Enw'r Pwyllgor: **Name of Sub-Committee:**	Effective Clinical Practice Advisory Panel
Cadeirydd y Pwyllgor: **Chair of Sub-Committee:**	Dr Subhamay Ghosh, Associate Medical Director for Quality and Safety
Cyfnod Adrodd: **Reporting Period:**	5 September 2023 5 December 2023

Materion Ansawdd, Diogelwch a Phrofiad:
Quality, Safety & Experience Matters:

This report provides an update on the clinical effectiveness agenda within the Health Board and a summary of key matters discussed at the meetings of the Effective Clinical Practice Panel (ECPAP) held on 5 September and 5 December 2023.

The purpose of the ECPAP is to support clinicians and healthcare professionals to examine and improve the quality of care through a range of activities, including assessment against local and national clinical effectiveness standards and monitoring and improving the outcomes for patients and service users. ECPAP has a multidisciplinary membership, and meets quarterly to receive updates from the four sub-groups and discuss other key clinical effectiveness matters. A summary is provided of matters received by the Panel below.

Updates from Sub-Groups

Mortality Scrutiny Group

The Panel was updated on the progress of extending the Medical Examiner (ME) processes across Glangwili Hospital ahead of the statutory introduction in April 2024, highlighting the challenges involving scanning capacity which remain. An SBAR has been developed requesting additional resource to increase resilience and continue the roll out, however this is impacted by the existing financial constraints. This matter has been escalated and work continues to identify solutions, which ideally would include out of hours scanning opportunities as the Medical Examiner Service currently works weekends and bank holidays. Potential solutions should also address the arrangements for Prince Philip Hospital as it is recognised that the current arrangement of transferring the records to Glangwili Hospital for scanning is not sustainable and adds to potential delays. It is noted that the inability to roll out affects other areas of the Mortality Review process particularly around reporting.

ME processes have now been rolled out across the four Community Hospital sites. Some initial challenges were experienced relating to South Pembrokeshire Hospital following the relocation of Withybush patients (due to the RAAC issues) however these are being addressed.

Capacity constraints continue in relation to the clinical reviewers that are available to screen the increasing number of cases now being received from the ME Service. Screening is being undertaken in addition to the reviewer's substantive role as there is no dedicated resource for this, which is extremely time consuming. Additional screeners are being sought, however the capacity constraints have been highlighted on the risk register.

Panel members have acknowledged that the purpose of the ME process is to identify learning from patient deaths, however if resourcing constraints are restrictive then the ability to identify and share learning from deaths is being adversely affected.

The Panel discussed an emerging issue in relation to the completion of Proportionate Investigations in a timely way, noting that there are many outstanding investigations pending from across all four acute sites, as well as some Directorates. This is creating a gap in terms of the potential learning captured from Mortality Review, which may also have implications in relation to the Welsh Risk Pool share agreement. Proportionate Investigations are currently requested following discussion at the Multidisciplinary Mortality Review Panel of certain cases referred back to the Health Board by the ME Service. The triumvirate team is responsible for allocating the appropriate person to complete the investigation depending on the issues identified and the specific questions identified by the Multidisciplinary Mortality Review Panel. Whilst this is a new process, in response to the Medical Examiner Service scrutiny, it replaces the previous Stage 1 and 2 Mortality Review work, and is more targeted therefore is not anticipated to be additional work. It was proposed that numbers of outstanding proportionate investigations are shared with the respective Quality and Governance Groups to highlight and surface some of the issues at the groups.

The Panel was updated on the anticipated receipt of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Thematic Review, led by the NHS Executive, which considered DNACPR cases highlighted to Health Boards following ME Scrutiny. The final report is awaited, however the Panel discussed the requirement to consider any recommendations alongside existing discussions relating to DNACPR within the Health Board, recognising the necessity for a clinically driven decision-making group with reporting through the Health Board's governance structures. The need for further consideration was recognised and consequently it was agreed that this item would remain on the Panel's agenda.

Quarterly reports are now being received from the ME Service, comparing data from Hywel Dda with other Health Boards. Whilst this is helpful it was noted that the data is without denominators, therefore it is difficult to identify a true indication of the percentage of cases being managed through the various routes of the mortality review process. However, assurance was provided that the Health Board is not an outlier and appears to be comparable in terms of implementing the new Mortality Review processes in response to the ME Service.

Scoping for a Care After Death service continues and is being progressed through the Care After Death Steering Group.

Clinical Standards and Guidelines Group

The Group was informed of an internal audit to review NICE Guidance, undertaken in July 2023. See further detail below under heading ***Internal Audit - NICE Guidance and NICE Guidance Reporting***.

The Group continues to receive an overview report of new and updated NICE and Health Technology Wales guidance and quality standards published, all of which are disseminated through the AMaT system. Consequently, the Panel was informed that the number of statements of compliance completed is growing, although there remain a number either in progress or overdue. This is being addressed through the Directorate Quality and Governance groups, with tailored reports being presented. Additionally, the Clinical Effectiveness team meet regularly to review what

has been disseminated and what is overdue for a statement of compliance, and triggers are in place to remind services to complete the work assigned to them.

In response to the finding in the internal audit relating to compliance monitoring and assurance reporting, reporting functionality within the AMaT system has been utilised. This provides an overview of the status and progress of previously disseminated NICE guidance. The changes to working practice introduced following the internal audit streamline the reporting function, and ensure that reports are shared across the Health Board's governance structure, including every Directorate Quality and Governance Group. Reporting will identify the areas not engaging with NICE guidance statements of compliance, and those non-compliant with NICE guidance. This will be accompanied by narrative around services that have been engaging and making progress using AMaT, and also highlighting particular services of concern and those that require escalation. It is anticipated that the quality and detail of the information available will improve and afford greater scrutiny and oversight.

The Group welcomed the Service Development Manager from the Smoking and Wellbeing Team who presented progress in relation to the statement of compliance undertaken for NG209 Tobacco, preventing uptake, promoting quitting, and treating dependence. The Group was informed that completion of the statement of compliance within the Audit Management and Tracking System (AMaT) provided the opportunity to gauge the significant progress made during the preceding three years. The Health Board's compliance with this guideline is currently 86%. Increased staffing levels had enabled the team to progress numerous workstreams and enhance service delivery across the wider tobacco agenda including prevention, education and smokefree premises which had been identified by NICE. Work had taken place in school settings and hospital locations, including clinical and mental health wards, where the focus was to support and not introduce punitive measures. Taking a holistic approach to problem solving had seen the team working with a wide range of stakeholders including youth justice, drug and alcohol services, local authorities, educational establishments, charities and trade unions. Future workstreams would include Vaping which was an emerging issue. A new smoking strategy in development will provide a breakdown of each of the responsibilities as health inequalities prevention, smoke free environments, smoking and cessation support and collaboration. Upon ratification, the AMaT system will be updated identifying each of the groups participating in the guideline. A programme of regular audits was now being carried out which would drive compliance.

The Group was updated on work being undertaken with key priority areas including discussions via the Stroke Steering Group to incorporate a review of the new National Stroke Guideline using the AMaT system; and ongoing work with the diabetes service to use AMaT to capture a review against the Welsh Government Diabetes Quality Statement.

The Group has been kept informed of developments with the HealthPathways project, including regular presentations and a demonstration of the system. The Group was advised that delegate research undertaken by the National Planned Care programme had identified that Health Board's and Trust's experienced significant difficulties in conducting three yearly pathway reviews, which had resulted in some GP practices halting the use of the HealthPathways. Consequently, a National Pathway sharing process had been developed in Wales which establishes collaboration and resource sharing across Health Boards. Hywel Dda University Health Board will have responsibility for updating General Surgery, Urology and Cardiology pathways in addition to hip and knee aspects of musculoskeletal care. The HealthPathways work does not currently sit within

any of the existing governance structures, however, consideration was being given to the feasibility of reporting to the Clinical Standards Guidance Group on a bi-monthly basis.

The Group was notified of two Effective Clinical Practice Roadshow events that have taken place, one in Bronglais General Hospital in July 2023, and another in Glangwili General Hospital in November 2023. The purpose of the roadshow is to showcase the good work that is taking place to improve effective clinical practice, featuring projects supporting compliance with NICE and other guidance; Quality Improvement projects; Clinical Audit projects; and Research projects. The events are multi-professional, welcoming clinical colleagues from across professional groups and including operational and management teams.

Clinical Audit Scrutiny Panel

The Panel was informed that increased levels of participation from a greater number of services in the forward clinical audit programme have been seen. There are 45 identified projects which represents a significantly higher number than previous years, however the focus has remained on quality.

Challenges with participation levels in the National Clinical Audit programme continue to be escalated via triumvirate teams and service leads, with some areas being steadily resolved. However, response and engagement levels continue to be limited in some instances. A meeting has taken place with Clinical Leads to discuss the current situation, identify processes to escalate concerns regarding a lack of engagement and to agree and ratify departmental/service decisions not to participate fully in audit process. Non-participation in audits continues to be discussed at the Clinical Audit Scrutiny Panel and Audit and Risk Assurance Committee meetings.

Areas being focused on include the Epilepsy 12 Audit, with engagement from the Directorate and a plan in place to begin participation; the National Audit of Dementia, with work underway by the department to start the audit and provide as much support as possible, as well as gaining agreement to an extension to the audit deadline to ensure sufficient data collection; and the National Laparotomy Audit with ongoing meetings taking place with Withybush General Hospital to address the concerns raised in relation to data collection. The Panel recognised the importance of acknowledging the fact that the majority of national audits are on track and doing well.

A visual presentation of a breakdown of the audits and what is outstanding was presented to the Panel, demonstrating areas of good progress in relation to audit participation.

A meeting with the Medical Education department has also been arranged to discuss issues raised by the Audit and Risk Assurance Committee in relation to concerns regarding the lack of engagement by clinicians.

The Clinical Audit Team are also working with the Directorate's Improving Together sessions to include performance in relation to clinical audit in the Improving Together packs for discussion at the respective sessions.

Whole Hospital Audit Meetings (WHAM) continue to take place with good levels of participation.

Clinical Written Control Documentation Group

The Panel was informed of the number of written control documents that had exceeded their review dates. A number of these are either pending post review approval or have secured extensions to their review dates as assurances had been received that they were fit for purpose. Work is on-going to ensure that the documentation which is out of date remains fit for purpose. The Panel was informed that meetings are being arranged with the relevant individuals and groups to gain assurance where necessary.

Members noted that where a group had delegated responsibility to sign off guidelines or procedures, reference to that responsibility had been included in the group's terms of reference.

Changes have been made to the procedure for approving Document Approval Form (DAF's) which would now be completed by the appropriate approving group. The process for ratifying Welsh Health Specialised Services Committee (WHSCC) documentation has also changed and there was no longer a requirement for a Clinical Written Control Documentation Group review.

An ongoing issue was flagged to the Panel in relation to Policy 341 - Prescription Administration of Emergency Oxygen in Adults Guideline which has been highlighted through various channels including the Clinical Written Control Documentation Group, Medication Error Reporting Group and mortality review in terms of oxygen prescribing errors. This piece of documentation has been out of date for five years and was therefore raised this with the Panel. Discussions have taken place with the service and an appropriate policy contact lead has been identified. However, the Panel recognised the wider issue of oxygen prescribing in the Health Board and the value of a more strategic group across disciplines, looking at the provision and use of oxygen across the Health Board. It was agreed for this issue to be taken to the Executive Quality meeting.

Other key matters considered at ECPAP meetings in March and June 2023 are summarised below:

Terms of Reference Review

The annual review of the Panel's Terms of Reference was undertaken, reflecting changes in governance and reporting following the Internal Audit of NICE guidance. This included increased oversight of NICE Guidance dissemination arrangements at the ECPAP and Operational Quality, Safety and Experience Sub-Committee. Other amendments were made to reflect the change in naming of the NICE and National Guidance Working Group to the Clinical Standards and Guidelines Group; the inclusion of the Consultant in Public Health Medicine as a Core Member and clarifying the Nursing representation.

Annual reviews of the Terms of Reference have been undertaken by each of the four sub-groups reporting to the Panel, and have been ratified by the Panel.

Internal Audit - NICE Guidance and NICE Guidance Reporting

The Panel was reminded that the purpose of the audit was to review the dissemination process; the systems and processes in place to support dissemination and assurance regarding NICE guidance. It was acknowledged by the Panel that the period under review coincided with a period of change including the introduction of new systems and processes. A finding of limited assurance was

reported, and the team has worked hard to implement the changes required from the audit recommendations.

Action has been taken in relation to the three main areas of finding as follows:

1. The timelines for disseminating updated NICE guidance - the introduction of AMaT enables the Clinical Effectiveness Team to become more responsive as AMaT publish a weekly report detailing new and updated NICE guidance. As a result, new and updated NICE guidance is now disseminated to identified guidance leads on a weekly basis, requesting compliance statements to be completed within a set timeframe. There may be instances where dissemination is delayed if an overall guidance lead is not clear, and in these cases advice is sought from the Clinical Standards and Guidelines Group, as per the Terms of Reference.
2. The identification of nominated leads to undertake reviews of NICE guidance - as an outcome of the internal audit finding, a member of the Clinical Effectiveness Team is now identified as the overall guideline lead with a service lead identified from the relevant Directorate and requested to complete a statement of compliance. Previously, guidelines were initially disseminated for information only, enabling leads to determine an appropriate lead or stakeholder however, individual responses could cause delays in the completion of statements of compliance. Therefore it is anticipated that the changes will improve oversight and timeliness.
3. Compliance monitoring and assurance reporting – following the findings of the internal audit, there are new arrangements in place for reporting of NICE guidance dissemination status and compliance. Reports including disseminated guidance, allocated leads and status of statements of compliance are presented at Directorate Quality and Governance Groups, as well as via the Clinical Standards and Guidelines Group and Effective Clinical Practice Advisory Panel. An escalation procedure has been developed and occasions where there has been a continuous lack of engagement, discussion and consideration is made whether to escalate via Operational Quality, Safety and Experience Sub-Committee. The outcome of the audit and the new reporting arrangements were documented in an SBAR which was shared with the respective Directorate Quality and Governance groups, the Clinical Standards and Guidelines Group, Effective Clinical Practice Advisory Panel and Operational Quality, Safety and Experience Sub-Committee. Directorate Quality Governance Chairs are added as stakeholders to enable monitoring and maintain oversight.

The Panel acknowledged the resourcing challenges and capacity which Directorates are currently experiencing and the additional work that the NICE compliance status monitoring could generate. Enabling and encouraging stakeholders to engage is a time-consuming process, however the team will focus on maintaining effective, supportive working relationships and avoiding over reporting.

The Internal Audit report was presented to ARAC on 17th October 2023. It was recognised that the audit findings were as expected however the revised processes will help drive the Effective Clinical Practice Delivery Plan forward.

Effective Clinical Practice Delivery Plan 2023/24

An update report on the actions within the Effective Clinical Practice Delivery Plan was provided to the Panel at the September and December 2023 meetings. In particular the Panel was updated in regard to the following:

- The development and promotion of an Effective Clinical Practice Toolkit which is available to access on the Health Board's intranet enabling all staff to learn more about AMaT and Effective Clinical Practice, and providing a step-by-step guide for this work.
- Progress in relation to exporting data from the AMaT system using Application Programming Interface (API). Once data can be exported discussions will take place with the performance team to include that data in the Improving Together dashboards. This will enable triangulation of the data from AMaT with other sources of Health Board data to show trends from a quality and safety perspective.
- Clinical Effectiveness Roadshows that have taken place in Bronglais General Hospital and Glangwili General Hospital (see update above) and plans are in place for future events for the remaining Hospital sites.
- The programme of services attending the Clinical Standards and Guidelines Group for support on clinical effectiveness work undertaken, particularly completion of statements of compliance using AMaT.

Health Technology Wales Adoption Audit Report 2023

The Adoption Audit Report for 2022-2023, published by Health Technology Wales (HTW) was shared with the Panel, for information only as it had previously been discussed.

Hywel Dda University Health Board had participated fully in the adoption audit and engagement levels were greater than other Health Boards which was positive to note. HTW have taken on board feedback resulting in the next adoption audit being moved from the busy winter period to the following spring. HTW have also agreed to be more pro-active in communicating with Health Boards by informing them of topics they intend to appraise at the consultation stage, supporting clinician participation.

As Welsh Government were commencing several health technology initiatives during the coming year the Panel considered whether the Health Board collaborate with its university partners in relation to HTW. It was not clear whether there was engagement between the Health Board and universities or if the universities were members of the HTW stakeholder's forum.

Interventions Not Normally Undertaken

Correspondence has been received from Dr Chris Jones (Deputy Chief Medical Officer) and Nick Wood (Deputy Chief Executive NHS Wales) regarding Interventions Not Normally Undertaken (INNU) which contained 139 procedures that had either appeared on at least one Health Board list, were on a list of Academy of Royal Medical Colleges evidence-based interventions or part of a WHSCC Commissioning arrangement. National work has been anticipated in relation to INNU following discussions taking place across organisations, including involvement of Health Technology Wales and the Welsh Value in Health Centre. It was acknowledged that the Health Board's INNU list had not been updated for some time, in anticipation of this national work.

A Task and Finish group has been established within the Health Board to develop a local response to the national developments. A national group has met once and the Panel was appraised of the

discussions and plans to progress. There is good engagement with Health Technology Wales to appraise the current evidence.

There is general consensus that the terminology should be changed to Evidence Based Interventions, which is a more accurate reflection of the agenda.

The Panel discussed the key principles of INNU/Evidence Based Interventions, recognising that clinical procedures need to be considered on an individual, evidence-based basis and the Health Board policy will need to reflect this requirement. Supporting resources should clearly outline the criteria when the procedure can be undertaken and provide the opportunity to govern and audit cases where INNU/Evidence Based Interventions procedures were proposed or had taken place. A blanket ban is not appropriate and would be difficult to manage.

The Panel acknowledged the opportunity to incorporate the INNU/Evidence Based Interventions work into the Health Pathways programme to ensure that Primary Care clinicians are not referring patients for interventions that would not be provided in the secondary care setting, thereby reducing inappropriate referrals and significantly benefitting waiting times. It was confirmed that Primary Care are very supportive of this approach and are represented at the Task and Finish Group.

Hywel Dda Paediatric Congenital Heart Disease Standards self-assessment review

A presentation was given to the Panel at its December meeting regarding the Hywel Dda Paediatric Congenital Heart Disease Standards self-assessment review, detailing that a network was formed in 2016 following the adoption of the NHS England congenital heart disease standards. This network brings together clinicians, managers and families, working collaboratively for congenital heart disease patients to ensure that systems are in place and running correctly.

The presentation highlighted the purpose of the peer review, the current provision and activity within the Health Board, the risks and the actions to help mitigate these risks, the compliance against the relevant standards and the actions which are outstanding against the peer review.

Assurance was provided to the Panel that the current RAAC situation in Withybush General Hospital was not impacting adversely on this work, as the cardiology services for routine and planned activity run from an outpatient facility for children at the back of the hospital. Any urgent or emergency cases would come under the admission pathway and be seen at Glangwili General Hospital. The Panel was also informed of the recent Board approval of a new enhanced outpatient service at Withybush paediatrics with rapid access so children who are on the follow up waiting list to have been seen in the acute phase will be seen in Withybush General Hospital. The pathway for Ceredigion children was also confirmed, with the vast majority going to Alder Hey, which is outside of the network. A joint clinic is run by an Alder Hay Consultant four times per year and there is a very small population from Bronglais General Hospital who will feed into the South network strategy. Specialised transport, if required, will also be commissioned to North Wales, North East Wales and North West England depending on the diagnosis at the time.

The Panel discussed the potential for comparative activity data across Wales, over a period of 3 or 5 years. The possibility of an all-Wales paediatric cardiac services network was also raised, to support an all-Wales assessment review, and it was agreed that this would be considered outside of the Panel.

Human Tissue Authority (HTA) Report

The HTA report has historically been received by the Panel following an internal audit into Human Tissue Authority compliance. Two reports were shared with the Panel at its September 2023 meeting, to ensure oversight. The reports referred to the Mortuary and Blood Transfusion arrangements and noted that visits to mortuaries featured in the HTA compliance checks.

The HTA inspections identified similar concerns to those previously identified by the Mortality Review Group with regards to the capacity mortuary staff have to complete work associated with HTA compliance as well as the bereavement work. The Panel was informed that the two statutory responsibilities could conflict with each other and this had been highlighted through the Care after Death Steering Group. A number of challenges have been highlighted and risks are recorded on the Health Board's Risk Register.

Work is being undertaken to identify opportunities for standardisation across Health Board sites covering responsibility for bereavement, care after death and support for families; implementing consistent working practices; managing ME service obligations; and ensuring compliance with HTA standards.

Health Technology Wales Annual Report 2022/23

The Panel was informed that the Health Technology Wales Annual Report had been published and was included with the Papers of the September 2024 meeting, for members perusal.

Risgiau:
Risks (include Reference to Risk Register reference):

The following risks appear on the Health Board's Risk Register:

- 1118 - Planning Objective 5K - Failure to develop processes for effective clinical practice.
- 689 - The Royal College of Physicians Medical Records Standards - Good medical record keeping
- 1282 - Mortality Review – recently amended and increased to reflect the delay to Glangwili General Hospital roll-out and capacity constraints in relation to Medical Examiner letter screeners.
- 1283 - NICE and National Guidance (836 & 844 combined)

Gwella Ansawdd:
Quality Improvement:

- Continuous review and development of the Mortality Review process, and response to the national review of the All-Wales Framework.
- Development of Mortality dashboard to support the presentation of themes, triangulation of data and promotion of Health Board wide learning.
- Health Board wide communication and engagement with teams and services to ensure awareness of the Medical Examiner Service, the Mortality Review process and the All-Wales Framework.
- Response to the findings and implementation of the actions arising from the DNACPR Thematic Review (once received).
- Continued implementation of management actions arising from the Internal Audit of NICE Guidance.

- Document Approval Forms for new Clinical Written Control Documentation to be signed off by the appropriate approving group with a summary of approved forms being reported into each Clinical Written Control Documentation Group meeting.
- Implementation of a number of actions to ensure a more robust process to flag out of date clinical written control documentation .
- COPD Audit has seen significant increases due to a concerted effort by the CAD and auditing teams
- A number of national audit action plans have been submitted and subsequent actions will be monitored
- Successful WHAM with shared learning opportunities

Argymhelliad:
Recommendation:

For the Quality, Safety and Experience Committee to take assurance from the update provided from the Effective Clinical Practice Advisory Panel.

Dyddiad y Cyfarfod Pwyllgor Nesaf:
Date of Next Sub- Committee Meeting:

19 March 2024