Bundle Joint Audit and QSE Committee 5 November 2019

9.30am to12.00, Boardroom, Ysbyty Gwynedd, Bangor LL57 2PW

1 09:30 - JAQS19/1 Chairs' Welcome

2 09:35 - JAQS19/2 Declarations of Interest

3 09:37 - JAQS19/3 Apologies for Absence

4 09:39 - JAQS19/4 Minutes of Meeting Held on 6.11.18 for Approval of Accuracy, Matters Arising and Review of Action Log

JAQS19.4a Minutes JAQS Public 6.11.18 V0.2.docx

JAQS19.4b Summary Action Log JAQS Committee live version 29.10.19.doc

5 09:54 - JAQS19/5 Draft Clinical Audit Policy & Procedure - Dr David Fearnley

Recommendation:
The Joint Audit and Quality, Safety & Experience Committee is asked to approve the policy

JAQS19.5a Clinical Audit Policy_coversheet.docx

JAQS19.5b Clinical Audit Policy.docx

JAQS19.5c Clinical Audit Policy_EQIA.doc

6 10:39 - JAQS19/6 Draft Clinical Audit Reporting Templates - Dr David Fearnley

Recommendation:
The Joint Audit and Quality, Safety & Experience Committee is asked to comment if the level of detail suggested is sufficient and to discuss what further information may be required.

JAQS19.6a Clinical Audit Templates_coversheet.docx

JAQS19.6b Clinical Audit Templates.docx

7 10:54 - JAQS19/7 Clinical Audit Report 2019 - Dr David Fearnley

Recommendation:
The Joint Audit and Quality, Safety & Experience Committee is asked to acknowledge this update and consider what additional information is required going forward.

JAQS19.7a Clinical Audit Report_coversheet.docx

JAQS19.7b Clinical Audit Report.doc

8 11:39 - JAQS19/8 Clinical Audit Plan Update - Dr David Fearnley

Verbal update

9 11:44 - JAQS19/9 Briefing on Governance Review - Ms Dawn Sharp

Recommendation:
The Joint Audit and Quality, Safety & Experience Committee is asked to note the context and progress of the governance review and the emerging considerations

JAQS19.9a Governance review_coversheet.docx

JAQS19.9b Governance review.docx

10 JAQS19/10 Date of Next Meeting

To be arranged - November 2020

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Joint Audit and Quality, Safety & Experience (QSE) Committees

Minutes of the Meeting Held on 6th November 2018 in the Boardroom, Preswylfa, Mold

Present:

Medwyn Hughes	Independent Member (Joint Chair)
Lucy Reid	Independent Member (Joint Chair)
Cheryl Carlisle	Independent Member
John Cunliffe	Independent Member
Jaqueline Hughes	Independent Member
Lyn Meadows	Independent Member

In Attendance

Deborah Carter	Associate Director of Quality Assurance (for Minute 18.7)
Tracey Cooper	Assistant Director of Nursing (for Minute 18.6)
John Day	Head of Service, Audiology (for Minute 18.8)
Russ Favager	Executive Director of Finance
Sue Green	Executive Director of Workforce and OD
Dave Harries	Head of Internal Audit
Gill Harris	Executive Director of Nursing & Midwifery
Grace Lewis-Parry	Board Secretary
Melanie Maxwell	Senior Associate Medical Director
Evan Moore	Executive Medical Director
Teresa Owen	Executive Director of Public Health
Dawn Sharp	Deputy Board Secretary
Rod Taylor	Director of Estates and Facilities (for Minute 18.6)
Adrian Thomas	Executive Director of Therapies & Healthcare Sciences

Agenda Item	Action By
JAQS18/1 Joint Chair's Opening Remarks The meeting was jointly Chaired by the Chairs of Audit and Quality, Safety and Experience Committee who welcomed members to the meeting.	
JAQS18/2 Apologies for Absence Apologies for absence were noted as follows:- Michael Rees, Mark Thornton	
JAQS18/3 Declarations of Interest There were no declarations of interest made at the meeting.	

JAQS18/4 Minutes of Meeting Held on 9.11.17 and Matters Arising The minutes of the Joint Meeting held on 9.11.17 were confirmed as a correct record. Members expressed disappointment that a number of the actions identified within the Minutes had not been progressed and it was agreed that a separate action log be prepared and updated to reflect the progress of those actions not yet complete.	DS
JAQS18/5 Quality Improvement (QI) Hub JAQS18/5.1 The Senior Associate Medical Director/ 1000 Lives Clinical Lead provided a presentation on the Quality Improvement Hub initiative, which was being led by the Medical Directorate with exception reporting to the Quality and Safety Group. The Hub, which had been launched on 20th September 2018 was intended to be the place where members of staff interested in QI could build ideas, enhance skills and capacity and create a strong network sharing and developing ideas together. It was open to all staff and supported by web resource. It aimed to nurture a culture of continuous improvement, develop skills, knowledge and better ways of working. The quality framework supported the quadruple aim of improving population health, reducing care costs whilst at the same time satisfying providers and ultimately patients. JAQS18/5.2 Members commented that with regard to design, use of mobile devices was key if management were to achieve a range of staff accessing it. The project would be part of the BCU wide website redesign however a new content management system would need to be put in place first. Next steps were to consist of numerous elements which included a bespoke communication campaign, roadshows, collaboratives, further website development, newsfeeds, QI conference, academic improvement career pathways, identification of internal faculty of QI champions, sponsorship, establishing mechanisms for measuring value and identifying QI projects of the month and developing the criteria/process for a 2019 achievement award. **RESOLVED:** That the presentation be received and the progress on implementation of the QI Hub be welcomed.	
JAQS18/6 Audit Tracker – National Standards for Cleaning in NHS Wales JAQS18/6.1 The Director of Estates and Facilities and the Assistant Director of Nursing, Infection Prevention and Control joined the meeting to provide an update in terms of the progress of the Internal Audit recommendations and the timetable for completion of the remaining actions, following presentation to the Audit Committee in September 2018. JAQS18/6.2 Internal Audit had made a number of recommendations following their review of BCUHB compliance with National Standards for Cleaning in NHS Wales in 2017. Management responses had at that time been taken forward with oversight being provided by the Strategic Environmental Cleanliness Group. Following the Stevens Review in August 2017, the Safe Clean Care Programme had been established to take a lead on a number of work-streams including cleanliness and the Strategic Environmental Cleanliness Group had been disbanded. The Safe Clean Care Programme Board reported	

to the Quality and Safety Group. Cleanliness matters were also reviewed at Local Infection Prevention Groups, the Infection Prevention Sub-Group, and within the Estates & Facilities Divisional Meetings. A summary was also incorporated within the Annual Performance and Accountability Framework, and the Annual Infection Prevention Report to the Board.

JAQS18/6.3 Work had progressed in line with the 90-day plan cycles (currently completing cycle 2 for Secondary Care, and cycle 1 for Community Hospitals). Work to review progress with the audit recommendations had highlighted that despite the focus on 90-day plans there remained a need for a group to focus on the strategic longer-term requirements. A framework for this was currently being developed in order to mitigate the risk. A plan was being finalised for a phased return to monthly auditing using a risk-based approach. This would be implemented from January 2019. It was recognised that this would not fully meet the audit frequencies in the National Standards in all locations. However the risk-based approach would ensure focus on priority areas of higher risk, maximising available resources.

JAQS18/6.4 An Addendum to the Cleaning Responsibilities Framework was being agreed to ensure ward sister/charge nurse responsibility for participation in and sign off of Credits4Cleaning (C4C) audits was clear and implemented. This would include confirmation of an agreed framework to track completion of nursing actions required in the audits, as this remained outstanding. Members were informed that infection rates had dropped following the introduction of the Safe Clean Care programme and that this would need to be articulated more clearly and reflected in future Infection Prevention and Control reports. The timetable was to complete the framework by the end of December 2018, with implementation from January 2019.

JAQS18/6.5 The Safe Clean Care Programme Board had considered the model of cleanliness training and monitoring at the meeting on 5th January 2018. As it was recognised that compliance with the audit frequency as set out in National Standards would require additional resources, a decision was taken by the Programme Board to reduce the frequency of audits in order to facilitate staff training. The identified cost-pressures required to meet national audit frequency would be considered as part of the 2019-20 budget setting process, along with any other cost-pressure subsequently identified. Members noted that BCU was one of only two Health Boards in Wales piloting the new cleaning audit monitoring tool.

RESOLVED: That

(1) the status updates within the audit tracker, in response to recommendations from Internal Audit be noted;

(2) the decision taken in January 2018 by the Safe Clean Care Programme Board relating to the reduction in audit frequency, and the plan and timescale for introduction of a monthly risk-based audit programme from January 2019 be noted; and

(3) the additional resources required to fully meet the audit frequency in the National Standards be considered as part of the 2019-20 budget setting process, along with any other cost-pressure subsequently identified.

JAQS18/7 Ward Accreditation

JAQS18/7.1 In July 2018 work had commenced on the process for developing a new Accreditation Programme for all inpatient Wards / Units across BCUHB. Following the success of the Safe Clean Care campaign earlier in the year, the Accreditation programme was an opportunity for the Health Board to implement a set of standards to frame the quality, safety and patient care agenda.

JAQS18/7.2 Phase 1 (Nov 2018) currently underway would see the programme introduced across all Inpatient Wards (including Community Hospitals, Paediatrics, Women's and Mental Health / Learning Disabilities). Phase 2 (Late Summer 2019) would see the programme disseminated to other areas such as Theatres and outpatients etc. The aims of the programme were to provide strong Leadership from Ward to Board, and to:-

- Embed the principles of the Safe Clean Care programme;
- Implement agreed standards across the Health Board;
- Provide a framework for the overarching quality and safety agenda;
- Deliver what mattered most to patients;
- Improve reliability of care;
- Consistent approach to assessing quality.

JAQS18/7.3 Benefits included providing an opportunity to share and celebrate excellent practice; a 360 degree review of a ward; reduction in avoidable harm; improvements in patient and staff experience; standardisation of QI language; visible standards across the Health Board; ownership of data and QI at ward level; and increased Board assurance. The Associate Director explained the methodology, areas reviewed and scoring used and set out the progress to date.

JAQS18/7.4 Following accreditation wards would receive a certificate if Bronze or Silver, if Gold the ward would receive a wall plaque etc. If a ward was classified as 'white' there would be a period of support for 12 weeks and then following a further 12 week period the ward would then be eligible for further review. If a ward was 'red flagged' the ward would require immediate intervention and would then be subject to the 'white ward' process. The Associate Director confirmed that external accreditation information would be triangulated and used as part of the briefing pack.

JAQS18/7.5 Members questioned whether there was likely to be any adverse reaction from patients in respect of those wards receiving lower accreditation. Based on experiences from other parts of the Country this was not evident.

RESOLVED:

That the presentation be received.

JAQS18/8 Audiology Standards

JAQS18/8.1 The Clinical Director of Audiology/Consultant Clinical Scientist (Audiology) provided Members with an overview of the Welsh Government endorsed National Audiology service quality standards and the outcomes of the external audit of the BCU

Health Board Audiology Service. The Director provided the overall context in terms of service provision which operated on a Pan BCU wide basis. JAQS18/8.2 Members noted that the standards were evidenced based, developed to a prescribed health agency format and referenced to national health policy. They had been developed with service user representatives and mapped to the Health Service Standards for Wales. They were subject to robust external audit. Outcomes of the audits had been used locally to identify areas for improvement. There had been a reduction in variation of service quality within BCU Audiology (West vs Centre vs East). Audit results indicated a progressive improvement in service quality. The standards were broad/comprehensive thus reflecting the patient pathway/experience. Looking to the future, standards were being developed for other Audiology services such as cochlear implants, balance and tinnitus services together with primary care Audiology. JAQS18/8.3 Members raised concerns regarding the fact that there remained some variance between sites and hoped that this could be eliminated in due course. **RESOLVED:** That the presentation be received.	
JAQS18/9&10 National Clinical Audit and Outcome Review Plan 2017/18 Update Report and Clinical Audit Plan 2018/19 JAQS18/9-10.1 The Executive Director of Therapies and Health Sciences provided an introductory presentation setting out the background to the formation of the Clinical Audit Plan and the process that then followed in terms of outcome review, in addition to providing overall context for the progress or otherwise of those actions as outlined in the last Joint Committee meeting. In view of timing, and their inter-relationship, both agenda items were taken together. The outcome review report had been compiled by the Corporate Team of Clinical Audit and Effectiveness Facilitators. The information was an indicator of ongoing liaison with the individual site-based Clinical Audit Leads for each National topic. The Plan included the NHS Wales National Clinical Audit Plan together with the Health Board Corporate Clinical Audit priorities for 2018/19. JAQS18/9-10.2 Members raised concerns about the number of gaps in the audit report submissions and the clear lack of consistency by those completing. As currently drafted it was not possible to identify what the achievement was against the audit standards and where those standards were not achieved the plan of remedial action going forward was also unclear. Members noted that a number of issues were identified as a result of the audits including inadequate consent taking, variances in service provision across sites and data integrity. JAQS18/9-10.3 It was acknowledged that clinical audits by their very nature were resource intensive and Members felt it important that any resource issues should be clearly identified along with potential solutions. The Director of Therapies and Health Sciences agreed to review the future format of the report together with the reporting structure and timetabling which would be routed via the Quality and Safety Group in the first instance. This might in turn affect the future timing of the 2019 Joint Committee.	

JAQS18/9-10.4 Other concerns expressed related to not having the presentation shared in advance, changes in staffing resulting in functions ceasing to be carried out (as referenced in the report) and the connection between formulation of the BCU elements of the plan being underpinned by a risk based approach. Internal Audit agreed to offer support in terms of the process and overarching methodology but highlighted that this had the potential to impact on the currently agreed Internal Audit Plan. Any requirement to deviate from the existing Audit Plan would need to be formally agreed by the Audit Committee. **RESOLVED:** That the Executive Team re-examine the BCU elements of the clinical audit plan and the process going forward including future presentation, tracking and follow up of recommendations arising, with input from Internal Audit as appropriate.	AT
JAQS18/11 Date of Next Meeting Confirmed as 5th November 2019 subject to review to accommodate any revision in process for clinical audit reporting as described above.	

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position *(provided by Dr Melanie Maxwell 28.10.19)* *Green – completed* *Amber – on track* *Red – not progressed due to resource or other issue*	Revised Timescale
Actions from meeting held on 9.11.17				
Adrian Thomas	JAQS 17/5 Clinical Audit Report – Future reports to take on board the suggestions put forward by the Committee namely:- • Future plans to have a unique identification number against each project • Intended outcomes to be captured as well as progress on specific recommendations • Summary of main headlines to be captured for reporting to the Board. • RAG rating system to be adopted and whether recommendation was implemented and within timeframe	November 2018	Completed Closed audits are asked to report evidence of change Reports as planned will include highlights and outlier status / standards for improvement. For tier1 this will be national and local. Quarterly reporting template will document if the audit is on track or delayed- and any remedial action	

	• Trajectory showing whether improvements are being made year on year • Indicators to show whether all leads within a particular area are working to the same level • Consideration to be given to whether commissioned services should be included within future Audit Plans • Emphasis to be placed on reflective learning and examining the results of audits in conjunction with performance data in order to provide effective triangulation;		Needs further discussion to understand a level of reporting that is meaningful Reporting full, partial and no compliance with audit activity by area This needs to be within the contracting arrangements; all UK hospitals take part on the NACOR audits Emphasis is being placed on improvement activity and reporting/sharing work.	
Gill Harris/Adrian Thomas	JAQS 17/5 Clinical Audit Report – GH &AT to discuss highest risk factors outside the meeting.	December 2017	Superseded by discussion and agreement of corporate clinical audit plan at QSG. Revised interim plan includes risk assessment - this will be strengthened going forward (Sept 2019) Approved plan has risk stratification within it	Close

Adrian Thomas – Dawn Sharp	JAQS 17/5 Clinical Audit Report – Future Audit Committee to give consideration to how recommendations from Clinical Audits are followed up.	November 2018	Being addressed as part of the update report prepared for March 2019 Audit Committee. This will be included within the new clinical audit policy and process This is within the draft policy and procedure	Close
Gill Harris	JAQS 17/5 Clinical Audit Report – Areas of concern noted around stroke. GH agreed to liaise with MD Radiology re forthcoming report on Stroke.	December 2017	Action superseded. Subsequent reports presented to QSE Committee. There is an action plan to support the SSNAP audit documented in the report on the agenda for 5.11.19	
Adrian Thomas	JAQS 17/5 Clinical Audit Report – Dementia Strategy to be cross checked against clinical audit plan	November 2018	This will be considered as part of the revised annual plan (Sept 2019) This is within the annual plan	Close
Adrian Thomas	JAQS 17/5 Clinical Audit Report – good news stories to be included in future reports	November 2018	Addressed as part of the update report prepared for March 2019 Audit Committee. This will form part of the reporting system to be developed (QSE reports) This is within the templates	Close
Adrian Thomas	JAQS 17/6 Clinical Audit Plan – AT to give further consideration to the process around inclusion of individual clinical audits within the plan and review the arrangements for the tracking of clinical audit recs with a view to adopting a similar system to that in place for internal and external audit recs.	November 2018	Further consideration given to the process and outlined as part of the update report prepared for March 2019 Audit Committee. This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources. This will be part of the business case – outstanding action	

Dawn Sharp	JAQS17/7 – Quality Assurance Frameworks and Governance Arrangements – report to be presented to the December 2017 QSE	December 2017	Actioned. This will be reviewed as part of the development of the clinical audit policy and process. Will be picked up as part of the ongoing governance review	Close
Dawn Sharp	JAQS17/8.1 – Chair's assurance report – to be prepared.	December 2017	Actioned. Complete.	Close
Dawn Sharp	JAQS17/8.2 – consideration be given to holding an additional meeting prior to November 2018 should the need arise.	November 2018	No additional meeting required	Close
Actions from JAQS meeting 6.11.18				
Dawn Sharp	JAQS18/4 – action log to be prepared and updated to reflect the progress of those actions not yet complete from last meeting	March 2019	Complete	Close
Adrian Thomas	JAQS18/9&10 – Clinical Audit and Outcome Review Plan and update reports – ET re-examine the BCU elements of the clinical audit plan and the process going forward including future presentation, tracking and follow up of recommendations arising, with input from Internal Audit as appropriate.	March 2019	Progress report update on agenda for Audit Committee March 2019 This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources. This will be part of the business case – outstanding action. Need to agree templates; manual collection of information in the interim to populate the reports	
Actions from JAQS meeting 5.11.19				

Joint Audit and Quality & Safety Experience Committee

5.11.19

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Draft Clinical Audit Policy & Procedure
Report Author:	Dr Melanie Maxwell Senior Associate Medical Director/ 1000 Lives Clinical Lead
Responsible Director:	Dr David Fearnley, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	To seek approval from the Committees
Approval / Scrutiny Route Prior to Presentation:	This policy was developed following a workshop with clinical staff from across BCUHB. It has been agreed by the Quality &Safety Group. It was reviewed at Audit Committee in September 2019 and a workshop held around its further development in October 2019.
Governance issues / risks:	This is a new policy & Procedure. The governance arrangements are currently complicated and oversight needs to be strengthened. This will be amended in light of the ongoing quality governance review. There are significant resource gaps in the supporting Clinical Audit and Effectiveness department who will manage the process; a business case will be developed to address this and interim arrangements are being sought.
Financial Implications:	The current departmental budget is £91K overspent due to non-recurrent funding for efficiency savings; the team are below the planned establishment. A business case is in development to support delivering this policy.
Recommendation:	The Joint Audit and Quality, Safety & Experience Committee is asked to approve the policy

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√

1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and Governance			
Equality Impact Assessment Attached			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Version & Reference Number

Clinical Audit Policy & Procedure (DRAFT)

Author & Title	Clinical Audit Policy. Trevor Smith (Head of Clinical Audit and Effectiveness).
Responsible dept / director:	Office of the Medical Director. Dr David Fearnley
Approved by:	Audit Committee
Date approved:	
Date activated (live):	
Documents to be read alongside this document:	BCUHB Quality Improvement Strategy (2017-2020).
Date of next review:	
Date EqIA completed:	28 October 2019

First operational:					
Previously reviewed:					
Changes made yes/no:					

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document

1.0 Introduction / Overview:

1.1 Clinical Audit:

Clinical audit is a multi-professional, multidisciplinary activity.

"*Clinical audit is 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.*"

(New Principles of Best Practice in Clinical Audit (HQIP, January 2011).

"Audit is not concerned primarily with fault or discrepancy finding, but with the examination of working practice to improve effectiveness". Dickens (1994)

Within the Health Board clinical audit is embedded within the future direction of improvement activity. Audit is a tool within the quality framework, identifying and prioritising improvement activities (Quality Planning) and providing assurance about service quality (Quality Control).

Figure 1: Quality Cycle: based on Juran and Godfrey (1999).

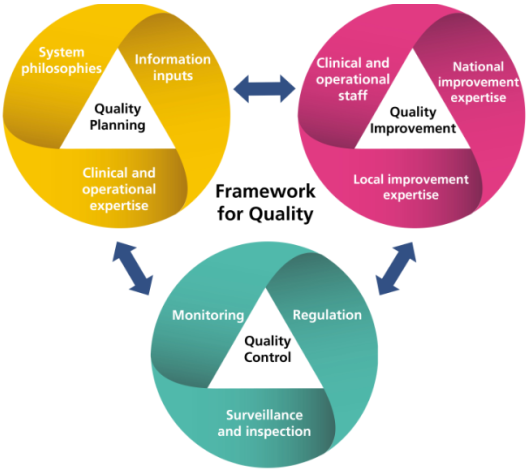


Figure 2 below illustrates the clinical audit cycle for any selected topic:

2.0 Policy Statement

This policy is applicable across all services participating in clinical audit within the Health Board. It sets out the expectations of the Health Board with respect to audit planning, multidisciplinary participation, and acting on the audit findings to maximize its effectiveness.

Clinical audit planning prioritises externally mandated requirements (as documented in the annual *National Clinical Audit and Outcome Review Plan* from Welsh Government), as well as local priorities in line with the Health Board's strategic objectives and risks.
Services should consider audits that provide information and/or assurance relating to key risks and strategies, such as the quality improvement strategy, and other service improvement activity relevant to the Health Board's priorities using the agreed tier structure (see section 8.1).

3.0 Aims / Purpose

This policy aims to support a culture of best practice in the management and delivery of clinical audit.
The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures.

4.0 Objectives

This policy outlines processes in relation to clinical audit activity within BCUHB. It will reinforce its role within the quality framework in delivering quality improvement and quality control.

This includes:

- Topic selection based upon priorities (national and local).
- Local governance arrangements
- Clinical audit and effectiveness training
- Patient and carer involvement
- Roles and responsibilities
- Assurance about the effectiveness of services in relation to best practice

5.0 Scope.

This policy relates to all staff with potential to participate in clinical audit activity within BCUHB; either by professional requirement, individual interest or relevance to the specific pathway / care group related to their role.

6.0 Roles and Responsibilities

6.1 Chief Executive Officer (CEO).

The Chief Executive Officer has overall responsibility in relation to the statutory duty for quality within the organisation and for participation in the mandatory requirements for clinical audit participation, as set out within the Welsh Government's *National Clinical Audit and Outcome Review Plan (NCAORP).*

6.2 Executive Medical Director.

The Executive Medical Director is the Executive lead for clinical audit and effectiveness activity; ensuring that the BCUHB audit plan aligns with mandatory requirements, organisational priorities and is supported across all clinical services including primary, community and secondary care. The Clinical Audit and Effectiveness Department is located within the Office of the Medical Director.

6.3 Professional Leadership Roles.

This group includes other clinical executives, medical directors, nursing directors and other clinical leaders. Staff in these roles will support the implementation of this policy within services that fall within their remit and sphere of influence.

6.4 Clinical Audit Lead.

Clinical audit leads promote clinical audit within their service. They play a key role in the construction and agreement of their service's annual clinical audit plan, allocation of individual audits to a lead auditor, approval of audit projects and the agreement/review of action plans. They will support their clinical lead in implementing this policy locally, and attend the relevant forum where this is discussed.

6.5 Lead Auditors.

Lead auditors are responsible for individual audits. They will ensure the clinical audit cycle is completed in line with their service's clinical audit annual plan. This will include data collection, discussion of the findings and development and delivery of the action plan to improve care. It is their responsibility to escalate any delays or concerns to their Clinical Audit Lead or directly with service leads through the governance framework in place.

6.6 Other Staff.

All staff have a duty to ensure they are providing effective care to deliver best outcomes for patients. Participation in relevant clinical audit to enable benchmarking against key standards, supporting the development of subsequent action plans and undertaking quality improvement activity is expected.

6.7 Clinical Audit and Effectiveness Department.

The department's role is managing the audit process. This includes working with services to develop the annual clinical audit plan, maintaining a central repository of audit activity, monitoring the timely implementation of the plan and delivering assurance reports to relevant governance groups culminating in an annual clinical audit report.

This department will provide proportionate support to BCUHB staff for all stages of the clinical audit cycle; priority is given to the mandatory audits (national or local).

This department delivers ad hoc audit and effectiveness training (see section 11).

7.0 Groups / Committees

The following Groups / Committees have a role in ensuring that clinical audit activity within their remit is optimised in terms of improvement potential and assurance. This will include approval, reporting and monitoring as relevant to each group's terms of reference. (See Appendix 1 – governance structure)

7.1 Audit Committee

The Audit Committee is the approving committee for the annual plan (national and locally prioritised audits). It will seek assurance on the overall plan, its fitness for purpose and its delivery. The role of the Audit Committee is to seek assurance on:

- Does the organisation have a plan - and is it fit for purpose?
- Is it completed on time?
- Does it cover all relevant issues?
- Is it making a difference and leading to demonstrable change?
- Is change supported by recognised improvement methodologies?
- Does the organisation support clinical audit effectively?

7.2 Quality, Safety and Experience Committee (QSE)

The Quality, Safety and Experience Committee requires more detailed assurance that clinical audit is supporting the delivery of effective health care. It requires assurance that clinical audit is used to identify areas for improvement and subsequent actions deliver better outcomes for patients.

QSE will receive the clinical audit annual plan and recommend its adoption to the Audit Committee. It will be the approving committee for the Clinical Audit Policy and Procedure.

7.3 Joint Audit & Quality Committee

This committee meets annually. It includes all members of the Quality, Safety and Experience Committee and Audit Committee. Its purpose is to jointly review the effectiveness of clinical audit and receive the annual audit report.

7.4 Clinical Improvement and Audit Group (CIAGs).

CIAGs are additional audit management groups within the East and Centre. They provides a forum where clinical audit and service evaluation are reviewed and actions agreed; they provide an opportunity to interface between primary and community services. They will escalate any concerns to the relevant Quality & Safety group. They report directly to the Clinical Effectiveness and Audit sub Group.

7.5 Quality and Safety Groups

At each level of service, these groups ensure there is an effective audit function, delivering robust audit that supports quality planning and assurance; leading to safe high quality services. Risks identified through the clinical audit process and outcome will be considered, mitigated and/or escalated as appropriate.

7.6 Clinical Effectiveness and Audit sub Group (CEAsG).

CEAsG provides a forum where clinical audit and service evaluation is discussed as a standard agenda item. In relation to clinical audit, CEAsG receives exception reporting from a number of effectiveness-related groups including the Clinical Improvement and Audit Groups (or equivalent Quality and Safety Group).

This group reports to the corporate Quality Safety & Experience Committee.

8.0 Registration of audits:

All local clinical audit projects conducted within the Health Board must be approved prior to registration, either by the relevant Quality & Safety Group (Tier 2) or by the clinical audit lead (Tier 3), in advance of registration with the CA&E department.

There is a clearly defined application procedure for registration, which involves the following steps:

8.1 Registration Tiers within BCUHB.

Tier 1: National "must do" audits. These are mandated by Welsh Government or other regulatory bodies such as *Medicines & Healthcare products Regulatory Agency* (MHRA). *NB*: All National Clinical Audit and Outcome Review Plan (NCAORP) projects must be incorporated within relevant Divisional/Directorate annual clinical audit plans. They are prioritised above other audits.

Tier 2: Local priority audits: These 'local must do' audits support delivery of the Quality Improvement Strategy goals and priorities, including accreditation requirements specific to the service, NICE guidance compliance, safety audits, audit related to high risk activity and corporately agreed service improvement priorities.
NB: All Corporate projects agreed at BCUHB Quality & Safety Group as priorities must be incorporated within relevant Division/Directorate annual clinical audit plans.

Tier 3: Local audits. This activity relates to those audits that have been prioritised by the Division/Directorate to be included within their local, annual forward plan for clinical audit activity (see section 8.3 below). These should be risk based. All Tier 3 projects must:

- be approved by their Divisional/Directorate Clinical Audit Lead or Primary Care Lead. *NB:* These should not be approved unless there is local capacity and completion will not detract from completing Tier 1& 2 audits, including the associated improvement work.
- be registered with the Clinical Audit & Effectiveness Department (registration form accessed through intranet site via link: http://howis.wales.nhs.uk/sitesplus/861/page/45363
- provide a blank copy of the data collection pro-forma / spreadsheet.
- have a registration form signed by the lead auditor or their clinical supervisor and the Divisional/Directorate Clinical Audit Lead or Primary Care Lead.

NB: It is recognised that tier 3 audits may be undertaken as part of education and/or training, to learn the methodology. However, they should still be subject to completion of the audit cycle.
Quality improvement projects may be driven by audit results; however, they fall outside the scope of this policy. Quality improvement projects should be registered on the quality improvement hub (https://www.bcuqi.cymru)

8.2 Clinical Audit and Effectiveness Department Registration Database

All approved projects are allocated a unique ID number. A database is held within the Clinical Audit and Effectiveness Department, storing all Health Board registered clinical audits/ service evaluations. This facilitates audit activity reporting, identifies potential re-audits and provides evidence to support reviews and Health Board-wide comparison of findings. It

enables quality planning and identification of quality improvement projects to support reliable care.

8.3 Annual Divisional / Directorate Clinical Audit Plan

An annual clinical audit plan will be agreed within each Division/Directorate including Primary Care and Community Services by the end of January. Early allocation of suitable lead auditors and the resources including clinicians' time required to complete the audit will optimise completion of the plan.

A systematic approach which enables the multidisciplinary team to prioritise and agree upon topics for inclusion would be recommended with domains which may include:

- ***Frequency*** ('how often' or 'how many'?)
- ***Degree of risk*** (likelihood of something going wrong or not being done).
- ***Level of concern*** (how important is the question?)
- ***Outcome*** (what is the impact in relation to potential for improvement/harm?)

(Welsh Assembly Government, 2003)

8.4 Corporate Clinical Audit Annual Plan

The corporate clinical audit annual plan will be agreed by the end of February each year.
This will include all identified tier 1 and tier 2 audits.
Tier 1 audits will capture in-year data collection and/ or review of report and action planning. Some audit reports will be an analysis of historic data, usually from the previous year.
Tier 2 audits will be based on audits identified by the Clinical Executive Leads as well as Divisional Management teams in line with section 8.1 above.

8.5 Clinical Audit and Effectiveness Department Support

The Clinical Audit and Effectiveness Department is resourced to support Tier 1 and Tier 2 activity. Tier 1 activity will be prioritised.
Clinical Audit and Effectiveness (CA&E) staff will meet with lead auditor(s) to assess the level of support they require and to:

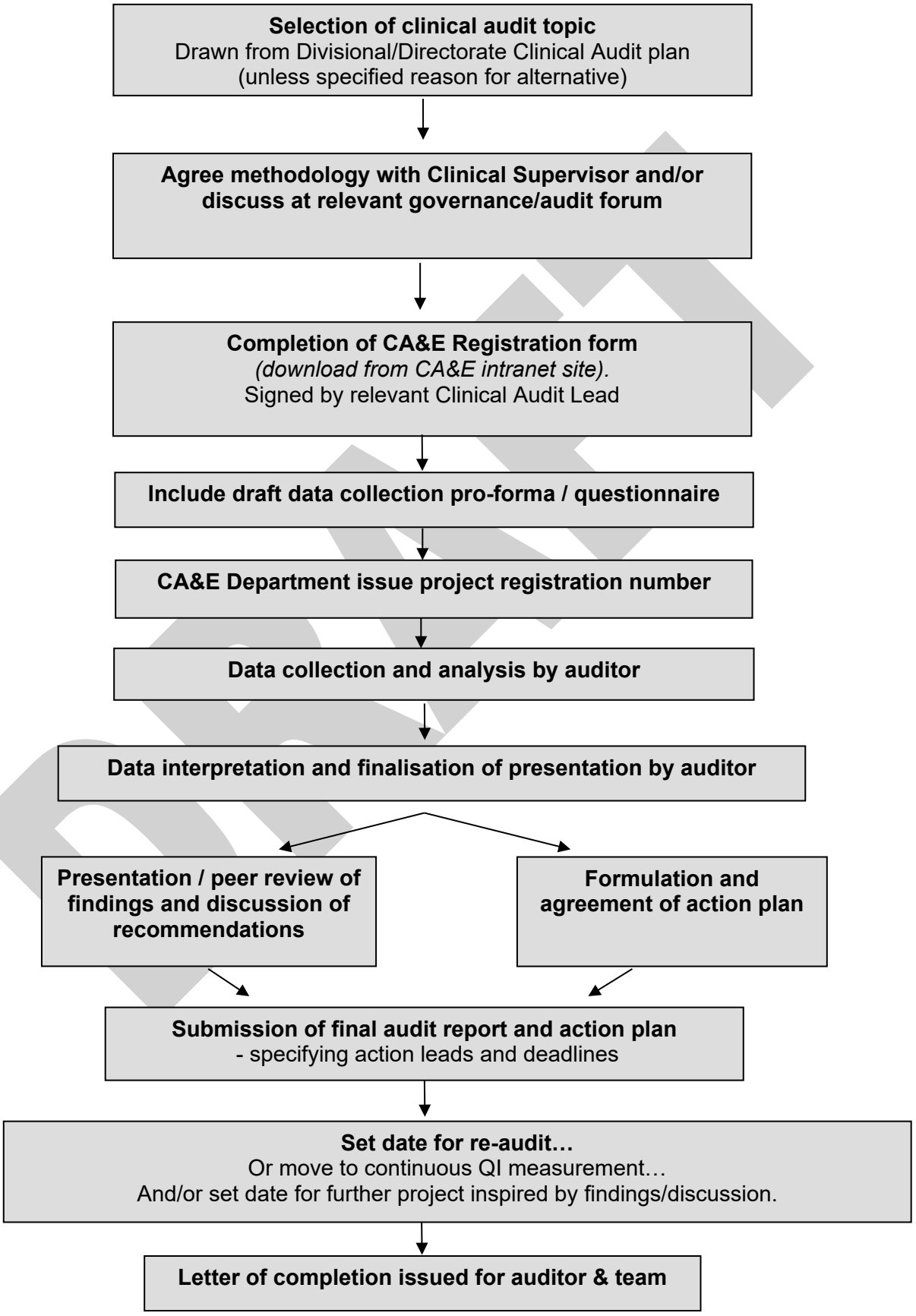
- Identify potential for patient participation/involvement.
- Identify potential for multidisciplinary participation/involvement.
- Agree the proposed methodology.
- Assist/advise with identification of evidence-base/critical appraisal.
- Assist with construction of clear and measurable audit standards.
- Agree data collection pro-forma/questionnaire format.
- Confirm local management support.
- Confirm the appropriate Divisional/Directorate audit lead is aware of the project.
- Agree project timescales (including planned presentation date).
- Ensure Welsh Government returns are completed in a timely manner.

8.6 Assurance Reporting

The Clinical Audit and Effectiveness department will produce quarterly annual plan monitoring reports to the Quality, Safety & Experience Committee. These reports will be cumulative, building to an annual report that will be received by the Joint Audit & Quality Committee in November each year. The report will document progress against the plan and highlight key service improvements related to clinical audit activity.

PROCEDURE

Figure 1: **Algorithm displaying clinical audit registration and progression.**



9.0 Developing a Clinical Audit Project

The process for clinical audit project development, registration and progression are displayed in algorithm format above.

9.1 Selection of topic

The Divisional / Directorate Annual Clinical Audit plan identifies the topics for Supervisors advising their trainees, juniors and other colleagues. Staff contacting Clinical Audit and Effectiveness department for advice will also be directed to these plans and the relevant Clinical Audit Lead for their clinical area.

9.2 Multidisciplinary audit

Clinical Audit Leads and lead auditors will assess all audits in relation to their potential for multidisciplinary and multi-professional involvement. Consultation with all relevant staff groups should occur. Where applicable, the lead auditor will be advised to invite participation from colleagues representing other professionals appropriate to the topic and also consider Managed Clinical Services colleagues such as Radiology and Pathology.

Multidisciplinary audit refers to a clinical audit team composed of representatives from at least two different disciplines (ideally those associated with the episode of care being audited).

9.3 Patient and Public Involvement

In planning each audit the potential for service user, carer and/or public involvement should be assessed and promoted. This may involve communication with appropriate forums relevant to the topic and/or the service to achieve this. This would range from gaining feedback regarding the proposed audit pro-forma/questionnaire to direct involvement where possible with other stages of the audit, guided by the relevant Information Governance considerations.

9.4 Presentation / dissemination / feedback

All lead auditors will feedback their findings to the relevant service forum, where peer review will confirm that the findings are clinically robust. In addition, findings will be shared as widely amongst the Health Board as appropriate to the topic.
Auditors will agree, in discussion with their Clinical Audit Lead, the appropriate venue for PowerPoint style presentation (see Appendix 2 - template) and efficacy of utilising other media options (poster, circulation of brief written report, intranet, etc.).

9.5 Action planning

Where recommendations are made as a result of the audit, an action plan must be developed following consultation with the relevant staff (ideally at a service forum). Peer review will ensure that findings are disseminated and ascertain whether the recommendations are robust. The action plan must be specific, objective, set within measurable timescales and accountable in relation to who is responsible for each action. (See appendix 3 - action plan template).

9.6 Submission of Clinical Audit Report

On completion of the audit, the lead auditor is required to provide the Clinical Audit and Effectiveness department with a copy of the final report and action plan (see Appendix 4 – report template).

9.7 Re-audit

Re-audit is not always necessary. For example, if no improvement needs have been identified or there is an alternative methodology to ensure improvement. In the latter case, it is important that all recommendations are tracked and monitored through the appropriate committee. Where assurance is required through audit, this needs to be included within a future clinical audit annual plan.

9.8 Letter of Completion for Project Lead

On receipt of the final report, the lead auditor/team (who demonstrate direct contribution) will be issued with a letter confirming their participation by the Clinical Audit and Effectiveness department. This letter will include additional bullet points as evidence is provided, such as:

- Presentation/dissemination/Peer Review of findings.
- Agreement of recommendations/action plan.
- Implementation of intervention.
- Re-audit (or clearly scheduled date and allocation of new lead).
- Clear link to another related project topic (audit, service evaluation, research).

9.9 Assurance

The Clinical Audit and Effectiveness department will be responsible for:

- Collating the annual clinical audit plan each new financial year,
- Providing the Quality, Safety and Experience Committee with cumulative quarterly reports leading to an annual report that monitors progress against the plan.
- Providing JAQS with an annual report against plan.

10.0 Equality, including Welsh Language

An Equality Impact Assessment (EqIA) has been completed and a positive impact anticipated.

11.0 Training

All staff participating in clinical audit activity should have a good understanding of this methodology.
There is an 'e' learning '*Introduction to Clinical Audit'* training session which is accessible through the BCUHB intranet site:
http://howis.wales.nhs.uk/sitesplus/861/page/59825

In addition, the Clinical Audit & Effectiveness department will respond to requests to provide face to face sessions for teams where this can be delivered within capacity.

12.0 Review

The Clinical Audit Policy, as a new policy will be reviewed in one year's time and then on a three year cycle.

13.0 References

DICKENS, P. (1994). In: Welsh Assembly Government. (2003). *An introduction to clinical audit.* Wales

Healthcare Quality Improvement Partnership (HQIP). (2011). *New Principles of Best Practice in Clinical Audit.*

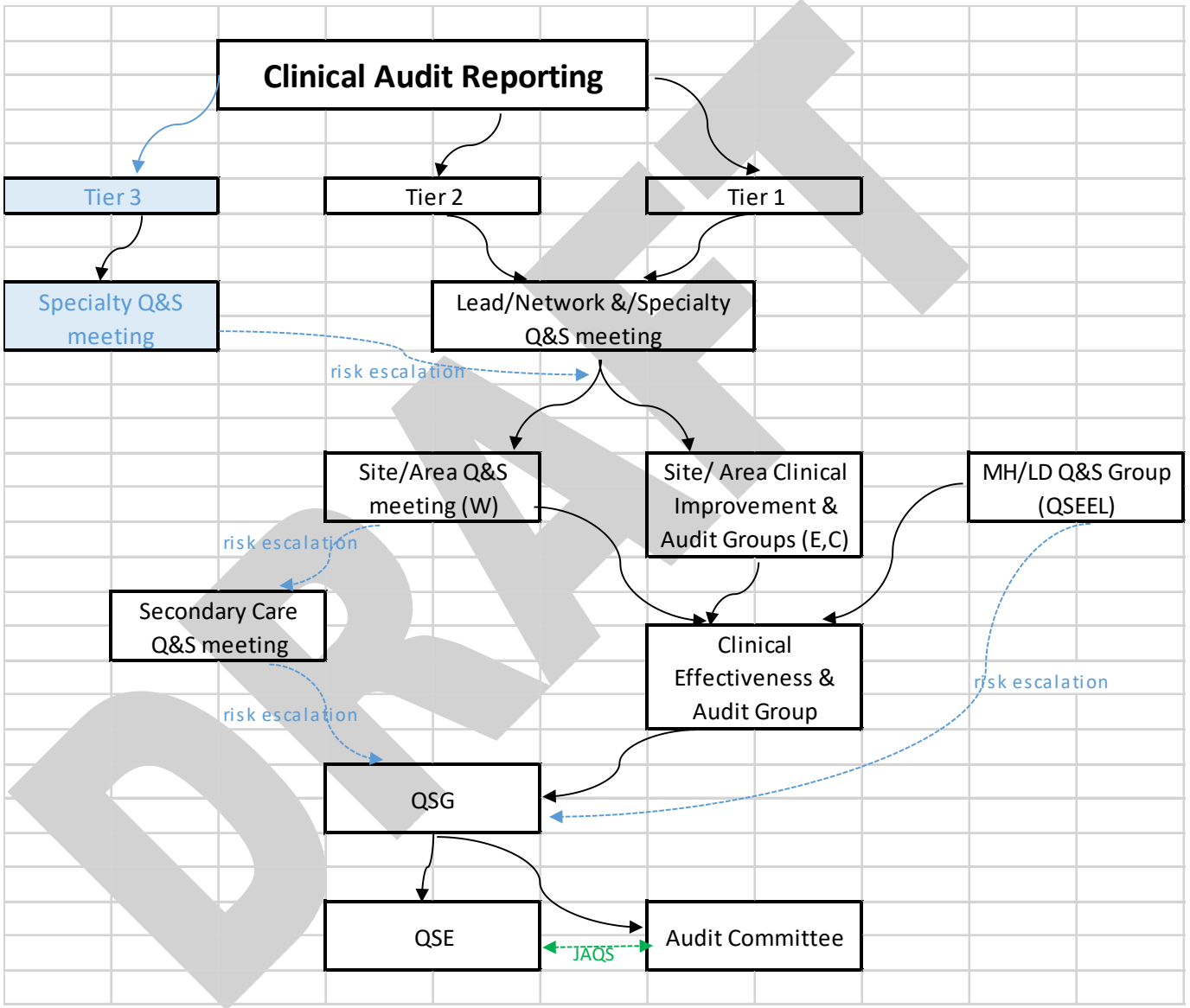
JURAN, J.M., GODFREY, A.B. (eds). (1999). *Juran's Quality Handbook.* 5th Edition. New York: McGraw Hill.

Welsh Assembly Government. (2003). *An Introduction to Clinical Audit*. Wales.

14.0 Appendices

Appendix 1: Governance

NB: Quality governance structures are currently under review and this will be amended once agreed.



Appendix 2: Template for PowerPoint presentation slides.
Here you will see suggested slide headings which contain guidance notes to advise on what to include within each section.

Using PowerPoint to present your findings

Title of Audit……

Project lead / team

Service / Specialty

Date of presentation

Name of forum

Introduction / Background

Set the scene…..

- Outline why you conducted it and provide enough background information regarding the setting and history of the unit/team.
- State which guidelines/standards/research you selected to measure practice against?
- Explain treatment/care pathway (include relevant structures and processes).
- Refer to previous audits, associated findings or recommendations.

01/08/2019 *2*

Aim / Goals

Specify your Aim:

- This will be an overarching statement, which highlights what you want to achieve.

Specify the Objectives:

- This breaks down the aim into manageable, measurable and objective actions.

01/08/2019 *3*

Methodology

What was audited and how?

Include sample criteria:

- Inclusion/exclusion criteria?
- Random, stratified, etc.
- How many did you audit?
- Where applicable, demographics may be added.
- Specify the dates within which your sample falls.

Include data collection:

- Retrospective or prospective?
- Who collected the data?
- Provide details of your pilot study (numbers, changes made).

01/08/2019 *4*

Standards

- What were the standards that you measured against?
- What was the evidence-base?

01/08/2019 *5*

Results

What were your results against the standards you measured against.

- Draw out the meaningful data
  - Choose and appropriate graphical format. What is your n value and total? Don't forget your chart title.
  - Consider presenting percentages against each standard, alongside comparable data where applicable (e.g. previous findings or other dept).

Remember…….

- A consistent approach to use of numbers or percentages will minimise confusion.
- Maintain anonymity of clinicians and patients.

01/08/2019 *6*

Conclusions

- Please highlight problem areas, improvement needs and any areas of good practice.
- Draw together your findings, highlighting main points for discussion and action.

01/08/2019 7

Recommendations / Action Plan

What now?

Include

Recommendations and relate back to your audit standards.

- Where were these discussed (forum).

Describe your action plan.

- Specify who is responsible for each action – ensure that they agree to this!
- Set timescales and review dates (if applicable) for each action.
- Make actions realistic and achievable.

Date for re-audit (if appropriate).

01/08/2019 8

Next steps

After presenting your findings:

Communication is key.

- Agree:
  - action plan following peer review discussion.
  - review date to monitor actions.
  - Re-audit date.
  - Consider: continuous measurement, research or other QI methodology (as appropriate).
- Ensure handover of actions to willing colleague if leaving.
- Agree on appropriate further dissemination of results to MDT colleagues.

01/08/2019 9

Appendix 3: Action planning template

Title			
Audit Lead		**Author:**	
Contributors			
Approving Committee		**Date:**	
Is this on the risk register		**If yes, Score:**	

Action Plan:
(Please complete the action plan to specify how improvements will be made - i.e. what will be done, when and by whom?)

Problem identified	**Action**	**By Who**	**By When**
Re-audit:	Date:	By Whom:	

Appendix 4 (overleaf): Template for final Clinical Audit report

Use attached guidance sheet: "Using Template Format for Clinical Audit Report".

Auditor (person conducting audit):	**Audit No:**	**Date:**
Audit Team members:	**Speciality / Service:**	

Full title of clinical audit project:
Include enough information to make the topic and location clear.

Introduction / background:
Set the scene for your audit. Outline why you conducted it and provide the reader with enough background information to understand the setting and history of the unit/team.

- What are the reasons for selecting this topic?
- Which guidelines/standards did you select to measure practice against?
- Refer to and summarise any relevant research or other forms of evidence.
- Outline topic-specific information and explain abbreviations or specialised terminology.
- Explain treatment/care pathway (including relevant structures and processes).
- Refer to previous audits and associated findings or recommendations.

Specify Aim:
This will be an overarching statement, which highlights what you want to achieve.
Specify Objectives:
This breaks down the aim into manageable, measurable and objective actions.

Standards:
What were the standards that you measured against – what was the evidence-base?

Methodology:
Explain the audit methodology you used, including sample criteria, time period and data sources used (i.e. what was audited and how?)

This section is important as it needs to make explicit the *'who, how, when and where'* elements of your project procedure. As in a scientific report, it is important that anyone wanting to replicate your project can do so by following your methodology.

The sample:

- Were there any inclusion/exclusion criteria?
- How was your sample selected? - random, stratified, etc.
- How did you identify participants? - Information Dept, admission book, etc.
- How many did you audit?
- If cases were missing - specify why (e.g. notes missing).
- Where applicable, demographics may be added (either here or in your results section)
- Specify the dates within which your sample falls.

The data collection:

- Was your data collection retrospective or prospective?
- Who collected the data?
- When were pro-forma/questionnaires completed/returned?

The pilot:

- Provide details of your pilot study (numbers, changes made).

Did you include your pilot data in your final analysis? If not, outline reason (e.g. data items changed significantly following pilot).

Results:
Provide the results of audit against the standards that you were measuring against and also any supporting or additional information. *Table format provided below*.

- Present only results that relate to the audit criteria.
- Don't be tempted to flood the reader with unnecessary data. The clarity of the point you are trying to communicate may be lost.
- Follow a logical order and grouping of results (such as the care pathway).
- Draw out the meaningful data and present in an accessible and graphical format (where applicable).
- Ensure all charts and tables are titled and state the 'n value' (total number 'out of').
- State how the data was stored and analysed (such as Excel or SPSS).
- It may be useful to use a table to present percentages against each standard, alongside comparable data where applicable (e.g. previous findings or other dept).
- A consistent approach to use of numbers or percentages will minimise confusion.
- Maintain anonymity of clinicians and patients.
- Use objective statements and avoid subjectivity.

No.	Standard	% Achieved	% Not Achieved
1.			
2.			
3.etc.			

Conclusions:
Please highlight problem areas, improvement needs and any areas of good practice.
Draw together your findings, highlighting main points for discussion and action.

Recommendations:
Clearly state your recommendations and relate back to your audit standards.

Action Plan:
Please complete the action plan to specify how improvements will be made - i.e. what will be done, when and by whom?
Complete the action plan to specify how improvements will be made (i.e. what will be done, when and by whom).
Following discussion of the recommendations at the appropriate forum, construct an action plan.

- Specify who is responsible for each action – ensure that they agree to this!
- Set timescales and review dates (if applicable) for each action.
- Make actions realistic and achievable.
- Set a date for re-audit (if appropriate).

Problem identified	Action	By Whom	By When
Re-audit:	Date:	By Whom:	

How has / will the clinical audit improve patient care? Please summarise the way in which your findings and implementation of recommendations will improve care.
References:
All full list of references should be provided using a recognised referencing system (such as Harvard).
Appendices:
Always include the clinical audit pro-forma within your appendices.
Ensure that a copy of the report is sent to the Clinical Audit and Effectiveness Department and the Specialty / Service clinical audit lead.

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EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown "due regard" to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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University Health Board

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Clinical Audit Policy & Procedure
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This policy describes the management and processes needed for effective, efficient clinical audit. It relates to all services across the Health Board and all staff participating in audit. The aim is to reinvigorate clinical audit to ensure it is part of the quality framework identifying areas of good practice, areas that require improvement and proving assurance when these changes have been made. The objectives are to increase the effectiveness and efficiency of audit across the services.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Executive Medical Director. Quality, Safety & Experience Committee Audit Committee
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	BCUHB Quality Improvement Strategy. National Clinical Audit & Outcome Review Plan (NCAORP) - Annual release
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	This policy relates to all staff with potential to participate in clinical audit activity within BCUHB; either by professional requirement, individual interest or relevance to the specific pathway / care group related to their practice.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	There needs to be: • Good communication and dissemination regarding the policy. This will be through an implementation plan including: ➢ BCUHB Intranet. ➢ Relevant BCUHB groups and forums. ➢ Cascade through Clinical Audit / Governance / Quality leads.

		➢ BCUHB Communication Department circulations. • Resources to support engagement in participation (capability and capacity of staff, lack of digital infrastructure). • Clear understanding of processes related to the policy.

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	**N**		The policy addresses engagement with clinical audit activity at all levels within BCUHB: • Tier 1: National Clinical Audit & Outcome Review Plan (Welsh Government mandated projects). • Tier 2: BCUHB Corporate clinical audits. • Tier 3: Locally prioritised clinical audits (Divisional / Directorate). Clinical Audit & Effectiveness (CA&E) Department support is provided equally to all BCUHB staff and with respect for diversity. All CA&E Department team members have completed the Equality & Human Rights online training. This is a mandatory training requirement for staff within BCUHB.
Disability	**N**		*As above.*
Gender Reassignment	**N**		*As above.*
Marriage & Civil Partnership	**N**		*As above.*
Pregnancy & Maternity	**N**		*As above.*
Race / Ethnicity	**N**		*As above.*
Religion or Belief	**N**		*As above.*
Sex	**N**		*As above.*
Sexual	**N**		*As above.*

Orientation			
Welsh Language	**N**		*As above.*
Human Rights	**N**		*As above.*

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	Clinical Audit & Effectiveness (CA&E) Department support is provided equally to all BCUHB staff and with respect for diversity. All CA&E Department team members have completed the Equality & Human Rights online training. This is a mandatory training requirement for staff within BCUHB. The premise of clinical audit is to establish the extent to which evidence-based standards are evidenced in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	The premise of clinical audit is to establish the extent to which evidence-based standards are evidenced in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all.
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	The policy would: • Promote good practice as outlined above and encourages adherence to National guidance and standards.

	• Promote standardisation and equality of access to good practice. • Encourage patient and public involvement in clinical audit activity.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	Clinical Audit Policy

2. Brief Aims and Objectives: (Copy from Form 1)	This policy will act as a foundation to underpin clinical audit project management and guide the enthusiasm of BCUHB staff as they seek to gain an objective measure of their performance and achieve improvement needs through clinical audit activity.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No ✓
3b. Could any of the protected groups be negatively affected?	Yes	No ✓
3c. Is your decision or policy of high significance?	Yes ✓	No

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No ✓
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic? The assessment above and within Part A demonstrate the positive impact that this policy will have upon the promotion and quantification of good practice. This will optimise equality of access to standardised care and treatment that is evidence-based and reduce unnecessary variation.	
5. If you answered 'no'	Yes	No ✓

above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Record Details:	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes ✓	No
	How is it being monitored?	Review date will be set. Reporting and scrutiny of clinical audit occurs within the Health Board at many levels relating to Tier 1, Tier 2 and Tier 3 activity. This ranges from Divisional / Directorate forums, the Quality & Safety Group structure through to Audit Committee. The writing of the policy relates to recent strengthening of accountability regarding clinical audit activity within BCUHB.
	Who is responsible?	Regarding the policy, the Office of the Medical Director.
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? A process of review of reporting regarding clinical audit activity also forms part of the strengthening of accountability referred to above. This is to be explored through a bespoke workshop session.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	This will be reviewed alongside the scheduled review of the policy.

7. Where will your decision or policy be forwarded for approval?	BCUHB Joint Audit and Quality & Safety Committee

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	A bespoke workshop has been organised for this and other associated purposes. Attendees were requested to circulate to their relevant Quality & Safety Groups for feedback. Members of Clinical Improvement & Audit Groups (via the CEAsG) This was circulated to all divisional Quality & Safety meetings and the corporate Quality &

	Safety Group.

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Trevor Smith	Head of Clinical Audit & Effectiveness
	Dr Melanie Maxwell	Senior Associate Medical Director
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No potential negative impact identified	N/A	N/A
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	Strengthening of the Equality and Human Rights section of the document. Meeting with Patient Experience Manager	Trevor Smith	Before completion of final draft
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	No potential negative impact identified	N/A	N/A
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	No potential negative impact identified	N/A	N/A
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Strengthening of the Equality and Human Rights section of the document. Meeting with Patient Experience Manager	Trevor Smith	Before completion of final draft

Joint Audit and Quality, Safety & Experience Committee

5.11.19

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Draft Clinical Audit Reporting Templates
Report Author:	Dr Melanie Maxwell Senior Associate Medical Director/ 1000 Lives Clinical Lead
Responsible Director:	Dr David Fearnley, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	For discussion
Approval / Scrutiny Route Prior to Presentation:	The attached templates have not yet received prior scrutiny. It had been hoped to discuss the templates at the recent Audit Committee workshop but time did not allow for this to happen.
Governance issues / risks:	The templates need to provide sufficient information for the Committee to discharge its duties whilst not overwhelming the Committee. The risk is the resource to collate the required information if the clinical community does not engage with this process.
Financial Implications:	The current departmental budget is £91K overspent due to non-recurrent funding for efficiency savings; the team are below the planned establishment. A business case is in development.
Recommendation:	The Joint Audit and Quality, Safety & Experience Committee is asked to comment if the level of detail suggested is sufficient and to discuss what further information may be required.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	

2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and Governance			
Equality Impact Assessment Not required			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Annual Report:

LEAD SERVICE:	SECONDARY CARE			EAST	CENTRE	WEST	MENTAL HEALTH	PRIMARY CARE
	WMH	YGC	YG					
Nos audits registered from 1st April								
Nos new audits registered from 1st April								
Nos Tier 1								
Nos Tier 2								
Nos Tier 3 reported								
Tier 1								
Nos New in year								
Nos Ongoing (continuous monitoring)								
Nos re-audits								
Nos in progress								
Nos abandoned								
Nos Report available								
Nos Parts A/B overdue								
Nos Confirmed acceptable practice								
Nos completed projects								
Tier 2								
Nos New in year								
Nos Ongoing (continuous monitoring)								
Nos re-audits								
Nos in progress								
Nos abandoned								
Nos deferred								
Nos Report available								
Nos with action plan								
Nos confirmed acceptable practice								
Nos completed projects								

Narrative:								
Lead Service:	**SECONDARY CARE**			**EAST**	**CENTRE**	**WEST**	**MENTAL HEALTH**	**PRIMARY CARE**
	WMH	**YGC**	**YG**					
Tier 1 for each audit report								
Does it include local data?								
Highlight good practice (benchmarking)								
Is the organisation considered an outlier	Yes/No							
What is the standard(s) and action to address it?								
What are the local improvements								
Actions completed in year								
Evidence of improvement								
Tier 2 for completed audits								
Highlight good practice - standards meet expectation								
What are the local improvements								
Actions completed in year								
Evidence of improvement								
Requires re-audit? when								
Tier 2 ongoing audits								
Highlight good practice - standards meet expectation								
Areas for improvement - actions to address								
Reasons for abandoned audits								
Reasons for defering audits								

Tier 1 report

Title of Clinical Audit:				
Host Organisation:			Date of last National report:	
Data collection:	Continuous		Re-audit	New
BCUHB-wide lead:	East lead:		Central lead:	West lead:
Participated in data requirements:	East		Central	West
Part A / B completed:	East		Central	West

Examples of good practice related to this project:

Relates to improvements on previous audit performance/ achieving standards set

Standards requiring improvement :

BCUHB actions agreed:	By whom?	By when?	Progress:

Standards requiring improvement :

BCUHB actions agreed:	By whom?	By when?	Progress:
Progress against Plan	On track		Delayed (remedial action)

Tier 2 audits

Title of Clinical Audit:					
Status of audit	not started	data input	analysis	report writing	
	dissemination	action planning	improvement work		closed
Progress against plan:	on track		delayed (remedial action)		
Division(s):					

Examples of good practice related to this audit:

Relates to improvements on previous audit performance/ achieving standards set

Standards requiring improvement :

BCUHB actions agreed:	By whom?	By when?	Progress:

Standards requiring improvement :

BCUHB actions agreed:	By whom?	By when?	Progress:

Joint Audit and Quality, Safety & Experience Committee

5.11.19

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Clinical Audit Report 2019 (Draft)
Report Author:	Dr Melanie Maxwell Senior Associate Medical Director/ 1000 Lives Clinical Lead
Responsible Director:	Dr David Fearnley, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	For discussion
Approval / Scrutiny Route Prior to Presentation:	None – This is the first report in a new format that seeks to provide assurance about the effectiveness and efficiency of audit.
Governance issues / risks:	The report includes a participation by area for Tier 1 audits and those tier 2 audits analysed by the Clinical Audit and Effectiveness department. There is substantial tier 3 activity that requires further assessment. Respiratory audit compliance is the main concern – this is a resource issue and needs both additional posts and job planning to resolve. In 2019/20, we have submitted data to the National Audit of Care at End of Life for the first time. For those tier 1 that have reported out; there is some evidence of action planning but improvement will require re-audit. For tier 2 audits, this on more limited still. Currently this report provides limited assurance about the audit function; this should improve as the year progresses. There are identified risks around: • Poor implementation of the new procedure due to lack of resources within clinical teams. This will in part be mitigated through job planning, closer linkage of the plans to quality improvement activity and training. • Lack of resources within the corporate team to both support and track priority audits – a business case is being developed. If there is no additional resource then they will need to focus all activity on tier 1 audits
Financial Implications:	Need to explore options for tracking audit and actions – this is likely to have cost implications

Recommendation:	The Joint Audit and Quality, Safety & Experience Committee is asked to acknowledge this update and consider what additional information is required going forward.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and Governance			
Equality Impact Assessment Not required			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

DRAFT

Clinical Audit Report 2019

Quarter 2: from 01/04/19

1.0: Introduction

> "*Clinical audit is 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.*"
>
> *(New Principles of Best Practice in Clinical Audit (HQIP, January 2011).*

During 2019/20, BCUHB has been working to reinvigorate clinical audit and embed it within the quality framework; identifying improvement opportunities to support quality planning and also to provide assurance that changes made have led to improvement (see Appendix 1 – logic model).

Over the last quarter, there has been a focus on identifying the appropriate tier 2 (local priority) audits that are linked to key strategic priorities and risks, culminating in a plan that was approved at Audit Committee in September 2019. Going forward this plan (comprising of tier 1 (nationally mandated) & 2 audits) will be refreshed and approved in line with the new financial year. A clinical audit policy and procedure has been drafted and will be presented for approval at the Joint Audit, Quality & Safety Committee in November 2019. In parallel, work is ongoing to strengthen the clinical ownership of clinical audit through the existing governance structures. Whilst this work has been predominantly focussed within the acute sites to date, there is a commitment to ensure all services are represented going forward.

It should be noted that the quality governance review currently being undertaken will include a review of the clinical audit; changes will be made in line with the outcome of this review.

This report describes our position against the current plan and will evolve over time. Going forward, there is an expectation of quarterly reports to the Quality, Safety and Experience Committee that are cumulative with the Quarter 4 report being the full annual report and will be presented to JAQs in November each year.

2.0: Audit Activity

For the tier 1(nationally mandated) audits, BCU completed data submission to the majority of tier 1 audits. One was missing completely, the others partially complete (see below).
Reports have been received for 22 tier 1 audits. There is an assurance form required by Welsh Government to ensure that reports have been received, areas for improvement identified (Part A) and intended actions agreed (Part B). Twenty reports required this return of which 16 have either reported already or are on track to do so with plans awaiting discussion or sign off. Four have not responded within time and have been escalated; this includes the respiratory audits where no local data were inputted (see below). Table 1 reports the activity during the first six months of this plan.

KEY:

Yes	All the relevant services have complied with the requirement
No	No service has complied with the requirement
Partial	Some services have complied – and those services that have complied are named
N/A	Not applicable (at the time of writing)
N/R	Not required (by Welsh Government); usually not reported at HB level
In process	Relates to reports recently received where part A&B not developed and not yet due or developed and waiting for sign off

Table 1: Tier 1- National Clinical Audit & Outcome Review Plan (NCAORP)

Project reference	Title	Data submission	Report delivered	Part A/B returned
NCAORP/2019/01	National Joint Registry (NJR)	Yes	No	N/A
NCAORP/2019/02	National Emergency Laparotomy Audit (NELA)	Yes	No	N/A
NCAORP/2019/03	Comparative audit of critical care unit adult patient outcomes (casemix) ICNARC	Yes	No	N/A
NCAORP/2019/04	Trauma Audit & Research Network (TARN)	Yes	No	N/A
NCAORP/2019/06	National Diabetes Foot Care Audit	Yes	Yes	Yes
NCAORP/2019/07	Diabetes Inpatient Audit (NaDia)	Yes	Yes	Partial (Centre/East)
NCAORP/2019/08	Pregnancy in Diabetes Audit Programme	Yes	Yes	N/R
NCAORP/2019/09	National Core Diabetes Audit:			
	• Core Report 1 – Care Processes and Treatment Targets	Yes	Yes	N/R
	• Insulin Pump	Yes	Yes	Yes
NCAORP/2019/10	National Diabetes Transition Report	Yes	Yes	No
NCAORP/2019/11	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	In process
NCAORP/2019/12	National Asthma & COPD Audit Programme (NACAP): Children and Young People Asthma	Yes	No	N/A
NCAORP/2019/13	NACAP: Adult Asthma	Partial (Centre)	Yes	No
NCAORP/2019/14	NACAP: COPD	Partial data (Centre/West incomplete)	Yes	No
NCAORP/2019/15	NACAP - Pulmonary Rehabilitation workstream	Yes	No	N/A
NCAORP/2019/16	Renal Registry	Yes	No	N/A
NCAORP/2019/17	National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	In process
NCAORP/2019/18	All Wales Audiology Audit	Yes	No	N/A
NCAORP/2019/19	Stroke Audit (SSNAP)	Yes	Yes	Yes
NCAORP/2019/20	Falls & Fragility Fractures Audit Programme: National Hip Fracture database	Yes	No	N/A
NCAORP/2019/21	Falls & Fragility Fractures Audit Programme: In-patient Falls Audit	Yes	No	N/A
NCAORP/2019/22	Falls & Fragility Fractures Audit Programme: Fracture Liaison Service	No	No	N/A
NCAORP/2019/23	National Dementia Audit	N/A	Yes	In process
NCAORP/2019/24	National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	Yes
NCAORP/2019/25	National Audit of Care at the End of Life (NACEL)	Yes	Yes	Yes

NCAORP/2019/26	National Heart Failure Audit	Yes	Yes	In process
NCAORP/2019/27	Cardiac Rhythm Management	Yes	Yes	In process
NCAORP/2019/28	PCI Audit (previously Coronary Angioplasty Audit)	Yes	Yes	In process
NCAORP/2019/29	MINAP	Yes	Yes	In process
NCAORP/2019/30	National Vascular Registry Audit (inc. Carotid Endarterectomy Audit)	Partial	No	N/A
NCAORP/2019/31	Cardiac Rehabilitation	Yes	No	N/A
NCAORP/2019/32	National Lung Cancer Audit	Yes	Yes	Yes
NCAORP/2019/33	National Prostate Cancer Audit	Yes	Yes	Yes
NCAORP/2019/34	National Gastrointestinal Cancer Audit Programme: Oesophago-gastric:	Yes	No	N/A
	Bowel:	Yes	No	N/A
NCAORP/2019/35	National Neonatal Audit Programme (NNAP)	Yes	No	N/A
NCAORP/2019/36	National Maternity & Perinatal Audit: Organisational report:	Yes	Yes	In process
	Clinical report:	Yes	Yes	In process
NCAORP/2019/37	Epilepsy 12 - Clinical	Yes	No	N/A
NCAORP/2019/38	National Clinical Audit of Psychosis	Yes	No	N/A

There has been some improvement in participation to date. In 2019/20, we have submitted data to the National Audit of Care at the End of Life. There is one audit with no data submitted-

There does continues to be non-participation with the following NCAORP projects due to resourcing challenges:

- **COPD / Asthma (East and West).**
- **Fracture Liaison Service.**
- **Vascular audit (Lower limb Angiography)**

The sites have been asked for a plan to deliver these. West have identified some additional resource to support respiratory audit. In the East, this is more complex as they have staffing vacancies and reduction in consultant hours. This will be addressed through job planning and recruitment. It has been escalated to Secondary Care Medical Director.

Discuss held with the fracture liaison service requires additional administrative support; however this has not been forthcoming.

The missing information for the vascular audit relates to interventional radiology and needs to be addressed as more capacity becomes available.

Where parts A&B are overdue, escalation is in place and lack of leadership is the issue. Where services have not contributed to the report it is the same resource issue as above. There is ongoing dialogue with areas about the diabetes audit reports and subsequent action planning.

Table 2: Changes identified on Part A& B:

National Audit of Breast Cancer in Older Patients (NABCOP)	No outlier issues identified: A workshop was held to review and address data requirements and this is being addressed through the MDT Need to audit radiotherapy rates after breast conserving surgery and mastectomy to ensure conforming to best practice
National Audit of Care at the End of Life (NACEL)	No Health Board data was submitted. One recommendation of the report was to strengthen governance arrangements. The Introduction of a Palliative Care and End of Life Strategic Group - Planned from Nov 2019 will be chaired by Dr Chris Stockport.
National Lung Cancer Audit	YGC outlier – low referral for surgery?– They have established weekly attendance by Cardiothoracic Surgeon, established a physician led surgical follow up clinic, and a virtual nodule pathway; patients were also opting for alternative treatments that are offered. There is also a plan to audit the dataset again to see if opportunities were missed. WMH outlier – low chemotherapy? - Established a data error that was amended. Worked with clerks in service to ensure data entry was accurate.
National Prostate Cancer Audit	No outlier issues identified: A pathway to support NICE guidance with surveillance and use of MRI scanning has been developed and are in process for agreement. There are capacity issues that need to be modelled to ensure this does not lead to delay. There is a review of performance indicators for local practices and this requires resourcing.
Sentinel Stroke National Audit Programme	There were a number of issues raised throughout the pathway (6 nationally; 2 local). Changes implemented include developing a protocol to ring fence beds discussed at site safety huddles. Education and awareness sessions with the acute teams to improve early diagnosis, treatment and referral timing; pilot clerking proforma for patients to transfer to the stroke unit; business case for extra resources (stroke coordinators – 1wte/site/ SALT/ OT/Physio) ; pilot rapid CT pathway; enable stroke coordinators to request CT scans; pre alert system with WAST; improved referral processes for SALT assessments

Tier 2: Corporate Clinical Audit projects (2019/20)

Due to the late development of the full plan, a complete update is unavailable for this report for those audits not completed within the corporate Clinical Audit & Effectiveness Department. However, it should be noted that a number of tier 2 audits were not due to start until quarter 3.

There are some on-going audits and these have been reported on track; such as the ward manager's weekly audit, the ward accreditation programme. Audits performed within the research department are ad hoc dependent on the sponsorship of trial.

Table 3: Progress report:

Audit identifier	Audit title	Progress	Comment
CORP 19/20-03	Medications Transcription and eDischarge (MTeD)	On track	Data – almost complete. Draft report commenced
CORP/19/013	HASCAS End of Life Audit	Action plan being progressed	Action identified was out of date pathway in critical care; in process of updating (minor delay waiting for national release of new guidance).
CORP/19/20-02	Record Keeping (re audit)	On track	East data capture completed in this cycle
CORP/OMD/ Consent/19/01	Obtaining Written Patient Informed Consent within Secondary Care – A Retrospective Re-audit of Consent forms	Delayed action	Report discussed with secondary care Q&S group. No improvement since previous audit (2017) Action plans from sites awaited. Reminder in September meeting.

Tier 3 Clinical Audit projects registered by Quarter 2

A register of all Tier 3 projects is maintained by the clinical audit and effectiveness team based on registrations within the Health Board. Since April 2019, 245 projects have been registered (see Appendix 2). Forty of these audits span BCU. Twenty one tier 3 audits are completed.
Whilst the Health Board will be discouraging those audits that fall outside the key priorities there is a recognition that this is a heterogeneous group (see table 4) and include smaller specialties that do not have tier 1 or limited tier 2 involvement. Where a tier 3 audit identifies a significant risk this will be escalated and included in this report.

Table 43: Tier 3: Reason motivating (trigger) projects registered from 01/04/19

Trigger* ***NOTE:** There may be more than one trigger per project.*	**TOTAL** number of projects			
	West	**Central**	**East**	**Total**
Local response to findings from National Clinical Audit	11	14	11	**36**
NICE	13	13	15	**41**
Datix Incident	4	3	1	**8**
Risk Register	1	0	0	**1**

Complaints reported	2	2	1	**5**
Equality & Human Rights	0	1	0	**1**
Re-Audit	7	18	7	**32**
Intergrated Care Pathway	2	3	1	**6**
On approved Audit Plan	1	12	7	**20**
Other	37	50	44	**131**

6.0: Assessment

There is wide recognition within the leadership team that clinical audit does not currently lead to significant improvement and does not provide robust assurance. A plan is in place to move this forward.

This report will evolve and overtime will provide assurance that clinical audit is fit for purpose as defined by the governance requirements:

Does the organisation have a plan and:
The annual corporate audit plan was approved in September 2019. There have been no amendments to date.

- **is it fit for purpose? -**

The plan has undergone a risk assessment process and is owned by the clinical executives. It incorporates all nationally mandated audits and local audits that are considered essential based on risk, litigation or organisational improvement priorities.

- **it completed on time?**

There are gaps in completion of mandatory audit that need to be addressed. At the current time there has been non notification of delays other than those stated in this report. The implementation of the new policy and procedure will highlight this. Additional resources within the clinical audit and effectiveness team are required to allow tracking of all activity.

- **Does it cover all relevant issues?**

Going forward, there needs to be additional involvement of the divisions and primary care to ensure adequate representation of all services. There is significant tier 3 activity and whilst there is a recognised role for this it should not take precedence over tiers 1&2 including delivering the associate improvements.
Further clarity is required as to the BCU wide tier 3 projects and whether these need reclassification.

- **Is it making a difference and leading to demonstrable change?**

There are changes being reported on part B for the Tier 1 audits; re-audit/ improvement monitoring will confirm if this has led to demonstrable change. Capturing and reporting this information will be key to robust assurance
The lack of a central repository that enables tracking means it is time consuming to ensure action plans are completed and link change directly to those audits. Going forward re-audit needs to be highlighted within the report.

- **Is change supported by recognised improvement methodologies?**

There is opportunity to train staff in quality improvement and audit skills within BCU using the national training. There is a resource issue with regards quality improvement training and 1000 Lives are currently supporting our programme. Audit training is an e-learning package. There is also training available through Academi Wales. We are encouraging staff to complete projects that are priorities in their workplace and this would include audit action plan delivery.

- **Does the organisation support clinical audit effectively?**

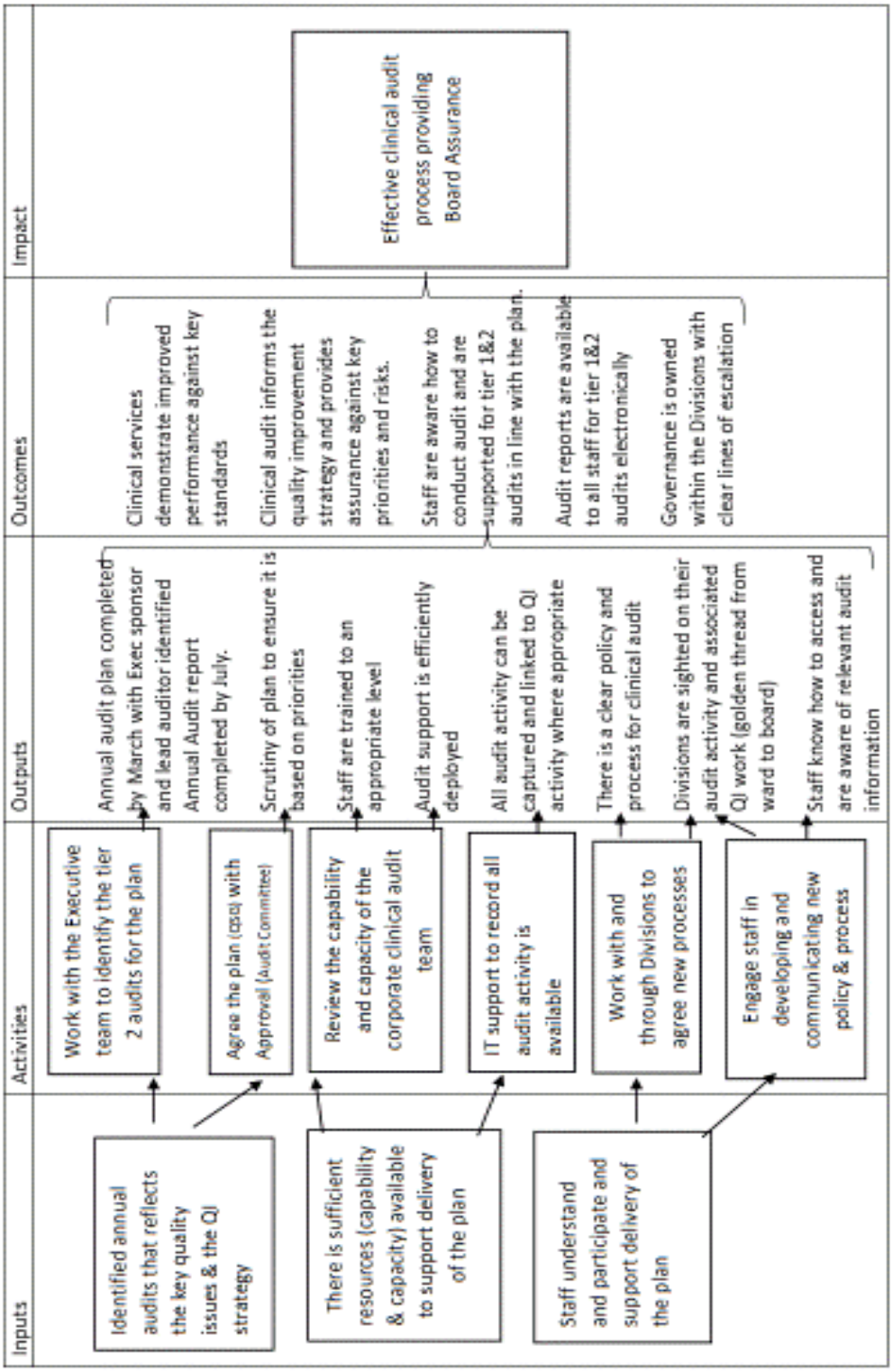
There is work to do to ensure all mandatory audit is encompassed within job plans; particularly the audit leadership roles. There is a mismatch between the planned establishment in the central team and the resource available; a business case will be developed to address this.
Implementing the new policy will provide opportunity to refocus activity ono tier 1&2 audits.

7.0 Next Steps

- Deliver the agreed corporate clinical audit action plan and associated improvements identified. Including full participation in Tier 1 NCAORP mandatory audits during 2020/21.
- Implementing the new clinical audit policy and procedure
- Developing the business case to ensure efficient and effective support for clinical audit.
- Agree the structure of future reporting to provide assurance around service quality as afforded by clinical audit.

8.0: Appendices

Appendix 1: Logic Model

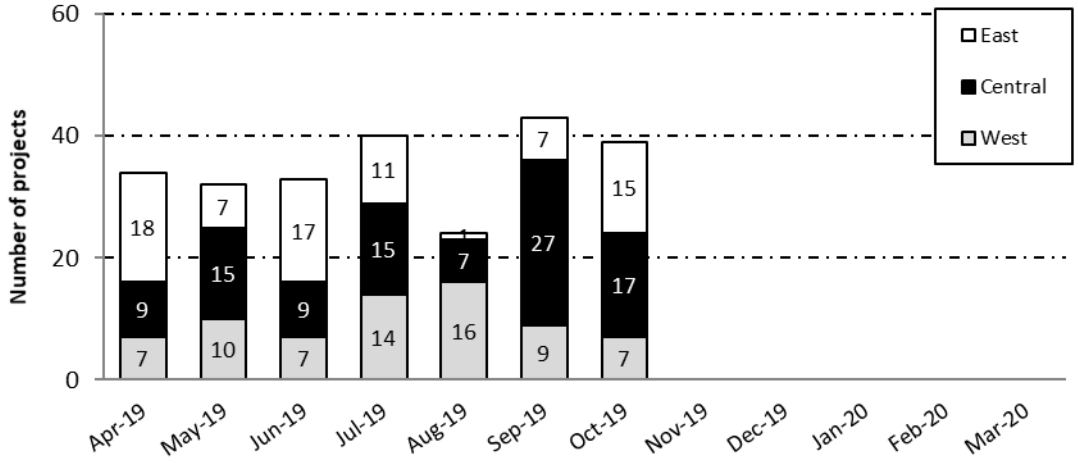


Appendix 2: Tier 3 Clinical Audit projects registered since 01/04/19

Department	**TOTAL** number of projects			
	West	**Central**	**East**	**Total**
Acute Medicine	2	5	3	**10**
Adult Mental Health	0	1	1	**2**
Anaesthetics/Critical Care	1	3	2	**6**
Audiology	1	1	0	**2**
Breast Surgery	0	1	0	**1**
Cancer Centre	0	2	0	**2**
Cardiology	2	2	0	**4**
Clinical Haematology	1	0	0	**1**
Clinical Oncology	2	2	0	**4**
Dental	1	1	0	**2**
Dietetics	1	3	1	**5**
Elderly Medicine	0	1	1	**2**
Emergency Department	1	3	0	**4**
Endocrinology/Diabetes	1	4	3	**8**
ENT	2	1	1	**4**
Gastroenterology	0	3	0	**3**
General Surgery	6	5	1	**12**
Gynaecology	4	1	4	**9**
Medical Oncology	0	1	0	**1**
Neonatal Medicine	0	3	1	**4**
Neurology	0	1	1	**2**
Obstetrics	4	6	7	**17**
Ophthalmology	4	0	1	**5**
Orthotics	0	0	1	**1**
Paediatrics	6	5	5	**16**
Pain Medicine	1	1	0	**2**
Palliative Care Medicine/Palliative Care	1	1	0	**2**
Pharmacy	3	3	1	**7**
Physiotherapy	2	0	0	**2**
Radiology	3	2	7	**12**
Respiratory	2	3	0	**5**
Rheumatology	0	1	2	**3**
Sexual Health/HIV Services	1	1	2	**4**
Speech Language Therapy	0	0	1	**1**
Trauma & Orthopaedics	4	5	12	**21**

Urology	4	2	4	**10**
Vascular Surgery	1	0	1	**2**
Other	9	25	13	**47**
Total	**70**	**99**	**76**	**245**

Figure 1: Tier 3: Number of projects registered per month between 01/04/19 to 23/10/19.



Joint Audit and Quality, Safety & Experience Committee

5.11.19

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Governance Review
Report Author:	Mrs Gill Harris Executive Director of Nursing & Midwifery, Deputy Chief Executive
Responsible Director:	Mrs Gill Harris Executive Director of Nursing & Midwifery, Deputy Chief Executive
Public or In Committee	Public
Purpose of Report:	This report is to update the joint committees on progress and emerging considerations form the ongoing governance review
Approval / Scrutiny Route Prior to Presentation:	No prior approval – update paper for the joint committees. Further Executive Team consideration of the emerging proposals is required.
Governance issues / risks:	None identified
Financial Implications:	None currently identified
Recommendation:	The Joint Audit and Quality, Safety & Experience Committee is asked to note the context and progress of the governance review and the emerging considerations

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and governance			
Equality Impact Assessment Not required for briefing paper of this nature			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Governance Review

Context

At the request of the Chief Executive and Chair a review of the governance and risk processes across the organisation is being undertaken.

Corporate governance is the means by which Boards lead and direct their organisations so that decision-making is effective and the right outcomes are delivered. For BCUHB this means delivering safe, effective services in a caring and compassionate environment in a way that is responsive to the changing needs of patients, public and service users.

Individuals working in in clinical teams providing NHS services are at the front line of ensuring quality of care to patients. Many of these staff are subject to professional regulation for which they are accountable. However, it is the Health Board itself that takes final and definitive responsibility for improvements, successful delivery (and equally failures) in the quality of care.

Evidence also suggests that there is a significant correlation between the governance behaviours a Board disseminates to its organisation and the level of performance achieved by the same organisation.

Robust governance structures that encourage proper engagement with stakeholders and strong local accountability will help us to gain trust and confidence of the people and communities that we serve. It is recognised that good corporate governance is dynamic and we should be committed to improving governance on a continuing basis through a process of evaluation and review.

Work undertaken to date

A comprehensive (although not exhaustive) review of the meetings currently taking place across the organisation and their reporting lines has taken place. These exclude operational line management meetings. This has identified a number of issues:

- Previously ‘unknown’ groups with no reporting lines.
- Different terminologies, membership and terms of reference being used by groups with similar aims.
- No clear methodology for escalating concerns.
- Groups which have apparent duplication of aims.
- No consistent reporting structure of Executive led groups to Independent Member chaired committees to allow independent scrutiny

Clearly the above currently poses a risk to the organisation and reflects the timeliness of the review.

Emerging Considerations

The proposals which are currently being considered sit alongside the emergent risk management review to ensure they are complementary.

- Clear reporting arrangements of executive led groups into an appropriate scrutiny committee chaired by an Independent Member should be put in place. This to be agreed with committee chairs.

- Consider splitting the Quality Safety Group into 3 groups due to volume of business it is trying to address:
  - Quality & Safety
  - Effectiveness & Outcomes
  - Patient experience and co-production

- Questions are arising for the potential need for an investment committee to reduce the burden on the Finance & Performance Committee.

- Consideration to be given to reducing the number of groups meeting across the Health Board with input from current Chairs to minimise the burden of meeting time on clinical and operational workloads.

- Clear Terms of Reference and reporting lines should be established for all groups which mirror those of the executive led groups.

- A risk based approach to escalation in line with the emerging risk management strategy.

- Consider establishing standardised meeting formats to optimise the time spent in meetings, including use of virtual meeting technology to reduce travel time.

Recommendation

The Joint Audit and Quality, Safety & Experience Committee is asked to note the context and progress of the governance review and the emerging considerations