NHS Board Meeting
25th March 2020

Lanarkshire NHS Board
Kirklands
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SUBJECT: **QUALITY ASSURANCE AND IMPROVEMENT PROGRESS REPORT**

i. 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.

ii. 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. The information within this report is also shared with, and discussed by, the Quality Planning and Professional Governance Group and the Patient Safety Strategic Steering Group, and is also presented in detail to the Healthcare Quality Assurance and Improvement Governance Committee.

iii. 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
March 2020

1. Introduction

This report provides an update on the current progress over January 2020 to March 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 Adverse Events & Duty of Candour

Work commenced early 2019 to improve the systems, structures and processes pertaining to adverse events with the aim of:

- Improving data quality
- Improving the Datix system to make reporting and reviewing easier
- Ensuring a standardised process across NHSL for SAER reporting and investigation
- Compliance with Duty of Candour
- Improving the quality of investigation reports
- Creating the opportunity to learn lessons from adverse events
- Improving communication with patients & families
- Improving visibility of compliance with review timescales
- Improving review timescales
- Improving communication for Cross-Board SAERs

Adverse Events Toolkit

A review of all adverse events pathways, procedures and documentation has been carried out 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.

All documents 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 Event Reviews Documentation Toolkit via the adverse events intranet page on First Port.

Adverse Event Pathways

A new Adverse Event Investigation Pathway has been developed for potential Serious Adverse Event Reviews (SAERs). The pathway has a 2 channel front sheet detailing the processes required to undertake a SAER or BRIEFING NOTE REVIEW (depending on level of review required). Further detailed pathways have been developed for maternity, suicide, infection control, child protection. Each of these separate pathways has been discussed with the relevant clinical leads for these specialties. The child protection pathway is currently being finalised.

Adverse Events Procedures

An Adverse Events Procedure document has been developed to include details of all stages in the SAER process, with guidance, templates and tools for staff to reference and support them to carry out a quality timely review.

These procedures were originally included within the Adverse Events Management Policy, a decision was made to extract them from the policy as the process and documentation is more likely to change and be updated, allowing the content of the policy to remain static for the timeframe of the review date.

Incident Management System

There have been many changes and updates made to the Datix System to support improvement particularly in the SAER process; these will result in the system being much more intuitive and user friendly for all staff accessing and recording detail, and will provide information to aid decision making on adverse events.

Continuous discussions and liaison has taken place with the Datix supplier to resolve a technical issue in the system which was caused by a faulty code when Datix was updated to a newer version at the beginning of 2019. This was resolved in December 2019, allowing the updates and amendments to be carried out on the system. Some of these are detailed below:

- More descriptive text incorporated onto the Datix system with pop ups and links to documents, i.e.: pathway, process and timelines.
- Additional options on drop down menus to include all commissioners' names, types of reviews commissioned, reasons for delays.
- Email Alert template updated to include details of where the incident occurred.

This work will be ongoing as we recognise there are a number of aspects that can be improved within the system.

Visibility of Compliance

The SAER reports have been updated, the way the data is presented and demonstrated on the charts has changed and additional reports are now included to clearly identify the problem areas. Listed below are the current reports produced on a monthly basis and are shared with the service management:

- **Number SAERs commissioned** *(NHSL)*
- **Timelines for SAERs (open & on target; time taken to complete & close; number open & overdue)** *(NHSL and individual sites/areas)*
- **Status Report detailing the overdue reviews with reasons for delays**
- **Performance Tables** *(NHSL and individual sites/areas)*
- **Performance Compliance run charts** *(NHSL and individual sites/areas)*

Additional reporting on thematic analysis is also being carried out, reports will be shared when finalised.

Monitoring Process

There is a new process being developed to alert when SAERs breach at selected checkpoints within the SAER process (SAER ALERT PROCESS).

The Tracker Tool has been reviewed and amendments made to the original timelines for each step of the process.

A new pathway to show how this process will be carried out, with selected checkpoints from the Tracker Tool will be transferred into questions to allow this information to be captured onto the Datix system and will be available within the Investigation Section for the Risk Facilitators to record the information. This tool will help to work out how much time should be taken on each stage of the process.

There will be regular monitoring on a weekly basis by the adverse events team who will run reports and highlight if any of the checkpoints are breaching the agreed timeline of number of days set for each of these steps in the process.

This new process will improve visibility of where the problem areas arise and allow early recognition of failure to meet certain checkpoints within the current process.

A report for monitoring Duty of Candour cases was introduced in October for the Quality Planning & Performance Group. This was also produced in December and the February report is currently being developed. This tracks the SAERs to establish which events are Duty of Candour and monitor compliance with the Datix fields to ensure all aspects of the legislation have been followed.

Training
Four SAER investigation training sessions were delivered in October and November 2019, venues in UHW and UHH. A series of education sessions have also been delivered to Mental Health staff who are involved in SAER investigations. In December a session on the SAER process was delivered for the West of Scotland Emergency Department trainee medical staff. As part of their development programme, the Chief Residents in NHSL also received a session of SAER reporting and investigation.

A Duty of Candour Think Tank event was also held in October 2019.

A decision was made not to schedule training through December, January & February, due to winter pressures as it was anticipated there would be low attendance levels. The next scheduled dates for training sessions are planned for March and April this year (3rd March at UHW, 7th April at Kirklands).

It has been recognised that one of the delays in completing SAERs can be securing a clinician as the lead reviewer, with a common reason for not wanting to participate being lack of training. We are hopeful that these further training sessions will support staff to be better informed, have a fuller understanding and address these issues.

This training also provides a different approach to starting a review e.g. not waiting 6 weeks to establish the full review team before commencing, if there are 2 or 3 available then start the review and share virtually..

There has also been training on reporting from the Datix system, this has been provided to multiple members of staff to allow ownership of reports, staff included - Risk Facilitators, Improvement Advisors, Maternity and Quality Directorate staff.

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 hospital sites and north and south areas.

Staff within the Adverse Events team will be attending a Certified Datix training course. The knowledge and skills gained from this course will be cascaded to other staff members of the team, building contingency within the department and alleviating the pressure of this being person dependant which has been an issue for the department. This will also allow necessary updates and

changes to be made to the system to align with the new processes and procedures that are evolving, allowing for the necessary monitoring and measuring of the data.

2.2 HSMR

The third release of HSMR data using updated methodology (introduced in August 2019) was published by ISD on 11th February 2020. The data includes case-mix adjusted 30-day mortality on admissions up to September 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.

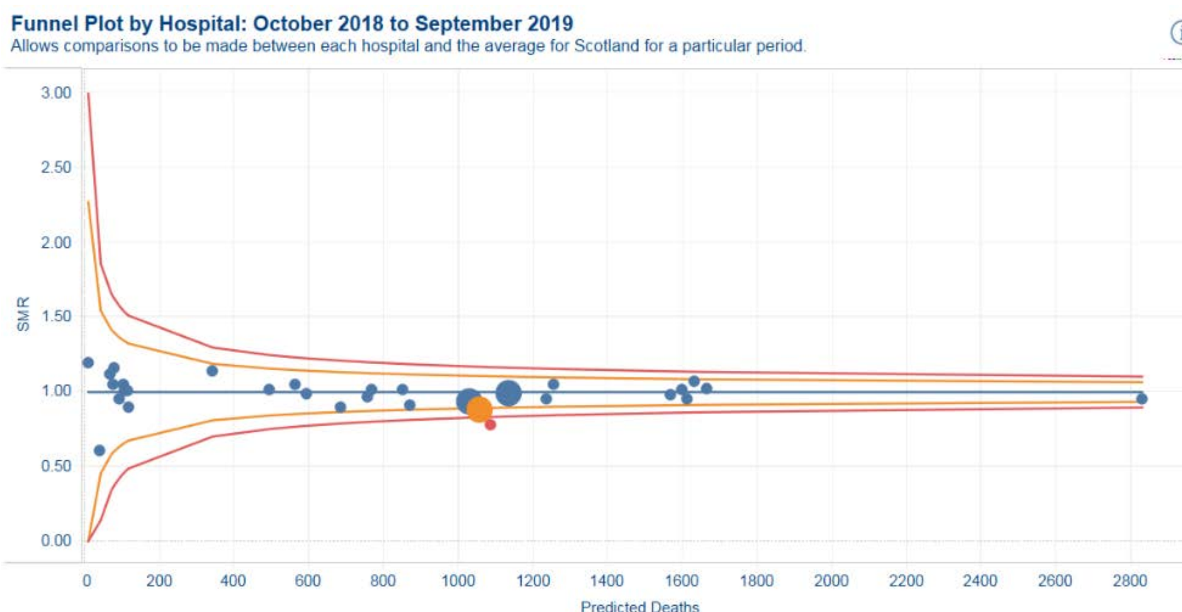
The 3 NHS Lanarkshire hospitals are represented on the funnel plot by the 3 large dots on the chart. University Hospital Monklands and University Hospital Wishaw are both within normal limits. University Hospital Hairmyres is below the lower control limit by between 2 and 3 standard deviations from the Scottish average. In this new model, trends over time are not captured for individual hospitals but they are reviewed internally through the Corporate Governance Report.

This will continue to be monitored through HQAIC.

Health Board of Treatment: NHS Lanarkshire

Period October 2018 to September 2019

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR	Comparison to Scotland on the Funnel Plot
Scotland	**25,616**	**25,616**	**703,020**	**3.6%**	**1.00**	**n/a**
NHS Lanarkshire	3,010	3,222	83,258	3.6%	0.93	**n/a**
University Hospital Hairmyres	924	1,059	23,652	3.9%	0.87	●
University Hospital Monklands	965	1,029	25,734	3.7%	0.94	●
University Hospital Wishaw	1,121	1,134	33,872	3.3%	0.99	●



2.3 Complaints

The Board previously noted difficulties relating to the production of complaint information, relating to technical issues with Datix. This work has progressed. Complaint information for Q2 and Q3 2019-2020 is being discussed at governance committees this month.

We are anticipating deployment of a Datix upgrade from 1 April 2020, with one further consultancy session required from Datix, followed by Patient Affairs training.

Datix web functionality will enable further consideration and development of reporting, including:

i. An ability to link a specific outcome to a specific issue/location – this should improve the richness of our data, enabling us to 'drill down' to the specific issues that have been upheld or partially upheld
ii. Production of meaningful data by specialty, locality etc.
iii. Improved functionality to record learning and actions (recognising improvement as a key driver of the Complaint Handling Procedure)
iv. Excellence in Care
v. Development of cumulative information/reporting
vi. Consider an approach to thematic analysis
vii. Consider frequency of reporting e.g. monthly if reports can be automated. The Complaint Handling Procedure identifies a requirement to produce quarterly and annual reports.

We plan to create a single complaints report that can be analysed by different governance committees. This is to encourage shared learning. For example, ensuring spread of learning from Ombudsman cases across Lanarkshire, and not specifically isolated to the particular site involved.

Processes and documentation are continuing to be reviewed in line with best-practice and learning from staff being accredited with the Queen Margaret University (QMU) Public Sector Complaint Management Award. QMU have approached staff (February 2020) to be involved in research, considering the impact of the learning on their complaint handling practice.

Work is continuing on identified recommendations within the Complaint Development Plan.

Patient Affairs staff attended the Scottish Public Services Ombudsman Improvement Conference in February 2020. This included consideration of the principles and processes behind revisions to the model Complaint Handling Procedure, with an increased focus on resolution, being applied in other sectors. There are no plans to review or refresh the NHS Complaint Handling Procedure.

2.4 Clinical Quality Project Toolkit

A new approach to support for local audit projects was agreed through the Clinical Effectiveness Group on 26th June 2019. Following this, a review of the Clinical Quality Project Toolkit was carried out and agreed changes have now been made to the various documents contained in the Toolkit. The Toolkit provides signposting and guidance for staff carrying out audit or service evaluation. The documents contained within the Toolkit will be continually reviewed and updates made accordingly.

The Toolkit can be accessed via the Quality Directorate Firstport page.
http://firstport2/staff-support/quality-directorate/default.aspx

A Quality Department staff guide has also been developed to provide a consistent approach to guidance for staff seeking support.

2.5 Best Start

The Clinical Audit team continue to work with the Maternity and Neonatal Services to monitor and report progress against the 23 Best Start recommendations. NHSL have so far completed 7 recommendations, 15 are on track for completion and 1 slightly delayed with mitigation. The third highlight report was produced in November 2019 with the next one due in May 2020.

In addition, we continue to provide support to the Neonatal Unit and Special Care Baby Unit in monitoring progress as they strive to meet the 7 Bliss Baby Charter principles which assess the quality of the family centred care that the unit delivers. Significant progress has been made since the baseline audit. Each principle is continually self-assessed with 126 (86.9%) of the 145 standards currently delivering on all aspects of the criteria. Gaining BLISS accreditation will contribute towards the attainment of the 5 neonatal recommendations within Best Start.

2.6 Child Death Review Pilot Project

This pilot project has been extended until March 2020 with an expectation that it will continue thereafter. The Clinical Audit team continue to assist with this project and have refined the database and reports as the project evolves. A scoping exercise is underway to ascertain the level of bereavement care that is provided by NHS Lanarkshire and its third sector partners following the death of a child or young person in Lanarkshire.

2.7 Cancer Audit

Staffing levels within the Cancer Audit team remain a concern due to one member of the team currently being on secondment. With the utilisation of overtime the team have met all deadlines to date. However, the submission of the 2019 Brain/CNS cancer audit QPI data is on hold. With agreement from the Cancer Management Team, the Managed Clinical Network for Cancer has been informed that NHS Lanarkshire will not be in a position to submit their 2019 Brain/CNS data by the 8th April 2020 submission deadline date. The Regional Cancer Audit Group have also been informed.

An annual programme has been agreed with the presentation of Quality Performance Indicator (QPI) data for one tumour type each month at the Cancer Strategic Leads meeting. QPI data for Gynaecological and Urological cancers have been presented to date with actions for improvement agreed.

2.8 NCEPOD

Consideration was given to participate in the latest NCEPOD study - The Physical Healthcare of Inpatients in a Mental Health Hospital. Participation has been declined by Mental Health & Learning Disabilities due to lack of capacity.

No casenote extracts were submitted from NHSL for the Dysphagia in Parkinson's study. NCEPOD have made another request for submissions of 4 NHSL casenotes. Consultants have been contacted.

2.9 Evaluation and benchmarking of national audits

The Clinical Audit teams continue to support the review and evaluation of nationally published clinical audit and statistic reports by facilitating the production of Evaluation reports. This process is however under review following the publication of the revised Scottish National Audit Programme (SNAP) Governance policy.

The processes described in the SNAP governance policy mirrors those that currently exist in NHSL, and in order to minimise duplication, the Clinical Effectiveness Group have been asked to consider whether the NHSL evaluation process can cease with the assurance that any issues are highlighted, and actions monitored by SNAP under this policy. The Clinical Audit team will continue to work with teams to provide assurance that, under any agreed new arrangements, data is being submitted and quality assured in line with the SNAP submission deadlines; provide assurance that reports are

being reviewed through the appropriate governance groups; and to seek reassurance that data is being used for improvement.

It has been agreed that Cancer QPI evaluation and benchmarking reports will be replaced with exception reporting to Cancer Management team and the Acute Clinical Governance & Risk Management group.

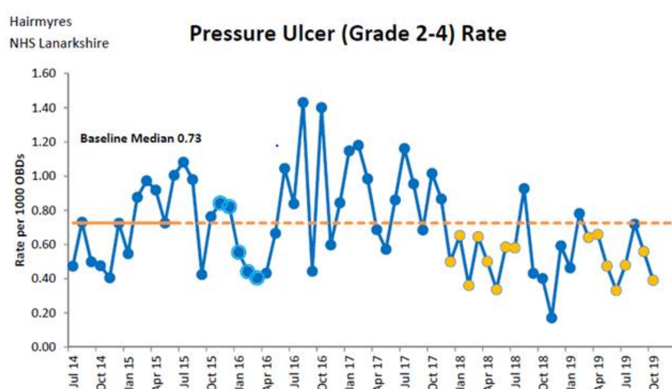
The evaluation process for all non-SNAP and non-cancer audits will remain unchanged.

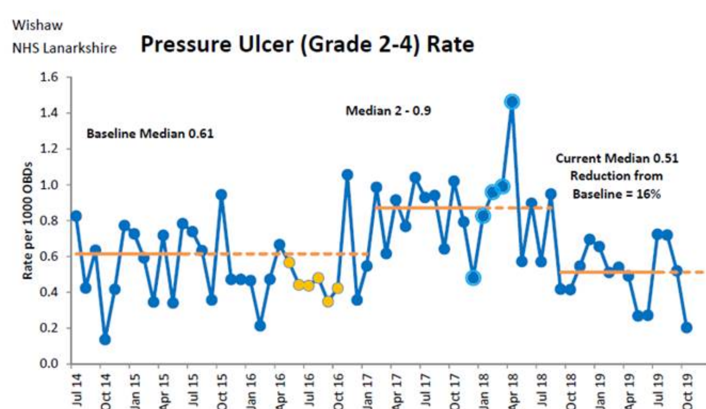
3. Quality Improvement

3.1 Pressure Ulcers

Healthcare Improvement Scotland have been reviewing data submitted from NHSL as part of the Scottish Patient Safety Programme Acute Care quarterly data submission. Feedback from Healthcare Improvement Scotland highlighted:

- A new signal of improvement with a shift below the median at Hairmyres.
- A sustained improvement with a temporary median at Wishaw. This is from sustained deterioration in the last reporting period.





The Senior Nurse Tissue Viability has been working with the Quality Directorate to improve the Datix recording of pressure ulcers. This includes improving the process for triggering a SAER for pressure ulcers. Analysis has found that 25% reported pressure ulcer harms were identified as moisture lesions.

Improvement work is ongoing supported by the Tissue Viability Service.

1. To improve the appropriate use of dynamic mattresses for patients in health and social care partnerships and the care home setting.

2. To improve pressure ulcer reporting, monitoring and educational outcomes of hospital acquired pressure ulcers Grade 2 and above, including suspected deep tissue injury, ungradeable and moisture lesions throughout the acute setting.

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

Preterm neonatal mortality: Improvement work has been implemented during 19/20 to focus on achieving 85% compliance with 3 agreed MCQIC measures (steroids, cord clamping and magnesium sulphate). A recent review has found that during 2019 there was 83% reliability with administration of steroids (<34 weeks) 69% reliability with administration of magnesium sulphate (< 30 weeks) 87% reliability with deferred cord clamping. Although the aim of 85% across all 3 measures has not been met, there is an improvement in all areas of the perinatal package and this collaborative work remains one of the priorities in the coming year.

Central line-associated blood stream infections (CLABSI): A 57% improvement has been highlighted in the 2019 CLABSI rate (5.6 / 1000 line days). Maintaining the CLABSI rate below 8/1000 line days will remain a priority in the coming year.

3.3 Falls

A draft Falls Strategy & Implementation Plan was presented to the NMAHP Governance Group in January 2020 and is scheduled for CMT March 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.

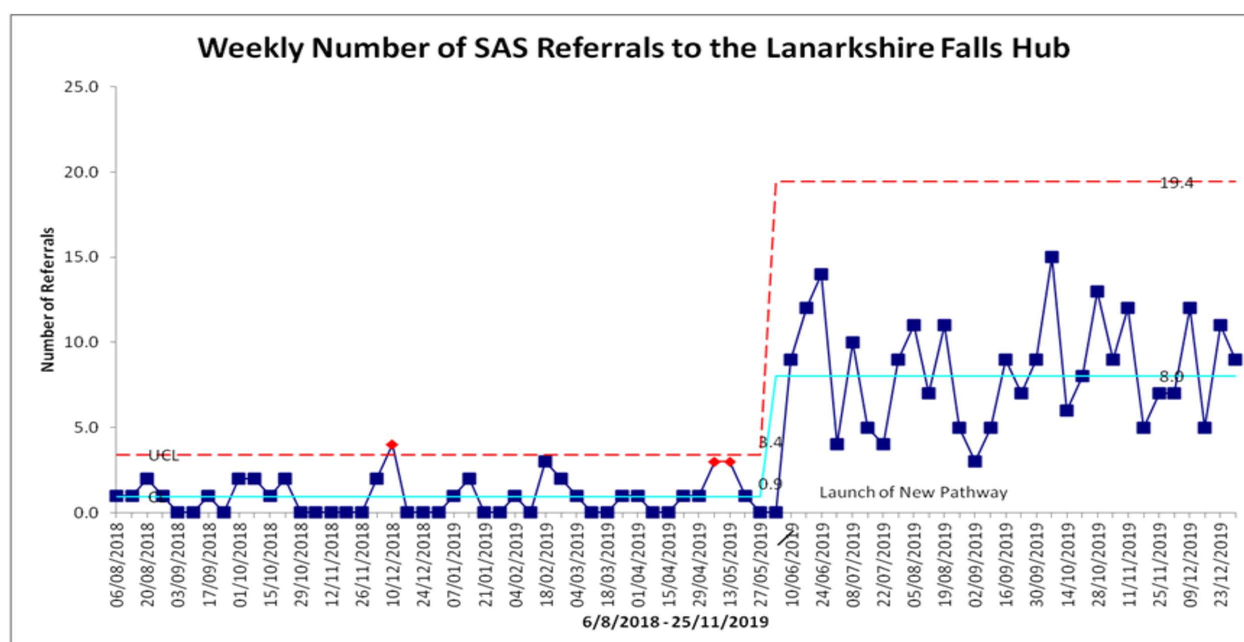
A meeting of subgroup leads will take place in March 2020.

A Prevention and Management of Falls in Hospital Collaborative planning meeting took place in February 2020. The launch of the Hospital Falls Collaborative will take place on 1st April 2020 (April Falls Day).

The Falls Register development continues. It was anticipated the new MORSE IT system would support this development however, the functionality of this IT system does not allow the visibility required across the whole system. A SLWG is taking place on 16th March 2020 to review this element as the sharing of information is integral to the whole systems Falls, Frailty and Bone Health pathways. ISD are currently supporting a Falls Register pathways analysis that will review people who have been registered as being at risk of falls or having fallen and identify what pathways across health and social care that this population have taken. Lanarkshire wide information is available and will be analysed at a locality level to inform service delivery and future improvement work aligned to the Falls Strategy.

The Scottish Ambulance Service, Lanarkshire Falls Service/Falls Register Hub and the Improvement Team have been working together to improve the pathway for people who have experienced a fall that has resulted in a SAS call. All patients who are non conveyed following a fall should be offered a referral to the Falls Pathway and a follow up by the Falls Register Hub. Referrals from paramedics direct to the Falls Register Hub have been increasing, with 25 of the 46 patients referred in January 2020 were non conveyed (i.e. remained at home). Patients who were conveyed to hospital have also been referred and this has led to better communication with hospital services regarding the patient's falls history. 5 patients who were discharged home from ED on the same day were reviewed by the Falls Register Hub.

Total referrals received January 2020 = 46 (27 from North Lanarkshire & 19 from South Lanarkshire)
Number conveyed to A&E = 21* (12 from North Lanarkshire & 9 from South Lanarkshire)
Number non conveyed = 25 (15 from North Lanarkshire & 10 from South Lanarkshire)
* Of the 21 conveyed to A&E, 16 were admitted to hospital; 5 were discharged home on the same day and reviewed by Falls Register Hub.



3.4 Quality Improvement Education

aEQUIP for Teams (5 full days over 20 weeks)

Cohort 8 graduated on 18th November 2019. During graduation there is an opportunity for the participating teams to present a story board to demonstrate how they have applied quality improvement methods to their improvement projects. These have included improving the completion of mandatory training in Mental Health wards, the introduction of one-to-one appointments for family members with members of the Brain Injury Team, increasing appropriate referral to AHP staff for assessment in the Emergency Department to tor reduce unnecessary hospital admission, improving operating theatre efficiency and supporting school teachers to identify and refer appropriately to Speech & Language services. The next Cohort will focus on Maternity, Neonatal, Paediatrics & Health Visiting.

aEQUIP for Individuals (1 day overview)

Six "open" sessions are planned for this year with Quality Directorate staff having discretion to deliver additional sessions to drive and support improvement for collaboratives such as "Falls".

aEQUIP for Leaders
A new programme is scheduled for Leaders commencing in March 2020. 2 cohorts will test the content/delivery of the programme in 2020. This programme is being led by the Quality Directorate, Organisational Development and Medical Education and will include leadership skills, coaching, project management and quality improvement methodology.

Scottish Improvement Leaders Programme (ScIL)
A regional Lanarkshire ScIL programme has been confirmed with NHS Education Scotland for SCIL Cohort 28 in May 2020. Applications close on 2nd March for the guaranteed 11 places for Lanarkshire staff (8 standard places & 3 for Excellence in Care)

CQL PQL Event February 2020
The Improvement Team supported the delivery of the Primary Care CQL PQL (Cluster & Practice Quality Leads) event that took place on 20th February for GP practices across Lanarkshire.
The focus of the day was on quality improvement methodology and how to apply this to support improvements in the GP practices and clusters. It was an opportunity for networking, sharing and local quality improvement development/planning.

3.5 Person-Centred Care Group
The purpose of the NHS Lanarkshire Person-Centred Care Group is to provide strategic direction and prioritisation for the Person-Centred Care portfolio of the NHS Lanarkshire Quality Strategy.
The strategic ambition for Person-Centred Care is to:
Ensure mutually beneficial partnerships are established between patients, their families, carers and those delivering healthcare that respect individual needs and values and demonstrate compassion, continuity, clear communication and shared decision making that encourages and empowers people to take responsibility for their own care and supports self-management.

This will be achieved by:
- Ensuring services are user focused
- Promoting control, independence and autonomy for the patient, their carers' and family
- Supporting staff to build resilience and psychological safety

The inaugural meeting of the Person-Centred Care group took place on 17 February 2020. Terms of Reference will be submitted to the NHS Lanarkshire Healthcare Quality Assurance and Improvement Committee for consideration and approval with reporting to follow as scheduled.

3.6 Patient Safety Leadership Walkrounds
No Walkrounds have been undertaken since the last update. The Senior Improvement Advisor has met with Acute Hospital Triumvirates to discuss the composition of the Walkround team going forward and Health & Social Care Managers for North and South Partnership have been contacted to provide details of the teams in their area before 30 March 2020 to enable a full community programme to be developed. In the meantime, the rolling programme continues with visits scheduled for April 2020. The Quality Improvement Team are in contact with Executive colleagues to progress open actions.

3.7 Value Management Collaborative
NHS Lanarkshire continues with 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) until March 2022.

A Value Management approach brings cost and quality data to the point-of-care to drive sustained improvement. Since the initial learning event Ward 5 (Medical), Ward 11 (Stroke Rehabilitation) and

the Adult Critical Care Unit in University Hospital Wishaw have been participating in weekly improvement sessions. The Focus of weekly sessions are:

- Communicating value management approach to wider team members
- Commenced process mapping
- Undertaking team readiness assessments
- Commenced completion of team agreements, outlining team members roles and responsibilities
- Review of baseline data to support identification of measures
- Developed linkage chart – linking strategic goals and measures of the organisation to team goals and measures
- Identifying areas for improvement
- Development of visual management boards
- Agreement of days / times for weekly ward huddles
- Preparing submission for monthly progress report required to be submitted to national team

4. Evidence for Quality

4.1 National and Local Evidence, Guidelines and Standards

A meeting to progress the finance for this project took place in February. To date, no funding source have been identified. An updated paper with revised costs for the next stage of development is to be forthcoming from SHOW. This will cover the period from April-June 2020. Within this time, we will also pursue to use of the national Right Decisions Platform to host all NHSL pathways and guidelines. Timescales for this have still to be agreed. It is hoped that the national platform will help with a reduction in overall costs. An updated paper with all costs including staffing will be presented to finance in March 2020.

4.2 Quality of Care

The mapping of the groups for Quality of Care has been completed. The next stage of work will be to trail the self-assessment process within one area of NHS Lanarkshire when the new standards become available from Health Improvement Scotland. A further presentation to South CMT will be given in March 2020.

4.3 Searching

The Evidence Team have completed 28 literature searches and 6 copyright searches between January and February 2020. Monklands Redevelopment Searches accounted for 13 of the searches completed over the period. Literature searches have been completed for areas such as; reception areas safety, power, gases and clinical equipment in a theatre setting and risks associated with fixed and mobile shelving.

Dr J Burns
Medical Director, Acute Division
March 2020