Meeting Date	**27 June 2023**	**Agenda Item**	**6.4**
Report Title	**Clinical Outcomes and Effectiveness Group Mid-Year Report**		
Report Author	Sharon Rağbetli, Clinical Audit & Effectiveness Manager		
Report Sponsor	Richard Evans, Executive Medical Director/Deputy CEO		
Presented by	Richard Evans, Executive Medical Director/Deputy CEO		
Freedom of Information	Open		
Purpose of the Report	This provides an overview of the work of the Clinical Outcomes and Effectiveness Group (COEG), providing a summary of performance with; Audit Plans for 2022/23, compliance with and the response to, published mandated national audits/registries and on mortality through the Learning from Deaths Panel.		
Key Issues	A successful bid to receive a two-year licence free period for use of the Audit Management and Tracking (AMaT) has resulted in a slow rollout of the full functionality of the system in supporting numerous improvements in the approach towards monitoring the previously outlined audit and improvement hierarchy and key national guidance.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Members are asked to: - **Note** the report.

CLINICAL OUTCOMES AND EFFECTIVENESS MID-YEAR REPORT

1. INTRODUCTION

The Executive Medical Director/Deputy Chief Executive set out his vision for a hierarchy of audit/improvement activities in September 2021, listing five levels. This report offers an update on delivery of and progress with, those topics that were planned at Service Delivery Group (Level 3) and Department levels (Level 4), supported by interrogation of the new Audit Management and Tracking (AMaT) system.

A National Learning from Deaths Framework published by the NHS Delivery Unit and Welsh Government. Adopted by the Health Board as the framework for delivering the new learning system, supporting local processes were established in May 2021 to screen, review and provide feedback on any concerns identified by the Medical Examiners (ME) Service.

2. BACKGROUND

The need for the revised hierarchy approach, particularly in reference to locally initiated audits, was substantiated by the very poor completion rates documented within the 2020-22 Bi-Annual Clinical Audit and Effectiveness Report. In recent years, large numbers of projects were authorised by Audit Leads on an ad-hoc basis, with the highest level of reported completion standing at 45% in both 2017/18 and 2018/19. These levels were only achieved with significant input from the Clinical Audit and Effectiveness team in chasing up outcomes and actions.

Service Delivery Groups and Departments were tasked with identifying necessary topics not covered by the mandated nationals or health board priorities, to form their forward plans for the audit year commencing April 2022.

Arriving in the Health Board in 2022, full functionality for the Audit Management and Tracking (AMaT) system and a solution to the access issues were only overcome in May 2023.

The National Learning from Deaths Framework published by the NHS Delivery Unit and Welsh Government has required the implementation of local processes to support the receipt, screening and review of information generated by the Medical Examiners (ME Service). The approach enables the Health Board to address any concerns and themes that emerge from the data collected, supported by a customised dashboard.

3. GOVERNANCE AND RISK ISSUES

3.1 Mandated Nationals (Level 1)

The Welsh Government mandated list of topics, in which the Health Board must participate for those services it provides, is attached as Appendix 1.

SBUHB were unable to contribute to the National Audit of Dementia due to the impact of the Butterfly Scheme being paused within the Health Board. The need to prospectively identify known and *potential* dementia patients and their carers for a period of time meant that it was not appropriate to undertake the project retrospectively, with the agreement of the audit hosts.
Confirmation has been received recently that the Butterfly Scheme will be slowly reinstated during 2023/24.

3.1.1 Assurance Proformas

Welsh Government no longer require the completion of two-stage assurance proformas following publication of the findings of mandated national audits/registry topics. However, the Health Board retained the internal process as an assurance mechanism for COEG to have oversight of highlights and associated actions.

Table 1. below details the number of Assurance Proformas issued and the responses received by Audit Year;

Assurance Proformas Returned	
1st April 22 – 31st March 23	1st April 23 to date
34/38	0/4

Table 1.

For the 2022-23 period, 2 responses are currently overdue; National Asthma and COPD Audit Programme – Drawing breath (NACAP) and the National Emergency Laparotomy Audit (NELA).and 3 of the 4 responses.

3.1.2 NCEPOD Studies

3 NCEPOD Studies were issued and participated in the 2022/23 Audit Year; Crohn's Disease, Community Acquired Pneumonia and Testicular Torsion. All studies are complete, were contributed to and we await publication of the reports.

For the new Audit Year to date 3 further studies have been issued and are on-going at various stages; Endometriosis, End of Life Care and Juvenile Arthritis.

3.2 Health Board Priority Topics (Level 2)

Consent to Treatment, Care in the Last Days of Life, DNACPR, WHO Surgical Checklist, Antimicrobial Stewardship and the Use of Chaperones were identified as health board priority audit and improvement topics by the Executive Medical Director/Deputy CEO.

Each live topic was launched via bulletins on the intranet pages, with a number also featuring in the SBUHB Bulletin that reaches all email inboxes. Status and progress with each of these topics is illustrated in Table 2.;

	Status	Cases	Individuals
DNACPR	Paused	203	7
Consent to Treatment	Live 15/07/22	472	19
Care in the Last Days of Life	Live 22/07/22	103	11
Antimicrobial Stewardship	Live 08/08/22	0	0
WHO Surgical Checklist*	Live 01/12/22	408	N/A
Use of Chaperones - Facilities	Ended	Targeted areas only	

Table 2.

Having a pool of topics that can be tapped into by doctors in training not allocated an Audit Plan topic has largely proven to be successful for those individuals and in building a baseline picture for the Health Board.

Signposting doctors in training to the list of HB Priorities was aided by an introduction to the hierarchies and priorities at induction via a video by the Welsh Clinical Leadership Training Fellow and General Surgery Registrar at Morriston. Individuals were offered an opportunity to participate at three levels, building up from basic data collection and submission of case via the AMaT system to data collection, analysis and presentation of 30 cases. In addition, there was the potential for them to complete a full QI cycle for Antimicrobial Stewardship. All participants received a certificate reflecting their level of input for their portfolios.

To date, multiple individuals have tapped into one or more of these priority topics to support their training needs. In the case of the WHO Checklist*, this is now adopted into normal practice to replace the paper versions previously in use. The project has started to roll out from the Morriston theatres that had been used to pilot the tool.

The Deputy Executive Medical Director has met with the lead for Antimicrobial Stewardship to agree an alternative approach to that previously offered whereby individuals had the opportunity to sign up to a full QI cycle. The approach moving forward will include a number of small snapshot audits, targeted to specific issues/areas and driven by the needs of the Antimicrobial Stewardship Group.

In all cases, updates and presentations on the topics have been received at COEG meetings.

3.3 Service Delivery Group and Department Plans (Level 3 and Level 4)

Table 3. provides the current status with Plans and Level 3 and Level 4 by Service Delivery Group;

	Completed @ Level 3	Completed @ Level 4	Deferred	Abandoned
Mental Health and Learning Disabilities	5/8	1/3	1	1
Morriston	0/2	40/61	19	24
Primary, Community and Therapies	2/2	6/12	4	21
Singleton and Neath Port Talbot	0/10	8/25	12	7
Totals	**7/22**	**55/101**	**36**	**53**

Table 3.

Originally, 212 topics were listed as planned across Levels 3 and 4. Audit Leads have taken the decision to defer a total of 36 projects to the 2023/24 audit year to date.

The majority of the 53 topics abandoned to date were in fact nursing projects that will feature within the Nursing Module of AMaT when the secured resources are in place to support.

Currently 50% of the remaining confirmed planned topics have been completed. These figures are subject to change as the Service Delivery Groups undertake the formal close down of 2022/23 plans and presentation of the 2023/24 plans.

3.4 Emergent Necessary Ad-hoc Topics (Level 5)

For the report period, an additional 25 topics were added in-year. The ad-hoc (Level 5) projects were required to meet qualifying criteria and were largely as a result of needing to support a number of Medical Student projects and participation in additional regional/national studies, not included within the Welsh Government list at Level 1.

3.5 NICE/Health Technology Wales Guidance (HTW)

COEG monitors compliance with responses to newly published/updated NICE and HTW guidance, issued to identified individuals through initial discussion at the monthly Executive Medical Directors Department and Service Delivery Group Medical Directors meetings.

SBUHB maintained 100% compliance with the second HTW Adoption Audit. The process for the completion and review of responses is supported by the Audit Management and Tracking (AMaT) system which is pre-populated with NICE guidance.

3.6 Audit Management and Tracking System (AMaT)

Use of the AMaT system was hampered by consistent access issues over an extended period of time, which affected user experience. These issues were only resolved by being the first organisation in the UK to successfully implement single sign on with it in May 2023.

3.7 Closing down 2022/23 Audit Plans (Level 3 and Level 4)

Service Delivery Group Medical Directors have been scheduled to formally close down their 2022/23 Audit Plans and to present the plans for 2023/24 to incorporate where appropriate, those topics yet to be completed for 2022/23.

Areas will now have more experience of the requirements and benefits of the AMaT system that generates a risk matrix score for completed topics. This may contribute to discussion in pre-populating plans where re-audit is indicated moving forward to ensure that issues and concerns are addressed and audit cycles are closed.

4. Mortality

A National Learning from Deaths Framework was published by the NHS Delivery Unit and WG; it has been adopted by the Health Board as the framework for delivering the new learning system. Under this framework, all deaths where the Medical Examiners (ME) Service has identified an issue are referred into the Executive Medical Directorate and screened to identify cases that are already undergoing an established process. Those requiring greater scrutiny are passed to the SBUHB Learning from Deaths Scrutiny Panel. This was established in May 2021 to screen, review and provide feedback on any concerns identified by the ME. The multidisciplinary panel meets on a weekly basis, utilising a rota system for the allocation of cases for review and discussion.

The Deputy Medical Director along with colleagues from the Learning from Deaths (LFD) panel have established a robust process to ensure there is a structure in how the Medical Examiner reviews are addressed within the HB. This is inclusive of having an oversight of formal review of deaths via Mortality Reviews and the Medical Examiner (ME) cases received at the LFD Panel and linking the ME cases with the crude mortality and condition specific outcomes.

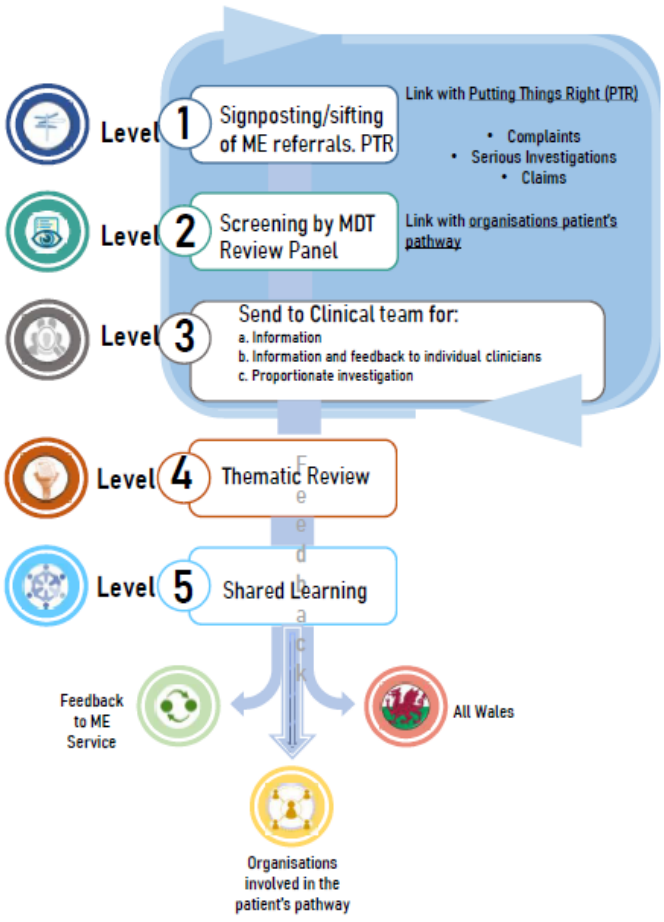
Dashboards have been built by the Business Intelligence team and currently this is being incorporated into the review process within the HB. The dashboards will help to identify outliers and bring about improvement plans as needed.

4.1 Medical Examiner Service and Mortality Reviews

The HB was the first in Wales to be fully compliant with the ME service and currently all the deaths from secondary care are send for a ME review.

4.1.1 Status of Referrals

There are different levels (1-5) for the ME reviews and as of January 2023, the LFD panel divided the Level 3 Proportionate Investigation section into three sub-sections.



3a – Close referral and email relevant team for information purposes only

3b – Close referral and email relevant team requesting feedback from discussions with individuals/team

3c – Proportionate Investigation

Table 4. overleaf illustrates the status of cases reviewed at Level 1 of the Mortality framework;

		Level 1					
	ME Referrals received	Screened out at Level 1, for existing process or closure	Closed at Level 1- No further action	Closed at Level 1- Awaiting reports from existing processes	Reviewed at Level 1 and sent for Level 3 Review		
					3a	3b	3c
Jan '23	80	65	4	33	19	8	1
Feb '23	105	87	15	38	17	16	1
Mar '23	99	85	10	46	14	12	3
Apr '23	95	50	4	29	8	9	0
May '23	103	47	8	32	3	4	0
Total	482	334	41	178	61	49	5
%	100%	69%	12%	53%	18%	15%	1%

Table 4.

Tables 5. & 6. illustrate the status of the cases reviewed under the ME system by the Level 2 Panel members;

		Level 2						
	ME Referrals received	Assigned to panel member for scrutiny	Waiting to be presented to panel	Presented at panel	Closed at Level 2 – No further action	Reviewed by Panel and sent for Level 3 Review		
						3a	3b	3c
Jan '23	80	15	4	11	4	1	3	3
Feb '23	105	18	14	4	-	1	2	1
Mar '23	99	14	14	-	-	-	-	-
Apr '23	95	45	45	-	-	-	-	-
May '23	103	56	56	-	-	-	-	-
Total	482	148	133	15	4	2	5	4
%	100%	31%	90%	10%	27%	13%	33%	27%

Table 5.

		Level 3 Reviews		
	ME Referrals received	3a	3b	3c
Jan '23	80	20	11	4
Feb '23	105	18	18	2
Mar '23	99	14	12	3
Apr '23	95	8	9	0
May '23	103	3	4	0
Total	482	63	54	9
%	100%	13%	11%	2%

Table 6.

The LFD have started to identify themes from the ME reviews and improvement work will commence on this once the dashboards are fully developed.

5. FINANCIAL IMPLICATIONS

The Associate Nurse Director, Corporate Nursing, was successful with a business case for additional digital and administrative resources to support implementation and rollout of AMaT within Nursing. The business case also covered an additional twelve months licence fees.

Consideration of how continued use of the system through payment of licence fees and any additional costs will be required if AMaT is assessed and confirmed as integral to the Health Board in supporting multiple work-streams.

6. RECOMMENDATION

The Committee is asked to note the report.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience
Compliance with national topics provides an opportunity to benchmark performance for quality, safety and patient experience, while the appropriate identification and planning of necessary local priorities can support improvements and provide assurance. The Learning from Deaths approach supports learning to ensure that patients at the end of life and their loved ones have the best possible experience.
Financial Implications
The benefits and impact of the AMaT system are expected to be wide ranging and a business case will be required to secure additional funding for its continued use, if deemed appropriate.
Legal Implications (including equality and diversity assessment)
None.
Staffing Implications
None.
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
Long term the aim is to continue to embed a new culture in terms of the prioritisation of audit and improvement activities, while balancing the need to meet requirements placed on doctors and healthcare professionals in training. Generating themes and learning from deaths will contribute towards striving to give patients at the end of their life and their loved ones, the best possible experience.

Report History	As required.
Appendices	**Appendix 1:** Revised list of Welsh Government mandated national audit and improvement topics

Appendix 1.

Annual Programme for 2022 - 23 of National Clinical Audit and Outcome Reviews in which all Welsh health boards and trusts must participate (where services are provided)

Acute	Audit website homepage	Contact	Collecting data in 2022/23
National Joint Registry	www.njrcentre.org.uk	enquiries@njrcentre.org.uk	Yes (W, E & NI)
National Emergency Laparotomy Audit *	www.nela.org.uk	info@rcoa.ac.uk	Yes (W & E)
Case Mix Programme (CMP)	www.icnarc.org	cmp@icnarc.org	Yes (W, E & NI)
Major Trauma Audit Trauma Audit and Research Network #	https://www.tarn.ac.uk/	support@tarn.ac.uk	Yes (W, E & NI)

Long Term Conditions	Audit website homepage	Contact	Collecting data in 2022/23
National Diabetes Audit *	General: https://digital.nhs.uk		(W & E)
Note this covers the following areas : National Diabetes Foot Care Audit	Footcare: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-foot-care-audit	ndfa@nhs.net	Yes
• National Diabetes Inpatient Safety Audit (NDISA)	NaDia: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-inpatient-audit	nadia@nhs.net	Yes
• National Pregnancy in Diabetes Audit	Pregnancy: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-pregnancy-in-diabetes-audit	npid@nhs.net	Yes
• National Diabetes	Core: https://digital.nhs.uk/data-	diabetes@nhs.net	Yes

Core Audit	and-information/clinical-audits-and-registries/national-diabetes-audit		
National Paediatric Diabetes Audit (NPDA) * #	www.rcpch.ac.uk/npda	npda@rcpch.ac.uk	Yes (W & E)
National Asthma and COPD Audit Programme (NACAP)* # **Note this covers the following areas :** • COPD Secondary Care • Adult Asthma • Paediatric Asthma Secondary Care • Pulmonary Rehabilitation	https://www.rcplondon.ac.uk/projects/national-copd-audit-programme https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-copd https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult-asthma https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-children-and-young https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-pulmonary-rehabilitation-workstream	copd@rcplondon.ac.uk	Yes (W & E)
Renal Registry (Renal Replacement Therapy) #	https://ukkidney.org/about-us/who-we-are/uk-renal-registry	renalregistry@renalregistry.nhs.uk	Yes (W, E & NI)
National Early Inflammatory Arthritis Audit * #	https://www.rheumatology.org.uk/Practice-Quality/Audits/NEIA-Audit	bsr@rheumatology.org.uk	Yes (W & E)
All Wales Audiology Audit #			Yes (Wales only)

Older People	Audit website homepage	Contact	Collecting data in 2022/23
Sentinel Stroke National Audit Programme (SSNAP) *	www.strokeaudit.org	ssnap@rcplondon.ac.uk	Yes (W, E & NI))
Falls and Fragility Fracture Audit Programme Including: • National Audit of Inpatient Falls • National Hip Fracture Database • Fracture Liaison Service Database *	https://www.rcplondon.ac.uk/projects/falls-and-fragility-fracture-audit-programme-fffap	FFFAP@rcplondon.ac.uk Inpatient Falls falls@rcplondon.ac.uk Hip Fracture Database nhfd@rcplondon.ac.uk Fracture Liaison Service Database FLSDB@rcplondon.ac.uk	Yes (W, E, NI))
National Audit of Dementia *	www.nationalauditofdementia.org.uk	nad@rcpsych.ac.uk	Yes (W & E)

End of Life	Audit website homepage	Contact	Collecting data in 2022/23
National Audit of Care at the End of Life (NACEL) *	https://www.nhsbenchmarking.nhs.uk/nacel	enquiries@nhsbenchmarking.nhs.uk	TBC (W & E)

Heart	Audit website homepage	Contact	Collecting data in 2022/23
National Cardiac Audit Programme (NCAP)	https://www.nicor.org.uk/	nicor-auditenquiries@bartshealth.nhs.uk	(W & E)
• National Heart Failure Audit *	https://www.nicor.org.uk/national-cardiac-audit-programme/heart-failure-heart-failure-audit/		Yes
• National Audit of Cardiac Rhythm Management *	https://www.nicor.org.uk/national-cardiac-audit-programme/cardiac-rhythm-management-arrhythmia-audit/		Yes

• National Adult Cardiac Surgery Audit* • National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) * • National Congenital Heart Disease Audit * # • Myocardial Ischaemia National Audit Project (MINAP)*	https://www.nicor.org.uk/national-cardiac-audit-programme/adult-cardiac-surgery-surgery-audit/ https://www.nicor.org.uk/adult-percutaneous-coronary-interventions-angioplasty-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/congenital-heart-disease-in-children-and-adults-congenital-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/myocardial-ischaemia-minap-heart-attack-audit/		Yes Yes Yes Yes
National Audit of Cardiac Rehabilitation	http://www.cardiacrehabilitation.org.uk/	corinna.petre@york.ac.uk	Yes (W, E & NI)
National Vascular Registry Audit *	www.vsqip.org.uk	nvr@rcseng.ac.uk	Yes

Cancer	Audit website homepage	Contact	Collecting data in 2022/23
National Lung Cancer Audit *	https://www.rcplondon.ac.uk/projects/national-lung-cancer-audit On 1 February 2022, the project transferred to the Royal College of Surgeons of England. It was previously run by the Royal College of Physicians.	nlca@rcplondon.ac.uk	Yes (W & E_
National Prostate Cancer Audit *	www.npca.org.uk	npca@rcseng.ac.uk	Yes (W & E)
Gastrointestinal Cancer Audit Programme (GICAP) *			Yes (W & E)

• National Bowel Cancer Audit • National Oesophago-gastic Cancer Audit	www.nboca.org.uk https://www.nogca.org.uk/	bowelcancer@nhs.net og.cancer@nhs.net	
National Audit of Breast Cancer in Older People (NABCOP) *	https://www.nabcop.org.uk/	nabcop@rcseng.ac.uk	Yes (W&E)

Women's and Children's Health	**Audit website homepage**	**Contact**	**Collecting data in 2022/23**
Paediatric Intensive Care Audit (PICaNet) * #	www.picanet.org.uk	picanet@leeds.ac.uk	Yes (UK)
National Neonatal Audit Programme Audit * #	www.rcpch.ac.uk/nnap	enquiries@rcpch.ac.uk	Yes (W & E)
National Maternity and Perinatal Audit *#	http://www.maternityaudit.org.uk/pages/home	nmpa@rcog.org.uk	Yes (W, E & S)
National Perinatal Mortality Review Tool	https://www.npeu.ox.ac.uk/pmrt	general@npeu.ox.ac.uk	Yes (W, E & S)

Other	**Audit website homepage**	**Contact**	**Collecting data in 2022/23**
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12) *#	https://www.rcpch.ac.uk/work-we-do/quality-improvement-patient-safety/epilepsy12-audit	enquiries@rcpch.ac.uk	TBC
National Clinical Audit of Psychosis *	https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis	NCAP@rcpch.ac.uk	Yes (W & EW)

(* denotes NCAPOP Audits)
(# denotes reports likely to include information on children and / or maternity services)

Clinical Outcomes Review Programme

The **Clinical Outcome Review Programme** (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies, which support changes to improve NHS healthcare.

Without high quality data, improvement in clinical care is unlikely to occur. National clinical audits and outcome reviews are focused on areas of healthcare considered to be important, where there are often issues of concern and where national results are considered essential to improve practice and standards.

With the ability to measure against recognised standards and compare services on a local, regional or national basis, clinical audit and outcome reviews are very powerful tools for assessing the quality of services being provided. When used as part of the wider quality improvement cycle, they provide a strong mechanism for driving service change and improving patient outcomes, but full participation and a determination to learn from the findings is essential.

Service provider contracts for these programmes have been awarded to the following suppliers (links are provided to website homepages):

Clinical Outcomes Review Programme	Programme website homepage	Contact	Collecting data in 2022/23
Medical and Surgical Clinical Outcome Review Programme *	http://www.ncepod.org.uk/ To include: - Community acquired pneumonia - Crohn's Disease - Endometriosis - End of life care	ncepod@nhs.net	(W, E) Yes Yes Yes Yes
Mental Health Clinical Outcome Review Programme *	http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicidepreventionnci - National Confidential Inquiry into Suicide and Safety in Mental Health	ncish@manchester.ac.uk	(W, E) Yes

Child Health Clinical Outcome Review Programme *#	http://www.ncepod.org.uk/ - Transition from child to adult health services - Testicular torsion	ncepod@nhs.net	(W, E) Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme *#	https://www.npeu.ox.ac.uk/mbrrace-uk	general@npeu.ox.ac.uk	(UK) Yes