Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	08 February 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Effective Clinical Practice Advisory Panel Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Philip Kloer, Medical Director and Deputy CEO
SWYDDOG ADRODD: REPORTING OFFICER:	John Evans, Assistant Director, Medical Directorate Lisa Davies, Head of Effective Clinical Practice and Quality Improvement (Medical Directorate)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an update on the clinical effectiveness agenda within the Health Board (HB) and a summary of key matters discussed at the meetings of the Effective Clinical Practice Advisory Panel held in September 2021 (the meeting scheduled for December 2021 was cancelled due to absences and operational pressures).

Cefndir / Background

The purpose of the Effective Clinical Practice Advisory Panel 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.

The Panel plays a key role in overseeing the development of an Effective Clinical Practice Strategic Framework, which will provide a structure for the delivery of HB Planning Objective 5K:

> *Establish a new process that involves all clinical service areas and individual clinical professionals, whereby we assess ourselves against local and national clinical effectiveness standards/NHS Delivery Framework requirements and fully contribute to all agreed national and local audits (including mortality audits). All areas and clinicians will need to be able to demonstrate their findings have been used to learn and improve and the process needs to be embedded within the HB's Quality and Governance process.*

A Clinical Director for Effective Clinical Practice has recently been appointed to support delivery of the clinical effectiveness agenda and an effective and robust effective clinical practice function across the HB. In particular, the Clinical Director for Effective Clinical Practice will have a key role to engage and support clinical service areas and individual clinicians to assess against local and national clinical effectiveness standards, and support

clinicians and service areas to demonstrate that their findings have been used to learn and improve, in line with Planning Objective 5K. A vacancy in this post meant limited opportunity to engage with triumvirates and quality and governance groups on the delivery of the Planning Objective, however the newly appointed Clinical Director will make a significant contribution to progressing this action.

The Effective Clinical Practice Advisory Panel is scheduled to meet quarterly during 2022.

Asesiad / Assessment

Key matters considered by the Effective Clinical Practice Advisory Panel in September 2021 are summarised below:

Effective Clinical Practice Strategic Framework Update

The purpose of the Effective Clinical Practice Strategic Framework is to support the delivery of Planning Objective 5K. A Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis was undertaken to inform the development of the Effective Clinical Practice Strategic Framework in order to gather input to co-develop a strategic approach, building on the strengths, opportunities, weaknesses and threats for clinical effectiveness identified by our clinical, operational and managerial teams. Under the circumstances the level of response received was good, however responses tended to reflect the current pressures within the system and highlighted the challenges and barriers associated with improving clinical effectiveness and striving towards clinical excellence in the current climate. However, a thematic analysis has been developed and this has informed an Effective Clinical Practice Strategic Plan which is currently in draft. The Strategic Plan builds from the SWOT by identifying, for effective clinical practice: What we do well; What we need to do more of: and our Biggest Challenges. This is structured under the headings of the three relevant Strategic Objectives - Striving to deliver and develop excellent services; Safe, Sustainable, Accessible and Kind Care; and Sustainable use of resources.

Additionally, work is ongoing to ensure that this Strategic Plan is embedded within the developing Quality Management System, and underpinning the delivery vehicle Improving Together, in recognition of the significant role and contribution of clinical effectiveness within the Quality Cycle.

Health Technology Wales Guidance

The Effective Clinical Practice Advisory Panel has oversight of the Health Technology Wales Guidance, and the Quality, Safety and Experience Committee is the Lead Committee for a planned annual Adoption Audit of Health Technology Wales guidance. An Adoption Audit Pilot is currently underway in relation to specific Health Technology Wales Guidance. This audit is ongoing for four pieces of guidance identified as priorities by Health Technology Wales, which are relevant to our HB. Engagement is underway with clinical and service leads to support the HB's submission by the 18th February 2022, as required.

The HB has been successful in securing funding from Health Technology Wales to support the development of systems and processes which will enable the annual Adoption Audit. This has afforded the HB the opportunity to invest in a new system – AMaT, which has previously been explored as a potential solution for the HB. This is a governance software which facilitates the tracking and management of clinical audit, clinical guidelines, ward level audit (and other functionalities are being explored at present). In the first instance this will support the tracking of Health Technology Wales and other national guidance (including National Institute for Health

and Care Excellence (NICE) guidance), and replace existing processes for clinical audit. It will also contribute to the delivery of Planning Objective 5K by providing a system to manage assessments against clinical standards. Hywel Dda University Health Board (HDdUHB) will be the fourth HB in Wales to introduce AMaT.

In the meantime, the Effective Clinical Practice Advisory Panel will maintain oversight for newly published Health Technology Wales Guidance, which is disseminated to service areas for decision on an Adopt or Justify position and a register is kept centrally. This will be replaced with AMaT once operational within the HB.

Royal College of Physicians Visit to Bronglais General Hospital (BGH) - Follow Up

The Effective Clinical Practice Advisory Panel received an update regarding the Royal College of Physicians (RCP) visit to Bronglais General Hospital, in 2020.

The RCP report was positive and well received, and although not detailed, it recommended areas for further consideration. An Action Plan has been developed, and all actions progressed through the site Operational Team, with the exception of action 5.5 relating to the Medical Service Increment for Teaching (SIFT) funds (this action has been completed as it related to developing post graduate education centre and establishing how SIFT funds are accounted for. During the past 12 months, the HB has undertaken an organisational wide review on SIFT and has reclaimed all SIFT funding from operational budgets).

A number of actions have been completed, with the remaining recommendations moved to the Strategic Log (as actions that require additional investment, capital funding or need to be addressed as part of a long term strategy). These recommendations form part of the scope of the Clinical Strategy for BGH and are likely to remain slowly progressing objectives over the next 1-2 years.

New Interventional Procedures

The Effective Clinical Practice Advisory Panel continues to provide oversight for the approval of New Interventional Procedures and has recently provided oversight for the approval of *NICE Interventional Procedure Guidance 560 (IPG560) - Microstructural scaffold (patch) insertion without autologous cell implantation for repairing symptomatic chondral knee defects.* Whilst this was approved, work is ongoing with the clinicians and service to ensure the effective capture of outcomes, and has also involved the Value Based Healthcare Team.

The New Interventional Procedures Policy has been subject to an interim amendment which provides for approval of applications for Interventional Procedures at Directorate Quality Governance Groups, subject to the provision of relevant information and clinical and service agreement. This is followed by senior clinical sign-off by the Deputy Medical Director for Acute Hospital Services. The Panel has a role to receive and log the approval, and provide any necessary scrutiny of the decision.

A comprehensive review of the New Interventional Procedures Policy has commenced and will take account of the findings from the INTRODUCE Study, led by the West of England Academic Health Network and undertaken by Bristol University. The research involved the review of Interventional Procedures Policies from Trusts and Boards across England and Wales, and the governance around surgical innovations. Findings were presented at a national event, titled **Safety and transparency in surgical innovation - can we do better?** The findings of the study will present opportunities for the review and development of the New Interventional Procedures Policy, and also highlight the need to consider the findings of the

recent Independent Medicines and Medical Devices Safety Review by Baroness Cumberlege, which further highlights the need for change.

The Effective Clinical Practice Advisory Panel was made aware of discussions surrounding the relationship between Tritech innovations and effective clinical practice, when new procedures and innovations are trialled within the HB. Some have implications relating to NICE guidance, in particular if NICE indicate that a procedure should not be used due to insufficient evidence of efficacy and outcomes. Early involvement is essential to ensure effective clinical practice whilst also supporting innovation wherever possible. It was also noted that there is a connection with the Medical Devices Group.

Discussions have taken place involving Research and Innovation, Medical Devices and Effective Clinical Practice and the ongoing update of the New Interventional Procedures Policy will reflect the relationship and support appropriate governance. This will also include governance around innovations evaluated through Tritech that are recommended for introduction into practice.

Process for External Reviews – Peer/Royal College Reviews

A process for External Reviews – Peer/Royal College Reviews has been drafted in response to the need for clarity on how external reviews are managed and communicated. The process is a management tool ensuring Executive oversight of the review; who the findings are communicated to and how recommendations are tracked; and how the findings are addressed. The draft process has been developed with involvement from the Assurance and Risk Team, and has been circulated to key triumvirates.

An opportunity has presented itself to pilot the process as part of the Cardiology Transformation Programme, as the Welsh Cardiology Network has agreed, together with the HB, to undertake a peer review. However this has been postponed until 2022, with the estimated start date still to be confirmed. Piloting the draft process would provide an opportunity to refine on the basis of its application in practice, prior to final approval.

Once approved, the proposal is that this process becomes embedded within the organisation, potentially as part of the HB's Management of External Agency Visits, Inspections & Accreditations Procedure.

Human Tissue Act Compliance

The internal audit report on Human Tissue Act Compliance included a management action relating to the reporting of Human Tissue Act (HTA) compliance to the Board with the recommendation to ensure periodic assurance reporting of HTA compliance, license status and relevant issues. Discussions have taken place with the Pathology Service (with regard to mortuaries) and Research and Development (with regard to Biobank) to agree reporting routes. It was agreed that an annual update be provided to the Effective Clinical Practice Advisory Panel, on HTA Compliance for both the Mortuary and Biobank, including license status etc, around the time that the Annual Compliance Report is prepared. This will be added to the Panel's Forward Workplan for March 2022 and annually thereafter, and captured in the six-monthly report to the Quality, Safety and Experience Committee to ensure a clear route to a Board level Committee.

The Audit Recommendation proposal was agreed with the Board Secretary and the recommendation confirmed as complete.

Feedback from the International Forum on Quality and Safety in Healthcare

A report has been prepared following the 2021 Institute for Health Care Improvement (IHI) International Forum on Quality and Safety in Healthcare, which was held virtually in June 2021 and attended by a delegation of 12 members of the HB's Clinical Quality and Safety Leadership team, and Quality Improvement and Service Transformation Team. The report summarises the feedback provided from participants under a number of key themes, and highlights lessons to be learned for HDdUHB.

An improvement plan is in development, in response to the opportunities identified from the Forum, and it was proposed that this be presented, together with the full report, to the Quality, Safety and Experience Committee in due course.

Updates from Sub-Groups

Mortality Review Group

It was reported to the Panel that stage 1 mortality review performance had held at 84.4% with a dip in April and May 2021, which is attributed to the pressures the sites have been under and with a Medical Examiner being on two sites only. This was acknowledged as a good achievement with the increases made in 2018 and 2019 holding through the COVID-19 pandemic and the dip in Glangwili General Hospital (GGH) having been recovered.

The Medical Examiner Service will be fully operational by 1st April 2022. All Medical Examiners have now been appointed and the HB is working within the South West Region which includes Swansea Bay UHB. Issues with implementation have been related to resource requirements such as scanning, however this additional funding has been approved to ensure resources on each site to support the Medical Examiner Service.

The All Wales Learning from Mortality Review Model Framework was presented to the Panel for discussion. This framework will entail the redesign of all HB's mortality review processes including stage 1, which will be provided in future for all deaths via the new Medical Examiner Service. The Framework has been approved nationally and HBs have been asked to ratify the new Framework via local governance processes, and agree its implementation within the HBs. Whilst awaiting formal approval of the Framework, work has taken place to develop local processes which are fully in-line with the principles and levels outlined in the new national approach. A multidisciplinary task and finish group, which included Clinical/Hospital Directors, Nursing, Therapies, Pharmacy, operational and corporate teams, was established to localise and adopt the framework, and the HB is now at the point where this process is being trialled, and will be developed iteratively as a process is refined that best fits local circumstances. This will enable the key principles of the Framework to be achieved whilst also allowing for local variation. Local processes include the development of a Multidisciplinary Panel, which met for the first time in January 2022. Membership of the Multidisciplinary Mortality Review Panel includes:

- Clinical Lead for Mortality (Chair)
- Primary Care Doctor
- Secondary Care Doctor
- Head of Nursing
- Assistant Director of Therapies
- Pharmacist
- Quality Assurance and Safety Team representative

- Quality Improvement representative
- IP&C and Professional Standards representative
- Patient Experience Team representative
- Legal representative
- WAST representative
- Site representatives from Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital and Withybush General Hospital

The Panel recognised that caution is required when communicating the new Framework and local processes to clinicians and service areas, as there is a change in terminology. Therefore, clear interpretation and description will be required.

A Clinical Lead for Mortality has been appointed, with responsibility for supporting the development and delivery of effective processes and learning from mortality reviews, in line with the Framework; and developing wider mortality accountability, scrutiny of all available mortality metrics and working with Clinical Directors and Clinical Leads to increase ownership and prioritisation of mortality across the HB.

The HB continues to contribute to national discussions regarding the implementation of the Framework and ongoing development as it becomes embedded across Wales. In particular, engagement is ongoing with other HBs in order to maximise opportunities to share learning and build from others' experiences.

The Panel reviewed the principles of the All-Wales Framework with a view to ratify to adapt and adopt locally, recognising that the framework cannot be followed exactly. Members present were supportive in principle however recognised that other members not able to attend may also wish to express their views, therefore it was agreed that the All Wales Framework would be circulated to members, and as no response received, taken as ratified.

Clinical Audit Scrutiny Panel

The Clinical Audit Scrutiny Panel (CASP) has continued to meet and has closed the remaining Clinical Audit programme, which was an extended programme over 2 years.

The forward Clinical Programme is in the process of being developed and the Clinical Audit Department is continuing to liaise with additional committees and services to build a more complete programme. The number of projects on the programme remains low due to clinical pressures.

At the time of the last Panel meeting (September 2021), the national audit programme was still suspended, however Welsh Government has subsequently indicated that the national programme has resumed. No official communication has been sent to HBs and emphasis is firmly being placed on the pandemic and clinical pressures. The Clinical Audit Department has been maintaining all mandatory processes since May 2021. The Health Board continues to pursue the Audits as if they were mandatory but maintaining sensitivity amongst services that are unable to contribute; Clinical Audit are monitoring as they would normally.

Whole Hospital Audit Meetings (WHAM) are ongoing, three have been successfully completed, including the first Whole Health Board Audit Meeting, held in September 2021. The whole HB meeting included four national audit presentations and a session on the Medical Examiner Service by Jason Shannon, Chief Medical Examiner. The event received very positive feedback and was well received by the audience. In future, the WHAM sessions will be alternating between site-based WHAM and HB wide WHAM to try to promote whole HB

learning and sharing opportunities whilst allowing site based audits enabling teams to present their audits.

The National Wales COVID-19 hospital audit is currently the only mandatory audit and as the HB's contribution has been limited to date, this was escalated by CASP to the Panel as a risk. This has been discussed at CASP and the reasons for the limited response are due to resource intensity, and the capacity for respiratory teams to contribute to the audit. Attempts have been made to resolve this, however they have not been effective, and levels of participation in Phase 2 of the Audit have continued to be low. Phase 3 of this audit has now commenced but HBs have been asked to finish data collection for Phase 2 first.

The CASP Terms of Reference were reviewed and presented to the Panel in September 2021. Changes were minor, to reflect changes surrounding the structure; renaming of the Quality, Safety & Experience Committee, and review of National audit reports removed. The revised Terms of Reference were accepted by the Panel.

NICE and National Guidance Group (NNGG)

There have been challenges in achieving quoracy for some time and consequently it was agreed that a comprehensive review of the Terms of Reference was necessary. Initially a series of questions were circulated to Group Members to inform discussion at a workshop taking place during a Group meeting. Unfortunately, this yielded a poor response however a further discussion was held at the last meeting of the Group in August 2021. Discussion highlighted that under the current terms of reference the Group was not fit for purpose and would need time to reconfigure into something more meaningful. The challenges of securing attendance and contribution of clinical and operational colleagues given the current pressures of the pandemic were noted.

This conclusion was shared with Professor Philip Kloer as Executive Lead, and it was noted that the newly developing Quality and Governance Groups will need to hold responsibility and ownership for NICE and National Guidance within their respective areas, and to complete the work at clinical and operational levels, whilst recognising there needs to be a central oversight function. The Terms of Reference are currently under comprehensive review, with a focus on developing a smaller core group and co-opting service and specialty representatives when required for detailed discussions. The newly appointed Clinical Director for Effective Clinical Practice will also provide clinical direction with regard to the purpose of the NICE and National Guidance Group going forward, and will oversee the development of the revised Terms of Reference.

The National Safety Standards for Invasive Procedures Steering Group Terms of Reference and Invasive Procedures Policy (IPP) were presented at the September 2021 NNGG meeting, and were ratified by the Panel, ahead of their presentation to the Clinical Written Control Documentation Group (CWCDG) for adoption. This is with the exception of the Appendix to the Policy, which is to be taken as a working document.

Clinical Written Control Documentation Group

Mr Yeung Ng, Consultant Urologist, has been appointed to chair the Clinical Written Control Documentation Group. Members expressed thanks to the Interim Chair, Ms Sue Beach, Lead Clinical Development Pharmacist, who will remain on the Group as a Medicines Management member.

The CWCDG is currently working to establish Directorate Groups across all Directorates. The groups have been asked to review performance and the processes, assurance and governance.

Policy 190 - Written Control Documentation Policy (Policy, Procedures and Guidelines) has been reviewed and consulted upon. It is recognised that there is a need to approve documents as quickly as possible, however this has to follow due process. The Mental Health and Learning Disabilities Directorate is an example where this balance has been achieved successfully therefore the aim is to roll out this way of working to the other groups. The review of Policy 190 also takes account of new requirements for accessibility, and a new template for policies has been developed to reflect this.

Nursing representation at the Group is being confirmed, and this was noted by the Effective Clinical Practice Advisory Panel. It was agreed that one regular attender and one deputy would be sought.

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	4.3 Provide assurance that the Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate. 4.5 Provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided across the breadth of the organisation's functions, is based on sound evidence, clinically effective and meeting agreed standards.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	All abbreviations noted in full in the report prior to being abbreviated.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	New AMaT system being procured but cost neutral due to funding provided by Health Technology Wales
Ansawdd / Gofal Claf: Quality / Patient Care:	No adverse quality and/or patient care outcomes/impacts
Gweithlu: Workforce:	No adverse existing or future staffing impacts
Risg: Risk:	Current risks relating to Planning Objective 5K are captured on the risk register and actions in place to mitigate.
Cyfreithiol: Legal:	No legal impacts or likelihood of legal challenge
Enw Da: Reputational:	No potential for political or media interest or public opposition
Gyfrinachedd: Privacy:	No potential impact on individual's privacy rights or confidentiality and/or the potential for an information security risk due to the way in which information is being used/shared, etc.
Cydraddoldeb: Equality:	No Equality Impact Assessment (EqIA) required