GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 20 July 2022 **Agenda item:** -

Year-end report of the Annual Quality and Clinical Audit Plan 2021/22 & Start of Year Annual Quality and Clinical Audit Plan 2022/23

Note : This paper was considered and approved at the Quality, Safety and Improvement Committee on 20 July 2022.

A copy of the paper and the Audit Wales Report is being provided to the Audit and Corporate Governance Committee for information.

Note the actions within this paper will be reviewed as part of the reporting on the Audit Action Log

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Approval/Scrutiny route:	Rhiannon Beaumont-Wood, Executive Director, Quality, Nursing and Allied Health Professionals Business Executive Team (5 July 2022)

	Quality, Safety and Improvement Committee (20 July 2022)

Purpose:
The purpose of this paper is to provide the Audit and Corporate Governance Committees with the year-end report on the 2021-22 Annual Quality and Clinical Audit Plan. The Plan contains both National (UK and Welsh) audits (externally determined) and Local audits (internally determined), and this paper includes analysis of the findings and recommendations of the completed audits. This paper also outlines the 2022-23 Annual Quality and Clinical Audit Plan for approval from the Quality, Safety and Improvement Committee

Recommendation:				
APPROVE ☒	CONSIDER ☐	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☒

The Audit and Corporate Governance Committee is asked to:

- **Receive assurance** on the progress of the Quality and Clinical Audit Plan for 2021-22
- **Approve** the Quality and Clinical Audit Plan for 2022-23

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	6 - Supporting the development of a sustainable health and care system focused on prevention and early intervention

Summary impact analysis	
Equality and Health Impact Assessment	An equality and health impact assessment is not required as there is no impact on policy or decisions relevant to Race, Disability and Gender duties.
Risk and Assurance	Welsh Government expects that all NHS organisations in Wales participate in quality and clinical audit. Healthcare organisations are required to have a cycle of continuous

	quality improvement that includes clinical audit.
Health and Care Standards	This report supports the Health and Care Standards for NHS Wales Theme 3 Effective Care Standard 3.3 Quality Improvement, Research and Innovation.
Financial implications	None
People implications	There is no anticipated impact on the workforce of Public Health Wales NHS Trust.

1 Introduction

The purpose of this paper is to provide the Quality, Safety and Improvement Committee with the year-end report from the 2021-22 Annual Quality and Clinical Audit Plan ('the Plan'). The Quality and Clinical Audit Plan 2021-22 references planned activity for both externally reported audits (at a national level both Wales- and UK-wide) and local, internally reported audits.

This paper provides detail on the status of audits included in the 2021-22 Plan, as well as a thematic analysis of the initial findings from the completed audits.

Based upon the progress and findings from the 2021-22 Plan, the 2022-23 Annual Quality and Clinical Audit Plan has been devised. A summary of what is included in this plan is outlined in this paper, for Business Executive Team approval.

2 Background

An initial Quality and Clinical Audit Plan was developed for the organisation in 2015/16 with subsequent annual iterations focussing on ensuring that all planned activity are collated into one master document.

Since February 2021, the organisation has had a dedicated officer to coordinate quality and clinical audit. Quarterly update meetings were introduced with teams known to undertake quality and clinical audit, which resulted in a significant increase in the number of internally reported audits being undertaken that are reported within the Plan. Furthermore, ongoing engagement across the organisation has raised awareness of the Quality and Clinical Audit Plan, and the 2022-23 Plan has begun to include areas of the organisation not previously included in the Audit Plan. This engagement work will continue for the next reporting period.

3 Annual Quality and Clinical Audit Plan 2021-22

3.1 Status of audits in the 2021-22 Plan

In this reporting year there had been an emphasis on engaging with Directorates to undertake audit in their area and to ensure all audit activity was reported within the organisational Plan. Overall, in 2021-22 there were 45 audits added to the Plan. The complete Audit Plan for 2021-22 is within Appendix B.

A breakdown of the status of these audits as of 31 March 2022 is below (figure 1):

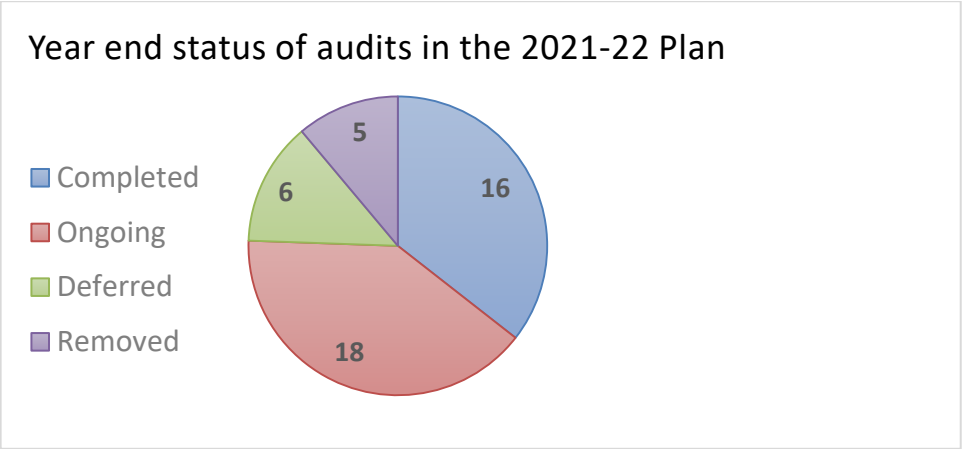

Figure 1: year-end status of 2021-22 Audit Plan

The 34 **completed or ongoing** audits are broken down by Division/Directorate below (table 1):

Table 1: Summary of completed/ongoing audits by directorate/division for 2021-22

Directorate/ Division	**Externally reported**	**Internally reported**
Screening Division	1	21
Health Protection	4	0
Quality Nursing & AHP's		3
Ops & Finance (Estates)		1
WHO CC		2
Primary Care Division		1
Microbiology		1
Total	**5**	**29**

The below table contains further detail of the 11 audits either **removed** from the 2021-22 plan or **delayed/deferred** to the 2022-23 plan:

Table 2: Status of audits removed/deferred from the 2021-22 Plan:

Status	**Directorate/ Division**	**Audit title**
Deferred to 2022-23 plan as audit unable to be undertaken in 2021-22 due to internal operational pressure	Antenatal Screening Wales (ASW)	Re-audit: Laboratory audit of sickle cell and thalassaemia request card completion
	Diabetic Eye Screening Wales (DESW)	(Re-audit) DESW participant documentation audit
	DESW	No Perception of Light Pathway
	DESW	Visual Acuity SOP Audit
Deferred to 2022-23 plan as audit unable to be undertaken in 2021-22 due to delays from interdependent work/ external factors	Quality, Nursing, and Allied Health Professionals	Consent Form 4(S) Audit (WAAASP)
	Newborn Hearing Screening Wales (NBHSW)	All Wales Audiology Audit
Removed from audit plan following review and not considered audit activity	World Health Organisation Collaborating Centre (WHO CC)	Evaluation of the Charter for International Health Partnerships in Wales
	WHO CC	Improvement project on implementation of the Well-being of Future Generations Act
Removed from 2021-22 Plan as superseded by a new audit	Wales Abdominal Aortic Aneurysm Screening Programme (WAAASP)	Consent process audit
Removed from 2021-22 Plan due to delays from interdependent work/ external factors. Ongoing delays mean unable to defer to 2022-23 Plan.	DESW	Audit of tropicamide SOP
Removed from 2021-22 Plan as new operational process deemed audit no longer necessary	WAAASP	Audit of new/updated SOP staff sign off

3.2 Thematic analysis on 2021-22 Audit Plan

As of 31 March 2022, 14 completed internally-reported audit reports have been received by the central Quality Team. These were reviewed, and the below table outlines the themes and origins of these audits, what standards they are being measured against, and the Health and Care Standards and domains of health care quality they align to. Although the baseline assessments were not measured against any explicit standards, they were undertaken to inform the development of local standards. Furthermore, they are aligned to Health and Care Standards and domains of health care quality, thus providing assurance against these.

A key objective for the quality and clinical audit programme is to strengthen a risk-based approach to audit (see section 5). This will involve ensuring all audits are linked to an evidence-based standard (policy/procedure/guidance) and thus providing assurance against this standard. Furthermore, a process to link audits to established risks will be developed, and this will form part of the thematic analysis for audits in 2022-23.

Appendix A contains a more detailed breakdown of the overall findings, areas for improvement and next steps identified in each audit.

Table 3: thematic summary of 2021-22 completed local audits

Theme	**No. of audits per theme**	**Origin**	**Standard audited against**	**Six domains of health care quality**	**Health & Care Standard**
Assurance	1	Ongoing required assurance of professional registration	PHW Policy (71.V5 Registration for regulated healthcare professionals)	Safe, Efficient, Effective	3.1 Safe and clinically effective care 7.1 Workforce Governance, Leadership & Accountability
Baseline assessment	2	Assessment of current practice to inform quality improvement	N/A (baseline assessment to inform	Efficient, Effective	Governance, Leadership & Accountability

			development of local procedure)		2.1 Managing Risk
Clinical process	1	Assessment of clinical process, potential to inform All Wales pathway	Local procedure/policy National guidance (The British Association for Sexual Health and HIV (BASHH) guidance on the management of syphilis)	Safe, Effective, Timely	3.1 Safe and clinically effective care 5.1 Timely access
Corporate process	1	Assessment of current practice to inform quality improvement	National guidance (HQIP Documenting local clinical audit: a guide to reporting and recording)	Effective	3.3 Quality Improvement 3.5 Record Keeping
Documentation	2	Ensure compliance with standards Following increase in administration errors	National guidance (Nursing Midwifery Code (2016), Record Keeping Guidelines NHS professionals, (2016))	Safe, Timely, Efficient	3.1 Safe and clinically effective care 3.5 Record Keeping
Incident management	3	Revised scope of policy resulted in increase of incidents reported. Updated procedure in line with this, audit to provide quality assurance of processes	Local procedure/policy (2R.36 - Incidents and Near Misses, 2R.37 – Sample acceptance policy)	Safe, Timely, Efficient	3.1 Safe and clinically effective care 3.3 Quality improvement 3.5 Record keeping

Pathway management	2	Review of pathway management following unexpected number of referrals	Local procedure/policy (Non-DR discharge and recall)	Safe, Timely, Efficient	3.1 Safe and clinically effective care 5.1 Timely access
Service user experience	2	Assessment of compliance with new standards introduced in 2019	National guidance (Breast Care Nursing Standards 2019)	People-centred, Equitable	3.1 Safe and clinically effective care 4.1 Dignified care

3.3 Further audit activity in 2021-22

3.3.1 Microbiology

As part of ongoing accreditation to ISO 15189: 2012 and regulatory compliance, PHW Microbiology adheres to a strict scheduled audit programme. Each laboratory follows a timetable that ensures every test in the scope of accreditation has a vertical audit performed to ensure compliance to ISO 15189:2012 clauses on a four-year rolling basis. As tests are added the scope of Microbiology, the tests will be added to the schedule. These can also be performed ad hoc to help with implementation of a new test. All laboratories also perform local scheduled audits according to a four-year rolling plan. The Microbiology Quality team also have an audit Manager that performs a Quality management audit on every laboratory. This is to check that they are adhering to the QMS as a whole. PHW Microbiology also perform ad-hoc 'Business resilience audits' on their large suppliers.

Audit reports are prepared monthly for discussion. Audits and their findings are regularly reviewed at the Network Quality meetings. All non-compliances are examined, and the same audits that are performed across the network are compared to identify trends in the findings.

3.3.2 Health and Safety

Health and Safety have had an ongoing audit plan wherein audits are undertaken on premises where PHW staff are tenants or hosted with a Health Board. These audits primarily cover compliance to the Workplace (Health, Safety and Welfare) Regulations 1992, but additionally cover several Estates related statutory regulations e.g. Regulatory Reform (Fire Safety) 2005, Control of Asbestos Regulations 2012 etc. Audits in their original format have remained on hold due to organisational demands and the Covid-19 response. Over the last year Covid-19 risk assessments have been reviewed to ensure actions are identified to mitigate the risks of Covid-19 transmission in the workplace. Regular compliance monitoring has also been implemented. Quarterly updates are provided to the Quality, Safety and Improvement Committee as part of the Health and Safety Report to ensure they are sighted on actions undertaken across the organisation specific to Covid-19.

As staff begin returning to our workplaces as part of the new working arrangements, the Health and Safety audit process will be revised as part of the work plan for 2022-23.

3.3.3 Infection, Prevention and Control

For 2021-22 there has been excellent engagement and compliance from the screening leads and teams in the IPC audit process. There are two

key performance indicators audited for screening. Environmental audits are conducted quarterly, and hand hygiene audits are conducted monthly. These audits are discussed for any non-compliance issues at the quarterly Screening Leads IPC meeting and then fed into the quarterly IPC group meeting. The audits are also referenced in the annual IPC report which goes to Quality, Safety, and Improvement Committee. There have been some challenges, especially where audits are conducted in premises not owned by PHW and resolution of issues has been slow.

4 Annual Quality and Clinical Audit Plan 2022-23

4.1 How the plan has been developed

At the start of the reporting year for 2022-23, 7 externally reported audits and 33 internally reported audits were identified to be included in the 2022-23 Plan, bringing the total to 40 audits.

Of the local audits, 17 originated in the 2021-22 Audit Plan. This reflects the 6 audits planned for 2021-22 but deferred to 2022-23 (as outlined in table 2), as well as a further 11 audits that commenced in 2021-22 but were still ongoing as of April 2022. The complete Audit Plan for 2022-23 is within Appendix C.

4.2 Engagement within the organisation

Over the past 12 months, significant effort has been placed on ensuring the Quality and Clinical Audit Plan represents the full scope of the organisation. Engagement has been taking place with directorates and divisions not currently registering audits into the annual plan. Meetings have taken place with WHO CC, QNAHPs, Health and Wellbeing, and Microbiology to raise the profile of the programme and to emphasise the inclusion of quality audits as well as clinical ones in the Plan. As a consequence of this engagement, WHO CC have registered two quality audits for both the 2021-22 Plan and the 2022-23 Plan. Furthermore, an ongoing clinical audit has been registered from Microbiology. Whilst no audit activity is currently planned in the other directorates to include in the 2022-23 Plan, this engagement has raised the profile of the Quality and Clinical Audit Programme, so colleagues are aware future audits need to be registered.

A key objective for 2022-23 is to build upon this engagement work and further raise the profile of the quality and clinical audit programme. A communications and engagement plan will be developed, to increase staff awareness and understanding of the quality and clinical audit plan. Furthermore this engagement will highlight the value of conducting audit for driving quality improvement.

In April 2021, the Quality Safety and Improvement Committee identified that the Internal Audit Programme and Quality and Clinical Audit Programme could be better aligned. Initial discussions have taken place between the two programmes on how to achieve alignment, and these will continue into 2022-23. This collaborative approach will help identify gaps in the organisation where no known audit activity is planned, and inform pro-active engagement efforts to these areas to encourage the uptake of quality and clinical audit.

5 Improvement initiatives

In 2021, Audit Wales undertook an audit of PHW's quality governance arrangements and made several recommendations for how the organisation can improve the coordination of its audit and quality improvement work.

Several improvement initiatives to the quality and clinical audit programme were outlined in the Interim Report in February 2022, which were developed to progress the recommendations made by Audit Wales as well as take forward recommendations made by the Quality Safety and Improvement Committee (QSIC) in April 2021.

The four recommendations from Audit Wales are below; below each are the related improvement initiatives:

1. Create a central repository to store and share all clinical audits, either in the quality hub or elsewhere
    - Facilitate learning from audit results through development of templates to showcase learning, and proactively sharing learning
    - Utilise available IT solution for a central repository in the interim e.g. SharePoint
    - Scope alternative digital solutions for a central repository
2. Develop a system to track and report progress implementing the recommendations of clinical audit to the Quality, Safety and Improvement Committee
    - Develop an action log system to track and report progress implementing the recommendations of audit to QSIC
    - Report progress on implementing recommendations to QSIC at interim and year-end
    - Update on implementation of audit recommendations to Clinical Governance Group on a quarterly basis
3. Develop a process to link the clinical audit plan more clearly to operational, corporate and strategic risk registers to demonstrate that audits are mapped to key quality and safety risks
    - Standardisation of prioritisation system for planning annual audit plan
    - Link the audit plan more clearly to operational, corporate, and strategic risk registers

    - Report to Business Executive Team on a quarterly basis where agreed audits are at risk of not being completed in the reporting period, and highlight any linked risks to these audits
4. Collate themes arising from the clinical audit programme and share these with the Quality, Safety and Improvement Committee. Future clinical audit plans should provide assurance that themes are being investigated.
    - Introduce standardised audit report template that ensures all necessary information is reported to enable theming of audit results
    - Develop thematic analysis of audit results and utilise this to inform future audit plans
    - Digitalisation to provide central and local dashboards and data analysis of audit results and themes

In relation to the above, the following has already been implemented:

- Action plans have been implemented based on the findings of audits in the 2021-22 Plan where non-compliance is identified. These will be reviewed with audit leads throughout 2022-23, and action plans will also be required for all audits completed in 2022-23 as part of an ongoing emphasis on the importance of this key stage of the audit cycle.
- A system of four priority levels has been developed and applied to all audits in the 2022-23 audit plan. This system will ensure all audit activity is aligned to strategic or operational priorities and responsive to concerns that arise. It also provides assurance that programmes are selecting quality and clinical audits using a risk-based approach or where it could be used an improvement tool. Guidance on what these priorities levels are and how they should be applied to the audit plan has been developed, and can be found in Appendix D.
- A new template for the reporting of audit findings has been developed and standardised, for use across the organisation to ensure audits are consistently reporting key aspects of the audit process. This includes identifying best practice standards to audit against, rationale for the audit, clearly reporting audit findings, and assessment of the results and the level of assurance they provide. The standardised audit report template was piloted in Feb-Mar 2022 in order to gather feedback on this new approach, and the finalised template was implemented on 1 April 2022 for all audits in 2022-23 Audit Plan.
- A thematic analysis has been developed for completed audits in 2021-22 (see section 3.2). This will be developed further for interim reporting and year-end reporting in 2022-23.

The PHW Quality and Clinical Audit Procedure is due to be reviewed by July 2022. This presents a timely opportunity to update the organisational procedure to reflect these improvements and changes to

audit process, to support staff and set clear expectations in relation to the organisational approach to quality and clinical audit.

6 Well-being of Future Generations (Wales) Act 2015

The report contributes to Goal 3 "Support the NHS to deliver high quality, equitable and sustainable services" This below information follows the five ways of working, as defined within the sustainable development principle in the Act, in the following ways:

An annual audit plan is conducted to support services to engage in activities to continuously improve by evaluating, developing and implementing innovative ways of working. The plan demonstrates the organisations commitment of continuous improvement

Where possible Public Health Wales seeks to validate the efficacy of its practice and to make continuous improvements. The annual audit plan is integral to supporting this work.

The audit plan impacts a number of the wellbeing goals, including "A Resilient Wales" and "A More Equal Wales"

The annual audit plan contains work across UK and Wales and includes other NHS bodies working together with Public Health Wales NHS Trust to provide the best outcomes

The audit plan is an important aspect of the organisation's governance arrangements, and, as such, helps the organisation to improve the quality and safeguard the high standards of the services provided by Public Health Wales

6 Recommendation(s)

The Quality, Safety and Improvement Committee is asked to:

- **Receive assurance** on the progress of the Quality and Clinical Audit Plan for 2021-22
- **Approve** the Quality and Clinical Audit Plan for 2022-23.

Appendix A: Breakdown and analysis of audit results from completed 2021-22 local audits

Audit theme	Standard audited against	Overall findings	Areas for improvement	Next steps
Assurance (NMC and HCPC professional registration)	PHW Policy (71.V5 Registration for regulated healthcare professionals)	129 nursing/midwifery staff holding NMC registration/PIN number 340 healthcare scientist/allied healthcare professional staff holding HCPC registration	41 HCPC-registered staff positions identified by manual search and not found by the automated link between ESR and HCPC register. 11 related to discrepancies in names, but no clear root-cause for other 30.	Currently developing mechanisms to better identify any deficits in staffing and will continue to improve our monitoring arrangements to ensure compliance with The Nurse Staffing Levels (Wales) Act 2016 Data validation exercise on ESR to ensure all HCPC registration details are recorded on ESR.
Baseline assessment	N/A (baseline assessment to inform development of local procedure)	Baseline assessment of current risk management within WHO CC Baseline assessment of recruitment procedure within WHO CC	Need better understanding of roles/ responsibilities/ tasks. No structured or documented local procedure. Need to formalise risk monitoring and reporting. Local procedure in place but identified need for documentation and standardisation	Implement local risk management procedure supported by risk register template. Create risk report to present at meetings. Audit to be devised once changes implemented Procedural documentation to be implemented and then audit to be devised.
Clinical process (ASW)	Local procedure/policy National guidance (The British Association for Sexual Health and	**44.81% compliance** Good rate of obtaining confirmatory blood samples following both positive and reactive results. The audit captured the importance of the screening programme in	Areas for improvement highlighted by this audit include documentation and multi-disciplinary team working. To note: Due to the considerable work pressures	Presentation of cases and the audit findings at local and national meetings All members of MDT to undertake e-learning package

	HIV (BASHH) guidance on the management of syphilis)	identifying people with previously unknown infection. Good rates of bleeding babies born to mothers treated for syphilis during pregnancy	across all health boards the return of audit forms was not completed and a number of patient's notes were not available.	
Corporate process (QNAHPs)	National guidance (HQIP Documenting local clinical audit: a guide to reporting and recording)	**79.63% compliance** Variation in the reporting of quality and clinical audit results and inconsistent inclusion of necessary information	Audit standards only identified in a third of reports. Actions to be taken only identified in a third of reports. Inconsistent comparison with previous audit results.	Introduction of new standardised audit report. Implementation of action plans. Re-audit following implementation.
Documentation (BTW)	National guidance (Nursing Midwifery Code (2016), Record Keeping Guidelines NHS professionals, (2016))	**97.57% compliance** 9 out of 16 audit questions had 100% compliance (increase from 4/16 in 2017-18).	Completing demographics Some records not being fully signed by the nurse The correct procedure being followed when the record requires amending due to an error	Findings reported to programme board and regional nursing teams. Re-audit to be completed in 2022-23.
Documentation (CSW)	National guidance (Nursing Midwifery Code (2016), Record Keeping Guidelines NHS professionals, (2016))	**93.5% compliance**	Overall there was a number of HMR forms compared to LIMS with documentation issues such as: little information written on the form for family doctor, requester and no NHS number. Some difficulties regarding transcribing hand-written forms.	Review of SOP Raise concerns of missing information with individuals/teams Investigation from Informatics and Data Services regarding NHS numbers Monthly re-audit for 4 months following implementation of revised SOPP
Incident management (CSW – quality review of reporting of incidents)	Local procedure/policy (2R.36 - Incidents and Near Misses, 2R.37 – Sample acceptance policy)	**76% compliance** Increase from 69% compliance in 2020-21.	Identified non-compliance with SOP including incident open for longer than 30 days, delays to review and approval, delay or failure to return adverse event pro-forma, and issues with same staff member conducting different stages of the process.	Share findings with each region and at governance and quality meeting. Review SOP in line with new Datix system.
Incident management (CSW – pilot 1	Local procedure/policy (2R.36 - Incidents	**68% compliance** (regarding the return of pro-formas with 21 day standard)	The majority of the information provided by the sample takers were stating the category of	Review and revise the pro forma to ensure the document provides the guidance on how

of revised adverse event pro-forma)	and Near Misses, 2R.37 – Sample acceptance policy)		incident/error. The information did not provide the programme as to the reason why the incident/error had happened (causative affects).	to complete and why the information is valuable, and required to be returned within the timeframe as per Incident Management Policy PHW (30 days).
Incident management (CSW – pilot 2 of revised adverse event pro-forma)	Local procedure/policy (2R.36 - Incidents and Near Misses, 2R.37 – Sample acceptance policy)	**76% compliance** (regarding the return of pro-formas with 21 day standard) Recording of information on the pro-forma more detailed than in pilot 1, with greater pro-forma return and compliance with the 21-day return standard.	Still a proportion of pro-formas not being returned at all. Some pro-formas missing required information	Revise SOP Feedback issues to LHBs
Pathway management/ errors (DESW – inadequate image pathway)	Local procedure/policy (Non-DR discharge and recall)	Majority of cases referred to ophthalmology are due to inadequate images. Almost 50% of inadequate images recorded as being due to media opacity. Opinion recorded by an image taker is 3 times more likely to be classed as adequate, suggesting they have a different level of acceptance of image quality.	40% of images taken too quickly following dilation. Ambivalence on interpretation of media opacity.	Refresher for grading staff on Image Quality Criteria. Provide additional information as to why participant has been recalled to clinic to help image takers. Implement annual audit supported by Gloucester Retinal Education Group.
Pathway management/ errors (DESW – discharge pathway)	Local procedure/policy (Non-DR discharge and recall)	Identified that a failed trigger resulted in 40 participants not automatically becoming eligible for an appointment as per the pathway due to an upgrade of OptoMize changing the configuration	The programme is still following procedures that were implemented prior to OptoMize upgrade (in March 2021), and need to be reviewed.	Review OptoMize 4.7 configuration of immediate recall and agree process. Update SOPs following review. Develop process of examining the reason for referral Conduct a review of other ICO queues within OptoMize 4.7
Service user experience (BTW – survey feedback)	National guidance (Breast Care Nursing Standards 2019)	**98.9% compliance** 11 out of 12 audit questions had 100% compliance. Overall results demonstrate service users have a	Only area not achieving 100% compliance was service users feeling that they understood most/all of the information provided regarding their	None reported.

		positive experience and feel supported	results, which was 86.8%. The other 13.4% answered they understood 'some of it' – no respondents answered 'none of it'	
Service user experience (BTW - process audit)	National guidance (Breast Care Nursing Standards 2019)	**99.03% compliance** For standards where improvement was required in last year's report: • 96% of women who underwent a biopsy met a nurse, increase from 88% last year • The nurse was present when 100% of women were given a cancer diagnosis, improved from 86% last year • 96% of women were offered a pre-operative consultation within 7 days of diagnosis, an increase from 91% last year Consistency in data entry has improved this year also.	None reported	None reported

Appendix B

Quality and Clinical Audit Plan 2021-22:

Clinical Audit Plan 2021-22.xlsx

Appendix C:

Quality and Clinical Audit Plan 2022-23:

Clinical Audit Plan 2022-23

Appendix D: Process for setting priorities for the Quality and Clinical Audit Plan

An effective quality and clinical audit programme should reflect key national, organisational and local drivers for quality improvement. A system of prioritisation ensures key drivers for improvement and risk mitigation are balanced with projects that are important at the directorate / division / service level (HQIP, 2016). All quality and clinical audits should contribute to strategic or operational priorities.

Compiling and prioritising the annual quality and clinical audit plan at the start of the year does not limit new projects from being added to the plan and prioritised appropriately. Indeed, new 'must-do' audits may be added in response to concerns that arise. Similarly, staff-led innovative ideas may be proposed throughout the year to be considered.

The National Healthcare Quality Improvement Partnership 'Developing a Clinical Audit Programme' guidance (HQIP, 2016) has been used to inform the following priority levels.

This guidance consists of four priority levels to be assigned to all quality and clinical audits:

- Priority level one: External 'must do' quality and clinical audits
- Priority level two: Internal 'must do' quality and clinical audits
- Priority level three: Directorate / division level priority quality and clinical audits
- Priority level four: Staff member interest quality and clinical audits

<u>Priority level one – external 'must do' quality and clinical audits</u>

These are audits which are mandated by external bodies and reported externally. For instance, these may include audits required by Welsh Government, audits required for external accreditation schemes, or audits of externally imposed standards, e.g. to demonstrate compliance with the required standards for UK National Screening Programmes.

<u>Priority level two – internal 'must do' quality and clinical audits</u>

These are audits based on high risk, high cost or high profile topics. For instance, these quality and clinical audits may arise from:

- Significant risk issues
- Serious incidents
- Claims
- Persistent / local concerns arising from trend analysis of complaints and/or incidents
- Priorities identified via patient and public involvement initiatives
- Evidence of a significant issue from service user and consumer feedback
- Issue that could have significant impact on service delivery

<u>Priority level three - directorate level priorities</u>

There may be audits which are important at the directorate / division / service level, which do not meet the criteria of high-risk, high-cost or high-profile, which would fall into the third priority level. These audits play a critical role in quality improvement. These quality and clinical audits may arise from:

- Evidence of variation in practice

- Concerns and incidents (not considered high-risk or serious)
- Audits undertaken as part of clinical speciality networks
- Areas identified through Health and Care Standards reporting where further improvement could be made (i.e. a score of 4 or 5).

Priority level four – staff member interest audits

These are audits proposed by individual members of staff, which may be for personal interest of an improvement that could be made, for training or revalidation purposes. Focus on making improvement should still be central to these proposed audit projects. These audits should be reviewed by Quality Leads / Business Leads (as appropriate) to determine if the topic concerned is high-risk or high-cost, or a directorate level priority, and therefore should be granted a higher priority level.

Re-audits

When a re-audit is undertaken, the priority level of the re-audit should be reviewed and assigned accordingly. The priority level does not necessarily have to remain the same as that applied to the original audit. For example, an audit may have been undertaken that was a Priority Level 3, however the findings evidence significant variation in practice that presents a significant risk. Improvements are implemented, and a re-audit is undertaken at Priority Level 2, as this is now addressing a high-risk concern.