ITEM 13

NHS Board Meeting
20th December 2023

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 Executive Medical Director and Executive Director of Nursing. The information within this report is also shared with, and discussed by, the governance groups that report to the Healthcare Quality Assurance and Improvement Committee including the Quality Planning and Professional Governance Group, the Safe Care Group, the Person Centred Care Group and the Clinical Effectiveness Group.

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.

The NHS Lanarkshire Quality Strategy 2023-2029 describes True North statements for the Board and from them, an annual True North Action plan will be developed for each year of the strategy.

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	☒

True North Statements:

We work with our service users to ensure our care is person centred	☒
We deliver the right care at the right time in the right place to the right people	☒
We deliver harm free care	☒
We demonstrate that we are a learning organisation	☒
We implement Quality Improvement and Innovation	☒
We make NHS Lanarkshire a great place to work	☒
We demonstrate compassionate leadership	☒

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 True North Statements identified in the Quality Strategy and the Measures of Success contained within the associated True North Action 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 the corporate risks which have implications for clinical quality. These are reviewed at every meeting and an assessment made if there are any new risks that require to be captured.

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 2023-2029

11. CONSULTATION AND ENGAGEMENT

NHS Lanarkshire's Quality Strategy 2023-2029 was approved by HQAIC in April 2023 and launched in May 2023.

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 October 2023 to December 2023, of plans and objectives set out in the Quality Strategy to achieve the Lanarkshire Quality Approach.

An update of the True North Action Plans was presented to HQAIC in November 2023 which indicated that 6 actions were completed and the others (92) are on track. A further update will be provided at the February meeting. The first edition of the COMPASS newsletter has been published which provides guidance regarding local implementation of the True North actions. This first edition focused on Person Centred Care and was received well at the November HQAIC meeting.
The staff Safety Culture Survey has completed with 2868 responses which is approximately 20% of the workforce. Once the results have been received the Quality Directorate will work with Organisational Development to compare the results with recent i matter results and plan methods to communicate the findings to the organisation. Work will them commence on an improvement plan based on the results.

1. Assurance of Quality

1.1 Child Death Reviews

The Child Death Review (CDR) team continue to make excellent progress, with ongoing support from the National Hub and our Stakeholders.

Since the 1st October 2021 to 31st October 2023, we have received notification of 176 deaths (an increase in 28 since the last report) from the National Record Service (NRS). All deaths continue to be scoped and vetted to determine the best fit for process and review, in line with the Scottish Government criteria. To date, 20 CDR meetings have taken place. The table below provides an overview of all deaths received in the aforementioned timeline, by the Review Type category; and Review Status (Completed/In Progress/Not for Review).

ReviewType	Completed	In progress	Not for review	To be vetted	**Total**
Aftercare		5			**5**
Child Death Review	17	8			**25**
Child Death Review SUDI	3	4			**7**
Neonatal M&M	9	31			**40**
No review - Not care experienced	1		68		**69**
No review < 22 weeks gestation			3		**3**
Police Review		1			**1**
Review led by another Board	6	7			**13**
Review led by another Service	2	7			**9**
Review type to be confirmed		2		2	**4**
Total	**38**	**65**	**71**	**2**	**176**

The CDR team continue to meet with our multi-disciplinary CDR Learning & Review Group (formerly CDR Oversight Group) with the next meeting scheduled for 6th December 2023.
The newly established Public Health Population Governance Group has now taken over from the North Support Care & Clinical Governance Group as the Child Death Review Programme's main Governance group.

The CDR team are continuing to work with the National Hub for upload of completed and signed off core datasets to the Healthcare Improvement Scotland Quality Assurance Dashboard. To date, there has been no national review and no deadline confirmed of when this will be expected. There is a further National Hub meeting for all Boards taking place on 15th January 2024.

Work remains ongoing with our Systems Development Team for a full transition of NHSL Child Death Review tracking data to the LanQIP system. This development is making good progress with the data having now been moved over. The next step of the process is to work on building reports to display this data and information, including actions from learning summaries. This will allow a more efficient way of capturing and displaying data from notified child and young person deaths, and will assist in identifying themes and areas of increase or concern. This function will also offer great support in monitoring actions from our reviews with the ability to pull reports on their updates for follow up, as well as sharing the learning and areas that have seen improvement.

CDR are now using the Learning Bulletin as an initial platform for sharing learning identified from reviews and have now had inclusion in the Bulletin for two editions to date. The CDR team are also working towards the development of a CDR Sharing Learning Pathway with support from our CDR Learning & Review Group. The purpose of this pathway is to clearly identify and map out the flow in which we will share learning from child death reviews, ensuring that we are capturing the correct audience via key groups. This will assist in ensuring that learning and actions from the programme are being given wider awareness not only nationally but locally and that the relevant information is being brought to the focus of the key services involved with children and young people.

1.2 Adverse Events

Work continues to enhance the DATIX incident reporting system to improve ease of recording and reporting for staff in the organisation.

Following the introduction in July 2023 of Kilbryde Hospice as a location onto the Datix system, there have been 24 incidents reported to date. The majority of the incidents have been recorded under the category of falls followed by medication administration and also pressure ulcer incidents.

To support staff recording cardiopulmonary incidents a draft pathway and guidance document have been developed and circulated to all hospital sites for comments. When agreement is reached and documents approved, these will be incorporated onto the Datix system in the form of links, for staff to easily reference.

Initial meetings have taken place to discuss improvements to the process of recording and reporting Infection, Prevention & Control (IPC) incidents on Datix. Consideration is being given to adding new data fields to minimise the current volume of paperwork required for data collection and to maximise any learning from these incidents.

A review of the adverse events web page is being carried out to change the format and layout, incorporating folders for specific areas/topics such as - Patient/Relative Engagement, Writing the Report, Analysis Tools, Templates.

The LearnPro modules have been reviewed and updated to reflect the changes on the Datix system, to make it relevant with current screenshots, wording and descriptions. These have been submitted to the Organisational Development team who are working on this prior to the new versions being made available on LearnPro.

1.3 Duty of Candour

At the time of reporting, there were 127 Significant Adverse Event Reviews (SAERs) commissioned between October 2022 and September 2023.

During the most recent quarter (Q2: July – September 2023) there were 29 SAERs commissioned, 10 of which were retrospectively recorded incidents, occurring in June 2019, January, July and December 2022, January, February, March, May and June 2023.

These retrospectively recorded incidents were recorded as self-harm, wrong/delayed/misdiagnosis, child death and a falls incident following a complaint received.

Currently 28% (35 of the 127) significant adverse events have been recorded as triggering the legislation for Duty of Candour. 85 SAERs have concluded with 42 remaining open and on-going.

From the 35 cases that were recorded as triggering the legislation, all cases were assessed for compliance with the following elements of the regulations recognising if the patient died and there were no relatives to contact or following an attempt, relatives would not engage, this would still count as compliance:

- Apology given
- Patient or Relative informed of the adverse event
- Significant Adverse Event Review commissioned
- Patient or Relative invited to participate in review
- Patient or Relative informed of the results of the review including invite to a meeting

Full compliance was achieved for all concluded incidents.

The addendum to the Duty of Candour Annual Report (2022-2023) has been completed and submitted to Healthcare Improvement Scotland (HIS) and shared within NHS Lanarkshire structures.

All significant adverse events recorded as Duty of Candour are completed, closed and have been assessed for compliance with the elements of the regulations.

There were 42 adverse events reviews still ongoing at the time of publication of the Duty of Candour Annual Report, these have all now concluded, with 20 of these events triggering the legislation, resulting in a total of 53 incidents where duty of candour applied for NHS Lanarkshire during time period April 2022 to March 2023.

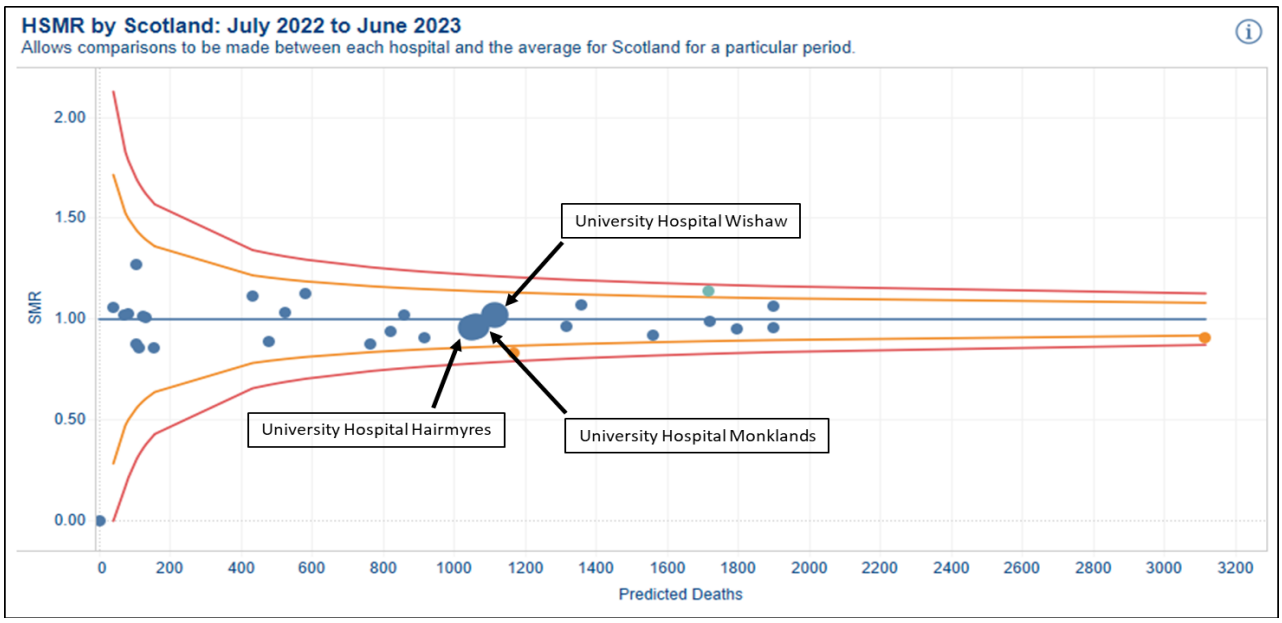
1.4 Hospital Standardised Mortality Rate (HSMR)

The latest release of HSMR data was published by ISD on 14th November 2023. The data includes case-mix adjusted 30-day mortality on admissions from July 2022 to June 2023.
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.

In this model, trends over time are not captured for individual hospitals. However, these are reviewed internally through the Corporate Quality and Safety Dashboard Review Meetings. This will also continue to be monitored through HQAIC.

NHS Lanarkshire is currently displaying 0.98 – no change in ratio from the previous reporting period (April 2022 to March 2023).

The 3 NHS Lanarkshire Acute hospitals are highlighted on the funnel plot as the three larger dots with labels, as below. All hospitals are shown to be within control limits for the current reporting period in comparison to the HSMR for Scotland (1.00).



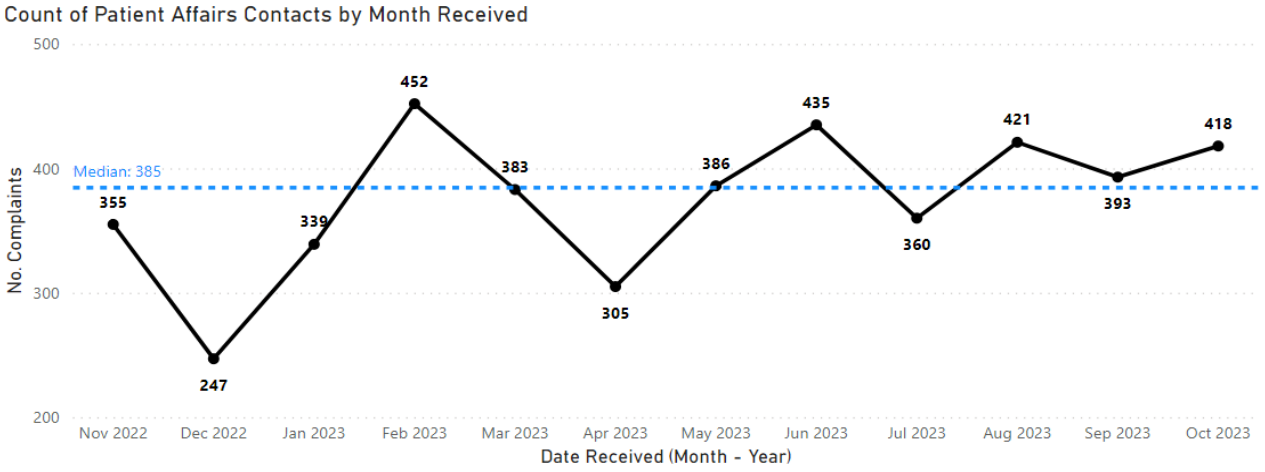
Health Board of Treatment: NHS Lanarkshire

Period: July 2022 to June 2023

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR	Comparison to Scotland on the chart
Scotland	**28,079**	**28,079**	**644,767**	**4.4%**	**1.00**	**n/a**
NHS Lanarkshire	3,159	3,230	69,155	4.6%	0.98	n/a
University Hospital Hairmyres	1,004	1,052	21,939	4.6%	0.95	●
University Hospital Monklands	1,017	1,061	19,736	5.2%	0.96	●
University Hospital Wishaw	1,138	1,117	27,480	4.1%	1.02	●

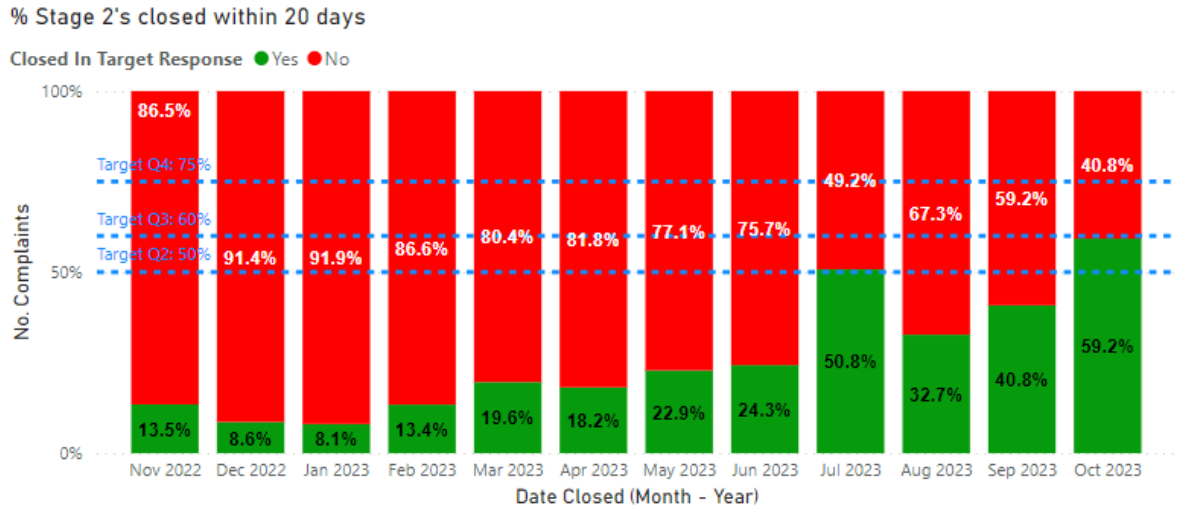
1.4 Complaints

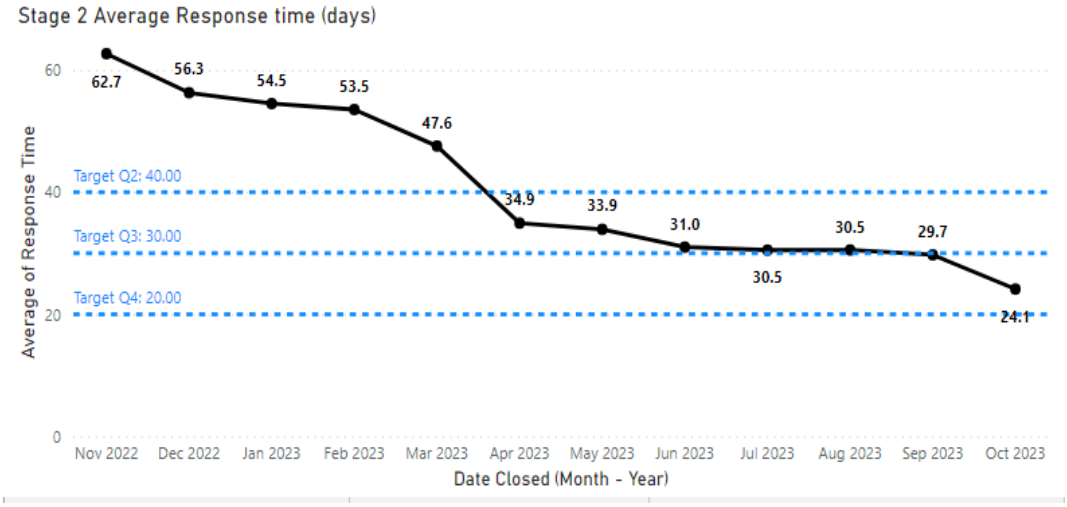
Received activity continues to be above the median. In October 2023, this included 155 enquiries, 164 stage 1 complaints and 74 stage 2 complaints (includes escalated).



Detailed performance information for **closed** activity is incorporated into the Integrated Performance and Quality Report (IPQR). At the time of writing, October 2023 performance information is available:

- **66%** of complaints closed at stage 1 (exceeding target)
- **59%** of stage 2 complaints closed within 20 working days (not meeting target, but improvements made)
- **24 days'** average stage 2 response time (exceeding current target)





The NHS Lanarkshire Stage 2 toolkit (September 2022) has been evaluated by an external expert, and the team have been commended for its excellent approach to managing Stage 2 complaints. The toolkit is an impressive resource which demonstrates a good practice approach to complaints management. The supporting documents are thorough and compliant with the NHS Model Complaints Handling Standards.

In relation to the Escalation Procedure (2023), the external expert noted that:

> "We welcome this Escalation Procedure which focuses on the quality of the complaints response and will be particularly useful in more complex or contentious complaints. You quite rightly reference the SPSO principles of quality investigations and demonstrate a robust process to assess the complexity /risk or impact of a complaint. We agree that some complaints may not follow a linear process and the procedure may require a more flexible or adaptable approach, on a case by case basis perhaps involving separate elements being investigated in tandem."

NHS Lanarkshire's patient affairs and complaints lead showcased some of our complaints improvement work at the recent Scottish Public Services Ombudsman (SPSO) national conference, with NHS Lanarkshire being the only NHS Scotland representative on discussion panels.

Cumulative data for Q1 and Q2 SPSO determinations for 2023-2024 is noted below:

Outcome	**UHH**	**UHM**	**UHW**	**Mat**	**North**	**South**	***Corp***	***Total***	**%**
Upheld	1		2					**3**	**8%**
Partially upheld	1							**1**	**3%**
Not upheld		3	1			1		**5**	**14%**
Not proceeding	7	8	3	3	4		*1*	**26**	**70%**
Other	2							**2**	**5%**
Total	*11*	*11*	*6*	*3*	*4*	*1*	*1*	**37**	**100%**

The high percentage of cases not proceeding, is primarily due to SPSO being satisfied that NHS Lanarkshire have completed a robust investigation, with learning identified as appropriate.

Interim resource has enabled a number of improvements to progress, including:

- Concluding thematic analysis of mental health complaints and commencing analysis for the 'out of hours' service complaints.
- Development of a 'flash report' to improve accessibility and readability of key complaint performance information.
- Reduced drafting delays.
- Further scoping of child-friendly complaints processes and reflections (national implementation currently planned for April 2024).
- Increased person-centred contact from the outset of complaint investigations.
- Enhanced reporting on themes and learning actions. We are in the process of automating reports for learning. Actions will only be closed off when sufficient evidence of the agreed learning from complaints has been returned.
- Progressing implementation of direct entry of Stage 1 complaints to Datix, further promoting that all staff are empowered to resolve complaints at stage 1.

2. Quality Improvement

2.1 Operation FLOW 2

The Improvement Team were commissioned by Operation FLOW 2 Task & Finish Group 4 to use quality improvement methods to support improvement work across the Flow Teams in the 3 acute sites as part of the Task and Finish Groups work on its objectives of embedding the Flow Foundation Bundle (FFB) and developing a Target Operating Model for safe patient flow over the 24-hour period.

Following the previous 2 workshops on the 22nd August and 22nd September, a further workshop was held on 21st November with a wider range of stakeholders including staff working within patient flow teams across the three acute sites and members of the site triumvirates and management teams.

The purpose of this workshop was to describe each of the elements of optimum safe patient flow; Demand, Capacity, Activity, Queue, Flow and Variation and identify what would be required in each of these elements to design the Target Operating Model (TOM) for use across all Flow Teams in the acute sites in Lanarkshire.

At the workshop staff were grouped by job family to review the patient flow Target Operating Model and share their feedback on the roles and responsibilities outlined for site and system patient flow. The groups were supported by a facilitator and individual group feedback was shared and discussed with the wider group.

The stakeholders in attendance have a role in supporting the proposed Target Operating Model. There was valuable discussion about each of the roles within the TOM to establish which were core roles and which were supporting roles. There was also discussion about role blurring and the need for absolute clarity on the purpose, remit and duties of each of the staff roles within the TOM from Band 3 to Band 8c staff.

The feedback captured will inform the ongoing development of the patient flow Target Operating Model to ensure maximum impact. Key stakeholders will be invited back to a future session to further refine the model. Work will be progressed by the Chair of the Task & Finish Group to progress the issues raised with job roles and remits. The outputs from the workshops are reported to the Task & Finish Group 4 and the Operation Flow Executive Group.

2.2 Access QI National Programme

The Access QI collaborative uses quality improvement methods to identify the root cause of waiting times issues in local service and implement solutions to change demand or increase activity, leading to sustainable

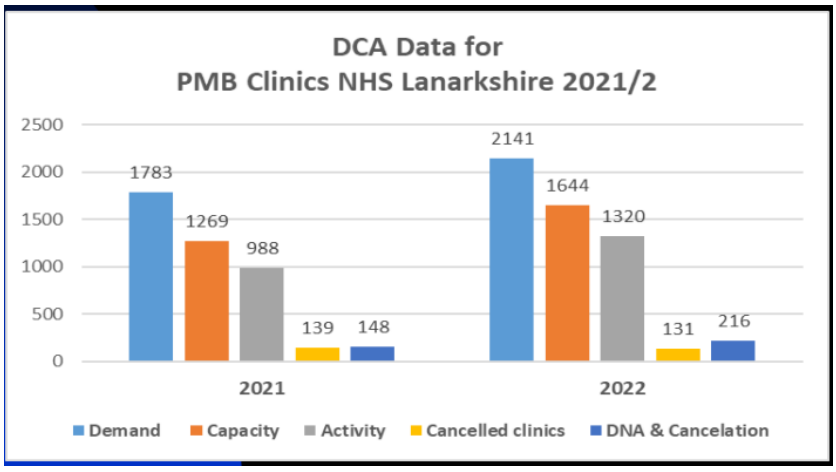
reductions in waiting times. The current phase is focused on supporting Ear, Nose and Throat (ENT), Gynaecology and Urology services through a Scottish Patient Safety Programme style improvement collaborative.

In August 2022 a team from gynaecology from NHS Lanarkshire joined the programme led by a Consultant in Obstetrics & Gynaecology. The focus of the improvement work is to reduce waiting times for patients with Post-Menopausal Bleeding (PMB) and a suspicion of cancer(SOC) to the PMB clinic. At the start of this work patients with PMB are referred under the SOC pathway (risk of endometrial cancer around 9.6%), with a target to be seen within 2 weeks. This target has not been met for long time.

The use of HRT increased remarkably in the last few years and the incidence of PMB is more common in women on HRT. A lot of evidence suggesting the PMB/HRT subgroup of patients have a lower risk of endometrial cancer comparing with PMB only patients (odds adjusted ratio 0.229, Clarke 2018)

The aim would be to achieve national / regional agreement on separating the PMB/HRT subgroup from the PMB SOC pathway, where the target would be for patients to be seen as urgent within 6-8 weeks. The aim of this improvement work is that by 31st January 2024, 95% of the new patients attending the PMB clinics through the cancer referral pathway within NHS Lanarkshire should be seen within 2 weeks from their referral.

Quality Improvement (QI) methodology and tools were used to provide the improvement approach. The initial stage of the improvement journey focused on Understanding Your System so that we can properly understand the problem.



Demand, Capacity, Activity and Queue (DCAQ) data was used to provide a baseline for the data and also to monitor progress against the tests of change being tested in the improvement work.

Process mapping of the current patient pathway was carried out to identify the differences between "work as planned" and "work as done", variation and waste.

Based on the baseline data above for the 2021/22 and the outputs from the process mapping the team generated some change theories to test:

1- Close the 26% Demand versus Capacity gap; reduce the increased demands due to more PMB / HRT referrals by amending the pathway and removing this subgroup from the SOC cancer pathway.

2- Close the 21% Capacity versus Activity gap; increase the utilisation of our existing capacity by preventing undelivered clinics and reducing the lost appointments (short notice cancelation and 'Fail to Attends' (FTA).

3- Explore other modules of care if required; clarify the one-stop approach. It may be cost effective but feedback is that there is less satisfaction for patients & staff and need logistics for Ultrasound.

The team moved on to the Testing Changes stage of the improvement journey using the Model for Improvement and Plan, Do, Study, Act (PDSA) Cycles.

PDSA 1- Amending clinical pathway by gaining agreement from local and national governance groups to change the clinical pathway and to separate PMB/HRT from the PMB/SOC subgroup. This will optimise the utilisation of our limited resources and allow us to direct them to target the high risk group. It will also increase satisfaction for all PMB and this HRT subgroup, provide reassurance and reduce anxiety. In NHS Forth Valley a team have started testing this from Jan 2023.

In NHS Lanarkshire we have carried out an Evidence Review (14 papers) supported by the National Access QI team so that our improvement work is supported by the most up to date evidence base. In addition, two retrospective audits covering around 3 years, 4818 PMB patients including 287 patients on HRT have been carried out.

Study period	November 2017 – July 2020	February 2022 - April 2022
Total PMB referrals	4290	528
PMB on HRT / total PMB	186/4290 (4.3%)	101/ 528 (19.1%)
On HRT <6 months	24/186 (12.9)	11/101 (10.9%)
TV USS	186/186 (100%)	101/101 (100%)
Abnormal TV USS	53/186 (28.5%)	36/101 (35.6%)
Hysterscopy	58/186 (31.2%)	45/101 (44.6%)
Abnormal hysteroscopy	28/186 (15.1%) 28/58 (48.3%)	16/101 (15.8%) 16/45 (35.5%)
Histological Assessment	92/186 (49.4) %	35/101 (34.7%)
Histological Abnormality (cancer / hyperplasia)	0 (0%)	0 (0%)
seen within 2 weeks	0 (0%) ???	0 (0%)

These findings supported the option of amending the clinical pathway and creating a dedicated pathway for the PMB/HRT patients with a wait time up till 8 weeks rather than consuming the SOC pathway clinic slots.

Following agreement by the national clinical group to separate some subgroups from the cancer pathway to reduce demands and stream patients to the right pathway a test of an amended pathway has been in place since 15th October 2023.

Data is being collected and will be analysed to identify if the change results in the planned improvement in waiting times.

PDSA 2 - Setting up the system to ensure all the planned clinics will be delivered. As part of the planning for clinic capacity a quarterly update report has been developed and is shared with all of the Consultants who carry out PMB clinics advising them of the number of clinics to be achieved throughout the remainder of the year to meet the agreed targets. This ongoing reporting will help to monitor and reduce / prevent planned clinic cancellations.

PDSA 3- Setting up a system to reduce the numbers of FTA and short notice cancellation. Data analysis had identified a higher number of FTA and short notice cancellations for clinics held on a Monday. A test of a new additional reminder process was planned however there were issues with the resources available to support this, administration staff time 2 hours per week, and this is currently trying to be resolved.

As a result of this work in NHS Lanarkshire there is now a national move to change the HRT pathway and the Consultant in Obstetrics & Gynaecology has become a member of the national team working

towards establishing a national pathway for postmenopausal bleeding across Scotland. The team have also attended two further Access QI Learning Sessions to share their work.

This work has also been presented at the National Centre for Sustainable Delivery Modernising Patient Pathways Programme Gynaecology Specialty Delivery Group.

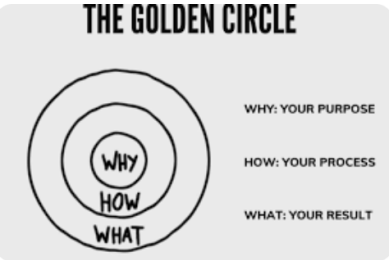
2.3 Care Assurance Framework and Standards – Paediatric Nursing

As part of the NHS Lanarkshire Paediatric Modernisation Board, a Short Life Working Group led by Associate Nurse Director, North HSCP commissioned the Improvement Team to provide robust quality improvement methodology to the review of the Care Assurance Framework including Care Assurance Standards to the inpatient paediatric wards 19 and 20 at University Hospital Wishaw and the Integrated Community Children's Nursing Service (ICCNS).

A workshop was held on 26th October 2023 and staff from both the wards and the community service attended. The Golden Circle as described by Simon Sinek was used as a framework for the session.

The Golden Circle includes:

1. Why – Your Purpose
2. How – Your Process
3. What – Your Result



In reviewing any area of work we should always start with why. Staff usually know what they do and how they do it but they do not always know why they do it. This lack of understanding of the purpose can affect the engagement of staff with undertaking the what and how and can therefore mean that we don't always see the results we would like to.

The paediatric nurses started with the why and described why a Care Assurance Framework and Standards were important and needed in their area of work. They described it as being vital to be able to demonstrate to children and their families that the care they provided was safe, effective and child centred. They also agreed that it was also vital for staff to have evidence of the high standard of quality and professional care they provide.

The nurses designed their own definition of Care Assurance for the inpatient and ICCNS areas. They were fully engaged in this and proud of what they designed.

They were then supported to review the standards in use at present in NHS Lanarkshire and NHS Lothian and from this identified a list of Core Standards for use in their service.

The workshop enabled the nurses to design their:

1. Why – Your purpose, to have agreed Care Assurance Standards to be able to evident that the care provided is safe, effective and child centred.
2. How – Your process, to have agreed the Care Assurance Framework and Core Standards themes in use in the service.
3. What – Your result, to have evidence of the quality of care delivered by the service.

A further workshop is planned for November 2023 to describe in more detail the Core Standards and to design a data and measurement approach to collecting and analysing the data over time to provide assurance that the quality of care is being achieved.

The outputs from this work will be reported into the Paediatric Modernisation Board.

(Sinek, S. (2011). *Start with why*. Penguin Books.)

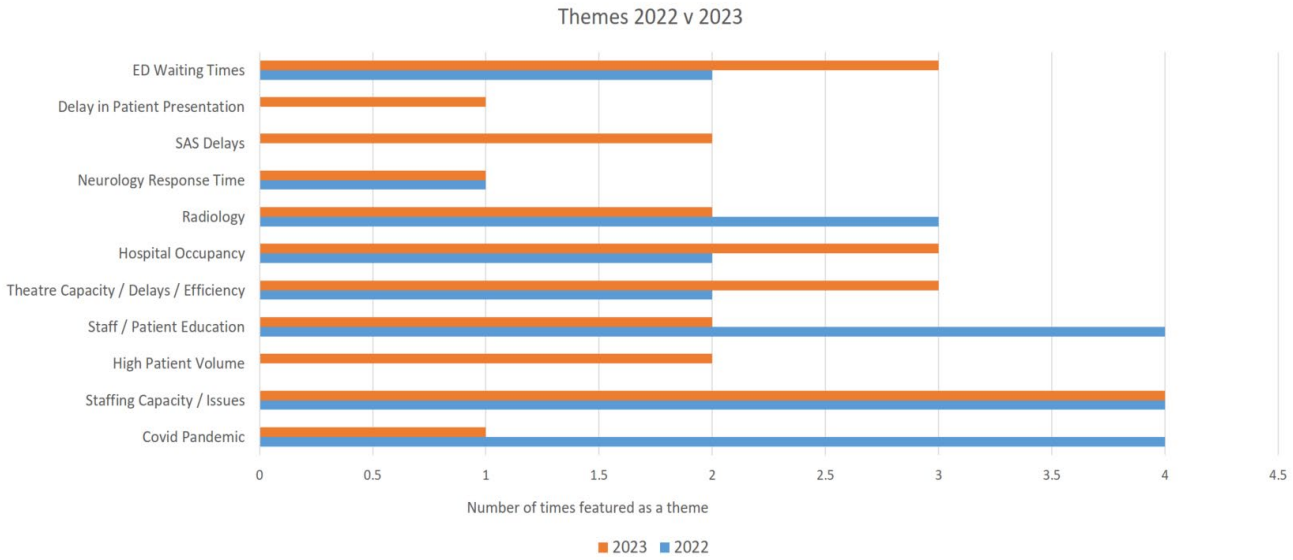
3. Evidence for Quality

3.1 National Audit Activity

Scottish National Audit Programme (SNAP)
In May 2023, SNAP wrote to Board Medical Directors highlighting Key Performance Indicator (KPI) outlier status across seven of the nine national audits. The three negative outliers flagged for NHS Lanarkshire spanned two audits, the Scottish Renal Register (SRR) and Scottish Hip Fracture Audit (SHFA). Audit Leads in both areas completed a formal investigatory report and action plan which was submitted to SNAP in June 2023 along with our comments in relation to a number of other KPIs that were flagged for action, but were not considered formal outliers. Progress updates have been provided via Clinical Effectiveness Group (CEG) and Quality Performance & Professional Governance Group (QPPGG) throughout the year. Six positive outlier KPIs were also highlighted and audit leads were written to by the Director of Quality, in order to recognise their efforts in achieving performance significantly better than the national average.

NHS Lanarkshire's local governance process for managing national audit outliers was reviewed earlier this year and the process now involves Divisional Directors at an earlier stage and also provides additional guidance and support for Audit Leads when developing the investigatory reports and action plans, ensuring a consistent, quality return from NHS Lanarkshire.

A thematic analysis of contributing factors to non-achievement of national audit KPIs was completed for the 2023 audit outliers and a comparison was made against the 2022 themes. Results are displayed below and were discussed at the Clinical Effectiveness Group. The group concluded that many of the themes were all linked to system issues in capacity and flow and access to Radiology is recognised as a national problem. Each KPI has an action plan to address the other issues such as any education requirements.



The Clinical Audit Team are testing a process to provide in-year progress against the Action Plans that are developed in response to SNAP outliers. A progress template has been developed to make the return easy to complete and less burdensome for Audit Leads. The template was shared with Audit Leads from the Scottish Hip Fracture Audit as part of our test of change, in September. The completed template has been received and an update will be provided via Acute Clinical Governance & Risk Management Group with assurance/escalation via CEG/QPPGG. Next steps will be to request completion of the template by Stroke and Renal Audit Leads.

Scottish Cardiac Audit Programme (SCAP)
The Scottish Cardiac Audit Programme runs in financial year as with the other national audits. The 2022/23 outlier notifications for SCAP were received in August 2023 and the Investigatory Report was completed by Cardiology Audit Leads and returned to Public Health Scotland (PHS) in early October 2023. The report highlighted one negative outlier, which was 'Time from First Hospital to PCI within 72 hours for NSTEMI patients'. Lanarkshire are achieving around 38% in this KPI, against the UK average of 55%. Very few Boards in Scotland are currently achieving this KPI. An Action Plan has been submitted to PHS and will be taken forward by the Cardiology Service Improvement Group.

NHSL was also flagged a positive outlier for our 'Door-to-balloon within 60 minutes (STEMI)' KPI. The Director of Quality has written to leads to congratulate them and their teams on this achievement. NHSL were a positive outlier (3SD or more from the mean) with 83.9% performance against a UK benchmark of 73.6% and the second highest performing board in Scotland.
From 2023/24, the SCAP audit data is now submitted quarterly, with Q1 and Q2 data already submitted for this year. There has been real improvement in the quality and completeness of this audit dataset as a result of collaborative improvement efforts between the Cardiology Team and the Clinical Audit Team.

3.2 Local Audit Activity

Local Clinical Audit Projects
Between 1st April and 22nd November 2023 there have been 54 new clinical audit projects submitted through the Clinical Quality Project Register. These projects involve a wide and varied range of sites and specialties.

The Project Register now allows uploading of clinical audit reports and findings (posters, presentations etc.) to enable better sharing of learning from audit. Project leads are contacted as part of the standard follow-up process and asked for an update on progress and to share any findings. Any member of staff can search for a project and view any associated documents.

Public Protection
The Clinical Audit Team continues to support the Public Protection Service with data management and reporting. Dashboard style reporting is in development, with both new and current measures being developed and adapted. The transfer of the Consultancy Calls and Adult Protection databases to LanQIP were completed earlier in 2023 and the service is now using both without issue. Further to this, the Gender-Based Violence Consultancy Call database has also been transferred to LanQIP, bringing this work back under the management of the Clinical Audit Team. Close working will continue with the service on reporting and discussions continue in respect of transferring the remaining systems hosted by the Clinical Audit Team to LanQIP.

Food, Fluid and Nutritional Care (FF&NC)
FF&NC Committee meetings have been re-established, with part of the group's remit being to develop and monitor an audit programme for Food, Fluid and Nutritional Care and to develop and agree a reporting structure. A short life working group has been established to identify and review audit tools and to develop a timeline of planned audit activity.

MS Access Databases – MSO365 License Changes
As part of the wider organisational migration to Office 365, work continues in transitioning the MS Access databases hosted on the clinical audit server to alternative platforms. In addition to the four databases that have been transferred to LanQIP to date, we expect further work to commence in respect of transferring the next cohort over in the coming quarter. Further to this, discussions have taken place with colleagues from TRAK in regard to the potential transfer of the Stoma service database.

3.3 National and Local Evidence, Guidelines and Standards

Effective Use of New Technologies
Our process for the review and assessment of Health Technologies publications from Scottish Health Technology Group (SHTG) and Interventional Procedures Guidance from National Institute for Health & Care Excellence (NICE) continues to be effective in assuring that new publications of Health Technologies are appropriately considered within NHS Lanarkshire.

There have been 32 new publications from January 2023 to October 2023. These were appropriately reviewed and those which are relevant to NHS Lanarkshire and for further consideration have been disseminated on for assessment at the Governance Groups of Acute, North SHCP and South HSCP.
All assessment decisions have been reported back to the Clinical Effectiveness Group (CEG) and any outstanding assessment reports from the 3 Governance Groups are also reported to this Group.

3.4 Clinical Standards
Healthcare Improvement Scotland(HIS) have published details of the following new clinical standards.

Standards Final:
Bairn's Hoose Standards

- Final standards were published in May 2023

Bowel screening standards

- Final standards were published in August2023

Standards in draft phase:
Core Screening Standards

- Draft standards were published in May 2023 with final standards expected later this year.

Congenital Heart Disease Standards

- Draft standards were published in July 2023 with final standards expected November 2023

Standards for cataract surgery: all complexity, all healthcare settings

- Draft standards were published July 2023 with final standards expected December 2023

All these published standards have been appropriately disseminated within NHSL and reported through Clinical Effectiveness Group.

3.5 Realistic Medicine
A meeting of the Realistic Healthcare Group took place on the 8th November with invited members from the Scottish Government Realistic Medicine team. The NHSL team provided updates on activity within the board on:

- Shared decision making survey
- Primary care toolkit
- Raising awareness on realistic medicine within NHSL internally
- Value based health and care action plan

There were also discussions on health literacy and the realistic medicine alignment of their plans to the True Norths plans and reporting the progress of work through the Clinical Effectiveness Group.

There were also 2 presentations on the day:

1. TEC Team spoke about Telecare, ConnectMe, NearMe, BlantyreLife and the community alarm system redesign. This work provides many benefits such as:
    - Reducing health inequalities
    - Reducing isolation

- Health promotion
- Empowering self-management of long term conditions (reducing GP and outpatient appointments)

2. One of the Realistic medicine leads provided an update on her work using shared decision making for high risk surgical patients currently waiting for surgery from the following specialties:
    - Colorectal / general
    - Vascular
    - Orthopaedic
    - Ophthalmology

    120 patients have been seen with results demonstrating that when given time to explore the possible implications and complications in more detail, 50% of patients chose not to proceed with the procedure.

Dr C Deighan
Board Executive Medical Director
December 2023