**NHS Board Meeting**
**25th October 2023**

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

## i. PURPOSE

This paper is coming to the Board:

| | | | | | |
|---|---|---|---|---|---|
| For approval | ☐ | For endorsement | ☐ | To note | ☒ |

The purpose of this paper is to provide NHS Lanarkshire Board with an update on the Lanarkshire Quality Approach and on progress with quality initiatives across NHS Lanarkshire.

## ii. ROUTE TO THE BOARD

The content of this paper relating to quality assurance and improvement initiatives has been:

| | | | | | |
|---|---|---|---|---|---|
| Prepared | ☐ | Reviewed | ☐ | Endorsed | ☒ |

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

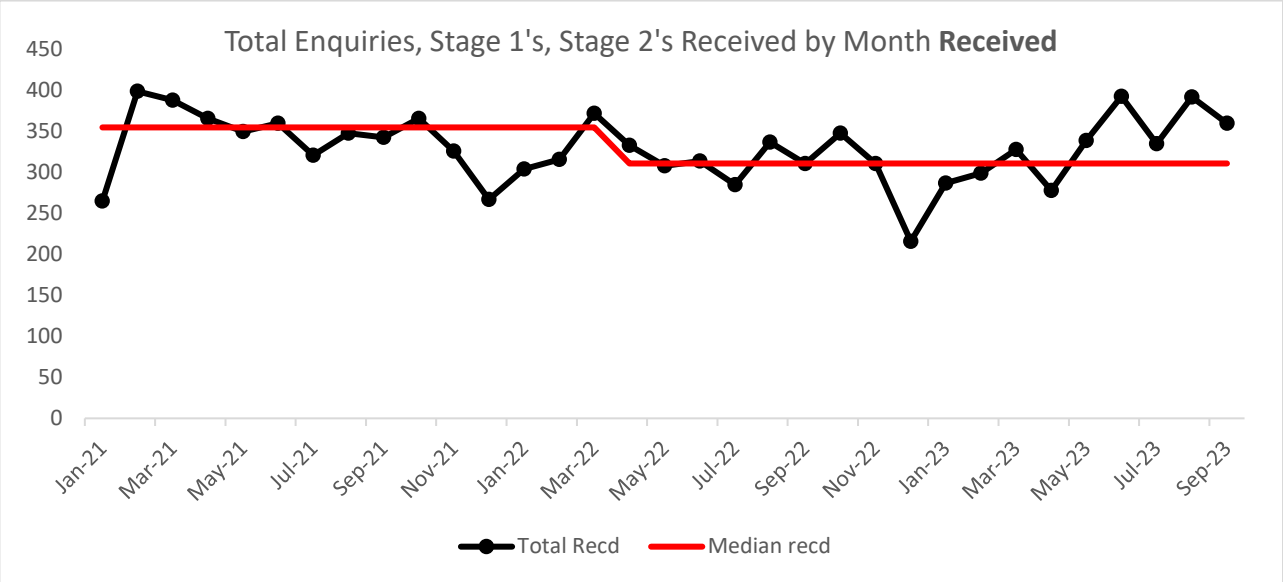
The first set of True North Action Plans were presented to HQAIC in September 2023 and an update will be provided at the January meeting. To promote the True North statements a bulletin is being prepared for each one that will include an animated video, information and suggestions on implementing that particular aim. These will be released throughout the coming year so that a year from the initial release, all seven True Norths will have been promoted. The first release is: We work with our service users to ensure our care is person centred. This will be presented to HQAIC in November.

The staff Safety Culture Survey will be released on the 30th of October on the first day of NHS Lanarkshire's Staff Health & Wellbeing Week. Promotional materials and methods to engage with the survey are organised and engagement with the external provider has been positive.

## 1. Assurance of Quality

### 1.1 Complaints & Patient Affairs

Received activity continues to be above the median. In September 2023, patient affairs received 159 enquiries, 142 stage 1 complaints and 59 stage 2 complaints (includes escalated).

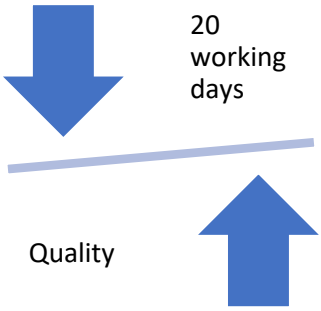



Detailed performance information for September **closed** activity is incorporated into the Integrated Performance and Quality Report (IPQR):

- **75%** of complaints closed at stage 1 (exceeding target)
- **43%** of stage 2 complaints closed within 20 working days (not meeting target)
- **29 days** average stage 2 response time (exceeding current target)

To support ongoing improvement, a number of developments have progressed, including:

- The stage 2 Escalation Procedure has been reviewed and shared for consultation. The procedure outlines indicative timescales and responsibilities for each stage of the process, the trigger points and process for escalation of delays, and examples of when it is appropriate to apply extensions to timescales. The procedure recognises that achieving a 20-working day response must be carefully balanced with maintaining a quality complaint investigation, and that a high quality complaint investigation involves taking time to identify root causes, redress, improvement and corrective action. We want to support a listening and learning culture (for complainants and staff) to achieve quality, whilst also maximising KPI delivery.




| Benefits of a timely response | Benefits of a quality response |
|---|---|
| An undue delay may cause the complainant and staff involved additional distress. A timely response reduces this distress for both parties. | A robust and learning focused investigation will lead to a more considered and person-centred response for the complainant and learning for the organisation.<br>Ensuring that our complaint responses meet the SPSO principles of a quality investigation reduces the likelihood of SPSO proceeding to full investigations. |

The procedure introduces the motto of:

**Robust timescales + Quality = Person centred complaint handling**

This messaging was further endorsed through a recent Pulse article. The article also emphasises the value of stage 1 resolution at the frontline, providing a further opportunity to circulate stage 1 guidance and an overview animation.

- Dashboards have been further developed to assist with identification and monitoring of process bottlenecks.
- Stage 2 complaints that are categorised as extreme and major are to be reviewed by an executive staff member prior to signature. Both the Executive Medical and Nurse Directors receive a weekly report of extreme and major complaints, in addition to activity with media and elected representative involvement. Handling will continue to be in accordance with agreed organisational procedures avoiding a two-tier process.
- An initial meeting has been held to consider improvements in governance of complaint handling with North & South HSCP representatives. It has been agreed that Datix Complaints Module will be opened up to governance staff in the partnerships as a pilot. This will enable better tracking of the HSCP complaints.
- Interim additional resources are currently being put in place for patient affairs. Other duties are also being reviewed, to create capacity.

NHS Lanarkshire's patient affairs and complaints lead has been asked by the SPSO to participate in a panel discussion at their conference, to showcase best practice complaint handling, and to share experiences of learning and improving from complaints, and building a positive culture of learning from complaints.

Over the past years, a number of process developments have been introduced in NHS Lanarkshire, to support learning being at the heart of the complaints procedure and utilising information to inform service development and improvement, including:

- Amended witness statement processes and documentation to encourage reflection and learning from those closest to the source of the complaint – recognising that they may be best placed to make improvement suggestions
- Learning and actions are communicated to the complainant within a specific 'learning summary' at the conclusion of the Stage 2 response (for upheld/partially upheld complaints). Anecdotal information suggests that this approach supports the declining number of SPSO cases proceeding to investigation – they are content that we have completed a robust investigation and have identified learning.
- The Healthcare Complaints Analysis Tool (HCAT) has been applied in a small number of areas. Scaling up has been significantly hampered by service pressures and resource. We currently have short-term interim resource working with mental health on applying HCAT.
- Learning is recorded on Datix to ensure that robust evidence of agreed actions is provided. We plan to further enhance functionality and reporting over the coming months, and consider how we can better utilise themes and trends.
- Complaints has been incorporated into the organisational Learning Bulletin.

### 1.2 LanQIP

Development work continues to improve the reliability and efficiency of complaints reporting. This has resulted in more measures and reporting being generated automatically through a LanQIP complaints dashboard. This work will continue throughout the coming months, with the aim to use data collected via a new LanQIP module to augment the complaints reporting process. The benefits of this work are:

- any bottlenecks are clearly identified so improvement work can be targeted
- live time data so services are aware of their current position
- ability of better reporting to see trends and shifts in the data
- additional coding of the data so reasons for delays are captured

Given the success of the complaints development project, work has commenced on enhancing and streamlining Incidents Management reporting. Data will be automatically extracted from Datix and transformed before being loaded into a data warehouse for reporting. This will allow automated calculation of measures along with the ability to develop and distribute more real time dashboards and paginated reports. These will automatically refresh, eliminating the manual effort which is currently required.

The programme of work to bring old legacy systems into the new LanQIP platform which began last year has recommenced, with the NHS Lanarkshire Stroke Audit system (SAIL) currently under development and a number of Clinical Audit MS Access databases planned for redevelopment.

### 1.3 Quality Data & Measurement

As we approach the beginning of the winter season, and with the emergence of new Covid-19 variants, it was agreed with Public Health leads that the Covid-19 and flu data linkage for hospitalised cases that was reported previously should be re-established. Some of the previous Covid-19 surveillance systems have been stood down and there is reduced testing, which gives more importance to the ability to monitor Covid-19 and influenza across the health board.

The Data and Measurement Team have taken receipt of the first extracts of positivity from the central laboratories; and utilised admissions data to provide an initial review of current status of both Covid-19, and Influenza across the Acute Sites. The team have also introduced a component of Covid-19 Surveillance to the Corporate Management Team Scorecard.

Work has commenced on development of a Detect Cancer Early (DCE) Measurement Plan, to support the DCE Action Plan. This will involve sourcing and prioritising performance measures and corresponding data that will allow the progress of key actions to be monitored. Measures include monitoring uptake of various screening programmes, and access to diagnostics by deprivation category.

Work continues with North and South Partnership representatives to progress the development of Partnership dashboards, with periodic review of current key performance indicators. Additional measures, such as Universal Pathway Interventions, District Nursing, Home Visit and Mental Health service performance have been agreed.

## 2. Quality Improvement

### 2.1 Operation FLOW 2

The Improvement Team were commissioned by Margaret Meek, Director of Hospital Services and chair of Operation FLOW 2 Task & Finish Group 4, to undertake process mapping across the 3 acute sites Flow Teams. This was to help achieve the objective of embedding the Flow Foundation Bundle and to develop a Target Operating Model for safe patient flow over the 24-hour period.

The purpose of the request was to bring quality improvement methods and tools to the work of understanding the current processes and pathways in use in all 3 acute hospitals Flow Teams. It was already known that there is variation across the three hospital teams including:

- Operating hours
- Team skill mix and team size
- Line Management arrangements
- Competing priorities for staff time

The aim was to understand the current pathways and processes, analyse these and identify areas of good practice to share, areas of variation and areas where there could be improvements made.

A good definition of a process describes it as a series of connected steps or actions to achieve an outcome. The processes within healthcare settings have often evolved over the years as changes have been grafted on to established working practices. There can be many different layers in addition to the patient process or journey. These include communication processes and administration or paperwork processes, and often involve a number of departments. In addition, changes to the pathways and processes introduced as a result of Covid-19 and space or staffing restrictions also add to the variation.

Process mapping is a recognised quality improvement tool which helps to better understand a system by mapping each of the steps within it.

The pathways and processes which were identified for this mapping work were:

- The role of the Flow Team in the safe management of flow and patient placement
- The role of the Clinical Night Manager in managing flow overnight
- The Escalation Procedure process on each site

This session provided the opportunity for the three Flow Teams to come together to discuss their roles, their daily duties and the steps they are involved with in the process of supporting both elective and emergency flow in the three acute hospitals.

Using this process mapping tool enabled all of the steps in the daily processes to be identified, who carried out the steps, identify if there was there any variation, issues of waiting or clarity needed in the understanding of why the steps were carried out. The outputs of the mapping of the "current state" position will inform the development of a Target Operating Model for use across all Flow Teams in the acute sites in Lanarkshire. The new model is being developed by Task & Finish Group 4 which involves standardising job roles and reducing variation in practice across the sites which will provide a clearer understanding of the steps required within the process to deliver more efficient management of flow.

## 2.2 Infection Prevention and Control Collaborative

Infection Prevention and Control (IPC) is critical to keeping people safe when they are receiving health and social care. IPC is integral to quality health and social care delivery as anyone in these settings are at risk of developing an infection.

Good IPC practice can help reduce the prevalence of infections (including healthcare-associated infections - HAIs) which are associated with the delivery of care in hospitals, long-term care facilities including care homes and other care settings.

NHS Lanarkshire Infection Prevention and Control (IPC) Collaborative ran from June 2021 – June 2023. NHS Lanarkshire identified that there was work to do to improve our Healthcare Associated Infections such as Staphylococcus Aureus Bacteraemia (SAB), Clostridioides Difficile Infection (CDI), Escherichia Coli Bacteraemia (ECB) and also Hand Hygiene compliance.

The Faculty Steering Group developed a Change Package in 2021 which described the overall vision for the IPC Collaborative which was to reduce healthcare associated infections and improve hand hygiene compliance across specific areas in NHS Lanarkshire.

The Institute of Healthcare Improvement (IHI) uses collaborative learning model for achieving breakthrough improvement that was innovated in 1995 and has been continuously improving ever since, called the Breakthrough Series. The IHI Breakthrough Series Collaborative approach was used as the framework for the Collaborative.

The aim of the collaborative was to bring together a large number of teams across NHS Lanarkshire with a shared aim of improving outcomes associated with hospital and healthcare associated infection. Enrolment of participants was undertaken by each of the 5 Operational Units, led by the Chief Nurses.

Baseline data for the previous 2 years was provided to the teams to help understand the system and identify where to focus the improvement efforts. Different approaches to identifying teams were taken across the acute hospitals and HSCPs. This variation was possibly due to a number of factors including: availability of Senior Charge Nurse (SCN)/Team Leader in teams to lead the work, capacity and experience of the SCNs/Team Leaders in some areas, some areas had higher infection rates but didn't have staff capacity to engage etc. The knowledge and understanding of Quality Improvement methodology may also have caused variability/challenges within the teams.

There were initially 50 teams across University Hospital Hairmyres (UHH), University Hospital Monklands (UHM), University Hospital Wishaw (UHW), and North and South Health and Social Care Partnerships (HSCPs) enrolled in the Collaborative.

Each team, supported by their Improvement Advisor as QI Coach, worked through the stages of the improvement journey.

The teams used quality improvement methodology such as the Model for Improvement and Plan Do Study Act (PDSA) Cycles and tools such as process mapping, cause and effect diagrams and force field analysis. When identifying their project aim each team was directed to review their data on infection rates and identify what the main infection problem in their areas was. The teams mainly focused on the following topics:

- Catheter Acquired Urinary Tract Infection (CAUTI)
- Peripheral Venous Catheter (PVC) Bundle Compliance
- Hand Hygiene
- Standard Infection Prevention and Control Procedures (SIPs)
- Environment
- Dialysis line SABs

- Methicillin-resistant Staphylococcus aureus / Carbapenemase Producing Enterobacteriaceae (MRSA/CPE)
- Patient Observations Equipment
- Personal Protective Equipment (PPE)
- Peripherally Inserted Central Catheter (PICC) Line SABs
- Antibiotic Therapy

Each team also generated change ideas that they thought might make an improvement to the infection problem in their area that they were trying to fix. They then prioritised their change ideas and began testing them.

Data collection tools were developed to help the teams capture baseline data and data over time. This data would assist in the evaluation of whether the changes they were testing were making an improvement or not. Teams were supported to use time series data, data visualisation and run charts.

Learning sessions were also held which provided an opportunity to hear from local and national experts on aspects of quality improvement and infection and were valued by those who attended. The most positive feedback was in relation to hearing the journey of other teams in their improvement project. The sessions provided some renewed energy for teams, a chance to reflect on how they could use anything they had learned in their own project and a chance to celebrate the work achieved by the teams in still challenging times.

We need to acknowledge that the Collaborative was launched during the first wave of the pandemic when no one knew how long the challenges of Covid-19 would remain. The Collaborative then ran for 2 years which were extremely challenging in terms of Covid-19, acuity and volume of patient activity, elective and emergency activity increases, staff absence, staff morale and exhaustion from this unprecedented activity.

Time and capacity for staff to engage in the work was the main obstacle for the teams. Staff were keen to make improvements but did not always have time released to work on the improvement project.

By the end of the Collaborative 27 teams had met their improvement aim. The teams are now working to sustain and embed the changes as normal practice and will continue to be monitored by the teams.

The following are some examples where teams achieved their project aim:

| Team | Improvement Topic | Aim achieved |
|---|---|---|
| Acute Medical Receiving Unit(UHM) | SABS | By May 2023, PVC maintenance bundle completion in AMRU will be >95% to reduce SAB infections. |
| Renal Unit Ward 1 (UHM) | SABS | The days between incidence of tunnelled line related SABS in Renal Dialysis Unit A will exceed 100 days by May 2023 |
| Ward 10 (UHM) | SABS | By May 2023 ward 10 will have greater than 100 days between PVC associated SABS. |
| Ward 12 (UHM) | SABS/ PVC | By July 2023, Ward 12 UHM aim to improve PVC compliance to consistently greater than 85%. |
| Ward 22 (UHM) | SABS/ PVC | By May 2023, ward 22 UHM will have > 90% compliance in PVC insertion, maintenance and removal bundle completion |
| Ward 12 (UHH) | PVC | Aim 95% or above in compliance with PVC insertion and maintenance bundle by June 22 |
| Ward 9 (UHH) | PVC | By Oct 22 ward 9 have 365 days between SABS in ward 9 |
| Ward 9 (UHW) | PVC | By Oct 22 ward 9 have 365 days between SABS in ward 9 |
| Ward 21 (UHM) | CAUTI | By May 2023 ward 21 will reduce the use of catheters in stroke patients by 30% and therefore will reduce incidence of CAUTI. |
| Glenmore Ward (Coathill) | CAUTI | By May 2023 Glenmore Ward, Coathill Hospital will have >100 days between CAUTI |
| Stroke (UHH) | CAUTI | To improve CAUTI bundle completion from 84% to 100% by March 2022 |

| | | |
|---|---|---|
| Ward 15 (UHH) | CAUTI | To achieve 97% compliance in the use and completion of CAUTI bundles within ward 15 by October 2021 |
| Ward 15 (UHW) | CAUTI | To achieve 97% compliance in the use and completion of CAUTI bundles within ward 15 by October 2021 |
| ICST1 East Kilbride (South HSCP) | CAUTI | 50% of patients with suspected and/or confirmed CAUTI, on one district nurses caseload in East Kilbride Integrated Community Support Team 1, will have their catheter changed within 72hrs of an antibiotic being prescribed, by June 2023 |
| CaRES Hamilton (South HSCP) | Environmental Cleanliness | CaRES Hamilton will achieve 90% reliability with environmental cleanliness in their team office, by June 2023 |
| CamGlen Treatment Room (South HSCP) | Wound Management | By June 2023, all patients attending Camglen Treatment Room, with a leg wound that has not healed within 2weeks of initial assessment, will receive a Doppler Assessment |
| Clydesdale Treatment Room (South HSCP) | Wound Management | By June 2023, Lanark Treatment Room in Clydesdale will: *Achieve 95% reliability with 1st line antimicrobial dressing choices, in line with NHS Lanarkshire's Acute Wound Management Formulary *Reduce the use of specialist wound products as 1st line dressing choice by 50% |
| Hamilton Treatment Room (South HSCP) | Hand Hygiene | Douglas Street Treatment Room will achieve 100% reliability with hand hygiene, by June 2023 |
| Ward 19 & 20, UHW (North HSCP) | Hand Hygiene, SICP's and unit cleaning schedules | Ward 19 & 20 UHW will achieve 95% compliance with SCIPS Audits 2 (Hand Hygiene) & 6 (Control of the environment) by April 2023 |
| Coatbridge Health Centre, Treatment Room (North HSCP) | Hand Hygiene and Treatment Room daily cleaning schedule | By March 2022, Coatbridge Health Centre Treatment Room will have 100% compliance with Daily Cleaning Schedule.<br>By March 2022 Coatbridge Health Centre will have 100% compliance with Hand Hygiene |
| Intensive Psychiatric Care Unit, UHW (North HSCP) | Hand Hygiene and Daily IP&C walkround | Increase Hand Hygiene compliance to 100% in IPCU by September 2022<br>Increase Daily Walkround compliance to 95% in IPCU by September 2022 |
| Ward 3, UHW (North HSCP) | Hand Hygiene and Daily IP&C 'sweep' (walkround) | Increase Hand Hygiene compliance to 100% in IPCU by September 2022<br>Increase Daily Sweep compliance to 95% in IPCU by September 2022 |
| Podiatry Prescribing Team (North HSCP) | Hand Hygiene, Appropriate Antibiotic therapy, Wound Management | Ensure appropriate use of antimicrobial dressings and achieve 80% compliance with NHS Lanarkshire Acute wound management formulary by January 2022<br>Timely and appropriate anti-microbial prescribing is achieved. 95% compliance with formulary & microbiology by January 2022<br>To achieve 95% compliance with Hand Hygiene protocol amongst podiatry staff by January 2022 |
| Beechgrove Care Home | Hand Hygiene | Increase hand hygiene compliance in Beechgrove Care Home to 75% by February 2022 and 95% by June 2023 |
| Stroke (UHH) | Hand Hygiene | To improve Hand Hygiene compliance for all staff members within the ward to 100% by September 2021 |

Once changes have been evaluated and the aim is achieved it is important to articulate the connections between new behaviours and organisational success, making sure they continue until they become strong enough to replace old habits. The new ways of working need to become embedded in the organisations culture.

The teams are working with their Senior Leadership Teams to spread the outputs of their projects to other areas within their hospitals/localities.

The Improvement Team are developing a Sustain Package with the teams to provide them with the support materials to help them to sustain their improvements.

A full detailed report is available.

## 3. Evidence for Quality

### 3.1 Cancer audit

Regional Annual Cancer Quality Performance Indicators has been published for the following tumours:

- Ovarian 2020/2021
- Endometrial & Cervical 2021/2022
- HBP 2021
- Breast 2021
- Lung 2021
- Colorectal 2021/2022
- Head and Neck 2021/2022
- Melanoma 2021/2022
- Renal 2021
- Testicular 2021/2022
- Bladder 2021/2022
- Acute Leukaemia 2021/2022
- Lymphoma 2021/2022

NHSL continues to perform well at a regional level. A total of 21 actions were requested, and action plans have been submitted, for 10 of the 13 tumours reported. No action was requested against renal, acute leukaemia or endometrial and cervical QPIs.

Thirteen actions have been fully implemented, 6 actions have been agreed but not fully implemented and 2 actions were deemed not applicable to NHSL. Progress against all actions continues to be monitored through quarterly/biannual local reports and is reported through the Cancer Service Clinical Governance Group and the Quality Performance and Professional Governance Group.

QPIs where targets are consistently not met or results are consistently below the WoS average, do not routinely result in an action plan request from the MCN. This is due to the level of detail provided by NHSL within the Performance Summary reports which provides assurance that the board already has an improvement plan in place or there is a justifiable reason for outlier cases. Where issues or concerns are identified the Cancer Audit Team informs the Cancer Clinical Lead and seek clarification on the requirement for further action. Any exceptions are reported via the Clinical Effectiveness Group and the Cancer Service Clinical Governance Group.

Concerns were raised at the WoSCAN Clinical Effectiveness Leads meeting in March 2023 regarding the requirement for an increase in resources at Board level to support additional national performance indicators. The new request to audit breast recurrence requires additional resources as this work involves manual individual clinical record review and is very time consuming. A temporary resource has been identified through the wider Quality Director staffing budget for the first year of reporting, however this is non-recurring and an alternative solution will be required in order to continue to support this in subsequent years.

At the Regional Cancer Oversight Group in July 2023 the regional Clinical Lead acknowledged the significant time and resource implications and advised discussions with HIS would need to take place in order to look at a reduced number of more focused QPIs. Timescales for discussions and outcomes have not been provided.

### 3.2 Patient information

Testing of the new MEG platform is now complete, and training undertaken on all aspects of the platform. Unfortunately, due to significant staff shortages in the Medical Illustration team and a temporary move of a member of Knowledge Services to other work we have had to push back the launch until 1st November 2023.

The translation work is progressing well. Examples would include patient leaflets, patient letters, medical reports and case notes. Twenty-four requests for translations have been processed since the last Board report in May 2023. The translation work will move to new platform which will manage the translation

requests more effectively by enabling NHSL staff to place their own translation requests. A DPIA is currently being completed and we hope to have the new system in place by the end of the financial year.

A review of all leaflets due to expire in May 2023 – September 2023 has now taken place, with authors of all leaflets due to expire in October 2023 and November 2023 contacted with an advisory notice and request to review before the leaflet's expiry date. A total of 30 new leaflets have been received since the last Board report, with each one undergoing a readability check by the patient information team.

Two 'Writing Information for Patients' training sessions have taken place with 12 people attending.

### 3.2 Health Literacy

The True North for Knowledge Services has been agreed:
'*We will develop a 3-year plan for NHSL to become a health literate organisation to support people to navigate, understand, and use information and services to take care of their health*'.

Actions for the plan being considered include:

- An enhanced health literacy training programme;
- development of a toolkit for writing effective patient letters;
- the introduction of the PIF (Patient Information Forum) TICK, UK-wide quality mark for health information;
- the development of an NHSL network of Health Literacy Champions.

We have developed a training session on recognising fake news aimed at S6 pupils which will be piloted in a high school and then offered as a learning resource to all schools.

The acute libraries now feature a display to inform patrons of the meaning of health literacy and demonstrating some tools and techniques they can use with their patients'/service users.

The patient information training now features a section on health literacy and is well received by attendees.

A preliminary conversation has taken place with Practice Education to look at how we can support care home staff who work with residents on shared decision making and this will be ongoing.

### 3.3 Corporate Policies Update for Board Report October 2023

Compliance percentage dipped below the 95% tolerance level (94.12%) in July 2023. There were 14 policies (9.15%) due beyond 10 days in August 2023, and 15 (9.8%) in September 2023. The dip in compliance is due to pressures on staff/staff absence and some policies being given to newer members of the team who may not have received the earlier notifications. This has been compounded with an IT issue between June 2023 and September 2023 with the Corporate Policies inbox. We expect recovery in the next report.

Corporate Policies Team have reported to Communications Department that we are no longer able to see policies listed in upload date order on the public website which is a key function of our reporting. The Lead Web and Digital Officer has advised this feature will no longer be available, as the necessary plug in would negatively impact other functions on the site. As a short term measure, Corporate Polices are now keeping a written record of the policies uploaded every month to maintain assurance in the system. This requires increased staff time due to a manual process however alternative solutions to the issue are currently being sought.

Corporate Policies have been identified as a suitable partner to trial the new REDCap system, as a replacement for Microsoft Access. This system will automate the process for when policies require to be updated including the communication with the authors and provide the history of changes for traceability

purposes. The team has been in touch with the Programme Manager at Clinical Audit, regarding our participation in the trial, and have been advised we will be contacted following DPIA approval.

**Dr C Deighan**
**Board Executive Medical Director**
**October 2023**