NHS Board
29 January 2020

Lanarkshire NHS Board
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SUBJECT: QUALITY ASSURANCE AND IMPROVEMENT PROGRESS REPORT

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	☒	AOP	☒	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 Management	☐				

10. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

An E&D Impact Assessment has been completed for the Quality Strategy 2018-23

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:

Approve	☐	Endorse	☒	Identify further actions	☐
Note	☒	Accept the risk identified	☐	Ask for a further report	☐

The Board is asked to:

1. Note the range of work throughout NHS Lanarkshire to improve the quality and safety of care and services;

2. Endorse the governance approach to this work and in particular the assurance being provided by the Healthcare Quality Assurance and Improvement Committee; and

3. Support the ongoing development of the Lanarkshire Quality Approach.

13. FURTHER INFORMATION

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

QUALITY ASSURANCE AND IMPROVEMENT
January 2020

1. Introduction

This report provides an update on the current progress over November 2019 to January 2020, of plans and objectives set out in the Quality Strategy to achieve the **Lanarkshire Quality Approach**. The routine monitoring of this work is with Executive scrutiny from the Quality Planning and Professional Governance Group which submits a Highlight Report to each meeting of the Healthcare Quality Assurance and Improvement Committee.

2. Assurance of Quality

2.1 Complaints

Work is progressing on implementing the prioritised Complaint Development Plan. Patient Affairs staff are continuing to embed learning from achieving the accredited Queen Margaret University (QMU) Complaint Management Award. Processes and supporting documentation are being reviewed, based on best-practice complaint handling.

The Datix technical issue that hindered development of the complaints module has been resolved allowing the required developments to take place to produce useful and timely information.

Work is underway to create the functionality to record multiple complaint issues, against different locations and outcomes. This will vastly enhance reporting, supporting production and analysis of fruitful information, including a focus on identified learning from upheld/partially upheld complaints.

A draft revised quarterly reporting template for complaints has been developed and circulated to Governance committees for comment. The criteria is based on the national complaints handling Quality Performance Indicators and following feedback, a regular reporting schedule will be agreed for 2020/21.

The Scottish Public Services Ombudsman (SPSO) reported NHS Lanarkshire statistics on 17th October 2019 regarding complaints they received during 2018-19.

In total, **99** contacts were made to the SPSO about the NHS Lanarkshire, of these:

- 32% (32/99) were concluded at the advice stage
- 27% (27/99) were concluded at the early resolution
- 40% (40/99) were concluded at the investigation stage

The majority of NHSL complaints received by the SPSO during this time period related to clinical treatment or diagnosis (71%), followed by complaints about appointments / admissions (8%) and communication / staff attitude (6%). This reflects the national figures which includes the same subjects as the top 3 themes complained about.

40 investigations were undertaken of complaints taken to the SPSO. Of these:

- 53% (21/40) were upheld or partly upheld
- 40% (16/40) were not upheld
- 3% (1/40) were resolved
- 5% (2/40) were withdrawn

53% of NHSL complaints investigated by SPSO were fully or partially upheld during 2018/19. This demonstrates a 12% reduction from the previous year (2017/18 – 65%) and is 5% lower than the national uphold rate for SPSO complaints in 2018/19 which was 58%. This provides assurance to NHSL that we are continuing to make improvements in our performance against the National Complaints Handling Procedure.

In 2018-2019, NHS Lanarkshire (including contractors) nationally represented 7.8% of NHS complaints proceeding to advice stage (34/435), 7.46% to early resolution (33/442) and 10.7% of investigations (49/454).

As part of Quality Week during November 2019, Dr Dorothy Armstrong delivered a session focusing on person-centred complaint resolution. Further work will be progressed on embedding a culture and focus on resolving issues at Stage 1 of the complaints process.

2.2 Adverse Events

Adverse Events New National Notification System
NHS boards have been instructed to notify Healthcare Improvement Scotland (HIS) of all Significant Adverse Event Reviews commissioned for category 1 events recorded from 1st January 2020, with the first data submission to HIS expected by 6th February 2020; data will be submitted monthly thereafter.

The initial data submission is minimal notifying of the date and category of event. On completion of the SAER additional information will be requested, however the content has still to be decided.

NHSL has been part of an expert users group to support HIS in the development of this system and will continue to be involved in further developments.

Datix System
Work has commenced on enhancing existing data fields within the Datix system to support the capture of more relevant information on Adverse Events such as; rationalising the number of category descriptions so events are grouped under the correct category, re-labelling some of the fields to be more descriptive and changing the order of questions to have a better flow. This will provide better data for analysis and be easier for staff to use. Changes are also underway to improve the information provided for notifications of category 1 events and to provide automatic feedback to staff of the action taken of an event they have reported.

Standard reports have been developed and made available to staff of various specialties and areas, allowing them to be self-sufficient and produce reports more timely for sharing at local groups and committees at each of the acute hospital sites and north and south areas.

Adverse Events Toolkit
A full review of the adverse events pathways, procedures and documentation has been carried out over the last few months and agreed changes made to the various documents. An official launch date of **1st January 2020** was agreed to commence using the new pathways, procedures and documentation.

The documents and pathways will be continually reviewed and updates made accordingly. When updates are carried out, details of these will be communicated to the Risk Facilitators to cascade this information within the hospital sites and areas.

The updated documents can all be accessed on the adverse events webpage via First Port.
http://firstport2/staff-support/quality-directorate/assurance/adverse-events/default.aspx

A new process is in development to improve compliance with the investigation timeline for SAERs which will include increased scrutiny of achieving targets during the investigation and ensuring patient/relative notification if the timescale will not be met. The process will require risk coordinators to assess the time taken for each element of the process to ensure the investigation is on track to meet the 90 day aim.

2.3 Duty of Candour

Duty of Candour cases are regularly monitored, and the most recent report was submitted to the Quality Planning and Professional Governance in December 2019. There are some events that are known to be Duty of Candour as soon as the event occurs such as a medication overdose however for other events the investigation is required to establish the organisational responsibility for the event such as a fall (i.e. could this have been prevented?). This is why for some of the events that are open (still being investigated) we know they are Duty of Candour while for others we need to wait until the conclusion of the investigation.

The data in this report demonstrated from 1st April 2019 until 30th November 2019 39 SAERs were commissioned; of these, 18 investigations have closed and 21 remain open.

- 12 cases have been recorded as triggering the legislation for Duty of Candour
- 11 cases have been recorded as not meeting the legislation for Duty of Candour
- 16 cases are unknown at this time due to the investigation not being complete

Of the 12 cases that trigger the legislation, none of these have been completed and closed however in all these cases the patient/relative have been informed of the event and an apology given. The other elements of the legislation such as sharing the findings of the review, cannot be confirmed until the investigations have been concluded.

2.4 Local Audit Activity

An evaluation of local audit project activity and assessment of benefit to organisation was undertaken due to recognition that support is given to help set up audits but the results are frequently not fed back or followed through to deliver an improvement. A new approach of support for local audit projects has been agreed through the Clinical Effectiveness Group. Staff seeking support will be signposted to the appropriate service, protocol or guideline and the Clinical Quality Toolkit is in the process of being updated accordingly.

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

Local processes for management of NCEPOD studies have been developed and are being continuously reviewed to ensure robustness. The local processes include actions to be taken and responsible leads for each stage of an NCEPOD study, including:

1. Receipt of notification of a planned new NCEPOD study
2. Consideration to participate in planned study
3. Participation in NCEPOD study
4. Case identification
5. Medical record extracts
6. Clinician questionnaire
7. Organisational questionnaires
8. Report publication
9. Recommendation checklist

NHSL is currently participating in 5 NCEPOD studies which are at various stages in the process:

- All hospital sites have been invited to complete Clinical and Organisational Questionnaires for an **Out of Hospital Cardiac Arrest study** and a **Dysphagia in Parkinson's** study.
- Participation in a new study, **Physical Health in Mental Health Hospitals** is under consideration by the Mental Health Learning Disabilities Clinical Governance Group and Site Clinical Governance Groups.
- Two studies have been published, **Mental Healthcare in Young People and Young Adults Study** (2017) and **Pulmonary Embolism Study** (2018). As part of the publication NCEPOD provide a recommendations checklist and these have been shared with the relevant services.

2.6 HSMR

The second release of HSMR data using updated methodology (introduced in August 2019) was published by ISD on 12th November 2019. The data includes case-mix adjusted 30-day mortality on admissions up to June 2019.

Data is presented as a Funnel plot to allow comparisons to be made between each hospital and the average for Scotland for a particular period.

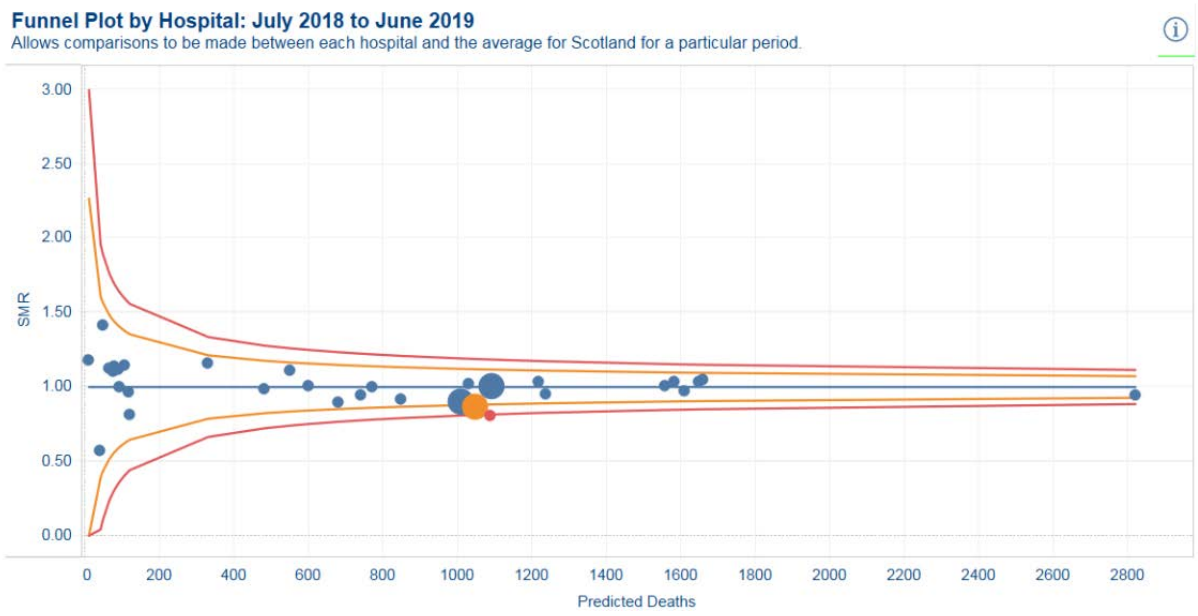
The 3 NHS Lanarkshire hospitals are represented on the funnel plot by the 3 large dots on the chart. University Hospital Monklands and University Hospital Wishaw are both within normal limits. University Hospital Hairmyres is below the lower control limit by 2 standard deviations from the Scottish average. This is a positive outcome for the Hairmyers site, as a lower HSMR is desirable.

This will continue to be monitored through HQAIC.

Health Board of Treatment: NHS Lanarkshire

Period: July 2018 to June 2019

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR	Comparison to Scotland on the Funnel Plot
Scotland	**25,525**	**25,525**	**697,417**	**3.7%**	**1.00**	**n/a**
NHS Lanarkshire	2,912	3,145	82,753	3.5%	0.93	n/a
University Hospital Hairmyres	902	1,045	23,971	3.8%	0.86	
University Hospital Monklands	912	1,008	25,328	3.6%	0.90	
University Hospital Wishaw	1,098	1,091	33,454	3.3%	1.01	



3. Quality Improvement

3.1 Healthcare Improvement Scotland Acute Kidney Injury (AKI) Collaborative.

The Acute Kidney Injury (AKI) improvement work continues across the 3 acute hospitals with NHSL wide learning events occurring every 4 months.

As part of the collaborative, NHSL laboratory have improved access to AKI alerts for staff (previously requested monthly). 11 staff across the 3 acute sites now have access to the live AKI alerts for patients and respond appropriately which facilitates the opportunity to provide treatment sooner and prevent progression of the condition.

In addition to this generic work Hospital Acquired AKI improvement work has commenced with the gastroenterology ward 10 at UHM in October. The ward have a multidisciplinary quality improvement team who have been meeting on a regular basis and initial baseline data from patients with AKI alerts has been collated. This data includes:

- patients with an AKI alert
- patients with Hospital Acquired AKI (first alert occurring 2 days or more after a patient has been admitted to the hospital)
- patients who have a progression of the AKI alert level

The initial focus of the improvement work has been education for nursing and medical staff and testing methods to improve awareness of AKI patients on the ward to ensure they have the appropriate treatment and monitoring.

Healthcare Improvement Scotland have visited the QI team on ward 10 and supported the approach taken. The team have also participated in a WebEx with the other boards participating in the work.

3.2 Maternity and Children's Quality Improvement Collaborative (MCQIC)

Healthcare Improvement Scotland are due to review the Partnership Agreement with NHSL however due to changes in personnel nationally and locally this has been postponed.

The improvement work to reduce Post-Partum Haemorrhage (PPH) continues with the aim changed to; reduce all Post-Partum Haemorrhage (PPH) > 1500mls by 15% by March 2021.

Stillbirth improvement work aims to achieve 95% compliance with fetal movement discussion between 20 and 24 weeks. Current compliance is 90%. NHSL is a Best Start early adopter site and it is envisaged that as part of this initiative the fetal movement improvement work will be strengthened due to increased awareness of this aim.

3.3 Quality Medicines Strategy

A short life working group has been established to facilitate the development of the Medicines Quality Strategy Implementation and Measurement Plans. A draft Implementation Plan has been developed which will be endorsed by Quality Performance and Professional Governance.

3.4 Deterioration/Management of Sepsis

Patient Trak electronic observation sepsis tile is on trial at University Hospital Monklands. It is envisaged that this will support early recognition and response.

Discussions have taken place regarding the recognition of deterioration within the community setting. District nursing staff in North HSCP have been focusing on improving the use of the National Early Warning Score (NEWS). By collecting baseline observation information from patients, it is easier to identify if they become unwell such as an infection that could lead to sepsis. The use of the score also provides better information for GPs to respond to with the aim of managing patients at home before deterioration requiring hospital admission. Links have been established between Acute and Community staff to support education/training and identify areas for whole systems working.

3.5 Falls

A draft Falls Strategy & Implementation Plan was presented to the NMAHP Governance Group in January 2020 and will be presented to the Safety Plan Steering Group February 2020.

The Falls Strategy sub groups will support the implementation plan across the whole system:

> Group 1: Community Engagement, Strength & Balance, Home Safety, Self-Management, Bone Health.
>
> Group 2:'Take Action Earlier' & targeted personalised support, Frailty and fracture risk identification, Frailty and Bone Health evidence based interventions.
>
> Group 3: Response following a fall. Scottish Ambulance Service, Scottish Fire and Rescue Services, Community Alarms, Care Homes and pathways/review following a fall.
>
> Group 4: Build an Integrated approach through whole systems enablers Data & Measurement, Falls Register, Education & Training.

The CMT data huddle falls information identified that the overall falls rate in hospitals during 2019/20 had reduced. However the data showing falls with severe harm had continued to increase. The main aim should be overall falls as it can be by chance if a fall results in a severe injury or not. In an attempt to analyse the falls with severe harm, a selection of the events reported were reviewed. This found that in several cases the harm was over estimated in the categorisation of the event on Datix and demonstrated a lack of understanding as to how to score these events.

To provide support to staff recording falls, a description of the type of injury expected within the different harm categories has been developed and distributed. This will continue to be reviewed to assess if there is an improvement with the new guidance.

Falls improvement work in Acute and Community Hospitals continues however due to hospital pressures recent meetings have been cancelled. It is planned to commence a Hospital Falls Collaborative that includes both Acute and Community Hospitals in February.

The Falls Register documentation is being upgraded as part of the new MORSE IT system which will be an effective long term solution to the sharing of information regarding people at risk of falls or who have had interventions due to falls. As this does not support the visibility of the register in the short term a SLWG will to review this element as the sharing of information is integral to the whole systems Falls, Frailty and Bone Health pathways.

Scottish Ambulance Service are reviewing their data sharing agreement with NHS Lanarkshire in relation to the transfer of information from Electronic Patient Record Form (EPRF) directly to the Falls Register. This has delayed further testing of the referrals being directly sent electronically to the Falls Register Hub. However, improvement work has continued with Paramedics making telephone referrals to the Falls Register Hub for both patients who are conveyed or non-conveyed following a fall. This has led to successful outcomes for patients as they now receive follow up via the Falls Register Hub and community services. It has also led to improved communication during transitions of care where the Falls Register Hub liaise with hospital staff to advise of falls history and recent interventions. The number of referrals made by Paramedics to the Falls Register Hub is variable in comparison to the total number of patients treated by SAS. It is envisaged that the use of the electronic transfer of information from EPRF to the Falls Register Hub should improve this. Improvement work has also identified that the level 1 Falls Conversation contained on the EPRF needs to be more accessible for Paramedics. Scottish Ambulance Service are working with their IT service to make the necessary amendments that will improve the falls pathway for patients in Lanarkshire.

3.6 Quality Improvement Education

aEQUIP for Teams (5 full days over 20 weeks)
Cohort 7 graduated on 7th November 2019. During graduation there is an opportunity for 5 teams to present a story board to demonstrate how they have been applying quality improvement methods to their team improvement projects. These have included improving the uptake of flu immunisations in schools, Joy in Work in Intensive Care, Occupational Therapy utilisation in Primary Care, reducing Gaviscon prescription in babies and improving clinical time for community nursing staff. Cohort 8 and Cohort 2 of South HSCP aEQUIP are underway. Practice Education staff have supported the facilitation of Cohort 7 & 8 which has been very helpful. The programme content is currently being reviewed to ensure the content is up to date and of a high standard.

aEQUIP for Individuals (1 day overview)
Two quality improvement education sessions aimed at individual health and social care staff were delivered during Quality Week November 2019, with a further session delivered in December 2019 for approximately 40 staff. A further session is scheduled for January 2020.

aEQUIP for Leaders
A new programme is being planned for Leaders which will include other management skills that enhance quality improvement such as managing change and project management. This programme is being led by the Quality Directorate and Organisational Development and is currently in development with a short life working group.

Scottish Improvement Leaders Programme (ScIL)
A regional Lanarkshire ScIL programme has been confirmed with NHS Education Scotland for SCIL Cohort 28 in May 2020. This will assist NHSL to build QI expertise with a guaranteed 11 places for Lanarkshire staff. Lanarkshire are paired with NHS Forth Valley for this cohort and the content and delivery will be the same as previous courses.

3.7 Mortality Case Note Review

A mortality case note review took place in September 2019 at University Hospital Hairmyres. 52 cases were reviewed and a draft report and action plan are awaiting final sign-off from the hospital Management Team. This review highlighted that there has been a reduction seen in the number of harms experienced by the patient cohort from January 2019 compared to the cohorts from October 2016 and May 2017. The results were generally positive with some opportunities highlighted for improvement. Headlines from the review include:

- Four patients had a harm identified that contributed to their death however these were not due to errors in care, but occurred as a result of their condition for example hospital acquired pneumonia. These cases are still an opportunity for learning to assess if there was opportunity for earlier identification or alternative treatment.
- A Hospital Anticipatory Care Plan (HACP) form was found in 82% (32/39) of patients notes who were admitted for active care. There were an additional 2 cases where the HACP was mentioned but the actual document was not present in the notes.
- Of the 52 cases reviewed, patients were recognised as imminently dying in 92% (48/52) of the cases.
- 94% (49/52) of patients had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision documented in line with national policy.
- For 73% (38/52) of patients, the DNACPR form was completed correctly.

A mortality case note review has been arranged for University Hospital Wishaw for February 2020. The acute site leads are meeting in January 2020 to review and modernise the forms and to discuss and agree mortality review processes going forward to ensure we learn from the care provided.

3.8 Patient Safety Leadership Walkrounds

Executives and Non-Executives, supported by the Quality Directorate completed 27 Patient Safety Leadership Walkrounds in acute hospital settings during the calendar year 2019 as recorded on the Lanarkshire Quality Improvement Portal (LanQIP). The Programme expanded to incorporate Community Hospitals with seven visits undertaken during the same timeframe.

Frontline staff value the opportunity to connect with the Executive to share exemplar practice, as well as discussing issues impacting on the safety, efficiency, or effectiveness of their practice. Professionalism and dedication of staff is a regular highlight along with collaborative working and the focus on continuous professional development and training. Issues for discussion often include estates, facilities and environmental issues along with workforce / succession planning. A total of 24 actions are recorded on LanQIP as a result of these discussions; 16 having been progressed to closure and eight remain still to be closed which relate to:

- Cleland Hospital: Inadequate GP cover
- UHH: concern related to CCU capacity
- UHM: Radiology - only 1 CT scanner
- UHM: Pharmacy staffing
- UHW: Wd 16 variation in ward round approaches.
- UHW: Compliance with guidance related to what clinicians request for Radiology

- UHW: Issue with position of TV in a Wd 11 room
- UHW: Issue related to discharge lounge traffic in Wd 11

The Quality Directorate undertook a review of the programme during 2019 with key stakeholders as well as taking cognisance of feedback from frontline staff from the areas visited. The number of departments and locations to be visited far exceeds the capacity of the Executive to visit annually, so alternative visiting team composition is being considered to ensure all areas are visited regularly. The Safety Plan Steering Group discussed an initial scoping paper in November 2019 that would see the acute hospitals Triumvirate Management Teams join the programme as part of the Walkround visit team. This proposal needs further discussion and development before being revisited by the Safety Plan Steering Group. The desire for visits to take place out with normal working hours will also be considered as part of this review.

The Quality Improvement Team will continue to lead this review and develop the visit programme for 20/21 which to include Community Services and Health Centres.

3.9 Quality Week

NHS Lanarkshire's third annual Quality Week took place from 18th to 22nd November, with staff involved in a variety of events and training sessions promoting quality, developing staff capacity and capability and celebrating the improvement work taking place across the organisation.

A selection of training sessions were delivered during the week including:

- Human Factors for Quality Improvement
- aEquip for Individuals
- The Great Taboo (conversions about death and dying)
- Complaints session
- Realistic Medicine
- Quality Improvement Education and Networking event
- Significant Adverse Event training

A 'Celebration Event' was held at the South Lanarkshire Council Banqueting Suite on Tuesday 19th November 2019 which was attended by approximately 170 staff. The event, which was opened by Neena Mahal, Chair of NHS Lanarkshire, provided staff with information and presentations linked to the six quality domains in healthcare - Safe, Effective, Person-Centred, Timely, Efficient and Equitable. Chief Executive Calum Campbell presented the People's Choice Award to the six winning posters, chosen by the attendees who had selected their preferred posters of the 36 submissions from the three acute hospital sites and both Health and Social Care Partnerships.

3.10 NHS Lanarkshire Person-Centred Visiting

NHS Lanarkshire implemented person-centred visiting during 2019 with the annual review accepted by HQAIC on 14th November 2019. Acute and community hospitals do not have 'time restricted' visiting, whilst mental health wards have timed visiting.

3.11 Value Management Collaborative

NHS Lanarkshire was successful in their application to participate in the new Value Management collaborative, led by the Healthcare Improvement Scotland (HIS) ihub, working in partnership with NHS Education for Scotland (NES) and the Institute for Healthcare Improvement (IHI). It will run from August 2019 until March 2022.

Value Management is a new collaborative that aims to test and spread an innovative model developed within NHS Highland that supports clinical and finance teams to apply quality improvement methods combining cost and quality data at team level to deliver improved patient outcomes, experience and value.

The focus of the collaborative in year one is three teams in one hospital site, within NHS Lanarkshire these wards are Ward 5 (Medical), Ward 11 (Stroke Rehabilitation) and the Adult Critical Care Unit in University Hospital Wishaw. In year two the approach will be spread to the remaining teams on this hospital site and in year three further spread of this approach out with the initial hospital site to other areas within NHS Lanarkshire.

4. Evidence for Quality

4.1 National and Local Evidence, Guidelines and Standards

A paper on the next stage of development was presented to CMT presented in December. It was agreed that the Quality Directorate would liaise with finance to identify funding for the next stage of the process. A clinical lead, project manager, IM&T and administration staffing have will be required to take the project forward. An update on the proposal will go back to CMT following the financial discussions.

4.2 Quality of Care

There has been no further updates from HIS on the Quality of Care process and the results from the internal review process. The Ayrshire and Arran report is still awaiting publication.

Presentations on the new process to North, South and Acute Groups have been completed. Returns from the internal mapping of the exiting committee structure have been returned to the Evidence Team. The next stage of evidence gathering will be presented to CMT for approval.

4.3 Searching

The evidence team have completed 51 literature searches, and 21 copyright searches between October 2019 and December 2019. The Evidence team have agreed with the MRP team to employ a band 5 searching librarian to work directly with them to ensure all the required evidence for MRP development can be found timeously. Over 200 potential evidence searches have been identified so far. Literature searches have been completed for areas such as; laminar air flow, radiation protection strategy, use of curtains/blinds in acute care for privacy, control light, and improved ventilation.

Dr L Findlay
Acting Medical Director
January 2020