NHS Board Meeting
29th March 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 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 January 2023 to March 2023, 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.

The development of the New Quality Strategy for 2023-2029 is complete and will be presented at the April HQAIC for endorsement. From May 2022 the strategy has been discussed in various forums to allow staff to be involved in the development. There has also been good staff and public feedback that has been reflected in the document. A draft of the new strategy was presented to CMT and HQAIC in February 2023 and feedback from the groups has been considered in the current version. Comments have been supportive and the style of the new strategy welcomed.

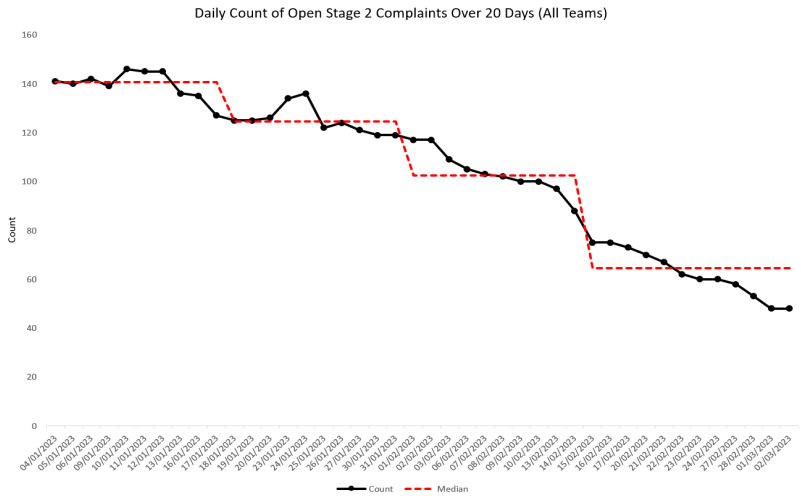
2. Assurance of Quality

2.1 Patient Affairs

Since transition of all patient affairs staff to the quality directorate, the team have worked together to reduce the backlog of Patient Affairs cases which has built up over the last 12-18 months. This backlog has been caused by multiple factors including reduced patient affairs staffing levels at various stages throughout the year, delays in statements and sign-off, increased complexity of complaints etc.

A significant development has been made in the automation of data to assist with workflow, prioritisation and identifying bottlenecks and delays for corrective action. Reports have been developed to identify current stage, specialty, triage category, and whether there is involvement from elected representatives or media. Information is circulated on a weekly basis to senior site staff, enabling easier identification and escalation of delays. Data on open cases is now reported to CMT on a fortnightly basis.

An escalation procedure has been developed and is being piloted on stage 2 complaints received from 1st March 2023. The escalation procedure introduces a number of timeline 'checkpoints' for statements and review of drafts to be received from staff. This procedure is based on a number of core principles including recognition that the thoroughness and quality of investigation should not be compromised by attempts to meet timescales.



The chart opposite highlights the progress made in addressing the Stage 2 backlogs since beginning of January 2023. It should be noted that the work to reduce the backlogs commenced in early November 2022 and backlog numbers were much higher at this point, but we only commenced tracking open cases in January 2023.

Type of Contact Received Vs Complaint Handling Team

Type	Corporate	PC North	PC South	UHH	UHM	UHW	Total
Enquiry	83	54	29	92	43	101	**402**
Stage 1 Complaint	12	29	11	66	79	91	**288**
Stage 2 Complaint	3	50	4	27	34	22	**140**
Compliment	1	12	20	11	7	5	**56**
Concern		2				37	**39**
Stage 2 Complaint - escalated	5	2	1	9	11	6	**34**
Access				2		1	**3**
Suggestion		1				2	**3**
Total	**104**	**150**	**65**	**207**	**174**	**265**	**965**

Q3 reports have been circulated to governance committees.
In summary, between 1st October 2022 to 31st December 2022 patient affairs received 965 cases. The table opposite displays the detail.

SG data was published in December 2022. Whilst acknowledging that performance may be influenced by a number of factors, including nature of services and resource, some comparative analysis is helpful. There is also variation in when complaints are opened and closed, impacting on performance.

Performance Indicators	NHSL 20-21	NHSL 21-22	Territorial Boards 21-22	NHS Scotland 21-22
Closed at Stage 1	62.9%	62.3%	49.3%	51.4%
Closed at Stage 2	30.8%	29.7%	37.3%	36.7%
Closed at Stage 2 (escalated)	6.3%	8.1%	13.5%	11.9%
Stage 1 – closed in 5 working days	78.8%	72.6%	72.7%	72.9%
Stage 2 – closed in 20 working days	51.2%	39.8%	50.3%	52.1%
Stage 2 (escalated) – closed in 20 working days	58.6%	30.2%	30.5%	30.9%
Total complaints closed within timescale	69.1%	59.4%	58.7%	60.3%

The SPSO are currently advising complainants that there is a delay of up to 7 months in allocating a Complaints Reviewer. There is also an increased focus on early resolution, with fewer cases proceeding to full investigation.

SPSO Final Determinations Received (1 October 2022- 31 December 2022):

Outcome	UHH	UHM	UHW	North	South	Corporate
Upheld	-	-	1	1	-	-
Partially upheld	-	-	-	-	-	-
Not upheld	-	-	-	-	-	-
Not proceeding	6	2	3	4	1	1

2.2 LanQIP

The redevelopment of the Clinical Audit Project Register is now complete and went live in early January. A comprehensive reporting solution is currently being developed to support reporting of Audit activity across NHS Lanarkshire and will be complete by the end of March 2023.

The programme of Access database redevelopment has been progressing well with five systems redeveloped and one already migrated and made live for users. The remaining systems will be migrated and report development will be completed by the end of March 2023.

Work continues to develop and embed the Morbidity & Mortality system across NHS Lanarkshire. A recent development to capture user staffing roles was completed and will be used to further improve reporting. An evaluation questionnaire is currently live and being populated by the users of the

system with some suggestions for improvements already received. Over the next few months a series of training videos will be created to aid in training and rollout of the system.

Significant developments have been made to enhance reporting for complaints including various paginated reports and dashboards that support the complaints team in the handling process and now allow staff across the organisation to access real-time dashboards on various complaint measures.

2.3 Adverse Events

The adverse events team continue to enhance the Datix system, as well as producing updated guidance, developing pathways and resolving daily requests and issues that arise. Some of the areas of development work progressed during 2022 include:

Ease of reporting and improved quality of data:

- Redesign of the Datix Incident form to include improved descriptions/information, colour coding, and better linkage between fields.
- Ongoing review and rationalisation of all Categories on Datix. To date there have been 124 categories in total that have been assessed, 44 of these retained and unchanged, 42 categories removed and 38 reviewed and renamed or merged with a more appropriate categorisation. This work is ongoing and involves working closely with Risk Facilitators to further improve category lists. Staff briefings and other links are being used to raise awareness on any updates to Datix categories.
- Development of a new Falls section on Datix which includes the full national agreed dataset and a new set of sub-categories.
- Review of the Pressure Ulcer section in Datix to allow consistency of reporting and data analysis across NHS Lanarkshire. This new dataset is supported by a guidance tool, an assurance process and a new pathway to support staff when recording these incidents to record accurate PU grades.
- Colour coding of relevant categories and subcategories on Datix to identify Never Event incidents to allow staff to report these easily, along with development of a new guidance document with a detailed list of each Never Event and how these should be recorded on the system.
- Work has commenced to develop a new dataset for Unplanned Admissions to ICU to establish if things could have been done differently to prevent the admission. This new dataset will be recorded using the "Ill Health" category and sub category "Unplanned admission to ICU". This is currently being tested at the UH Wishaw site and when approved will be rolled out to the other sites.

Update of functionality to allow better data management:

- Redesign of the Datix Claims module and transfer to the Datix web version.

Improved reporting pathways:

- Development of a new National Screening Programme dataset to ensure these incidents are escalated appropriately to Board Screening Coordinators, and where appropriate to national screening teams in National Services Division.
- A new Cardiac Arrest category and dataset was developed on Datix and processes for capturing the data are currently being tested on each Acute Hospital site. Once approved, guidance will be developed and shared to assist staff recording these incidents and the data can then be extracted directly from Datix to produce the site and corporate dashboards. This work allows improved review of cardiac arrests to determine if deterioration could have been identified earlier and the arrest prevented. The data also collects information on DNACPR and treatment escalation plans which would identify if response to cardiac arrest had previously been considered.

Improved monitoring:

- Development of a new Adverse Events dashboard to demonstrate compliance of all Category 1, 2 & 3 incidents against agreed timelines (closed <10, 30, 90 days). All Risk Facilitators were given a

demonstration on how to run the reports to show the data relevant to each hospital/site. The plan is for this dashboard to be made available on LanQIP in 2023.

- A review of the process for reporting and recording complaints onto Datix is underway, along with the Actions Module which is currently being developed. The current templates used by the Complaints team are being reviewed and updates carried out accordingly.
- Monthly SAER progress reports were redeveloped using Power BI software. The next planned step is to transfer these reports onto a live, interactive Dashboard format available on LanQIP which will allow the Risk Facilitators access to pull the data for each specific site at any time.

Learning:

- The NHSL Learning Bulletin continues to be produced to capture and share any learning from adverse events, complaints or any other areas where there's improvement work going on. A schedule of dates has been developed for publication of each edition; this will be on a quarterly basis.
- 343 staff have attended training on Significant Adverse Event Reviews which includes a reminder of Duty of Candour requirements, system thinking and Human Factors. Other Boards have requested places on this training which has been accommodated for a fee.

2.4 Child Death Reviews

Following completion of our first learning and implementation year, the Child Death Review (CDR) team are continuing to make excellent progress, with ongoing support from the National Hub.

Since the 1st October 2021 to 28th February 2023, we have received notification of 99 deaths from the National Record Service (NRS). All deaths continue to be scoped and vetted to determine the review and outcome decision, in line with the Scottish Government criteria. To date, 10 Child Death Review meetings have taken place. There are a further 4 CDR meeting's scheduled. The table below provides an overview of all deaths received in the above timeline, the review type category and progress status.

ReviewType	Completed	In progress	Not for review	Total
No review - Not care experienced		5	35	**40**
Neonatal M&M	9	13		**22**
Child Death Review	10	5		**15**
Review type to be confirmed		9		**9**
Review led by another Board	2	2		**4**
SUDI		3		**3**
Police Review	1	1		**2**
Review led by another Service	1	1		**2**
Aftercare		1		**1**
No review < 22 weeks gestation			1	**1**
Total	**23**	**40**	**36**	**99**

The last CDR Implementation Group meeting took place on 30th November and this group membership has now formed our CDR Oversight Group. The first meeting for the CDR Oversight Group took place on 9th March 2023. The overarching purpose of the Child Death Review (CDR) Oversight Group is to consider and monitor child death reviews in NHS Lanarkshire to ensure that every child and young person receives an appropriate and high-quality review in the event of their death and that learning, improvements and best practice is captured and shared from reviews across services, the wider organisation and nationally as appropriate.

In terms of governance, the CDR group presented at the North Support Care & Clinical Governance Group on the 8th December 2022 and plan to continue to present to this group until the new Public Health Population Governance Group is formed.

The reviews to date have produced several learning points and actions have been taken. A couple of examples are listed below:

- Family advised they did not receive support for meals during their stay in Wishaw causing significant financial implications, and also felt uncomfortable about leaving the child's side in addition to this. The Child & Young Person family fund is now in place. Parents are now also offered breakfast daily on the ward. There is also an information leaflet for parents displayed at every bed in the ward which signposts them to financial support and other relevant information.
- Some services do not have access to an up-to-date list of support services for grieving families. Meeting held with Child Bereavement UK. Information on direct referrals for bereavement support discussed and process for families to refer. CBUK information leaflet shared to allow us to share with staff and families both electronically or by post. National Hub also creating a family and carer leaflet for sharing, signposting to various contacts of information.

The National Hub launched the live Healthcare Improvement Scotland Quality Assurance Dashboard in February 2023 and all Health Boards are now invited to begin the upload and input of core datasets from each review to this secure portal. This milestone launch will begin to allow a national review and analysis of data across Scotland to share wider learning across all Health Boards.

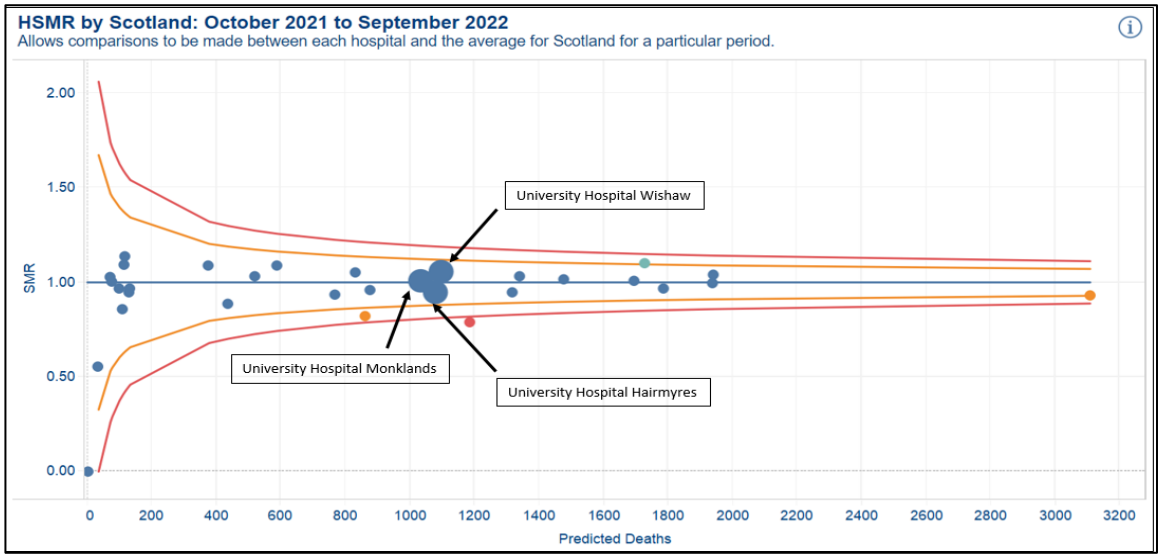
Work is currently ongoing with our Systems Development Team to develop a more efficient system in LanQIP for tracking and reporting child death review status and action plans.

To date, there has been no formal confirmation from the Scottish Government on funding for financial year 2023-2024.

2.4 Hospital Standardised Mortality Rate (HSMR)

The latest release of HSMR data was published by ISD on 14th February 2023. The data includes case-mix adjusted 30-day mortality on admissions from October 2021 to September 2022. 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 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).

In this new 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 1.00, a decrease of 0.01 since the last reporting period.



Health Board of Treatment: NHS Lanarkshire

Period: October 2021 to September 2022

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR	Comparison to Scotland on the chart
Scotland	**27,786**	**27,786**	**607,883**	**4.6%**	**1.00**	**n/a**
NHS Lanarkshire	3,224	3,209	65,389	4.9%	1.00	n/a
University Hospital Hairmyres	1,023	1,078	20,689	4.9%	0.95	●
University Hospital Monklands	1,042	1,033	18,442	5.7%	1.01	●
University Hospital Wishaw	1,159	1,099	26,258	4.4%	1.05	●

2.5 Quality Data & Measurement

The team have liaised with senior leads from Psychological Services to develop a reporting dashboard to assess site compliance with the Record Keeping Audit (RKA) tool. This would ensure all disciplines are afforded the opportunity to measure against the NHSL Core Record Keeping Standards; to improve record keeping practice; to share information related to audit findings within NHSL; and to aid in evidencing the requirement of registered practitioners.

The Data & Measurement Team continue to participate in the Multidisciplinary Team (MDT) approach to reducing Care Home Resident Attendances in Emergency Departments Project, which seeks to reduce the number of care home resident transfers to Acute Emergency Departments within Lanarkshire. The team have developed MDT templates to generate automated calculations to assess cost savings, and created PIVOT tools within the MDT Project dashboard to review MDT statistics, alongside medication information, number of falls etc.

The Child Health Dashboard Quality Indicators have been reviewed to ensure these still meet the requirements of the Children and Young People's Health Plan (CYPH) for Lanarkshire, which is now due for review in March 2023. Smoking Status; Child Health Reviews; Developmental Concerns; and Breastfeeding continue to be headline measures.

3. Quality Improvement

3.1 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.

NHS Lanarkshire has a team from gynaecology in the programme led by Dr Adeeb Hassan, Consultant in Obstetrics & Gynaecology.

The Improvement work is continuing to progress well although work slowed down slightly over the busy festive period and throughout January. The project team are well engaged. Some of the team attended the national Learning Session 3 in February 2023 with a focus on the theory of change, change ideas and measurement, all of which will be the focus when the team meet at the end of the March. The aim of the project has been further discussed and remains "By February 2024, 95% of the new patients attending the post-menopausal bleeding clinics through the cancer referrals pathway with NHS Lanarkshire should be seen with 2 weeks from their referral".

3.2 Achieving Excellence in Quality Improvement (aEQUIP)

NHS Lanarkshire has its own in house Quality Improvement (QI) education programme called aEQUIP. The programme is an introduction to Quality Improvement theory, methods, tools and techniques.

It enables participants to learn about and practice using QI methods. Enabling staff to move from an idea for an area that could be improved, through the stages of the improvement journey to be able to implement and evaluate their change ideas, then sustain their improvements.

This is delivered virtually over 4 x 2 hour sessions, using MS Teams.

During this year there have been 4 cohorts of the programme with a total of 118 staff taking part. Participants range from a variety of professions, roles and areas with NHS Lanarkshire.

To support implementing their learning, participants are asked to use the theory and practical skills to an area of their work. The following are examples of what participants said they would apply their learning to:

- Increasing the number of self-referrals within the care home liaison service
- Standardisation within the financial reporting
- Working with SLC in the Telecare team who are coordinating the analogue to digital alert alarm change over which has to be completed by 2025.
- Aim to reduce waiting times for psychological therapies to 18 weeks from referral to treatment
- Self-management graded exercise programme to be accessible to eligible stroke patients every day

Participants are asked to provide feedback about the course in some detail relating to each aspect of the programme so that we can continually improve it. Some of the overall feedback received was:

- *The virtual teams was better than I expected still valuable information gained*
- *It was an excellent course, very well organised.*
- *I did not have any knowledge or understanding of quality improvement before undertaking this course and have enjoyed the learning experience and I really enjoyed the course.*
- *It was absolutely brilliant! Perfectly paced and very informative.*
- *A very useful and interactive course.*
- *I enjoyed the course and think the content will be really relevant to my role.*

3.3 Scottish Patient Safety Programme Acute Adult Collaborative – Falls

The Scottish Patient Safety Programme (SPSP) is a national quality improvement programme that aims to improve the safety and reliability of care and reduce harm. Healthcare Improvement Scotland (HIS) launched the SPSP Acute Adult Collaborative on 22nd Sept 2021. NHS Lanarkshire are part of the Collaborative. The Collaborative has two workstreams; Falls and Recognising Deterioration. A partnership agreement has been agreed between Healthcare Improvement Scotland and each NHS Lanarkshire.

The Falls improvement work focuses on the reduction of inpatient falls and falls with harm. A driver diagram, change package and measurement plan has been co-designed and tested to describe aims, change ideas and measurement. The individual areas have developed their own aim statement such as the UHW units listed below have the aim of reducing inpatient falls by 20% by September 2023.

Informed by the results of the mapping exercise carried out in Dec 2021 and the falls data for each ward, the triumvirates at each Operational Unit identified wards/teams to be included in the SPSP Acute Adult Collaborative (Falls). These are:

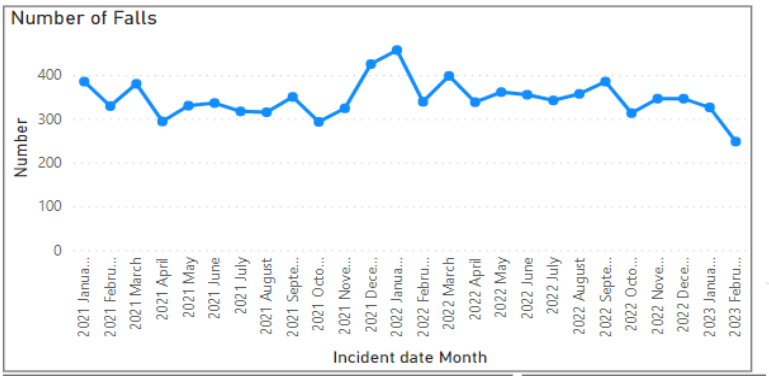
- UHH – Wards 14, 15 and 16. Acute Medical Receiving Unit and Stonehouse Hospital.
- UHW – Emergency Receiving Unit, wards 5 and 11.

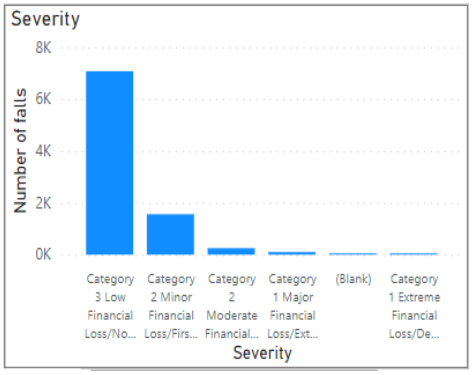
- UHM – Wards 10, 18 and 20.
- North – Kilsyth Victoria Hospital, Ward 24 at UHM and Logans Medical Practice, Wishaw.

All sites are progressing with planning and understanding their falls data, patterns, gaps and inconsistencies in their system in order to create change ideas for testing. Some areas have started testing in small but rapid PDSA cycles- supported by the QI team. Although teams are in early stages of the improvement journey- there has been widespread engagement and progress.

Change ideas being tested include; patient and staff placement, welcome pack including falls risk information, yellow wrist bands for patients at risk of a fall, falls safety walkrounds and physio and OT led activity class on a Friday.
Data is submitted to Healthcare Improvement Scotland as part of the Collaborative approach and the review by HIS of our most recent data submission shows our system to be stable in relation to falls.

Our local Falls Dashboard enables data to be viewed at ward, site and organisational level.





3.4 NHS Lanarkshire Infection Prevention & Control (IPC) Collaborative

NHS Lanarkshire launched an Infection Prevention & Control (IPC) Collaborative in June 2021 to support teams to make improvements in areas to reduce infection rates. Each operational Unit was invited to nominate 10 teams to take part. There are currently 41 teams in the collaborative with 28 (68%) teams actively engaged at present. Across the sites, teams are at different stages of their improvement journey.

UHH have 3 teams creating conditions and understanding their system and 5 teams testing changes. UHM have 4 teams testing changes and 4 teams implementing changes. North HSCP have 2 teams creating conditions and understanding system, 4 teams testing changes and 2 teams implementing. South HSCP have 1 team testing changes and 3 teams implementing. There are various change ideas being tested across sites for different projects.

For Peripheral Venous Catheter (PVC) work, changes being tested include the use of blue paperwork to raise awareness of PVC bundles in patient notes, using PVC bundle sticker prompts on PVC stations and desks, room PVC folders, and stickers on bins as a reminder of maintenance of PVC bundle completion when disposing of PVC material.
For hand hygiene work, change ideas include the use of a mystery monitor each week and rotating this role, hand hygiene added to daily safety brief template and hand hygiene added to induction pack.
For environmental standard projects, changes being tested include new cleaning schedules being developed; weekly walkrounds for cleaning schedule and cleaning schedule added to safety brief.
For Cather Acquired Urinary Tract Infection (CAUTI) work, change ideas include testing catheter passport, poster & CAUTI game to improve knowledge; development of a GP referral form for patients presenting with CAUTI symptoms.
For acute wound projects, change ideas include re-design of antimicrobial dressing stock cupboards, red-sign to highlight specialist stock in cupboard and acute wound formulary guidance link on all desktops.

In total so far 10 (36%) teams who have actively engaged have reached their aim and are working towards sustaining this and others have met and sustained change. This is as follows for each site:

- 2 teams have met aim and sustained change at UHH
- 4 teams have met their aim at UHM,
- 2 teams have met their aim in North HSCP
- 2 teams have met their aim in South HSCP.

Each team have set their improvement aim for their project. Their aim and progress to date is listed below:

UHH - Ward 9 - By Oct 22 have 365 days between SABS. Ward 12 - 95% or above in compliance with PVC insertion and maintenance bundle by June 22

UHM - Glenmore - exceeded aim of 100 days between CAUTI. Ward 21 has reduced use of catheters by 30% to reduce CAUTI. Ward 1 & 10 have gone more than 100 days between PVC associated SABs

North HSCP - Ward 19 and 20 - achieving aim of over 95% compliance with Hand Hygiene since September 2022. Coatbridge HC - consistently achieving aim for both Hand hygiene (100%) and Cleaning schedule (100%)

South HSCP - Clydesdale Treatment Room – use of 1st line antimicrobial dressing choices has increased from 50 to 100% Clydesdale TR – use of specialist wound care products as 1st line dressing choices has decreased from 50% to 0% Hamilton - all elements of hand hygiene bundle have improved (shift – 6 points above median of 77%)

Learning Session 1 was held on 18th May 2022, with 73 attendees. The evaluation from the learning was very positive with all responders saying that the session met their expectations, they found the session beneficial and informative. 89% of responders were very satisfied with the learning session content. Learning Session 2 was held on 25th November 2022 and again had good attendance and positive feedback.

4. Evidence for Quality

4.1 Corporate Policies

Corporate Policies Team submitted the most recent CMT report in December 2022. It outlined the ongoing effectiveness of the Corporate Policies assurance process as 95% compliance. KPI continues to be met successfully.

The administrative work of Corporate Policies is currently conducted on an Access database. Corporate Policies Team have initiated contact with colleagues for further information on alternative systems to replace Access. At this stage two systems have been identified as potential replacements, MEG and REDCAP. Following a review of these systems, Corporate Policies Team will liaise with Head of Evidence. No funding has been identified to date for either system.

4.2 Searching Services

A total of 34 requests for literature searches, 3 requests for copyright checks and 1 search and summary have been submitted via the eHelp portal since the last Board report searching services on 21st November 2022. Requests for searches came from the following teams and specialties.

- Health Improvement/Public Health
- Practice Development
- SALUS
- Psychology
- Change and innovation
- Vascular

- Physiotherapy
- Maternity
- Adult Nursing
- Community nursing
- Occupational Therapy
- Mental health
- Medical Director, H&SCP
- Intensive care
- Deputy Associate Nurse Director
- Medical Education

The copyright permission checks related to an image to be used in a Learnpro module and images to be used in patient information leaflets.

4.3 Cancer Audit

Published regional reports for 2020/2021 cases show NHSL continues to perform well at a regional level. Local reporting of 2021/2022 cases 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. In the majority of cases actions requested are applicable to all Boards and not specific to NHSL.

Detailed analysis was carried out to identify themes emerging through local and regional reports which was shared with the Cancer Management Team and the Clinical Effectiveness Group. The data was derived from commentary given in Performance Summary Reports submitted to the West of Scotland Managed Clinical Network for patients diagnosed between 1st April 2019 and 31st March 2022. Time delays, fitness for treatment, Covid and poor documentation were the main reasons stated.

- Time delay is a factor across a number of tumour types and in particular for Surgery and Investigation QPIs. This is largely due to system pressures and capacity issues. Cancer patient pathways are complex and are reliant on a range of services, e.g. radiology, pathology, surgery, laboratory. Each of these services are interdependent so when delays occur with one service this has an impact on the other services. QPI performance data is shared with all services via tumour specific MDTs to highlight areas of concern and facilitate discussion between the services.
- High levels of deprivation, comorbidities, patient fitness for treatment and late presentation of disease continue to be a factor in Lanarkshire's performance levels. There is a requirement to improve levels of health and to establish awareness campaigns aimed at encouraging patients to present early.
- Covid was a main factor due to the time frame analysed - patients diagnosed between 1st April 2019 and 31st March 2022.
- Efforts are being made to improve documentation across all tumour groups and tumour leads continue to work with colleagues to raise awareness and prompt good practice.

The local and regional reporting processes facilitates regular review of QPI results as well as review of individual cases not meeting QPIs which allows services to identify areas of concern and implement actions in a timely manner. It also facilitates continuous monitoring and evidence of improvement is reported to each of the services.

Improvement status	Time Delay	Patient unfit	Covid	Documentation
Evidence of improvement - now meeting target	11	5	9	8
Evidence of improvement - not meeting target	9	4	5	6
No evidence of improvement (unknown reason)	13	10	7	4
Not applicable*	11	14	2	4
Totals	**44**	**33**	**23**	**22**

*data for subsequent reporting period not available or QPI archived

A HIS review of Melanoma QPIs was carried out in Spring 2020 which focused on the 2019/2020 data. The report was published in November 2022. A total of 14 recommendations were made in the report. Only 2 recommendations were applicable to NHS Lanarkshire as follows: -

QPI 7i 1: *Diagnostic Excision Biopsy to Wide Local Excision - Pathology reporting time from date of diagnostic biopsy (21 days).* In order to improve, the review team recommend all WoSCAN NHS boards share good practice across the region. Where possible, adopt best practice, streamlined models of care such as using advanced nurse practitioners, as evidenced across NHS GGC and NHS Lanarkshire, and the plastic surgery outreach service set up by NHS Forth Valley.

QPI 9: *Imaging for Patients with Advanced Melanoma - Number of patients with stage IIC and above cutaneous melanoma who undergo CT or PET CT within 35 days of diagnosis.* The review team recommend that all WoSCAN NHS boards introduce measures in the melanoma patient pathway to ensure patients are given appropriate priority for PET and CT scans. Additionally, the review team recommend that all WoSCAN NHS boards introduce measures in the melanoma patient pathway to ensure patients are given appropriate priority for PET and CT scans. Additionally, there is the need for NHS boards to provide dedicated resources to address the radiology and pathology constraints.

4.4 Clinical Guidelines App

NHSL Guidelines App continues to develop, improve and grow in popularity:

- The COVID-19 Toolkit Evaluation has been completed. There is a new, less complex structure in place and the metadata is complete and up to date.
- There is approximately 800+ guidelines across 6 toolkits. The content will only continue to grow. The total number of amended or added guidelines between January-December 2022 was 510. This figure does not include guidelines removed from the system.
- In 2022 the App attracted more than 62,000 users, was viewed more than 511,000 times and more than 36,000 searches were performed in it.

A demo of the Once for Scotland Right Decision Mega-App took place followed by beta-testing – a new hosting platform and system for NHSL Guidelines App. This mega app will provide a single gateway to all Right Decision apps and toolkits, ensure quick deployments of fixes and enhancements to the system, and open opportunities for sharing tools and resources (e.g., guidelines between different health boards, question and answer pathways, forms, calculators etc.). Its aims are to:

- Address unwarranted variation in health and social care practice.
- Improve patient safety, reduce risk and harm.
- Improve the quality of care.

The Guidance on the Development, Approval, Review and Monitoring of Medicine and Non-Medicine Related Guidelines has changed. All non-medicine related guidelines will now need to be reviewed by the recently formed Guidelines Editorial Group (GED) before final approval, ratification and then submission for publication on the NHSL Guidelines App.

Medicine related guidelines will continue to be approved and ratified by Area Drugs and Therapeutics Committee.

A template for NHSL guidelines has been developed and should ideally be used for all locally developed guidelines. All changes are captured and communicated via the Guidelines Approval page.

The Clinical Guidelines Team (CGT) Actions for the Implementation Plan 2023-2024 has been agreed:

- Zendesk Implementation (by August 2023).
- NHSL Guidelines App transition to the Once for Scotland platform (by March 2024).
- Guidelines transition from the FirstPort to NHSL Guidelines App - testing and promoting the process (by December 2023).

- Implementation of the Reviewed Guidance on the Development, Approval, Review and Monitoring of Medicine and Non-Medicine Related Guidelines (by June 2023).

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March 2023