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:	January to September 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 7 March and 6 June 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 has been kept informed of developments in relation to the roll-out of the Medical Examiner Service (MES) and Mortality Review processes in Hywel Dda, particularly that the Medical Examiner system becomes statutory in April 2024.

Consequently, work has taken place to enable the introduction of processes to Community Hospitals by the beginning of August 2023 and the roll out to community and primary care from September 2023. Concerns about the lack of clarity in terms of the Primary Care Framework were expressed at the Panel, and at the point of writing the Health Board is still awaiting the final agreed national Primary Care Framework. This document will articulate the expectations and responsibilities in relation to receipt of MES cases, mortality review and investigation therefore clarity on these matters is essential in order to understand the resource implications to support the process. The Mortality Scrutiny Group is monitoring the capacity and resourcing requirements due to a concern around whether the current staffing is sufficient.

The full roll-out to Glangwili General Hospital continues to be delayed due to resource constraints for scanning, however progress has been made to support the introduction of MES processes in all medical wards and one surgical ward on site. An SBAR has been developed outlining the additional requirements for resource, in order to complete the roll-out. The risks associated with this have been reflected through an increase in the risk rating and resultant escalation of the Mortality Review risk to the Directorate level.

The Panel was informed that as part of Level 5 of the All Wales Learning from Mortality Review Framework, a Thematic Review of cases involving Do Not Attempt Cardio Pulmonary Resuscitation

(DNACPR) had been commissioned and undertaken across Wales. Each Health Board was asked to consider four cases involving DNACPR against an agreed investigation framework. The findings were discussed at an All-Wales meeting, with representation from palliative care medicine, and the final report with action plan is awaited. This will be overseen by the Mortality Scrutiny Group and reported via the ECPAP update in due course.

Issues identified by the Medical Examiner are captured into themes and reporting is taking place regularly to the Mortality Scrutiny Group. The intention, once all sites are fully operational, is for these themes to be shared with Directorate Quality and Governance Groups under the standardised agenda item for Mortality Review, however widespread reporting to Health Board Committees remains a risk until standardised processes have been introduced across all sites. Learning is also captured from any Proportionate Investigation undertaken and will also be shared once a sufficient number have been captured to identify themes. A bi-monthly Learning from Deaths meeting has also been scheduled, commencing from September 2023, which will focus on themes, data and potential learning. Discussions will feed into the Health Board's Listening and Learning Sub-Committee, as well as inform wider communication of learning across the Health Board.

It was reported that approximately 25% of MES cases are returned to the Health Board, which aligns with national figures. The number of Proportionate Investigations commissioned by the Health Board was previously higher than some Health Boards, however following national discussions regarding the agreement of consistent thresholds, local processes have been streamlined and consequently, the Hywel Dda figures have dropped and are now more in line with the national average. Additionally, a recognition of the considerable expertise that has been developed locally to screen and direct cases appropriately has resulted in a more streamlined approach for cases not needing to be discussed by the Mortality Review Panel, which releases both administrative and Panel Member capacity.

In order to identify, discuss and resolve any issues with the MES and Mortality Review processes, regular meetings have commenced between the relevant stakeholders which includes Stakeholder Operational Groups per County and a quarterly meeting between the Medical Examiner Service and Medical Directorate Mortality Review representatives. These have provided a valuable opportunity to improve communication and for both parties to raise any concerns which ultimately improves the flow and timeliness of the process. Issues addressed via these fora include addressing the unavailability of scanned documentation such as medication and observation charts; and ensuring that the MES does not send a backlog of cases through to the Health Board due to the impact this has on limited resources to process these, and instead maintain a steady flow of cases.

A Grand Round session was held in February 2023, providing an introduction to Mortality Review, with approximately 100 Doctors in attendance. Discussions focused on:

- DNACPR issues and issues around ceiling of care;
- Inappropriate admissions at end-of-life care, transfers between hospital at end of life;
- Communication issues between teams and services;
- Communication issues between families, wards and clinical teams.

The Mortality Scrutiny Group has oversight of ongoing work being undertaken across departments and all sites to improve the processes and consistency that enable MES scrutiny and ultimately Mortality Review to take place in a timely and effective way. This includes:

- Mapping of the mortality pathway from point of death to commencement of Medical Examiner scrutiny, in order to identify potential for barriers and delay, as well as inconsistencies in working practices across Health Board sites and consequently identifying opportunities to optimise and standardise the process;
- The piloting of a new MS Forms proforma to gather and share information on cause of death and contact details that contributes to a more timely completion Medical Certificate of the Cause of Death;
- The development of an SBAR to request additional resources for scanning at Glangwili General Hospital, to enable the completion of the roll-out of MES processes to all hospital wards and improve the sustainability of the Prince Philip Hospital scanning solution.

Scoping is taking place regarding the Health Board's Care After Death provision, including the potential for an integrated and centralised service and the resource requirements associated with this. Medical Directorate Mortality Review staff are represented on the Health Board's Care After Death Steering Group and the Mortality Scrutiny Panel receives regular updates as this work progresses.

Issues and risks regarding the full implementation of MES processes to support Mortality Review have been escalated by the Clinical Lead for Mortality to the Medical Director and Deputy CEO.

Monitoring of areas highlighted by the Deputy Chief Medical Officer (DCMO) where CHKS data demonstrated higher mortality rates than the average (as previously reported to the Committee) has been completed, enabled through investigatory work led by the Clinical Leads for the respective areas and a response providing assurance has been provided to the DCMO. Subsequent CHKS data demonstrates that the Health Board is no longer an outlier in areas previously highlighted. Review of the quality and accuracy of the CHKS data is ongoing.

Clinical Audit Scrutiny Panel

The Panel received a report that the March 2023 Whole Hospital Audit Meeting (WHAM) had sufficient support from presenting clinicians to fill the programme, which had previously been difficult to achieve.

Concerns continue to be raised with the Panel in relation to the completion of National Audits, with historical difficulties being recognised. It was reported that there are a number of audits for which engagement is variable and participation low in some sites (recognising that for some sites there is no concern). This includes:

- Dementia Audit in Prince Philip Hospital
- NELA Audit in Withybush General Hospital
- Cardiology Audit
- Respiratory Audit
- Epilepsy 12 audits for paediatric patients

Meetings with the respective services, key audit stakeholders and Clinical and Consultant Leads have taken place and action plans developed where possible. However, it was recognised that when lack of engagement has been over an extended period, there may be a requirement to escalate and the Panel was asked to consider options for when continuous attempts to secure engagement and participation have not been successful. The Panel recognised the challenges of

securing the time/capacity to undertake clinical audit but that this should be seen as an organisational priority. Further, the consequences or risk of non-compliance should be made clear and opportunities to identify what support is required for participation in clinical audit.

It was noted that securing Junior Doctor input to clinical audit through working collaboratively with the Medical Education Department, particularly in relation to antimicrobial management and supporting improved participation in the Start Smart Then Focus audit, was a solution that has been trialled. If successful, this approach could be rolled out for use across other audits.

Actions taken to address include:

- Engagement with Clinical Leads and Service Delivery Managers to develop action plans to increase participation, including risk assessment where necessary
- A request for discussion at the Clinical Leads meeting
- A slot at the Medical Leadership meeting was requested for September 2023, to raise the matter of engagement in clinical audit
- Ongoing support offered by the Clinical Audit Department.

However, it was proposed that an escalation approach is required for ongoing cases of non-participation, through the Board's governance structures, which would inform an approach and appropriate response when mandatory audits are not completed. Potential escalation routes were discussed, including highlighting via the Health Board's governance structures; managerially and professionally.

The Panel was advised that the Audit Department have experienced significant staffing challenges and the potential risks associated with this were highlighted. However, a training and recruitment plan has been developed.

Several positive developments were reported to the Panel including:

- Successful recruitment for the Forward Programme
- An increase in the number of suggested local audits (41 compared to 13 for the previous corresponding period) which when combined with the National Audit programme will total 71
- Continuing progress to incorporate AMaT into audit processes and departmental clinical governance meetings
- Considerable successes following the use of AMaT by nursing teams

Clinical Standards and Guidelines Group

Progress in relation to the review and update of the Management of NICE and National Guidance Policy has been reported to the Panel, including amendments proposed by the Group. The final approval took place by the Clinical Written Control Documentation Group (CWCDG) in April 2023.

The Clinical Standards and Guidelines Group continues to receive update reports on new and updated guidelines published by NICE, which included Medical Technologies Guidance (MTG's), and also newly published Health Technology Wales (HTW) guidance. Where required, Group Members advise on the appropriate dissemination of guidelines where an individual lead is not obvious, for example the HTW GUI017 Virtual Reality Distraction Therapy guideline (subsequently raised at the acute pain group); NICE QS76 Acute Kidney Injury (advice sought from the Clinical Lead for Acute Medicine and Senior Nurse, Resuscitation and Acute Patient

Deterioration); and NICE Guidance 207 Tobacco: preventing uptake, promoting quitting and treating independence (subsequently disseminated to Public Health). Although it was recognised that these guidelines cover many specialities and Directorates, reassurance was given that dissemination also included report presentation and discussion at all of the Directorate Quality and Governance Group meetings, therefore providing a good level of Health Board wide awareness.

The Panel was provided with regular updates on progress with implementation of the Audit Management and Tracking (AMaT) System. The Health Board's licence has been extended until January 2025 due to slippage in the Medical Directorate budget in 2022/23. The system suppliers continue to be responsive to the needs of Health Board's across Wales and continuously assist with developing the system in accordance with user needs. Networking between Health Boards across Wales continues through the Welsh AMaT Super User Group which supports the sharing of experiences and development of the system in Wales.

AMaT continues to be rolled out to increasing numbers of service areas. All new and updated NICE guidance and all HTW guidance is now proactively disseminated through AMaT directly to the guideline leads. The Group reported that there is a future potential for the use of AMaT to disseminate other Welsh documents such as Welsh Government Quality Statements, which will continue to be explored.

The Pelvic Health Pathway workstream groups were the first in utilising AMaT to complete statements of compliance against relevant NICE Guidance and representatives were invited to the Clinical Standards and Guidelines Group to discuss the outcome and their experience of using AMaT. One clinician who had completed the Statement of Compliance for a NICE guideline (NG73 – Endometriosis: Diagnosis and Management) reported positively on the experience, noting that as well as identifying areas for improvement, it was also an opportunity to recognise all of the aspects of care that the service was delivering well, in accordance with NICE guidance. The Group highlighted next steps which included utilising the AMaT functionality to develop action plans to address the areas where NICE guidance was not being complied with, and supporting alignment with the HealthPathways project. Progress with the AMaT work was also presented at the Pelvic Health Steering Group, which is supporting the action planning work.

The Trauma Rehabilitation Co-ordinators also attended the Group to provide an update on the work they had been undertaking in relation to NICE Guideline 211 - Rehabilitation after traumatic injury, and the completion of the baseline assessment tool. They outlined the challenges associated with completion of the tool, which was finalised in November 2022. However, the completed tool, identifying key themes and gaps, has since been shared with therapy leads, and subsequently taken through the Therapies Quality and Governance Group for presentation to the Heads of Service. This was then fed back to the Trauma Quality Improvement group in March 2023 and risks added to the risk register where appropriate. It was advised that future review of the baseline assessment tool will identify the impact of any changes to service will make. In particular, the discussions had enabled consideration of the roll out of technology for a self-directed rehab app, working alongside the South Wales Trauma Network. The Panel were informed that this was an excellent example of the use of the NICE baseline assessment tool and how barriers and gaps with compliance are identified.

It was reported to the Panel that a presentation had been provided by Philip Scott, Programme Director University of Wales Trinity St David, in relation to the NICE Computable Implementation

Guidance (NCIG) project and how narrative guidelines could be converted into a computable format. It was agreed that efforts would be made to link Philip Scott with services across the Health Board who would be able to utilise the data collection processes he is using, and where data is already being collected electronically such as prescribing, test requests and discharge summaries. Connections had been made in the first instance with Antimicrobial Pharmacists to explore antibiotic prescribing.

The Group continues to receive an update report detailing any Health Board risks allocated to the NICE and National Guidance DATIX theme. This highlights risks relating to guidance and enables consideration of how the service could potentially be supported by AMaT and other clinical effectiveness processes. Similarly, if there is a risk documented in AMaT the intention is to cross reference to the risk register to ensure it is recorded as a risk by the service. At the Group meeting in May 2023, two specific areas of concern were raised including one regarding the non-compliance with current Welsh Government and Royal Society of Osteoporosis guidelines relating to a specialist fracture service for osteoporotic patients. The Panel was advised that the Head of Value Based Healthcare and Service Delivery Manager were actively exploring the possibly of establishing a specialist clinic. The second concern related to the lack of availability of contrast enhanced diagnostic sequences as part of the prostate cancer pathway. The Panel were advised there had been a positive development and an initial dedicated scanning clinic would commence in the immediate future with a commitment to establish the second diagnostic scanning clinic in approximately three months' time. The clinics would initially commence in Bronglais General Hospital where the clinical expertise and newest scanner was located, with the second location likely to be Withybush General Hospital.

At its May 2023 meeting, the Group received an update on the HealthPathways Project by the Programme Manager and one of the GP Editors. It was noted that the aim of the project is to improve patient outcomes and experience through working collaboratively between primary and secondary care. There is an emphasis on prevention and self-care and the intention to provide primary care colleagues with immediate access to evidence-based pathways while preserving clinical autonomy and patient choice. An overview of the programme team and HealthPathways platform was provided and the Group was informed of the pathway design process including the use of evidence-based practice and learning from Cardiff and Vale's experience. The GP Editor explained that the agreed pathways are negotiated between primary and secondary care and are also going to be used by Nurse Practitioners, trainees, and locum Doctors. The Group was informed of the expected go-live date. A discussion ensued regarding the identification of variance between referral processes/pathways and clarity of the associated guidance regarding the referral process, recognising that this can cause duplication. It was noted that as AMaT is being used in the Health Board to capture deviation from NICE guidance consideration is required of who will be responsible for identifying and capturing deviations from NICE guidance within the agreed pathways onto the AMaT system. This generated a discussion about AMaT and primary care engagement including responsibilities and access.

New Interventional Procedures Approval

The approval of two new interventional procedures were brought to the attention of the Panel:

- Placement of Fiducial markers before Hypo-fractionated radiotherapy to prostate
- Foam Sclerotherapy

It was noted that whilst the applications were approved through the usual channels, the approval at Directorate Level was taken via Triumvirate action initially due to the timing of meetings. However, both applications have since been discussed at Scheduled Care Quality and Governance meeting and no concerns identified.

Of note, the Foam Sclerotherapy was seen as a positive development for Hywel Dda patients, having been a procedure that patients could receive previously but would need to travel to Swansea Bay University Health Board for treatment by Swansea Bay Consultants. Approval for the procedure to be introduced would see the provision within the Health Board by visiting clinicians from Swansea Bay. The placement of fiducial markers before Hypo-fractionated radiotherapy to prostate has been introduced following the adoption of Health Technology Wales guidance on Extreme HypoFractionated Radiotherapy (EHFRT) for localised prostate cancer - Extreme HypoFractionated Radiotherapy (EHFRT) - Health Technology Wales

At the May 2023 meeting of the Group, members were reminded of the importance of informing the Clinical Effectiveness team if coming across procedures classed as new, including new equipment, variations in technique and particularly new devices being brought to the Health Board by external supplier representatives. In these instances it may be necessary to undertake the new Interventional Procedures approval process to ensure appropriate governance is in place. The Clinical Effectiveness team is working closely with the medical devices and procurement teams and are looking to adopt a new equipment registration form obtained from Swansea Bay University Health Board. Discussions are also underway to improve communication to clinical and service staff, through the use of an animated video and discussion at Grand Rounds, recognising that early involvement will reduce clinician frustration and prevent delays by creating a smoother process. The group discussed options to support communication and dissemination.

The Panel was informed that collaborative work with the Therapies Directorate continues, involving scoping the potential for aligning the ME/CFS work with the post-viral service. The Panel was notified that funding has now been secured from the Welsh Government and a meeting arranged with the Isle of Man who have developed an ME/CFS and Long Covid Service, to learn from their experience. This learning opportunity was identified because of collaborative work undertaken with the Chair of the Wales ME/CFS Support Group. It was noted that the work had been a positive experience and highlighted on-going collaboration across the wider sector which would provide opportunities to engage with and deliver benefits to ME/CFS patients.

The Panel was advised that an internal audit of NICE guidance was ongoing, reviewing the identification, dissemination, and compliance with NICE guidance across the Health Board. On conclusion of the audit feedback will be provided to the Panel.

Clinical Written Control Documentation Group

The Panel received update reports from the Clinical Written Control Documentation Group. This included a summary of the status of written control documentation at the February meeting, detailing 331 documents:

- 255 of which were within their review dates
- 64 of which exceeded their review dates but were currently in the process of being reviewed, of which 11 were pending

The Policy Team have progressed work to group the documentation in to “owning and approving groups” which would facilitate more effective information management. Reassurance was also being sought that out-of-date documentation remained fit for purpose and could remain accessible on the revised Clinical Policy Intranet page. Gratitude was expressed to the Policy Co-ordinator and her team for their diligent work chasing up, reviewing and cataloguing policies.

The Panel was assured that enquiries were on-going in relation to the ownership of the Prescription and Administration of Oxygen in Adults Policy as identifying the specific group responsible for managing the Policy had proved challenging.

A meeting had also taken place in relation to service specifications which had historically sat within the remit of the Group. It was agreed that service specifications would continue to remain in the clinical policy service area, however, the Group would not be responsible for or participate in scrutinising the documents.

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

Effective Clinical Practice Strategic Plan and Delivery Plan

At its March 2023 meeting, the Panel received the Effective Clinical Practice Delivery Plan, following approval of the Strategic Plan in January 2023. The Delivery Plan focuses on the delivery of the Strategic Plan, identifying key targets and deliverables for the year; and the systems, processes and governance that need to be in place to support. It was outlined to the Panel that the targets were strategically set, taking into consideration the limited capacity within the team and that the focus was on priority areas, which were identified in different ways and included both local and national priorities. Future progression and development include a more directive focus on how AMaT will be used, recognising the need for embedding processes and creating expectations of services through AMaT, including timescales and how services and directorates respond. The plan was shared with the Panel for oversight, discussion and feedback. The Panel discussed and noted that Planning Objective 5k, which informed the Strategic and Delivery Plans, had been stood down as a formal Planning Objective and operationalised but acknowledged that the Strategic and Delivery Plans would become business as usual and delivered through the policies, systems and processes that had been developed. This would ensure continued milestones including the delivery of AMaT, supporting healthcare professionals in the clinical environment and disseminating effective practice across the Health Board. The documentation has been updated to reflect these changes.

The Delivery Plan was approved and is available here - ECP Delivery Plan

A suite of resources have been developed to support the Strategic and Delivery Plans and were demonstrated to the Panel. The resources are available on the dedicated Clinical Effectiveness SharePoint pages of the Health Board’s intranet and can be viewed here - Effective Clinical Practice Strategic Framework . The resources include a toolkit consisting of animated videos which break the process into a simple step-by-step guide, supporting clinicians and service teams to follow the process to confirm effective clinical practice and identify opportunities for improvement. This also includes relevant links such as the Health Board’s Quality Management System. The resources are

intended to address capacity constraints within the Clinical Effectiveness Team by enabling teams and service areas to self-brief and develop their awareness and understanding independently. As well as being available on the staff Intranet, links to the resources have been disseminated to various clinical and professional groups via targeted e-mails, through global email and presented at key meetings such as Senior Nursing and Midwifery Team and Heads of Therapies.

The first of a series of Effective Clinical Practice Advisory Panel roadshows was planned to take place at Bronglais General Hospital (BGH), on 18th July 2023, which would be a lunchtime presentation. The event was designed to provide healthcare professionals with the opportunity to present good practice projects to other colleagues and was supported by the Hospital Director and other colleagues onsite.

A discussion took place at the Panel regarding the placement of information relevant to clinical and professional groups on Directorate specific intranet pages, and the challenge this potentially causes certain clinicians in finding the information. For example, the Effective Clinical Practice resources are placed on the Medical Directorate area but are relevant across the whole Health Board. Further examples were provided and the Panel was informed that the Communications Team are developing an easy access thematic system on the intranet which will assist staff in locating information irrespective of under which Directorate area it formally sits. It was agreed that discussions would take place with the Communications Team for a 'Quality and Safety' themed page, bringing together key resources across Medical and Nursing Directorates, and other areas of the intranet as required.

Health Technology Wales (HTW) Adoption Audit 2022/23

The Panel received an update on the HTW Adoption Audit 2022/23 and was advised that Hywel Dda University Health Board was one of a very small number of Health Boards submitting a full complement of responses to HTW. This included 11 HTW guidelines and a trial involving three NICE Medical Technologies Guidance (MTG). Responses were submitted through the AMaT system using a specially designed proforma designed by the AMaT suppliers to capture the information. This excluded the MTG's although the intention is that this will be enabled for future adoption audits. Further, whilst this year the submissions were completed by the Clinical Effectiveness team, using information gathered on the word proforma, the intention for future audits is that the services will be supported to submit the information directly onto AMaT.

Several of the guidelines this year were not recommending routine adoption, causing some confusion amongst clinicians, which was fed back to HTW. In response, HTW advised that they wanted to ensure that when technologies were not recommended for adoption within their guidance they had assurance that Health Boards were not using it. Further feedback to HTW included concerns in relation to:

- timing of the audit with winter pressures and seasonal festivities affecting engagement
- the question sets used
- the transparency of aspects of the audit which appeared to be commercially driven by technology suppliers
- the additional work the audit created for clinicians
- the alignment between NICE and HTW

- the process around the initial proposal for a technology to be appraised and opportunities for subject matter experts to get involved earlier, including as part of the consultation when a new topic of guidance is being developed

This feedback had been provided to HTW via a formal meeting with Health Boards arranged for this purpose, and the comments were positively received. HTW are now engaging earlier and writing to invite clinicians to participate in guidance consultations. However HTW advised that their timescales for consultations will remain shorter than the NICE process, in order to support timely publication of guidance.

In relation to the findings of the HTW audit, Panel members discussed an observation that most of the guidance was recorded as having limited impact or the guidance had been issued after an initiative had started and questioned if this was because HTW were relatively new or did it relate to the timing of the guidance. It was explained to the Panel that prior to 2020, there was no system in place for proactively disseminating HTW guidance, consequently clinicians may not have been aware of pre-2020 guidance and will not have factored the guidance into service developments. Examples were provided, such as the faecal immunochemical testing (FIT) and Flash Free style libre guidance where the introduction was well underway when the HTW guidance was published.

Consequently, it was recognised that HTW need to build confidence with clinicians as NICE have, and whilst HTW are focusing on being agile and rapid in their guidance publication approach, clinicians may disengage if the questions have previously been addressed in other guidance, particularly NICE.

The Health Technology Wales Adoption Audit Report 2022/2023 is appended for the Committee's information.

Interventions Not Normally Undertaken (INNU)

It was reported to the Panel that the Health Board policy relating to Interventions Not Normally Undertaken (INNU) was outdated and no longer fit for purpose, advising that approximately two years ago, the Health Board were contacted by the Welsh Government Planned Care programme and informed that work relating to INNU would be carried at a national level which resulted in the local policy review being paused. It has since been established that the national work has not progressed as anticipated, however discussions have taken place involving HTW and the Welsh Value in Health Team to develop a national approach to INNU. Information from Hywel Dda's 'INNU' activity (based on the original list) has been used to inform this, highlighting the procedures that are undertaken in higher volumes in the Health Board. The proposed approach is to identify the interventions which are consistent across all the Health Boards and start work on developing an INNU policy with HTW supporting the updating of the evidence base. This would then be developed into a policy and additional interventions added as required. Meetings with local clinicians will be scheduled, monitoring activities will be implemented and there will also be engagement with Primary Care to ensure individuals are not being referred inappropriately.

The Panel recognised the importance of the terminology used, and that INNU are procedures that are not routinely undertaken but in some cases there is a threshold and clear clinical criteria where the procedure can be undertaken. It was therefore considered an opportunity to revisit the language used, and noted that the description being used nationally had been "procedures of limited value".

It was noted that the on-going work has evolved from work previously undertaken to develop a local policy regarding procedures of limited clinical effectiveness which had subsequently evolved into a regional and national policy. There had not been any central monitoring of policy compliance across Wales for several years and having regard to the Value Based Health Care (VBHC) agenda, there was potential for savings across the Health Board.

Discussions have also taken place regarding alignment with the HealthPathways programme, as an opportunity to provide GP's with information on the criteria that must be met for a procedure on the INNU list to be undertaken. This will ensure that communication is taking place at the earliest opportunity and assists in managing patient expectations.

National Safety Standards for Invasive Procedures (NatSSIPs)

The Panel was advised that a NatSSIPs 2 Policy had been published nationally and it is now clearer within the Policy what constitutes an invasive procedure. There is also now a requirement for an identified named Board Member to govern and the requirement of a Clinical Lead specifically involved in clinical activity. This is to be supported through a multidisciplinary steering group. Consequently, the Health Board's Invasive Procedures Policy will need to be reviewed to ensure compliance with the NatSSIPs 2 approach. The Panel discussed the author of the Invasive Procedures Policy, as the previous author had taken the lead in the absence of anyone clear to write it, however had subsequently left the organisation. It was debated whether the Policy sits most appropriately within the Scheduled Care Directorate as invasive procedures are primarily carried out in theatres and outpatient areas, however it was noted that these procedures do also take place in Women and Child Health, Primary Care and Radiology Directorates, therefore the national safety standards also apply. It was therefore concluded that ownership and responsibility required further consideration and suggested that the patient safety leadership commission a group to oversee the work, as part of the Safe Care Collaborative, given the wide-ranging nature of invasive procedures across the Health Board.

It was also proposed that rather than having a local Policy for NatSSIPs 2, it may be appropriate to produce a summary/short guide locally, and direct staff to the national NatSSIP's 2 Policy. It was agreed that in principle there should be a move away from lengthy policy documents that staff are expected to read, towards summaries and guides, outlining the principles as an ease of reference rather than risk misinterpreting the main document.

The Panel discussed monitoring arrangements for NatSSIP's, recognising the importance of having robust control mechanisms in place to ensure the standards are monitored and achieved across every procedure. It was confirmed that the Welsh Government do not expect Health Board's to report on NatSSIP's, however there is an expectation that the Health Board was taking pro-active action to reduce the number of never events.

Clinical Record Keeping Policy

The Panel was advised that a new Clinical Record Keeping Policy was approved in February 2023, which has been developed for all clinical professionals. The policy sets out eight high level standards for good record keeping. The policy does not replace the record keeping standards and principles from registrant bodies, but simply outlines the basic standards as part of the Health Board's continuous efforts to improve record keeping.

Widespread communications have taken place through professional groups and networks, including a suite of resources available through a dynamic SharePoint site - Clinical Record Keeping Policy. The resources are designed to support good record keeping and the policy itself, with short video clips introducing what good record keeping looks like and featuring clinicians across professional groups introducing the eight key standards.

An audit programme that sits alongside the standards is in development, and AMaT will be looked at to facilitate this. ECPAP will have overall responsibility for receiving record keeping audit reports, recognising that the relevant Directorate Quality and Governance Groups would receive the audit outcomes and any issues brought to ECPAP.

Following presentation of the new Policy at the Operational Quality Safety and Experience Sub-Committee, it was agreed that a Clinical Record Keeping Policy Implementation Group will be established to support the ongoing communication of the Policy, along with implementation and audit. The Group will also support any quality improvement necessary to support improved compliance with the standards.

Risk Register Update

The Effective Clinical Practice Risk Register continues to be shared at ECPAP meetings.

The Panel was advised that the Clinical Standards and Guidelines Group will routinely receive a report for any new risks identified that have been allocated to the NICE and National Guidance Risk Theme on DATIX, this provides an oversight enabling identification of services who may benefit from the additional support of the Clinical Standards and Guidelines Group. This is a positive development in terms of risk management however consideration is needed of how risks captured on AMaT are aligned to formal risk management processes, and a discussion has taken place with the Risk and Assurance Team.

The Panel was notified that the risk scoring relating to mortality review had been increased to 12 to reflect the challenges being experienced in terms of completing the roll out to Glangwili General Hospital. This score reflects mortality related issues including delays in provision of scanned medical records and submission of cases to the MES and subsequent delays in processing cases received from the MES. This can ultimately impact on mortuary capacity. Good progress was being made, including appropriate escalation procedures, however, there is a continued risk and things are being progressed cautiously. The risk has also been escalated from service level to a directorate level risk and has been highlighted to Executive colleagues. The Panel was advised that the provision of additional resources will enable the Glangwili Hospital roll out to be completed and reduce the risk level.

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

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

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.
- Implement management actions arising from the Internal Audit of NICE Guidance.
- The policy team are working more effectively with owning/approving groups to ensure awareness of the documentation which falls under their remit including review dates and policy process. The development of quarterly reports on clinical written control documentation will be submitted to each owning/approving group.
- Clarity on the governance process around service specifications to be included in the 190 Written Control Documentation Policy. Definition of a service specification has been agreed - '*a document to outline the core and development service standards in terms of need and expectations of service quality*'. Service specifications can be housed on the relevant clinical policy service area and the standard policy template will be utilised, however CWCDG will play no part in scrutinising service specifications and they will be approved via the relevant groups/committees, with evidence of this approval being forwarded for archiving purposes.

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:

5th December 2023