ITEM 20

NHS Board Meeting
26th October 2022

Lanarkshire NHS Board
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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 07779421465

1. Introduction

This report to the Board provides an update on the current progress over September 2022 to October 2022, 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.

Work on the new Quality Strategy continues with a current focus on patient and staff engagement. There will be one general quality related question for staff and patients recorded through a variety of methods. The themes from the responses will be collated and reviewed to ensure that the new strategy reflects the priorities patients and staff have highlighted. Links have also been established with the Board 'Our Health Together' strategy to ensure alignment.

2. Assurance of Quality

2.1 Complaints

Scottish Public Ombudsman Annual Report

The Scottish Public Services Ombudsman (SPSO) published their annual statistics on 24 May 2022.

In 2021-2022, **94** complaints about NHS Lanarkshire were determined (closed) by the SPSO, which was an increase from 80 complaints determined the previous year (see table 1). The SPSO noted an overall national increase of 17% in the number of complaints received by their office, noting that they saw a substantial decrease in the number of complaints received in 2020-2021, likely as a result of the Covid-19 pandemic and the significant disruption to public services during the first quarter.

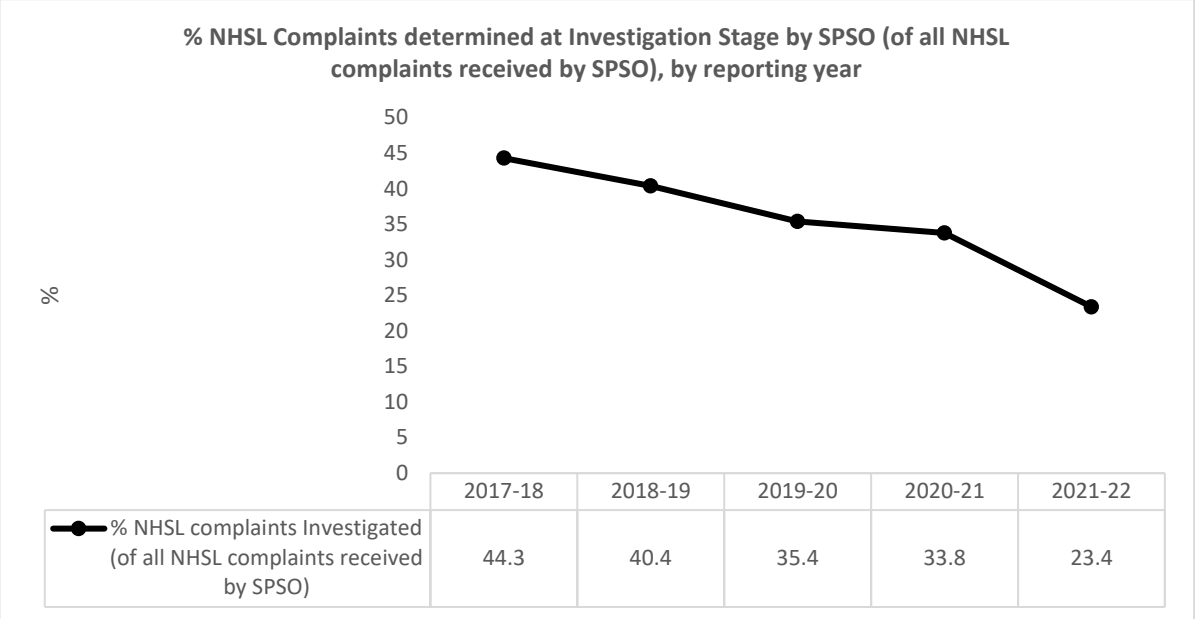
Table 1:

Reporting Year	NHSL Cases determined by SPSO
2021-2022	94
2020-2021	80
2019-2020	130

Of the **94** NHSL cases determined by the SPSO:

- **27 (29%)** of cases were determined at **Advice Stage** (i.e., complaint is out with SPSO jurisdiction, premature or unable to proceed). This represents an increase from 16% (13) in 2020-2021.
- **45 (48%)** of cases were determined at **Early Resolution Stage** (SPSO able to resolve complaint with the organisation, or there is considered to be no significant benefit from proceeding to a full investigation e.g., SPSO are content that NHSL have provided a robust Stage 2 investigation). This represents a slight decrease from 50% (40) in 2020-2021. For **67% (**30 of 45) cases determined at early resolution stage, the reason given by SPSO for not proceeding to investigation was good complaint handling by NHSL.

- **22 (23%)** of cases were determined at **Investigation Stage** (full investigation undertaken). This represents a decrease from 34% (27) in 2020-2021. As demonstrated in Chart 1 below, the % of NHSL complaints determined at the investigation stage by the SPSO has continued to decline since 2017 – 2018. This is a positive indicator of good complaint handling for NHSL.



	2017-18	2018-19	2019-20	2020-21	2021-22
% NHSL complaints Investigated (of all NHSL complaints received by SPSO)	44.3	40.4	35.4	33.8	23.4

Of the 22 NHSL cases determined by the SPSO at the Investigation Stage:

- 10 (46%) were fully upheld
- 8 (36%) were partly upheld
- 4 (18%) were not upheld

There were no public investigation reports published about NHS Lanarkshire during 2021-22.

NHSL Complaints Development

A Complaints Investigation Toolkit has been developed to promote a consistent and person-centred approach to management of Stage 2 complaint investigations. The toolkit provides an agreed set of guidance, templates and tools to be used by complaints investigators at each stage of the complaint handling process, from the point of receipt through to closure of the complaint. The toolkit is based on the national best practice Complaint Handling Procedure, and is focused on ensuring that learning from complaints is used to continuously improve NHS Lanarkshire services. The toolkit is available through the Patient Affairs & Complaints FirstPort site. The first iteration of the toolkit will be implemented in October 2022, with a review planned for end of January 2023. Promotion and awareness raising of the toolkit will take place throughout October / November 2022.

The acute Patient Affairs teams transferred to the Quality directorate on 1st August 2022. The newly established team are working closely to develop standard work processes including templates and case management systems. They are currently testing out a weekly team huddle to discuss outstanding cases and escalation of any issues. This model will also support collective prioritisation of higher risk complaints and a 'joined up' approach to addressing delayed complaint responses.

The team continue to work in extremely challenging times, with national recognition of the changing nature of complaints such as increased complexity and challenging behaviour, which has impacted on response times.

Recognising the difficult interactions which can include aggression and abuse, the Patient Affairs staff attended a clinical psychology session in August 2022, focusing on challenges and wellbeing. This is being followed up with a trauma informed awareness session and consideration of how this can impact on complaints processes.

2.2 Adverse Events

Datix developments

In line with the adverse events work programme, continued improvement and enhancements to the Datix system are being carried out, including the review of all categories and sub-categories; with the aim to reduce the number of these by either removing or merging them to enable the reporter to easily record incidents in a timely way.

The Laboratories category titled "Investigation" has been reviewed as part of the ongoing progress to reduce the number of categories available for selection when reporting an incident. It was agreed to remove this category name and redistribute the sub categories within a new category titled "Laboratories" as well as another titled "Radiation/Imaging Problems". Previously most incidents relating to Laboratories were being recorded within the "investigation" category which was also shared with Imaging and X-ray incidents. In terms of recording, this change will make it more efficient for the end user and also produce more accurate reporting. This was updated onto the Datix system in September 2022.

A new Falls dataset was implemented on Datix in April 2022. The category "Slips, Trips and Falls" was renamed to 'Falls', and a new set of sub-categories have been agreed for this new section. The question within the 'Falls' dataset - 'Was this fall witnessed or unwitnessed', allows for an incident to be recorded when a patient/staff member is unaware of how the injury was sustained or if they have been identified in a position that would or could only be the result from a fall. As part of the category review work it became evident that unwitnessed falls were being reported incorrectly under the category of 'Unexplained Injury', therefore as a result of this, the category 'Unexplained Injury' will be removed and relevant incidents recorded under this category will be recoded to a more appropriate category.

A new dataset to capture the detail for all child death reviews has been agreed and approved, with the intention of the dataset being incorporated onto Datix to allow these cases to be recorded and reviews carried out where relevant. The next step planned is for testing of the dataset applied to the system, prior to going live; following the testing period, communication will be shared accordingly along with full guidance and training arranged for staff with further support provided by the Child Death Review Team where necessary. Further communication around these Datix changes will be issued in due course via the adverse events team.

Adverse Events Toolkit

The latest version of the Adverse Events Toolkit (September 2022) has been uploaded and available on the Adverse Events web page and a copy uploaded onto the adverse events Shared Drive. The Toolkit has been updated with the following:

- Pathways to include updated Mental Health Review Pathway
- Mental Health Briefing Note updated version
- Guidance for Involving Patients & Families -APICTHS model updated
- Recollection Proforma for Staff June 2022-updated to include a section for "any additional questions"
- Timeline of Events and Timeline Actions documents added
- Tools to Support Review Investigations - word versions added
- Yorkshire contributory Factors - word version added

Adverse Events Training & Education

The adverse events team continue to arrange and deliver bespoke training sessions with staff and teams from the various services within the organisation.

Three of the four planned training sessions for "Investigating Significant Adverse Events", delivered by the Director of Quality, have been well attended with good feedback. There is one remaining date scheduled for December 2022. The aim of these sessions is to help provide staff with the knowledge, tools and techniques to feel confident when involved or participating in investigating significant adverse events. The session covers the following –

- Rationale for investigation & reporting
- Duty of Candour
- Communication with patient / family
- The investigation process
- Human Factors
- Understanding error
- Interviewing
- Recollection of events
- Report writing
- Causation codes
- Accident Causation Model
- Examples & Discussion

NHS Lanarkshire has been approached by smaller Boards such as NHS Orkney and NHS Western Isles for staff to join the SAER training. As the course is now on MS Teams this allows these remote areas to easily participate. A nominal fee is charged and feedback from the attendees to date has been very positive and they are grateful for the support. This is an example of how NHS Lanarkshire has a reputation of expertise and willing to help others.

2.3 LanQIP

The main focus of the LanQIP team over the last few months has been the development of a Clinical Audit Project Register module. The team have worked closely with colleagues in Clinical Audit to help identify and prioritise requirements to build a system that supports current processes and makes the reporting of audit activity easier for staff across NHS Lanarkshire.

Work continues to develop a programme of modules in LanQIP which will replace a number of historical Microsoft Access databases. These new modules will make datasets more stable and allow the Clinical Audit team to develop and distribute automated, real-time dashboards and paginated reports across the organisation. New modules for Public Protection and Optimal Reperfusion will go live over the next few months.

The planned spread of the Morbidity and Mortality Review modules has been delayed this year due to a number of factors including clinical teams still recovering from the increased activity over the past two years and staffing issues in the LanQIP team. The final quarter of the year will be dedicated to developing more training resources for Morbidity and Mortality and evaluating the current platform.

3. Quality Improvement

3.1 IPC Collaborative Update

The Infection, Prevention and Control (IPC) collaborative continues to be implemented across Lanarkshire. A review of participating teams has been undertaken to ensure they have capacity and are contributing to an overall reduction in NHSL's infection rates for Staphylococcus Aureus Bacteraemia (SABS), Escherichia coli (E. coli) bacterium (ECB) and Clostridium difficile (C. diff) infection (CDI). Learning Session 1 was held via MS teams in May 2022 and approx. 75 staff joined the event. A team from each operational unit presented their project. National updates were provided by Jo Matthews, Head of Patient Safety, Healthcare Improvement Scotland and Alex McMahon, Chief Nursing Officer. Feedback from the session was very positive; staff felt re-energised to continue with this work.

Currently planning for Learning Session 2 in November 2022 which provides teams with an opportunity to share their learning and progress updates. Most teams are at the stage of understanding the system, developing aims and testing changes. Glenmore ward at Coathill Hospital achieved their aim of greater than 100 days between Catheter Associated Urinary Tract Infection (CAUTI) at 160 days.

3.2 Leadership Quality Walkrounds

The Leadership Quality Walkrounds provide frontline staff with the opportunity to meet with an Executive Director, Non-Executive Director, Senior Clinician and Quality Directorate lead to discuss the areas of quality and safety where they have made progress and highlight any issues or concerns. Each walkround lasts approximately one hour and a 30 minute debrief is held with the operational unit triumvirate / senior leadership team.

The walkrounds recommenced in June 2022. Between June and September 2022, 21 inpatient areas have been visited across the 3 acute hospitals (8 x UHH, 8 x UHW, 5 x UHM). From November 2022 teams in both North and South Health and Social Care Partnerships will be scheduled into the walkround programme. Agreed actions are recorded for each of the walkrounds and are classified into 2 categories, 'Operational', which remain the responsibility of the host team or Senior Manager(s) and 'Executive', which require Executive intervention or escalation. The Quality Directorate will follow-up on all actions three and six months after the walkround to track to completion.

3.3 QI Education Programmes

The Quality Directorate provide guidance and support to staff in their application for national QI training programmes: Scottish Coaching and Leading for Improvement Programme (SCLIP), Scottish Improvement Leaders Programme (ScIL) and Scottish Quality and Safety Fellowship (SQSF). In recent recruitment opportunities for these programmes 15 members of staff secured a place on ScIL, 7 on SCLIP and 3 on the SQSF.

Two cohorts of approx. 60 staff have completed NHS Lanarkshire's Achieving Excellence Quality Improvement Programme (aEQUIP) since April 2022. Colleagues from the Golden Jubilee University National Hospital joined the April 2022 cohort to learn from our planning, delivery and approach to shape and inform their local Quality Improvement training going forward. The course continues to be well evaluated by participants and the online delivery provides flexibility for clinical staff.

A further 2 cohorts are planned for November 2022 and February 2023.

3.4 Falls – SPSP Acute Adult Collaborative and NHSL Strategy Implementation Plan progress

The Falls Strategy Group and Sub Group structure for delivery of the Implementation Plan is working well. The Falls Strategy Implementation Plan for 22/23 has 14 actions across 4 sub-groups which report into the strategy group. All 14 (100%) actions are progressing as planned.

In terms of the Scottish Patient Safety Programme (SPSP) Acute Adult Falls collaborative, work has been ongoing to 'understand the system' in terms of falls across all 3 acute sites and 2 partnerships in North and South. A mapping exercise against the national falls driver diagram was undertaken which combined with a 'deep dive' of falls data has helped to identify the teams participating in phase 1 of the collaborative. Teams identified:

- UHH: Acute Medical Receiving Unit, Wards 14, 15, 16 and Stonehouse Hospital.
- UHW: Emergency Care Unit, Wards 5 and 11.
- UHM: Wards 10, 18 and 20.
- North HSCP: Kilsyth Victoria Cottage Hospital and Ward 24, UHM.
- South HSCP: Ladyholm Hospital and Kello Hospital.

There are Improvement Advisors aligned to each of the operational units and they are working closely with each of these teams to provide targeted improvement support and mentoring.

3.5 Value Management Collaborative

Healthcare Improvement Scotland (HIS) advised the Board in September that the funding allocation for the Value Management improvement programme would cease at the end of October. The reason for this change is a reduction in funding to Healthcare Improvement Scotland from Scottish Government. This was very surprising and disappointing especially as the funding was assured for 12 months.
The funding was used to employ a 1-year contract of a band 7 improvement advisor to work specifically on the Value Management programme as recommended by HIS. However, as the employment contact still has 5 months until completion, the salary for these months is now unaccounted for. The Quality Directorate will realign funds and delay other recruitment to accommodate this shortfall as it would be unfair not to honour the original contract with the member of staff. The member of staff will be able to work on all the other improvement initiatives that are ongoing and continue to support the wards who were focusing on Value Management if they would like to continue the work they had started.
The work of Value Management will cease to be a separate programme with no national reporting, education or support, however we will embed the learning and the methodology in our general quality improvement work in NHS Lanarkshire.

4. Evidence for Quality

4.1 Cancer audit

Cancer Quality Performance Indicators for patients diagnosed in 2021/2022 with Testicular, Acute Leukaemia, Upper GI and Ovarian cancers have been reported to MDTs within 5 months of diagnosis meeting the locally agreed target. Due to staffing capacity issues delays in local reporting have been noted in the following cancer specialties:

Date from diagnosis		
6 months	• Head and Neck • Melanoma • Cervical	• Renal • Endometrial
7 months	• Lung	• HPB
8 months	• Breast cancer	
9 months	• Prostate cancer	

Reporting of the 2021/2022 Bladder QPI data has not been possible due to a delay in the formal review process at a national level.

Published regional reports for 2020/2021 cases show NHSL performed well at a regional level during that time period. Local reporting has allowed NHSL to provide details of actions already implemented for inclusion in the regional annual reports and as a result fewer action requests have been received. No actions were requested by NHSL for Ovarian, Colorectal, Breast, Lung, Lymphoma, Prostate, Acute Leukaemia and Testicular cancers in the latest regional reports. Actions Plans have been returned to the MCN for Upper GI, HPB, Melanoma, Head and Neck and Bladder. In the majority of cases actions requested are applicable to all Boards and not specific to NHSL.

Themes emerging through local and regional reports include capture of staging data for background and survival analysis, access to and reporting of imaging within the required time frames, access to clinical trials and record keeping. The cancer audit team continues to work with and support the cancer MDTs to improve performance in these areas.

Tumour specific Cancer Quality Performance Indicator (QPI) data is presented at the Cancer Strategic Leads meetings to highlight achievements and to facilitate discussion around challenges in meeting QPI targets and actions required. A number of meetings have been postponed due to service pressures, however meetings did proceed for Upper GI, Breast, Lung and Head & Neck. Due to service pressures, meetings have been rescheduled for Gynaecology and Melanoma. Meetings are scheduled for Colorectal in November and Acute Leukaemia and Lymphoma in December. Although the Urology Strategic Leads meeting did not take place Bladder and Testicular QPI data was presented and discussed at the Urology CME in April and Renal QPI data will be presented at the CME in October.

Risk: Boards had been informed by WoSCAN in 2021 that the national and regional Cancer QPI reporting system would be moving to a new platform as the existing platform was not stable. As a result of this, alongside the removal of MS Access and Crystal reports software by NHS Boards, there was an immediate requirement to review existing arrangement for local reporting and develop new processes and systems to continue local reporting and monitoring of Cancer QPI data. Plans were put in place to develop a local reporting process and system based on the development and implementation of the national reporting system, eCASE Business Objects reporting platform.

Work to progress the national system stalled in recent months due to various technical elements not being progressed within NSS. As a result, the Cancer Audit Team have been unable to make any progress. The impact will be a breach in local and regional reporting and an inability to deliver on the Implementation Plan.

The issue was escalated by WoSCAN at a national level and added to the NHSL Risk Register.

Subsequently a resource was identified within NSS to restart the development, however no timescales have been given. A 'Super Users' group has been established to move along the development and NHSL has been asked to represent WoS Boards at the fortnightly meetings. This early access to the system prior to implementation should allow the team to establish requirements for the development of a local reporting system. Business Objects training has been arranged for the team.

In the meantime, the team will continue to provide local reports using the existing MS Access databases and Crystal Reports whilst they are still available. If these packages are removed prior to implementation of the new eCASE Business Objects reporting platform it will not be possible to deliver on the local reporting schedule.

4.2 Clinical Audit Team

National Audit Activity

Scottish National Audit Programme (SNAP)
On 2nd May 2022, SNAP wrote to Board Medical Directors highlighting any outlier status across the nine national audits. The three negative outliers flagged for NHS Lanarkshire spanned two audits, the Scottish Trauma Audit Group (STAG) and Scottish Hip Fracture Audit (SHFA). Audit Leads in both areas completed a full investigatory report and these were submitted to SNAP by 10th June deadline along with our comments in relation to a number of other KPIs that were flagged for action but were not considered outliers. All reports were discussed via the Acute Clinical Governance and Risk Management Group.
Local Audit Leads for ten positive outlier KPIs were written to by the Director of Quality and Medical Director in order to recognise their efforts in achieving performance significantly better than the national average.

The table below provides thematic analysis of the contributing factors that were identified through each of the responses provided by the audit leads.

Theme	SHFA	SICSAG	STAG	SSCA	SRR
Covid pandemic	√	√		√	√
Staffing capacity (Inc. vacant posts, newly appointed staff & agency)	√	√		√	√
Staff / patient education	√		√	√	√
Theatre capacity	√				√
Hospital occupancy	√			√	
Radiology (Inc. CT/MRI/interventional radiologist availability)	√		√		√
Neurology response time			√		
ED waiting times	√			√	

SHFA – Scottish Hip Fracture Audit
SICSAG – Scottish Intensive Care Society Audit Group
STAG – Scottish Trauma Audit Group
SSCA – Scottish Stroke Care Audit
SRR - Scottish Renal Register
Scottish Cardiac Audit Programme (SCAP)

The Scottish Cardiac Audit Programme was brought on board to SNAP as part of the national audit programme on 1st April 2021 following a commission by Scottish Government. Scotland withdrew from the National Institute for Cardiovascular Outcomes (NICOR) audit (which was part of the Healthcare Quality Improvement Programme (HQIP)) due to procurement legalities which prevented continued participation. The SG considered data collection and monitoring of heart disease a vital objective of the Scottish Heart Disease Action Plan and therefore commissioned PHS to set up and deliver SCAP in an initial two phases.

Phase 1 of the delivery focuses on data items and standards required for procedures that are mainly carried out in specialist centres. In Phase 1 of the audit only the Percutaneous Coronary Intervention (PCI) dataset is relevant to NHS Lanarkshire and the Board were asked to submit data under the SNAP Governance process for this by 30th June 2022 for the financial year April 2021-March 2022. Issues with data quality and completeness have been flagged and the Clinical Audit Team are working closely with the key stakeholders within Cardiology Services to make improvements ahead of the 2022-23 data submission.

Phase 2 of the audit will focus on engaging with the clinical community to develop, launch, report and monitor indicators for:

- Atrial fibrillation
- Hypertension
- Coronary Heart Disease
- Heart Failure
- Devices

Local Audit Activity

Between 1st January and 30th September 2022 there have been 40 new clinical audit projects submitted through the Clinical Quality Project Register. Further details of the specific projects are available via the Clinical Quality Project Register.

The Clinical Quality Project Register is currently being redeveloped by the Systems Development Team to refresh the content and improve functionality for the Clinical Audit Team and for users, with enhanced

functionality to encourage shared learning. The register will continue to have three main functions; enabling users to register new clinical audit projects, request access to systems maintained by the Clinical Audit Team and request information contained within systems maintained by the Clinical Audit Team.

A new process is being tested for considering NHS Lanarkshire participation in new national or UK wide audits (out with SNAP). A checklist to support the existing audit project registration process has been developed to provide the Quality Directorate and the Board with assurance that audits, which are not managed or led by NHS Lanarkshire staff, comply with the NHS Lanarkshire clinical audit protocols on areas such as data protection, reporting and publication of audit results. The checklist should be completed by Staff who wish to participate in a National or UK wide audit on behalf of NHS Lanarkshire. This process will be supported by the Clinical Audit Team.

Public Protection
The Clinical Audit Team continues to support the Public Protection Service with data management and reporting. Reporting continues to be enhanced using data for improvement and the team is supporting improvement work within two localities in respect of Child Protection Supervision. The systems currently used to support the service were identified as suitable for transfer to LanQIP and work has recently commenced on migrating the first two systems away from their current MS Access platforms into LanQIP. On completion of this, the Clinical Audit Team will work with the service and our colleagues in the Software Development team to create new reporting modules which will make data reports more accessible for key stakeholders.

MS Access/Office 365
Work has recently started on migrating the first of the systems that were identified as being suitable for transfer to LanQIP from their current MS Access platforms. The Optimal Reperfusion audit as well as the Public Protection Consultancy Log and Adult Protection Support and Referral databases will be the first systems migrated by the Software Development Team. Work on redeveloping current reporting solutions will commence on completion of the system development and data migrations. There are still a number of access databases where an alternative system has still to be identified and/or funded.

Food, Fluid and Nutrition Care Audit
Support has been provided to the Audit of Food, Fluid and Nutritional Care (FF&N Care) with Clinical Audit representation on the FF&N Care Steering Group. A review of audit tools, the schedule of audit and reporting is in progress with the Mealtime Observational Audit Tool being the first area of focus in September 2022.

Care Experienced Notifications System (Previously known as CEL16 Looked After Children)
It was agreed at a meeting of the Care Experienced Notifications Group that the term 'CEL16 Looked After Children' was out of date and that the work should now be termed 'Care Experienced Notifications'. It was previously reported that with the phasing out of MS Access, the CEL16 database would be moved from MS Access onto LanQIP in 2022. However, due to limited resource within the Quality Directorate's System Development team, this work would be delayed into 2023. Due to this delay, the Associate Director of Nursing has confirmed that Morse will now host the Care Experienced Notifications System. The Clinical Audit team will continue to assist colleagues with a review of the data being collected and reported and will produce system specification documents that will aid the transition of the system from MS Access to Morse.

Best Start Programme/BLISS Accreditation
The Clinical Audit Team continue to support Maternity and Neonatal Services to monitor and report progress against the 23 Best Start recommendations. NHSL have completed 8 recommendations with 15 still on track.

Work has continued towards completion of all core mandatory training requirements for midwives and obstetricians. Despite the ongoing challenges, training has continued both face to face and online. It is hoped with the increased sessions planned for the rest of this year and next year, the trajectories will still

be attainable for 2023. A 3rd Progress Report was submitted to the Scottish Government in June 2022 with work underway to capture staff feedback and to ascertain skill/confidence levels pre/post training.

Maternity Patient Experience is captured weekly within the postnatal ward. Results of this are shared regularly with the teams and displayed within the wards. Regular reports are consistently evidencing both best practice and excellent patient care.

The Neonatal team have made excellent progress towards achieving Bliss Accreditation. Following the latest feedback from Bliss, 96% of standards are meeting all the requirements for assessment. Only 6 (4.4%) of the 137 standards are not yet complete. A parent and sibling room, staff boards, virtual tour and parent passport are all in progress and are expected to be complete by November 2022 with a pre-assessment visit planned before the end of 2022.

Work is about to commence on a sixth Best Start Highlight Report and a second Bliss Highlight Report.

4.3 Corporate Policies Update for Board Report October 2022

The most recent CMT report was submitted on time and highlighted the lapsed policies to be noted and those due for renewal in the coming months. The established Corporate Policies assurance process is working effectively and is meeting the 95% compliance KPI consistently. The team is happy to report that the outstanding policies have reduced from 8 in the springtime to 4 in recent weeks, updating some long outstanding policies.

We have recently updated our tracking system so that departments with "Once for Scotland" Policies will no longer receive regular review reminders about these particular policies. The email reminders for this month have been sent out to the appropriate authors and directors via the tracking system we utilise on Access and the updated policies are now beginning to come through.

All COVID extensions have now ended and processes have returned to normal practice and review schedules. Extension requests can still be submitted, however, these will be considered on an individual basis by Head of Evidence and Director of Quality and will not be granted for less than 6 months. Extensions will no longer be granted to policies that have already received one. Any requests for extensions where this is the case will be assessed by CMT.

Dr J Burns
Board Executive Medical Director
October 2022