Meeting Date	**20th June 2019**		**Agenda Item**	**5.4**
Report Title	**Clinical Senate Council Report**			
Report Authors	Richard Evans, Executive Medical Director			
Report Sponsor	Richard Evans, Executive Medical Director			
Presented by	Alastair Roeves, Deputy Medical Director			
Freedom of Information	Open			
Purpose of the Report	To inform the Quality and Safety Committee of the activities of the Clinical Council.			
Key Issues	The Clinical Senate Council has considered the development of the IMTP and Clinical Services Plan, as well as heard of and contributed to the development of the National Clinical Services Plan.			
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Recommendations	Members are asked to note the contents of the report.			

Report of the Clinical Senate Council

1. INTRODUCTION

The report sets out the items considered by the Clinical Senate Council at its previous meeting on 2nd May 2019, including actions and decisions taken.

2. BACKGROUND

The Clinical Senate Council has been established as a group of senior clinical leaders across all disciplines within the Health Board:

- to provide clinical expertise and guidance to the executives on policy, strategy, planning and organisational change, with endorsement or constructive challenge as appropriate;
- to lead the development and adoption, across the health board of:
  - clinical standards;
  - clinical pathways;
  - clinical systems;
  - clinical networks;
  - clinical programmes of work;
- to champion value-based healthcare;
- to monitor and take action, as appropriate, to reduce unwarranted clinical variation in pathways.

At the meeting of the Clinical Senate Council on 2nd May 2019, the following issues were discussed:

IMTP and Clinical Services Plan (CSP) – Working together

Ffion Ansari attended and presented details of the IMTP and CSP. Key people involved and TOR are to be shared with this council. Digitalisation is a limited resource, and the Health Board will need to prioritise the high profile items to deliver the plan.

Care, Value and Efficiency Framework in Swansea Bay

Claire Green (Finance Delivery Unit; FDU) attended to give a presentation on value and variation. The presentation included details of the 'efficiency framework' that has been developed by the FDU and could be used by Health Boards to evaluate cost, value and variation. Six specific Conditions that have been identified as having the combination of tools, data and structures in place to make them ideal for testing the efficiency framework, in this financial year, are: heart failure, stroke, cataract surgery, knee surgery, lung cancer and colorectal cancer.

National Clinical Services Plan

Alastair Roeves presented the National Clinical Services Plan, which had recently been shared with Welsh Government and Chief Executive Officers of Health Board.

The intention of the plan as drafted to date was to evoke discussion on how to deliver Prudent Health Care, by concentrating on outcomes that matter to patients and to promote Value-Based healthcare as the vehicle for delivery. The plan was for information regarding work being done at a national level and to provide an opportunity for the council to comment and influence the plan. Comments included the role of social services in the plan, and the contradiction between the 'care closer to home' policy, and the evidence for high volume sites achieving better outcomes. The need for recognition of community specialist teams (e.g. rehabilitation) was made.

3. GOVERNANCE AND RISK ISSUES

The Terms of Reference for the Clinical Senate Council and Clinical Senate Forum require further refinement to clarify reporting structures. Under discussion between Head of Corporate Governance and Executive Medical Director.

4. FINANCIAL IMPLICATIONS

None.

5. RECOMMENDATION

The Committee is asked to note the report.

Governance and Assurance							
Link to corporate objectives *(please ✓)*	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
		✓					
Link to Health and Care Standards *(please ✓)*	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
		✓	✓				

Quality, Safety and Patient Experience
Participation in the National Clinical Audit and Outcomes Review Advisory Committee programme of topics and its associated assurance process provides insight into the quality, safety and patient experience for these patient cohorts, benchmarking the Health Board's performance nationally.
Financial Implications
None
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)
None

Report History	The Clinical Senate Council will report to each Q&S meeting.
Appendices	Appendix 1. Recent National Audit and Registry Publications Appendix 2. National Clinical Audit & Outcomes Review Advisory Committee Publication Schedule Appendix 3. Outstanding Welsh Government Assurance Process Forms for Publications April to date

Appendix 1. Recent National Audit and Registry Publications

Medical & Surgical Review Programme: Acute Heart Failure Report 2018

In England and Wales there is an almost five-fold variation in inpatient mortality due to heart failure between acute hospitals (lowest 6%, highest 26%).

The National Heart Failure Audit which includes 80% of patients admitted to hospital with acute heart failure has shown that care delivered in a specialist cardiology ward is associated with a 40% reduction in mortality, but that the proportion of patients transferred to cardiology varies.

National Cardiac Audit Programme (NCAP) Annual Report 2018

This report by NCAP is the first to report on six major national clinical audits of care of patients treated in the UK for heart disease; Congenital audit, Heart Attack audit, Angioplasty audit, Adult Surgery audit, Heart Failure audit and Arrhythmia audit.

National Vascular Registry (NVR); Annual Report 2018

Being a procedure-based clinical audit, the NVR is designed to evaluate primarily the outcomes of care, with the aim of supporting vascular specialists to reduce the risk associated with the procedure. Short-term survival after surgery is the principal outcome measure for all vascular procedures, but the report also provides information of other outcomes, such as the types of complications that occur after individual procedures.

Fracture Liaison Service Database (FLS-DB) Annual Report 2018

The FLS-DB is the only national secondary fracture prevention patient level audit in the world. From our first annual report in 2016, we developed 11 KPIs critical for an FLS to be effective and highlighted variation in each of them, particularly in identification and monitoring. These were derived from NICE technology appraisals and guidance on osteoporosis and falls, and the NOS clinical standards for FLSs and quality standards for osteoporosis and prevention of fragility fractures.

National Bowel Cancer Audit Annual Report 2018

The report details data on over 30,000 patients diagnosed with bowel cancer between 01 April 2016 and 31 March 2017.

This year's audit report describes some ongoing improvements such as mortality rates following both elective and emergency surgery falling over the past five years and increased numbers of operations being performed laparoscopically.

Medical and Surgical Clinical Outcome Review Programme: Perioperative Diabetes Report 2018

Assessment of service structure at an organisational level and patient care at a clinical level.

Recommendations are formed from data provided by clinicians at the hospital caring for patients and from external peer review of a sample of cases.

Medical and Surgical Review Programme: Cancer in Children, Teens and Young Adults Report

Cancer outcomes in children and young people have improved dramatically over the last few decades with over 80% of those diagnosed now being cured of their disease. Of those who die, approximately half will do so from treatment related complications many of which are avoidable.

This report deliberately focuses on a sample of patients who were a high-risk group who died or who had an unexpected admission to intensive care. The rationale being that this is where care-planning, service provision and communication should excel. Any remediable factors in care for this group would benefit all children, teenagers and young adults receiving SACT.

National Diabetes Transition Audit 2011-2017

This report examines care provision during the period when young people with Type 1 diabetes move from paediatric to adult-based clinical care in England and Wales.

The findings of the report point to deterioration in annual care process completion, achievement of treatment targets and higher rates of diabetic ketoacidosis (DKA) when young people transition from paediatric to adult services, with considerable local service variation.

The report sets out recommendations for local specialist services, clinical commissioning groups and health boards.

National Clinical Audit of Seizures and Epilepsies for Children and Young People 2018 (Epilepsy 12)

The National Clinical Audit of Seizures and Epilepsies in Children and Young People, also known as Epilepsy12, shows incremental improvements in some areas of paediatric epilepsy service provision alongside a considerable need for improvement in others.

The results detailed in the report reflect data submitted to the organisational audit by 148 Health Boards and Trusts with a paediatric epilepsy service across England and Wales.
It includes the first 'yearly snapshot' of the organisation of paediatric epilepsy services for children and young people in England and Wales as well a case study of how paediatric epilepsy services have used their Epilepsy12 results to identify and undertake local quality improvement activities.

Appendix 2. National Clinical Audit & Outcomes Review Advisory Committee Publication Schedule		
Audit/CORP title	**Name of publication**	**Planned Publication Date (subject to change)**
National Lung Cancer Audit	Lung Cancer Clinical Publication (LCCOP) Report	Thu 14/02/2019
Prostate Cancer	Annual Report 2018	Thu 14/02/2019
National Lung Cancer Audit	Annual Report 2018	Mon 01/04/2019
Learning Disability Mortality Review Programme	Annual Report	Thu 09/05/2019
National Paediatric Diabetes Audit Report	Annual Report 2019	Thu 13/06/2019
Anxiety and Depression	Annual Report 2018	TBC
Medical and Surgical Clinical Outcome Review Programme	Themes and recommendations common to all hospital specialities	TBC
National Ophthalmology Database Audit	AMD – Feasibility Report	TBC
National Ophthalmology Database Audit	Glaucoma – Feasibility Report	TBC
National Ophthalmology Database Audit	Retinal Detachment – Feasibility Report	TBC
National Maternity and Perinatal Audit	2018 Clinical Audit Report	TBC
Specialist Rehabilitation for Patients with Complex Needs	Final Report (exact title TBC)	TBC
Sentinel Stroke (SSNAP)	SSNAP Quarterly Report (April-June 2018)	TBC

Appendix 3. Outstanding Welsh Government Assurance Process Forms for Publications April to date;						
Title	**Report Pub**	**Part A Due**	**Part A Rec.**	**Part B Due**	**Part B Rec.**	**Comments**
COPD - Primary Care Report (WALES ONLY)	14/12/2017	06/02/2018	Yes	03/04/2018	Yes	With Medical Director's Dept for checks
National Paediatric Diabetes Audit Report 1, Care Processes and Outcomes	12/07/2018	24/08/2018	Yes	19/10/2018	Yes	With Medical Director's Dept for checks
Dementia Spotlight Audit on Delirium Screening	09/08/2018	Not required	N/A	01/11/2018	**No**	Response outstanding from Princess of Wales
Oesophago-gastric Cancer	13/09/2018	11/10/2018	Yes	06/12/2018	Yes	Returned to UMD for review
Mental Health CORP, National Confidential Inquiry into Suicide and Homicide Annual Report (inc. topic specific report on risk assessment in mental health settings)	19/10/2018	16/11/2018	**No**	01/01/2019	**No**	Outstanding for health board
Mental Health CORP, National Confidential Inquiry into Suicide and Homicide Annual Report	09/10/2018	06/11/2018	**No**	01/01/2019	**No**	Outstanding for health board
Saving Lives, Improving Mothers' Care 2014-2016: Maternal Mortality surveillance and Maternal confidential enquiry (delivered by MBRRACE)	01/11/2018	29/11/2018	Yes	24/01/2019	Yes	With Medical Director's Dept for checks
National Emergency Laparotomy Audit (NELA) annual report	08/11/2018	06/12/2018	**No**	31/01/2019	**No**	Response outstanding from Morriston
Hip Fracture Database (FFFAP)	15/11/2018	24/12/2018	Yes	18/02/2019	N/A	

Title	Report Pub	Part A Due	Part A Rec.	Part B Due	Part B Rec.	Comments
National Vascular Registry (NVR)	28/11/2018	26/12/2018	Yes	20/02/2019	N/A	
Fracture liaison service database (FFFAP)	30/11/2018	28/12/2018	**No**	22/02/2019	N/A	Outstanding for health board
CORP - Acute Heart Failure - Failure to Function	22/11/2018	09/01/2019	**No**	06/03/2019	N/A	Response outstanding from Singleton
National Cardiac Audit Programme annual report	22/11/2018	09/01/2019	**No**	06/03/2019	N/A	Outstanding for health board
Bowel Cancer 2018	13/12/2018	10/01/2019	Yes	07/03/2019	N/A	
CORP - Perioperative Diabetes	13/12/2018	10/01/2019	**No**	07/03/2019	N/A	Outstanding for health board
Neonatal Sprint Audit Report	10/01/2019	07/02/2019	N/A	04/04/2019	N/A	
Clinical Audit Report and Maternal Intensive Care Sprint Audit Report	10/01/2019	07/02/2019	N/A	04/04/2019	N/A	
National Diabetes Audit - Transition Report	10/01/2019	07/02/2019	N/A	04/04/2019	N/A	
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People (2018)	10/01/2019	15/02/2019	N/A	12/04/2019	N/A	