technology Compared to Conventional Devices	The Swansea Bay University Health Board Audiology Department, like many NHS services, has had to adapt the way in which it provides hearing health services in response to COVID-19. Overall, these changes appear to have had a negative impact to patients. At this time it seems very unlikely that audiology services will revert to pre-COVID-19 practices. It is therefore necessary to address the reasons why patients are experiencing greater levels of dissatisfaction following hearing aid provision.
Community Paediatrics	Audit of Antenatal Referrals to the All Wales Managed Clinical Network for Paediatric Palliative Care	Pockets of good practice but overall poor co-ordination. Few referrals for PPC (18 over 5 years). Good planning and co-ordination when PPC involved allowed for preferred place of death in all cases where both wishes were known and baby survived delivery. General adherence to TFSL care pathway and NICE guidance.
Gynae Oncology	Pre-operative Screening Process for COVID-19 in Gynae Oncology	There was 100% compliance in COVID screening. A very good number of our patients had MDT priority 96.7%. 94% had anaesthetist PAC as well as 96.2% had a pre-operative consultation. Gynaecological oncological unit in Swansea was well ahead in escalation following the declaration of pandemic by the World Health Organisation. Prioritisation of patients for surgery instituted early. Swansea Gynaecological Oncology Centre checklist almost 1 month ahead of national guideline. Improvement needed in documenting advance consent (68%). Improvement needed in completion of the SGOC checklist for every patient, especially the Anaesthetic Pre-assessment section (11%).
Gynae Oncology	Are we Delivering Gynaecological Cancer Surgical Care Effectively during COVID-19 Pandemic?	Marked differences in demographic data (BMI, ASA and Comorbidities greater in Swansea). Swansea had more Uterine cancers (40.3% vs 27.8%). Surgical approach & complexity similar (>80% group 1 and 2). Similar length of stay compared to UK gynaecological oncology surgical outcomes and complications. Lower rates compared to UK gynaecological oncology surgical outcomes and complications. Intraoperative complication rates (3.9% vs 4.7%, p=0.65). Unscheduled critical care admission rates (0.7% vs 2.2%, p=0.9). Return to theatre (1.5% vs 2.3%, p=0.57). Reported post-operative complication rates for Clavien-Dindo II–V (24.8% vs 30.9%, p=0.14). Readmissions (1.5% vs 3.6%, p=0.29). With current COVID-19 protocol – None of the elective patients had COVID-19 within 30 days of surgery.
Haematology	Emollient use on reducing the prevalence of Occupational Irritant Hand Dermatitis (OIHD)	Occupational Irritant Hand Dermatitis (OIHD) is a common problem amongst Healthcare Workers. It accounts for 70-90% of all occupational skin disease. Pre intervention, 100% of all members surveyed found it would be beneficial to have a moisturiser on the ward to help reduce symptoms of OIHD. Post intervention, 1/3 of staff noticed an improvement in their symptoms. However only 38% of staff used the moisturiser post intervention hence we may need to increase awareness that they are present on the wards.
Maternity	Continuity of Midwifery Care and Carer	50% of women see more than 2 community midwives during their pregnancy. 68% of consultant led care see more than 2 Drs (up to 7 different Drs). This is for routine planned care.
Maternity	Bladder Care during Intrapartum and Postnatal Care	Poor compliance with recommendations. 26% had documentation of 2 hourly voids in labour. 29% of epidurals had indwelling catheter. 63% had no fluid balance chart 50% went more than 4 hours without a void or intermittent catheter. Following surgery only 50% had TWOC at 6 hours.
Medicine	Review of Usage and Effectiveness of Friday Ward Round Handover Sheets	Though considered highly important, there was less than 40% documentation frequency of DNAR status and escalation plans for patients on Friday Ward Rounds. Issues list also considered highly important were documented over 80% of the time. Observations, which though considered by guidelines is important to document, though thought less important on a survey of doctors, was documented 2/3rds of the time. VTE was prescribed and drug charts had been checked (i.e. did not need to be rewritten over the weekend) in over 90% of cases recorded
Medicine	Recognition of Preventable Risk Factors in Patients with Acute Coronary Syndrome	Inpatient screening for both dyslipidaemia and diabetes is suboptimal, and we are likely underdiagnosing these conditions in acute coronary syndrome patients

Neath Port Talbot & Singleton - Completed Projects 20/21 – 21/22

Specialty	Title	Brief Summary
Medicine	Clinical Audit and Quality Improvement Project on the Assessment and Management of Osteoporosis in Swansea Bay University Health Board	Sleep is an issue that is overlooked in FM patients and potential diagnosis of OSA can be missed. 66.2% of patients seen in clinic with FM could benefit from formal sleep studies. Screening and treating these patients for OSA can potentially offer a major improvement in the quality of life of these patients
Neonatal Intensive Care Unit	The Approach to Delayed Cord Clamping at Singleton Hospital	Overall, there is very good numbers of delayed cord clamping (DCC) in the notes (81.9%), however those where it isn't recorded, it is difficult to ascertain if DCC happened or if it was just not recorded. I will also need to investigate more whether the reasons for not DCC are written in maternal notes. Overall delayed cord clamping is being carried out at Singleton Hospital however there seem to be lower rate in premature babies
Obs and Gynae	Determine the Effectiveness of Infection Prevention Strategies Implemented in Vulval Clinic During COVID-19 Lockdown Period	No evidence of Covid infection related to clinic attendance. Caveat: small numbers. Spacing appointments reduced waiting times. High satisfaction rate (8-10/10 for all patients)
Obs and Gynae	Emergency Gynae Surgery Outcomes 18/03/2020 - 31/08/2020	Singleton mortality data compares well to that of available literature. Lockdown operations had a more prominent impact on patient's mental recovery than pre-lockdown operations. Sporadic use of preoperative COVID-19 swabs. Low rate of hospital COVID-19 transmission given testing criteria available
Obs and Gynae	Comparison of Body Mass Index in Pregnancy ANC to General ANC	Weight loss or stability of weight in pregnancy reduces the chance of lower segment caesarean section, pyrexia in labour / sepsis and SCBU admission. Post-natal Venous thromboembolism assessment is often poor and inaccurate
Obs and Gynae	A Study of Patient Outcomes with Retained Products of Conception Following Surgical Management of Miscarriage	68 patients underwent evacuation of retained products of conception (ERPC), 12 patients had retained products of conception of which 9 patients required a repeat surgical procedure. A trainee survey when asked their key concerns with ERPC (and the high retained products of conception (RPOC rate) described concerns with uterine perforation using the rigid cannulae.
Obs and Gynae	Cardiotocography (CTG) Audit	Women are receiving the appropriate method of fetal monitoring on labour ward. All cardiotocography concerns were escalated for review. 90% of cardiotocography's classified hourly, of these only 77% had "Fresh Eyes" performed. 66% compliance of stickers at obstetric review. Poor compliance with completing the sticker in full
Obs and Gynae	Audit on Outcome of Prolapse	Improve documentation. Everyone who deals with prolapse needs to undertake assessment and document in POP-Q form. Document blood loss in operating note
Obs and Gynae	Review of Outcomes for Small for Gestational Age Babies	In SBHB the SGA rate is 15.1%. All those with risk factors had serial scans, and all but one who did not have risk factors had a scan for another reason e.g. DFM. Those Induced under 37 weeks were admitted to NICU.
Obs and Gynae	Re-audit of Postnatal Contraception	Unplanned pregnancies have poorer outcomes. Offer of contraception provision increased from 0% in 2018 to 39% in 2019, and 50% in 2021. 72% of women had a discussion antenatally about postnatal contraception
Ophthalmology	An Audit of the Assessment of Optic Disc Swelling Referrals to the Ophthalmology Department, Singleton Hospital	Optometrists are our main referrers of optic disc swelling. We have not shown a clear consensus in how we investigate optic disc swelling. Based on the consensus guidelines for IIH and the European Headache Federation, we achieved a target of at least 95% at documenting VA and dilated fundus exams, we missed the target with the VFT. We are not using all the tools in our arsenal to rule out pseudo papilloedema
Ophthalmology	Evaluation of New Case Referral to Eye Casualty Clinic: Prior, During and Post COVID-19 Lockdown	All trauma and foreign body cases were affected by the general isolation policies. High IOP, papilloedema, anisocoria and retinal vein occlusion were reduced due to lack of opportunistic detection by optometrists. Retinal tears - difficulty accessing optician with what are usually relatively innocuous symptoms. Post phaco-reflection of very few cataract operations done

Neath Port Talbot & Singleton - Completed Projects 20/21 – 21/22

Specialty	Title	Brief Summary
Ophtalmology	A Retrospective Comparison of Corneal Perforation Rates at Singleton Hospital between September-December 2019 and 2020 (A service evaluation)	Number of corneal perforations has significantly increased during COVID pandemic. This is mainly attributed to missed or cancelled follow up visits in the majority of these cases
Paediatrics	Pancreatectomy Royal College of Pathologists Standards Audit	SBUHB Histopathologist met the current standard of an average of 15 lymph nodes for carcinomas of pancreas, ampulla of Vater and common bile duct in 2019. The average number of lymph nodes sampled was 19. The average turnaround time was 19.5 days (to the nearest half day). This does not meet the RCPath's guideline of 10 day turnaround time for malignancy (unless megablocks used)
Palliative Care	Review of Time Taken from Referral to Specialist Palliative Care to Referral Being Discussed by the Team (Community)	Where date of referral was available, all were received and discussed within 1 week of referral being made. All urgent referrals were discussed within 1 day. Where discussion by team is not within 1-2 days of the date of referral the data does not allow us to determine if the delay is because the referral takes a few days to get to the service or if there is an inbuilt delay within specialist palliative processes
Palliative Care	Assessment of Discharge Summary Information Dissemination to GP Practices	Specialist Palliative Care communication with primary care being stored on the wrong tab on WCP
Palliative Care	End of Life, Care and Symptom Control for Patients in Swansea Bay University Health Board Hospitals, and the role of the Care Decisions Tool (Non COVID-19 Related Deaths)	Improvement required in recording of Advance Care and Future Planning discussions via Welsh Clinical Portal. Improvement in recording of preferred place of care and death. Number of DNACPR forms completed during admission increased over 2 years; however evidence to suggest improvement is needed around timely completion and earlier discussions. Improvement in using Care Decision Guidance to support care in the last days of life. Improvement in documenting effectiveness of anticipatory medications. Evidence to improve holistic needs assessment in the last days of life
Palliative Care	Symptom Control and End of Life Care for Patients with COVID-19	Only 11% patients who died with COVID-19 had an end of life care plan completed. If referred to specialist palliative care to support care in the last days of life, that increased to 44%
Palliative Care	Audit of Palliative and End of Life Care in Patients Receiving Continuous Positive Airway Pressure for COVID-19	Use of CSCI medications for symptom control nearly doubled compared with first wave of COVID. Significant improvements in documented discussions with the patient and their family. Anecdotal reduction in staff distress and more confidence in decision-making. Room for improvement in use of the Care Decisions Guidance documentation; supporting bereaved families; and spiritual care for the patients. Input from Specialist palliative care is clearly effective at improving end of life care
Palliative Care	Is Primary Thromboprophylaxis of Palliative Care Cancer In-patients Compliant with National Institute for Health and Care Excellence Clinical Guideline NG89?	To consider VTE prophylaxis for inpatients receiving palliative care. 1st line should be LMWH. Do not offer VTE prophylaxis to those in the last days of life
Palliative Care	Are we Assessing the Effectiveness of PRN Medications?	Improvement in documentation of effectiveness from 25% to 39% to 55% after 2 cycles of the QiP. Ongoing challenges include: - Variety of scoring systems in place on IPU can cause confusion. Nurses replicate work on multiple different paperwork
Rheumatology	Screening for Obstructive Sleep Apnoea in Patients with Fibromyalgia	Sleep is an issue that is overlooked in FM patients and potential diagnosis of OSA can be missed. 66.2% of patients seen in clinic with FM could benefit from formal sleep studies. Screening and treating these patients for OSA can potentially offer a major improvement in the QoL of these patients. Further evidence is required into: How well does the questionnaires predict OSA? Does it actually improve symptoms or any other significant outcomes (BP, BMs…)?

Neath Port Talbot & Singleton - Completed Projects 20/21 – 21/22		
Specialty	**Title**	**Brief Summary**
Wales Fertility Institute	An Audit of the Uptake of Fertility Preservation Service for Transgender People in Wales	Data consistent with evidence that transgender uptake of fertility preservation is low especially amongst transgender men. Numbers expected to increase after COVID-19 pandemic due to recent opening of Welsh Gender Service and re-opening of WFI.
Wales Fertility Institute	An Evaluation of the Effect of Embryo Quality Frozen After Assisted Reproduction Treatments on Pregnancy Outcomes	Changes to GnRH regime treatment options and number of oocytes removed should be considered in the Welsh Fertility Institute to improve pregnancy outcomes
Wales Fertility Institute	Evaluation of Two Different Needles for Eggs Retrieval	No benefit in using the Double Lumen Needles and follicular flushing over the Single Lumen Needles. Outcomes are not improved, it costs £29.73 more per oocyte-pick up (OPU) and is associated with increased pain and procedure time
Wales Fertility Institute	Audit on Eggs Donation and Surrogacy	Most complied with HFEA guidelines followed by those set by the current SOP. With some particular areas of reduced compliance. This included counselling completion. Evidence, screening timeframes, some consent forms, male examination and marital status. Evidence urgent attention is needed for some cases of non-compliance. Further education of staff may be helpful with more complex arrangements. The care pathway could be individualised and include additional sections to improve compliance.
Wales Fertility Institute	Evaluation of Surgical Sperm Retrieval (SSR) in Cases of Azoospermia	Our most promising cut-off for identifying men unlikely to produce sperm capable of producing a healthy delivery following all treatment is 14.0IU/mL (sensitivity 40.8%, specificity 90.5%).
Wales Fertility Institute	Impact of COVID-19 on Early Pregnancy After Natural or ART Conception	IVF/ICSI success and early pregnancy do not appear to be affected by the COVID19 pandemic. Small sample size, change in patient age, and exclusion of COVID19 positive patients from the study may explain the non-significant results.

Morriston – Projects Summary

Projects by Specialty	Registered		Completed in	
	20/21	21/22	20/21	21/22
Anaesthetics	1	1	0	0
Burns & Plastics	14	-	6	-
Cardiology	6	1	4	0
Cardiothoracic Surgery	10	2	5*	0
Care of the Elderly	1	1	0	0
Colorectal	5	-	0	-
Critical Care Outreach Team	1	-	0	-
Diabetes and Endocrine	2	-	1	-
ECHO	13	2	5*	0
ENT	12	-	5	-
General Medicine	2	1	1	0
General Surgery	11	2	2*	1
Hepatobiliary & Pancreatic Surgery	3	-	0	-
Intensive Care Medicine	1	1	0	0
Laboratory Medicine	1	-	1	-
Microbiology/Infectious Diseases	1	-	0	-
Nephrology	1	-	0	-
Neurology	2	1	0	0
Oral and Maxillofacial Surgery (OMFS)	7	1	4	0
OMFS/Orthodontics	2	-	1	-
Otolaryngology	1	-	0	-
Paediatrics	4	-	1	-
Renal	1	1	0	0
Respiratory Medicine	1	-	0	-
Specialist Palliative Care	1	-	0	-
Trauma & Orthopaedics	10	3	5	1*
Urology	9	-	3	-
Vascular Surgery	3	-	1	-
Totals	**126**	**17**	**45**	**2**
Total completed from previous audit years			**3***	**1***

Comparison

↓ in the number of topics approved - from 126 in 2020/21 to 17 in 2021/22

Eventual completion rate 17/18 - 40%

Eventual completion rate 18/19 - 49%

Current completion rate 19/20 – 39%

Current completion rate 20/21 – 33%

Current completion rate 21/22 – 6%

Specialty	Title	Brief Summary
Burns and Plastics	BCC & SCC Excision Margins Audit	Improvement in adherence to guidelines seen. Ongoing significant rates of excision of benign lesions
Burns and Plastics	Pre-Operative Antibiotics for Ulcerated Skin Cancer Lesions	33.3% of SHOs did not know which antibiotic to prescribe beforehand and 100% compliance with guidelines when looking at drug charts (N = 11). Re-audit: 100% of SHOs are aware of the latest guidelines and 100% compliance with guidelines when looking at drug charts (N = 12)
Burns and Plastics	Paediatric Burns Safeguarding Audit	BURN Tool completion rate: 69%. Re-audited results: BURN Tool completion rate: 100%
Burns and Plastics	BCC and SCC Excision Margins Audit	Total of 66 lesions examined. Guidelines met 52% of the time
Burns and Plastics	Adherence to DIEP Guidelines	Excellent results post implementations (teaching during induction, discussion with breast reconstruction nurse and audit meeting presentation).
Burns and Plastics	Evaluation of human bites proforma for protection against blood borne viruses	Human bites poses risk to contracting blood borne viruses (especially when saliva and blood are involved). Patients with human bites should be dealt with according to public health guidelines and given appropriate vaccination and PEP in a timely manner to reduce risk of infection and complications. Should continue good practice and adhering to human bites guidelines and follow the objectives set out in first loop
Cardiology	Improving Management of Hyperlipidemia in Patients with Coronary Artery Disease	Lipid levels not being checked for all patients on admission with coronary artery disease. Lipid levels not being checked after starting Antilipid drugs. Failure to note sufficient patients who might be eligible for Evolocumab due to low testing
Cardiology	Retrospective Clinical Audit evaluating the changes to referral systems to the Cardiology Deparment During COVID-19	Based on the data from this retrospective clinical audit we have identified that the changes implemented improved the service provided by: Reducing the duration of inpatient stay. Reducing the interval between presentation to A&E and inpatient angiogram. Reducing the interval between presentation to A&E and a formal cardiology review. Implementation of recommendations can improve our service
Cardiology	A Closed Loop Audit of Pacing Pre Versus During The COVID-19 Lockdown	Total length of stay was reduced for inpatient and elective patients combined (in particular device to discharge time was halved) For inpatients specifically, admission to device time stayed roughly the same but device to discharge time halve (3.1 days pre COVID-19 down to 1.5 during the lockdown period)
Cardiology	Assessment and improving junior doctors knowledge on dermatological manifestation of systemic conditions for acute medical take	Majority of Junior doctors believe that the two weeks dermatology placement in medical school is inadequate preparation for their current post. To ensure this does not continue our QIP has started bridging this learning gap. Post intervention, there is an improvement of junior doctors' confidence in diagnosing, managing dermatological manifestations of systemic condition. Additionally, they are more confident in identifying conditions requiring emergency referral to a dermatologist/appropriate specialty. Short term - Guide to self-directed learning using dermatological flash card and quiz let for Dermatology lunch break. A bimonthly dermatology teaching program organized for junior ranging from F1 to SHO in medicine over a three-month period. Long term - Distribution of Dermatology handbook for medical students & junior doctors, as part of their induction packs. Integration of dermatology teaching into the established internal medicine teaching programmes for trainees and non-trainee. Integration of dermatology teaching into the established foundation doctor teaching programmes to be done by local dermatology trainees, non-trainee and IMTs with interest in dermatology
Cardiothoracic Surgery	Ability to Maintain Out-Patient Services in Covid Era	Drastic decrease noticed in face to face to clinics. Virtual appointments seen to be rising throughout the lockdown phase. In person clinic attendance seen to have an upward trend as we move ahead in the time line
Cardiothoracic Surgery	Effect of COVID-19 on the ability to maintain General Cardiac Surgery Service	The total number of lists made available have gone down from 10 per week to 5 per week showing 50% decrease in availability of operating lists. Total elective bed capacity has dropped from 25 to from 02/03/2020 to 24/08/2020, 68 of total cardiac surgery lists were made available. All 68 of which were used, achieving 100% utilization. From 30/03/2020 to 18/05/2020 no operating lists were available. During the total time frame 4 emergency surgeries were performed.
Cardiothoracic Surgery	Cardiothoracic SHO handover during COVID era	Handover is a vital part of clinical practice. Good handover improves clinical care and also improves patient and staff safety. Handover in written forms is very helpful to streamline the jobs

Morriston – Completed Projects 20/21 – 21/22 (contd.)

Specialty	Title	Brief Summary
Cardiothoracic Surgery	Quality Of Data Input In Discharge Advice Letters	The discharged advice letters can be further improved. The improvement can be brought forth by working on the parameters seen lacking in overall summaries. To improve upon the DAL's, a schematic will be posted in the Junior doctor's office detailing and highlighting the information that should be mentioned. Furthermore, the time from discharge of patient to completion of DAL will be aimed to be under 24 hours. Re-audit has been started picking up where the first cycle left off and will presented in the next meeting
Diabetes and Endocrine	Insulin Chart Audit	Weight of patient should be mentioned for accurate dose e.g. in COVID-19 patients (13%). Insulin Strength should be accurate and legible (84%). Special Instructions must be mentioned if there is any (10%). Device type (58%), needle size should be mentioned (6%). Prescriber and responsible team should be accessible and should mention bleep no. (38%). Should mention "On Insulin" on main drug chart (64%). Action taken on Hypoglycaemia should be documented. (60%) Insulin dose should be adjusted after hypoglycaemia. Teaching of colleagues and Nursing staff. Discussion with consultants. Make sure on Clerking and PTWR that insulin has been prescribed and dose checked with Pt, endocrinology letters or GP records. Trust Wide email to all the Doctors.
Emergency Care Hospital Operations (ECHO)	Introducing a CT head request proforma in ED between 09.00 – 17.00	Despite a theoretically more efficient system for requesting CT heads in-hours, the time taken for patients to be imaged did not significantly improve. From this review and the measurements we have included, we cannot conclude that the introduction of a CT head request proforma in-hours has demonstrably improved the efficiency for patients undergoing CT heads. However this is likely because through this review we have failed to capture the right data
ECHO	Clinical Documentation	Referrals are not well documented. Handwriting is generally legible. Time to be seen by A&E doctors can be long. Decisions to refer can be delayed. On average we are not referring within 4 hours. Medicine will review patients swiftly after referral. Teaching and reminders regarding documentation. Encourage team to maintain legibility. Help and support Juniors to make swift referrals after critical investigations and management has been started
ECHO	Facial Laceration in patients 18yrs and over	Inform and educate new cohort of Foundation Year 2 Doctors at or near induction. To re-audit in 4 - 6 months-time to assess whether a sustainable change has been made to the management of facial lacerations in adults as a result.
ECHO	Observations in the Children's Emergency Unit	HR, RR, SPO2 and temperature remained consistently well recorded pre, during and post introduction of POPS. Greater no.of children had repeat observations (obs) within an hour following introduction of POPS GCS, BP and CRT recording all significantly improved with the introduction of POPS but do not show sustained improvement with the introduction of the poster as an aide memoire. % of children with obs recorded on an age specific chart almost doubled from 48-80% following introduction of POPS. Following poster introduction, remained higher than pre intervention at 60%. No. of children getting initial obs within 15 mins decreased with both interventions but possibly other factors involved. Recommendation - staff training as to importance of full triage obs, recording on age specific obs chart and increased confidence in performing all obs on children of all ages. Should be re-audited.
ENT	Improving Completion of DALS in the ENT Department	In Dec 2020 completion of discharge advice letters (DALS) was 48% (Dec 2020). As a result of this QI project DALS completion rate increased to 88% (Jan 2021) and 98% (Feb 2021).
ENT	Prospective Review of ABMU Nasoendoscopy Usage within the ENT Department	Not provided
ENT	Retrospective Review of 'Attend Anywhere' Virtual Clinic Outcomes in ENT	Usefulness of implementing virtual ENT clinic - with high turnover of patients and discharge rate. Ability to review patients in a timely manner who's care may otherwise have been disturbed by COVID pandemic.
ENT	VTE Prophylaxis In ENT	Areas for development: Risk assessment. Documentation. Re-assessment after 24 hours
Morriston – Completed Projects 20/21 – 21/22 (Contd.)		
Specialty	**Title**	**Brief Summary**

ENT	QI Project on the ENT Handover List	The in-patient list can easily become disorganised without a good framework, particularly with constantly changing team members. This QI project demonstrated that a simple PDSA approach can improve patient handover in a timely manner and this framework could have wider benefits to all clinical teams.
General Medicine	VTE Prophylaxis in COVID-19 Cases	COVID patients are at an increased risk of Thromboembolic events. New HB Guidelines came out in April 2020 to emphasize this. Adherence to these guidelines has been very poor as very few people are aware. When sometimes guidelines are followed, not all the steps are completed. Main issues identified : weight documentation , prompt VTE prophylaxis administration - Dose review after swab results
General Surgery	An Audit of Outcome Pathway in Acute Admissions with Biliary Pathology	There has been improvement between the two cycles however we are still not meeting the current guidelines. With the lack of lists due to COVID and the ever increasing patient load who require intervention for biliary pathology it is likely that we will require further action to keep up with this demand. Although there was significant improvement in factors such as days waited for surgery and patients were being operated on much more acutely/ on index admission, the overall statistics show we still need to improve to ensure that we meet the current guidelines.
General Surgery	COVID-19 VTE thrombophylaxis in General Surgical patients - are we getting it right?	Areas for improvement: Below standard for changing VTE prescriptions as per guideline. Not checking baseline bloods. Not checking coagulation profiles three times a week. Delays from altering prescription to being delivered. Areas of good practice: Documenting patient weight. Indication for altered VTE prescription on drug chart. Prescribing correct brand or generic name of VTE prophylaxis. Awareness session delivered for junior doctors at general surgery Wednesday teaching of health board guideline, and to liaise with nursing staff about any changes to reduce delays to delivering prescription. If third wave of COVID patients in surgery, re-audit (although using new health board guideline which was updated in April 2021).
Laboratory Medicine	Evaluating the Clinical Performance of our laboratory immunoassay for female testosterone against the Gold Standard Method-Tandem Mass Spectrometry	This audit confirms that sending female samples with testosterone results above the reference range by immunoassay for confirmatory analysis by LC-MS is clinically justified to prevent misdiagnosis of hyperandrogenism
Oral & Maxillofacial Facial Surgery (OMFS)	OMFS Department Morriston Involvement In Globalsurg-Covidsurg Week: Determining The Optimal Timing For Surgery Following SARS-Cov-2 Infection.	All elective patients (bar one) were swabbed pre-admission. The one patient that was not swabbed was identified prior to admission onto Pembroke ward and kept away from those patients that had been swabbed pre-admission. Elective patients had all isolated following being swabbed, however some had not met the 14 days criteria. Emergency patient - not all patients are being swabbed on admission with 12% not being swabbed during October that were admitted to MaxFax for Surgery, this is an area that needs to be improved upon.
OMFS	Complications Rates of Fibula Free Flap Patients	Wound complications at fibula donor sites are high 42% (the literature also reports high donor site complication rate). Overall success rate of flaps 84% over 5 years. RTT salvage rate of flaps 61.5%
OMFS	Oral Squamous Cell Carcinoma Audit	Results showed overall improvement in clear and close margins compared with 2018, with standard for involved margins being met. Improvement in rates of involvement of margins in larger tumours compared with 2018. Involved margins were always deep/inferior margin, which is widely documented to be the most commonly involved margin. Increase in use of adjuvant therapy compared with 2018 noted
OMFS	Comparison of waiting lists for surgical exposure or removal of impacted maxillary canines pre and post Covid	Waiting times have increased by 153% during pandemic. Theatre lists for these patients were recommenced in December 2020 as a result of this project Patients with root resorption are now being prioritised as cat 2 on the RCS reprioritisation scale (as a result of the pandemic). Spontaneous eruption has occurred and some patients now no longer need surgery + no patients have been significantly impacted as a result of delays so far. Plan to continue data collection and re-audit waiting list in 3 years' time to monitor return to pre-pandemic waiting times

Morriston – Completed Projects 20/21 – 21/22 (Contd.)

Specialty	Title	Brief Summary

OMFS/Orthodontics	Audit of Orthognathic Surgery: length of treatment, record taking and surgical outcomes compared to 3D planning	Ball hooks not fit for purpose in theatre, Ball hook manufacturer has been contacted, new batch of ball hooks sent. Second manufacturer have sent another type of ball hooks to try. Record keeping data sheets have been introduced on clinic + BOS/BAOMS minimum data set print outs available in each surgery. Re-audit of ball hooks + record keeping planned with successor. Ball hooks not fit for purpose in theatre. Unable to complete original aim of comparing surgical outcomes to 3D planning as records incomplete. Length of treatment assessed but after presentation decided to review this post-pandemic due to pandemic-related delays
Paediatrics	Analyse the compliance of HB Policy Related to COVID Swab	30% of total patients were not tested ,means non-compliance of HB policy
Trauma & Orthopaedics	Quality Improvement Project – Discharge Advice Letter Completion Rate in Orthopaedics	Completing discharge advice letters (DAL) are important in improving communication between primary and secondary care. We managed to increase the DAL % compliance in orthopaedics from 21% to an all-time high of 94% after just 2 months. Raising awareness of DAL's amongst staff helps to increase the % DAL compliance rate. DAL are safe and effective forms of communication and need to be filled in thoroughly to aid in patient care after they are discharged in hospital
Trauma & Orthopaedics	Evaluation of Wound Problems and Surgical Site Infection in Hip Fracture Surgeries	SSI rate in Hip Fracture Surgery at Morriston at present is higher than national and published standards. There is a significant difference between SSI rate in 2019 (9.43%) vs. 2020 (2.51%) ($p<0.05$, Fisher Exact). Possible reasons for difference - Subcuticular skin closure, Consultant Performing/Directly supervising surgery, and Minimal Theatre traffic.
Trauma & Orthopaedics	Review of Fracture Neck of Femur Patients Managed with Total Hip Replacement	Recommendations: Accurate documentation of procedure performed – Modification of TOMS for better template including classification of fracture NOF and type of THR surgery - cemented, un-cemented and hybrid. NHFD accurate documentation - documentation of reason why hemi was performed if patient eligible for THR. Reason why unfit for THR. NICE eligible for THR or not – tick box in clerking form, at post take round to improve our eligible percentages, reducing eligible denominator by increasing compliance
Trauma & Orthopaedics	An Audit of the Management of Hot Swollen Joint in Adults	Standardization of our care among patients is one of the most valuable points to consider in our practice. One of the important concepts that the joint arthrocentesis check-list emphasis on is to ensure all our patients requiring joint aspiration get standard care as per our guideline. Therefore, increasing the level of our care with regards to patient safety ensuring all our patients having an opportunity in obtaining equivalent level of care.
Trauma & Orthopaedics	Fracture healing of posterior malleolus of ankle joint	CT is advisable in all posterior malleolar fractures to decide the treatment options and approach. Clear documentation of the outcome in the fracture clinic follow-up will be helpful to categorise. Early rehabilitation with physio. We recommend to do PROM study for further outcome measure.
Urology	Evaluation of Renal Colic Pathway for Adherence to NICE Guidelines and Local Pathway Guidance	Clear deficiencies of essential referral data identified in current renal colic pathway. Needs revision of protocol + optimisation of pathway.
Urology	Review of Haematuria Clinic Outcomes to Assess Effectiveness of Referrals for GA Biopsies/TURBT	Referrals for biopsy of red patch - Benign outcomes on GA biopsy.
Urology	Evaluation of revised renal colic pathway	Simple changes to proformas and multi-disciplinary discussion and involvement helps to significantly improve outcomes. Short Term action- Implement new proforma permanently. Re-audit in 6 months to evaluate continued compliance. Long Term action - Transfer renal colic pathway to e-referral
Vascular Surgery	Adherence to Nil By Mouth Guidelines	Significant improvement in knowledge amongst staff members - mainly foundation doctors and nursing staff.

Appendix 4. Service Delivery Group and Department Level Audit Plans 2022/23

Attached as Excel document

Appendix 5 – Current Version - Terms of Reference for Clinical Outcomes and Effectiveness Group

Clinical Outcomes & Effectiveness Group (COEG) Terms of Reference

Author: **Dr. Alastair Roeves, Interim Deputy Medical Director**

Review date: December 2021

Swansea Bay University Health Board's standing orders provide that *"The board may and, where directed by the Welsh Government must, appoint committees of the health board either to undertake specific functions on the board's behalf or to provide advice and assurance to the board in the exercise of its functions. The board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".*

In line with standing orders (and the Health Board's scheme of delegation), the board shall annually nominate a committee to be known as the Quality and Safety Committee. This committee's focus is on all aspects aimed at ensuring the quality and safety of healthcare, including activities traditionally referred to as "clinical governance".

The Clinical Outcomes & Effectiveness Group (COEG) is a sub-committee to the Quality & Safety Governance Group, which feeds into the Quality and Safety Committee. The detailed terms of reference and operating arrangements in respect of this committee are set out below.

Purpose

The purpose of the Clinical Outcomes & Effectiveness Group (COEG) is to:

- Provide assurance to the Quality & Safety Committee, via the Quality & Safety Governance Group, that there are appropriate systems in place for the development and monitoring of policy and standards relating to
    - National and Local Clinical Audits
    - Mortality Reviews and learning from deaths
    - NICE Guidance (as it applies in Wales)
    - Health Technology Wales (HTW) reports
    - Local Safety Standards for Invasive Procedures
- The committee will identify, manage and escalate risks to the Quality and Safety Committee via the Quality & Safety Governance Group, as identified.

Delegated Powers

The Clinical Outcomes & Effectiveness Group (COEG) will, in respect of its assurance role, operate as necessary to ensure that it is confident that arrangements for; clinical audits, mortality reviews and Medical Examiner referrals, NICE guidance and HTW reports, NCEPOD Reports, Patient Safety Notices and Alerts, Local Safety Standards for Invasive Procedures, Antimicrobial Stewardship and Infection Prevention and Control and the process for maintaining up to date guidance documents listed on the Clinical Online Information Network (COIN) are operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the health board.

Objectives

To achieve this, the Clinical Outcomes & Effectiveness Group (COEG) programme of work will be designed to ensure that:

1. **Mandatory National Clinical Audits - COEG will**
    a. **Receive** the NHS Wales National Clinical Audit **and** Outcome Review (NCA&OR) Annual Plan,
    b. **Communicate** to all Service Delivery Groups those audits the Health Board will participate in during the next audit year
    c. **Agree** a single named clinical lead for each audit at local health board level who will be responsible for coordinating any responses
    d. **Ensure** that any required responses back to Welsh Government regarding National Clinical Audits are coordinated and appropriate
    e. **Ensure** that Service Delivery Group clinical and senior management teams have, with respect to the published reports and online data relating to the NCA&OR audits
        i. reviewed the findings
        ii. considered the implications for their service (including a risk assessment)
        iii. set out improvement actions
        iv. Identify actions in their Service Delivery Group IMTP process to address any gaps highlighted.
    f. **Scrutinise** the clinical outcome data arising from national audits
    g. **Monitor** progress against the agreed improvement actions
    h. **Note** ad hoc responses provided by the Executive Medical Director on behalf of the Health Board to Welsh Government and national audit programmes
    i. **Provide assurance** to the Quality & Safety Governance Group that quality and service improvements in response to NCA&OR audit reports have been identified and progress is being monitored effectively

2. **Mortality data - COEG will**
    a. **Ensure** that the Health Board's mortality review process is fully implemented and meets the requirements set by NHS Wales and the Lead Medical Examiner for Wales from 1st April 2021.
    b. **Ensure** that Service Delivery Group clinical and senior management teams have, with respect to mortality review processes,
        i. reviewed any findings
        ii. considered the implications for their service (including a risk assessment)
        iii. set out improvement actions
        iv. Identify actions in their Service Delivery Group IMTP process to address any gaps highlighted.
    c. **Scrutinise** the trends arising from mortality reviews and mortality statistics
    d. **Monitor** progress against the agreed improvement actions.
    e. **Provide assurance to the Quality & Safety Group**, that all deaths (from April 1st 2021) are being reviewed and that lessons learned from these reviews are being used to inform Health Board and national improvement programmes

3. **NICE Guidance - COEG will**
    a. **Receive** publications from NICE, including guidance, guidelines, quality standards and pathways (but NOT when

publications relate specifically to medicines, which should be addressed by the Medicines Management Strategy Board)

b. **Ensure** that the Health Board has signed up as a NICE stakeholder
c. **Ensure** that there is a Health Board process for providing comment to contribute to NICE guideline development
d. **Receive** information from Service Delivery Groups regarding the identity of named clinical lead/s for each NICE guidance, who will be responsible for submitting responses to COEG
e. **Oversee** the systems and processes for dissemination of NICE guidance
f. **Ensure** that Service Delivery Group clinical and senior management teams have, with respect to NICE guidance,
    i. reviewed the NICE guidance
    ii. considered the implications for their service (including a risk assessment)
    iii. set out improvement actions
    iv. Identify actions in their Service Delivery Group IMTP process to address any gaps highlighted.
g. **Provide assurance** to Welsh Government that NICE guidelines have been considered, if requested

4. **Health Technology Wales (HTW) - COEG will**
    a. **Receive** publications from Health Technology Wales, which may include, but is not limited to, medical devices, surgical procedures, psychological therapies, tele-monitoring or rehabilitation
    b. **Agree** a single named clinical lead or established group for each Health Technology Wales guidance, at health board level, that will be responsible for coordinating responses.
    c. **Oversee** the systems and processes for dissemination of Health Technology Wales publications
    d. **Ensure** that Service Delivery Group clinical and senior management teams have, with respect to Health Technology Wales,
        i. reviewed the HTW guidance
        ii. considered the implications for their service (including a risk assessment)
        iii. set out improvement actions
        iv. Identify actions in their Service Delivery Group IMTP process to address any gaps highlighted.
    e. **Provide assurance** to Welsh Government that HTW guidance has been considered, if requested

5. **Patient Safety Notices - COEG will**
    a. **Ensure** effective dissemination of Patient Safety Notices

6. **Interventional Procedures - COEG will**
    a. Receive requests from Service Delivery Group Medical Directors on behalf of clinicians to introduce new techniques/procedures
    b. Agree a standard operating procedure for assessing and endorsing requests for the introduction of new techniques/procedures
    c. Provide assurance to the Quality & Safety Committee that appropriate governance has been applied in assessing all requests

7. **Discharge Summaries - COEG will**
    a. Receive from Service Delivery Groups their performance data in relation to discharge summary completion rates

8. **Local Clinical Audits - COEG will**
    a. **Oversee** a process of local clinical audit that ensures robust methodology, that progress is monitored and that outcomes are reviewed
    b. Through a proposal process **oversee** a process of local clinical audit that ensures robust methodology, that progress is monitored and that outcomes are reviewed
    c. **Provide assurance** to the Quality & Safety Governance Group that quality and service improvements in response to local audit reports have been identified and progress is being monitored effectively

9. **Infection Prevention and Control and Antimicrobial Stewardship – COEG will**
   a. **Discuss** the outcomes and effectiveness of actions taken by Service Delivery Groups to improve infection prevention and control and enhance antimicrobial stewardship
10. **National and Local Safety Standards for Invasive Procedures – COEG will**
   a. **Oversee** the Improvement Plan for LocSSIPs and
   b. **Report** on progress to the Quality & Safety Governance Group

11. **Guidance documents listed on the Clinical Online Information Network (COIN) – COEG will**
   a. **Act as an escalation point** for the process of maintaining up to date guidance documents listed on the Clinical Online Information Network (COIN)

Authority

The group is authorised by the Quality & Safety Governance Group to investigate or have investigated any activity within its terms of reference. In doing so, COEG shall have the right to inspect any records or documents of the Health Board relevant to the COEG's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by COEG); and
- other committee, sub-committee or group set up by the board to assist in the delivery of its functions.

COEG is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the board's procurement, budgetary and other requirements.

Access

The chair of COEG shall have reasonable access to executive directors and other relevant senior staff.

Sub-Committees

COEG may, subject to the approval of the health board, establish sub-committees or task and finish groups to carry out on its behalf, specific aspects of COEG business.

Membership

Chairperson - Interim Deputy Medical Director, or AMD for Quality & Safety

Members - All Service Delivery Group Medical Directors

Associate Medical Directors for

- Recovery
- Cancer Services
- Research
- Education & Training
- Quality & Safety
- Information & Digital
- Transformation
- Innovation
- Dental Services
- Non-COVID-19 Services

Executive Medical Directorate Manager – post vacant
Clinical Audit & Effectiveness Manager (Executive Medical Directorate)
Head of Quality & Safety (Corporate Nursing Directorate)
Director of Public Health
Clinical Director of Pharmacy
Clinical Effectiveness & Formulary Pharmacist
Assistant Director of Therapies & Health Sciences

Head of Information Services
Independent Member
Secretariat provided by Executive Medical Directors Department

If a member is unable to attend the meeting, a deputy may attend. However, the deputy must have sufficient authority to make decisions on behalf of the usual member.

The chair may extend invitations to attend COEG meetings as required to the following:

- Any persons identified as having a role within clinical audit, mortality reviews, NICE Guidance and assessment of health technologies,
- Anyone from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration at each meeting

Clinical Outcomes & Effectiveness Group (COEG) Meetings

Meetings shall be held monthly with the exception of July and December if the work programme allows and no less than quarterly.

At least five members must be present to ensure the quorum of the committee and must include the following:

- The COEG Chair or nominated deputy
- Four Service Delivery Group Medical Directors or their deputies

Reporting and Assurance Arrangements

The Clinical Outcomes & Effectiveness Group (COEG) will report directly into the Quality & Safety Governance Group. The minutes of the Clinical Outcomes & Effectiveness Group (COEG) will be submitted to the Quality & Safety Governance Group. The committee chair shall:

- bring to the Quality & Safety Governance Group specific attention to any significant matters under consideration by the committee;
- ensure appropriate escalation arrangements are in place to alert the health board chair, chief executive or chairs of other relevant committees of any urgent/critical matters that may compromise

Review

These terms of reference and operating arrangements shall be reviewed annually by the Clinical Outcomes & Effectiveness Group (COEG).

Applicability of Standing Orders to COEG Business

The requirements for the conduct of business as set out in the health board's standing orders are equally applicable to the operation of the Clinical Outcomes & Effectiveness Group (COEG), except in the following areas:

- quorum
- notice of meetings
- notifying the public of meetings
- admission of the public, the press and other observers
- paper circulation