Board Meeting
27th March 2019

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SUBJECT: QUALITY ASSURANCE AND IMPROVEMENT

1. PURPOSE

This paper is coming to the Board:

For approval	☐	For endorsement	☐	To note	☒

The purpose of this paper is to provide NHS Lanarkshire Board with an update on the Lanarkshire Quality Approach and on progress with quality initiatives across NHS Lanarkshire.

2. ROUTE TO THE BOARD

The content of this paper relating to quality assurance and improvement initiatives has been:

Prepared	☒	Reviewed	☐	Endorsed	☐

by the Medical Director and Director of NMAHPs.

3. SUMMARY OF KEY ISSUES

NHS Lanarkshire is committed to delivering world-leading, high-quality, innovative health and social care that is person-centred. Our ambition is to be a quality-driven organisation that cares about people (patients, their relatives and carers, and our staff) and is focused on achieving a healthier life for all. Through our commitment to a culture of quality we aim to deliver the highest quality health and care services for the people of Lanarkshire.

NHS Lanarkshire's Quality Strategy 2018-23 was approved by the Board in May 2018. Within it are four NHS Lanarkshire Quality Plans 2018-2023.

The paper provides an update on the following areas:

- Assurance of Quality
- Quality Improvement
- Evidence for Quality

4. STRATEGIC CONTEXT

This paper links to the following:

Corporate Objectives	☒	LDP	☒	Government Policy	☒
Government Directive	☒	Statutory Requirement	☐	AHF/Local Policy	☐
Urgent Operational Issue	☐	Other	☐		

5. CONTRIBUTION TO QUALITY

This paper aligns to the following elements of safety and quality improvement:

Three Quality Ambitions:

Safe	☒	Effective	☒	Person Centred	☒

Six Quality Outcomes:

Everyone has the best start in life and is able to live longer healthier lives; (Effective)	☒
People are able to live well at home or in the community; (Person Centred)	☒
Everyone has a positive experience of healthcare; (Person Centred)	☒
Staff feel supported and engaged; (Effective)	☒
Healthcare is safe for every person, every time; (Safe)	☒
Best use is made of available resources. (Effective)	☒

6. MEASURES FOR IMPROVEMENT

We will measure the progress we make towards our aim of delivering the highest quality health and care services for the people of Lanarkshire against the strategic priorities identified in the Quality Strategy and the Measures of Success contained within the associated Quality Plans.

7. FINANCIAL IMPLICATIONS

No financial implications are identified in this paper.

8. RISK ASSESSMENT/MANAGEMENT IMPLICATIONS

The Healthcare Quality Assurance and Improvement Committee oversee a corporate risk with controls in relation to achieving the quality and safety vision for NHS Lanarkshire. Corporate Risk 1492 - Consistent provision of high quality care, minimising harm to patients - is rated as Medium.

9. FIT WITH BEST VALUE CRITERIA

This paper aligns to the following best value criteria:

Vision and leadership	☒	Effective partnerships	☒	Governance and accountability	☒
Use of resources	☒	Performance management	☒	Equality	☐
Sustainability	☐				

10. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

An E&D Impact Assessment has been completed

Yes ☒ For the Quality Strategy 2018-23.
No ☐

11. CONSULTATION AND ENGAGEMENT

The NHS Lanarkshire Quality Strategy 2018-23 was approved by the Healthcare Quality Assurance and Improvement Committee and the NHS Board in May 2018.

12. ACTIONS FOR THE BOARD

The Board is asked to:

- Note the range of work throughout NHS Lanarkshire to improve the quality and safety of care and services;
- Endorse the governance approach to this work and in particular the assurance being provided by the Healthcare Quality Assurance and Improvement Committee; and
- Support the ongoing development of the Lanarkshire Quality Approach.

Approval	☐	Endorsement	☒	Identify further actions	☐
Note	☒	Accept the risk identified	☐	Ask for a further report	

13. FURTHER INFORMATION

For further information about any aspect of this paper, please contact Karon Cormack, Director of Quality. Telephone: 01698 858100.

Dr Jane Burns
Medical Director

QUALITY ASSURANCE AND IMPROVEMENT
March 2019

1. Introduction

This report provides an update on the current progress over January 2019 to March 2019, of plans and objectives set out in the Quality Strategy to achieve the **Lanarkshire Quality Approach**. The routine monitoring of this work is by the Healthcare Quality Assurance and Improvement Committee.

2. Assurance of Quality

HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

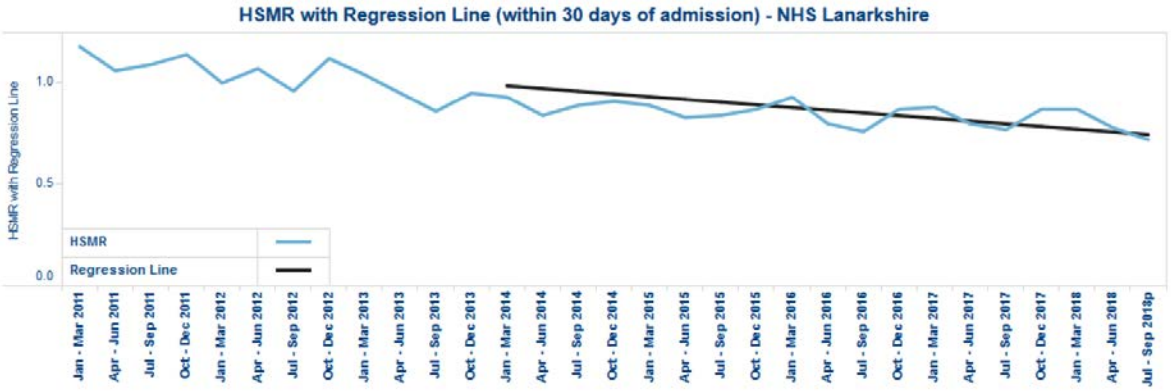
HSMR remains the Board's high level indicator of the quality and safety of care provided on our acute hospital sites. It is monitored on a quarterly basis and reported regularly via the Integrated Corporate Performance Dashboard to the Planning, Performance & Resources Committee, and in the Quality Report to the Healthcare Quality Assurance & Improvement Committee. The Scottish Patient Safety Programme's **aim is to reduce hospital mortality by 10% by the end of December 2018.**

HSMR data for July - September 2018 were published on 12th February 2019. The Scottish HSMR for July - September 2018 is 0.80 which represents a 13.2% reduction. The HSMR for NHS Lanarkshire's hospitals for the same time period range from a **reduction of 17.3% to 29.9%** and are shown in the table below and a chart demonstrating the Lanarkshire improvement is included at the end of this section.

	Scotland		NHSL		Hairmyres		Monklands		Wishaw	
	Crude Mortality	HSMR	Crude Mortality	HSMR	Crude Mortality	HSMR	Crude Mortality	HSMR	Crude Mortality	HSMR
January to March 2017	3.1	0.93	3.3	0.88	3.7	0.89	3.5	0.87	2.9	0.87
April to June 2017	2.8	0.87	2.8	0.8	3.4	0.86	2.9	0.76	2.3	0.77
July to September 2017	2.8	0.86	2.8	0.76	3.5	0.88	3.0	0.74	2.2	0.69
October to December 2017	3.3	0.95	3.5	0.88	3.7	0.83	4.0	0.92	3.0	0.89
January to March 2018	3.3	0.94	3.4	0.87	3.4	0.82	3.7	0.92	3.1	0.88
April to June 2018	2.6	0.81	2.7	0.78	3.2	0.80	2.7	0.78	2.4	0.77
July to September 2018	2.7	0.80	2.6	0.72	2.8	0.68	2.5	0.68	2.6	0.79
% change	-13.2%		-24.4%		-17.3%		-19.8%		-29.9%	

The decrease in HSMR rates since the beginning of 2017 demonstrate improvement. It is not easy to identify particular factors that influence this as it is more likely to be the accumulation of several work streams each making small improvements that when combined become significant. Although the results for NHSL continue to be good, we recognise that this is not something to be complacent about and therefore regularly review within the corporate and governance structures.

	Crude Rate (%)	HSMR	Change in HSMR (%)
Jul - Sep 2018p	2.6	0.72	-24.4



2.1 Corporate Management Team (CMT) Quality Huddle

The CMT quality huddle is a dashboard of quality and safety indicators presented as charts in a power point presentation at the start of every CMT meeting. This has been developed to provide measurement on key areas as a source of learning around how the system is performing to allow meaningful action to be taken to improve the areas identified. The huddle provides a balanced family of measures and includes a range of measures on unscheduled care, waiting times, delayed discharge, staff governance, communications, eHealth, Infection Control, falls, adverse events and user feedback. There is a schedule for which measures will be displayed each week and a narrative interpretation of the data for each chart is provided by the responsible Director. The focus on these measures provides opportunity for CMT to discuss an overview of progress against key indicators and can highlight any areas of concern or areas of improvement.

The Quality Directorate have provided further detail when required for areas of interest such as falls and unscheduled care to understand areas for further improvement or to provide further assurance around the system.
The huddle continues to evolve as the data provides learning across the system with measures still being developed for planning, public health and complaints.

2.2 Complaints Development

The Corporate Complaints team, along with Patient Affairs Managers from UHW, UHM, UHH and Primary Care commenced Cohort 6 of the Achieving Excellence Quality Improvement Programme (aEQUIP) for Teams in February. The team will together take forward a Quality Improvement project focussed on complaint handling through the application of Improvement Science tools, techniques and methods including data measurement and human factors.

The Quality Programme Manager for Complaints has been accepted for a place on the Foundations in Care Experience training course, which commenced in February 2019, and runs until end March 2019. The course, supported by HIS and NES and delivered by The Point of Care Foundation, has been developed for people working in roles responsible for improving care experience.

A collaborative workshop involving the Patient Affairs teams from each operational unit, triumvirate representatives, the Corporate Complaints team and the Director of NMAHPs is being scheduled for May 2019, to identify and agree a prioritised Complaints Development Plan based on the 15 Complaint Handling recommendations (previously shared in January Board paper) from the Complaints Procedure in NHS Lanarkshire review.

2.3 Child Death Reviews

In 2014, a Working Group report was accepted by Scottish Ministers which recommended Scotland establish a national Child Death Review system, given its higher child mortality rate when compared to other Western European countries. Subsequently, a Steering Group was established which recommended a CDR model for Scotland which would review the deaths of all live born children up to the date of their 18th birthday and the deaths of care experienced young people in receipt of continuing care or aftercare care at the time of their death, up to the date of their 26th birthday.

NHS Lanarkshire is one of three territorial Boards participating in the Scottish Government child death review pilot, alongside NHS Lothian and NHS Tayside. The proposal to participate in the pilot was approved by NHS Lanarkshire's CMT on 10th September 2018. The pilot will inform the work of the National Hub for the Prevention of Child Deaths.

The intention of the Lanarkshire pilot work is to learn from good practice examples, identify barriers and test improvement with regards to the implementation of a child death review policy and to test an IT system which could potentially be adopted in Scotland.

To date, NHS Lanarkshire has completed a baseline analysis identifying child deaths during 2016-2018 to better understand the prevalence and context of child deaths in Lanarkshire. A scoping exercise to identify current processes and practice in reviewing child deaths has also been completed. Findings from both exercises will be used to develop tests of change to inform the implementation of a child death review policy.

Clinical case records are currently being reviewed. The first six months of the pilot project will complete in March 2019 and funding has been extended for a further six months to progress to the next phase of the project, focusing on IT system testing and local policy implementation, following a test of change approach.

2.4 Best Start

Best Start is a five year plan for NHS Scotland which places the current and future needs of women, babies and families at the heart of redesigned maternity and neonatal services. As one of five early adopter boards, NHS Lanarkshire has begun to make significant progress in transforming local services. With a number of local recommendations already well established, this has allowed for a greater emphasis on those requiring the most focus.

In the last twelve months there has been a lot of great work, with the maternity, neonatal and community teams working together to improve person centred and

relationship care. A new AMU (midwifery led unit) was opened in April 2018, offering greater choice of place of birth. The transitional care unit has also been instrumental in allowing mothers and babies to stay together whilst reducing term admissions to the neonatal unit. Improving the continuity of midwifery care has also made great headway within Lanarkshire. A successful pilot began in Larkhall in August 2018, and whilst it has been challenging to adapt to a whole new way of working, the additional training and dedicated support from the consultant midwife has helped to build confidence in staff taking part. A further two pilot sites have now been identified, starting in Blantyre.

The Clinical Audit team have been supporting this programme since last year and in November 2018 developed the first NHSL Best Start Highlight Report, the response to which has been very positive and the report template has been highlighted as an exemplar for other boards. Work has already commenced on the next report, due May 2019, with continual support and guidance being provided to the clinical leads and associated teams on all national recommendations. Progress against the specific actions for NHS Lanarkshire is monitored via the NHSL Excellence in Care steering group chaired by the Director of NMAHPs, Irene Barkby.

2.5 NCEPOD (National Confidential Enquiry into Patient Outcome and Death)

A new process for consideration to participate in new studies is being developed and will be tested with 2 recently announced studies. They are Dysphagia in Parkinson's Disease and In Hospital Management of 'Out of Hospital' Cardiac Arrests.

20 NHSL cases were selected for inclusion in the Acute Bowel Obstruction Study and data collection has commenced. Organisational Questionnaires have been requested for UHH, UHM and UHW.

Study reports for Management of Perioperative Diabetes and Acute Heart Failure have been published. NCEPOD 'Recommendation Checklists' have been forwarded to the appropriate services for consideration. Three places have been secured at the forthcoming Local Reporters and Ambassadors Day which will provide guidance to ensure good compliance with completion of the NCEPOD audits.

2.6 Local Cancer Audit reporting

Regular, timelier reporting of national Cancer Quality Performance Indicators has been established for 8 of the 9 tumour types. Evaluations of the local reports are provided to the Cancer Management Team and the Clinical Governance and Risk Management Group to facilitate action planning and monitoring at an earlier stage.

3. Quality Improvement

3.1 Building Quality Improvement Capacity & Capability

During the last 12 months the Achieving Excellence in Quality Improvement Programme for Teams has continued to provide training in QI methods, tools and techniques to teams of frontline staff across NHS Lanarkshire. Each team undertake an improvement project during the 5 month training programme to demonstrate their application of the theory into practice.

In total 5 cohorts, 25 teams from across community and acute services have graduated from the programme and have delivered improvements in their chosen area of work to improve quality and safety for patients. The teams are multi professional and are both clinical and non-clinical:

1. Neonatal Team, UHW	14. Long-term conditions district nursing Team
2. Children's Services Team	15. Evidence/Knowledge Service Team
3. Clinical Quality Team	16. Ward 14, UHW
4. UHM Pre-Noon Discharge Team	17. Infection Prevention and Control, NHSL Team
5. Deteriorating Patients Team	18. Maternity Services Team
6. Community Falls Team	19. Speech & Language Therapy Team
7. Pan Lanarkshire Sexual Health Team	20. MSK Physiotherapists Team
8. Locality Modelling in North HSCP Team	21. Ward 10, UHW
9. Rheumatology Team, UHW	22. Hamilton Integrated Community Support Team
10. Clinical &Therapeutic Intervention Team	23. Orthopaedic Ward, UHW
11. Critical care and surgical team	24. Quality Directorate Business Support Team
12. Occupational Therapy Children and Young People Team	25. Ward 9, UHW
13. Management Support Team, UHM	

Whilst on the course, each of these teams work on a quality improvement project in their area and present the findings at the end of the course. Recent examples include reducing noise levels on a ward to improve patient comfort, providing meetings with relatives of in patients to help with discharge planning and improving the use of *Language Line* interpretation services. It is often the case that the improvement work continues after the course as more time is required to meet the aim or the work is further developed to include another objective or is spread to another area.

The course also ensures participants have the skills to interpret charts and data as well as the ability to develop or support future quality improvement initiatives.

Cohort 6 of the programme is underway and cohorts 7, 8 and 9 will be delivered during 2019.

The LQA Team Skills programme is now a one day education programme which focusses on Human Factors and Ergonomics and is delivered by a specialist faculty developed within NHS Lanarkshire. During 2018 there have been 74 trained in this programme which covers elements including risk, limitations of human performance, situational awareness, decision making, situational monitoring, team communication and conflict and mutual support.

3.2 Safety Leadership Walkrounds

Safety Leadership Walkrounds (referred to hereafter as walkrounds) are part of the organisation's programme of work to improve quality and safety culture and outcomes. Weekly Safety Leadership Walkrounds also support the organisation to achieve the implementation of the 'Patient Safety Essentials' (CEL 19, 2013).

Safety walkrounds are fundamental to developing an open and transparent culture where safety is seen as our organisational priority throughout Lanarkshire. They

provide an opportunity for frontline staff to engage with senior leaders to identify and celebrate good practice, excellence and attainment. They also provide a direct link for frontline staff to voice their concerns regarding potential quality and safety issues or challenges they may be facing.

The walkround visit is not an inspection but an opportunity for:

- Hearing about what gets in the way of delivering high quality, safe, person centred care
- Identify opportunities for improving quality and safety
- Promote a safety culture and encourage reporting of adverse events
- Leadership learning to identify and prioritise actions to improve quality and safety

From April 2018 to Feb 2019 there were 59 walkrounds carried out across acute hospitals, community hospitals and health centres in Lanarkshire. An Executive Director is always present and a Non-Executive Director is scheduled for every walkround. Any actions raised by staff are logged on the LanQIP system to ensure progress is made to resolve any issues raised by staff. Feedback from the walkrounds and any themes which emerge are included in the CMT Quality Huddle to ensure learning and improvements are made.

3.3 Medical Cause of Death Certification Improvement

The Healthcare Improvement Scotland Death Certification Review Service (DCRS) randomly select and review death certificates for quality and accuracy. Around 10% of certificates are selected for Level 1 review which are checked by the Medical Reviewer who then speaks to the certifying doctor, this typically takes one working day. Level 2 reviews involve speaking to the certifying doctor and checking relevant medical records which can take three working days. Incomplete and inaccurate completion leads to delays in death registration for families causing unnecessary delay, upset and distress.

NHS Lanarkshire "not in order" rate for 2017-2018 was:
Level 1 & 2 reviews – **36.9% compared to Scottish average of 27.8%**
Major Errors – **2.8% compared to the Scottish average of 2.2%**

DCRS recommended that the service would "continue to effect improvement on not in order rate" of medical certification of death in their 2017-2018 Annual Report.

NHS Lanarkshire agreed to undertake a quality improvement project with DCRS to improve the quality and accuracy of Medical Cause of Death Certificates. Dr Andrew Manchip (Medical Reviewer, DCRS) was the link with NHS Lanarkshire and was co-opted as a member of the NHS Lanarkshire Death Certification Implementation Group (DCIG) chaired by the Medical Director NHS Lanarkshire. DCIG requested the Quality Improvement Team lead on this improvement initiative for NHS Lanarkshire and an Improvement Group was formed in June 2018 consisting of Acute Medical Chiefs, Primary Care Associate Medical Directors, Council Registrars, Funeral Directors, Spiritual Care staff and Quality Improvement staff.

The Improvement Group reviewed the DCRS data and applied quality improvement methodology and tools to determine the project aim: ***Less than 2% of MCCD issued across Lanarkshire acute sites will contain 'major errors' by January 2019.***

Whilst the project aim was to improve the accuracy and quality of medical certification, the group recognized the potential for the project to reduce any unnecessary upset, delay and distress for families following a bereavement by looking at the verification and certification process in full. Additionally we anticipated that the focus could also deliver an improvement to the "not in order" rate for Level 1 and 2 reviews. Improvement activity started in June and local measurement was undertaken with Lanarkshire Registrars from 1 September 2018 to 31 December 2018.

Acute Services: One medical, surgical and care of the elderly ward were identified to be in scope for the duration of the project at each acute hospital site. Process mapping was carried out in each ward with Consultants, nursing staff and ward clerks. Administrative templates and "Top tip" cards were provided to aid completion accuracy and education sessions were delivered by Dr Andrew Manchip to improve the quality of completion.

Primary Care: An education session was delivered to more than 60 GP's and "flash reports" including data from DCRS along with "Did you know" facts were circulated to raise awareness and maintain focus.

Acute and Primary Care medical staff were encouraged to complete NHS Education for Scotland online e-learning modules around death certification.

Registrars noted errors on any MCCCD at registration from the areas in scope which provided local data in addition to data from DCRS for the MCCD selected randomly for review.

The Improvement Group met bi-monthly from June 2018 – February 2019 to review progress, reporting to DCIG in December 2018. NHS Lanarkshire "not in order" rate at this time was based on latest available data from DCRS Apr 18 – Sep 18:

Level 1 & 2 reviews – **30.7% compared to Scottish average of 27.6%**
Major Errors – **1% compared to Scottish average of 2.2%**

Outcomes from the project include:
Registrars: have reviewed the certificate envelopes with a view to standardising the information provided so it is consistent for North and South Lanarkshire residents.
Resources: the availability of bereavement booklets and certificate envelopes has been shared with primary care service colleagues through Practice Manager Meetings and e-mail cascade.
Education: face-to-face sessions delivered by Dr Andrew Manchip to FY1 doctors during induction, senior medical staff at grand rounds, morbidity and mortality meetings and other education opportunities.
E-learning: the availability of NES modules has been promoted through the staff bulletin and at face-to-face learning and awareness sessions.

Information: Quarterly flash reports were produced from DCRS data and circulated to medical staff.
Follow-up: Spiritual Care Services have developed contact cards signposting families to the NHS Lanarkshire Listening Service.
Process map: a best practice process map has been developed for death verification and certification for acute services based on all the test areas in scope.
Now that this improvement initiative has concluded, clinical areas have embedded the practice as routine.

4. Evidence for Quality

4.1 National and local evidence, guidelines and standards

An SBAR on the existing SIGN process will be presented to the Clinical Effectiveness Group in April 2019. This gives a number of recommendations for development of a more robust in-house dissemination and monitoring process. A report on actions will be made in due course. This work is reported through the Clinical Effectiveness Group and monitored by the Healthcare Quality Assurance and Improvement Committee (HQAIC).

4.2 Health Technology Assessments

Processes around new evidence, products and health technologies require to be developed and/or reviewed to assure the organisation that these are being appropriately considered by the relevant clinical groups and decisions around implementation are robust.

An SBAR has gone to the February Clinical Effectiveness group for consideration.

Recommendations include:

- Review the current process for dissemination of Health Technology advice / evidence from SHTG / NICE.
- Develop and agree a new process to support, document and monitor decision making by Clinical Specialties around new or reviewed evidence, products and health technologies
- Agree an organisational lead for overseeing the governance around Health Technology advice / evidence.
- Agree a lead committee with responsibility for monitoring decision making by Clinical Specialties around new evidence, products and health technologies.
- Review the current reporting of Health Technologies Advice & Evidence to provide more detail for relevant Clinical Governance groups

This work is on the Quality Strategy Implementation Plan and is monitored by HQAIC.

4.3 Clinical and Care Pathways

The SLWG that was established will take forward the development of a new system will now focus on the systems to support the referral pathways process rather than the local guidelines system and the quality development of new guidelines/pathways. A sub-group is to be established through the CE Group to take forward the strategic approach to the development of guidelines for NHS Lanarkshire. An internal audit report has highlighted a number of improvements for the system of managing clinical

guidelines and the delivery of these will be reported through CE Group. The existing IT system will also be updated where possible.

Clinical Guidelines has been recorded as a risk on the Quality Directorate risk register on Datix. This work is on the Quality Strategy Implementation Plan and is monitored by HQAIC.

4.4 'Real' evidence based medicine

The sub-group of the CE Group (mentioned above) will also take forward the Quality Strategy objective of ensuring the development of guidelines and/or pathways is evidenced based.

Karon Cormack
Director of Quality, NHS Lanarkshire
March 2019