NHS Board Meeting
27th March 2024

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 (HQAIC) 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

QUALITY ASSURANCE AND IMPROVEMENT
27th March 2024

Introduction

This report to the Board provides an update on the current progress over February to March 2024, of plans and objectives set out in the Quality Strategy to achieve the Lanarkshire Quality Approach.

As we are nearing the end of the first year of the Quality Strategy True North Action Plan, the Divisions have been planning what to include in the plan for 2024 - 2025 by facilitated discussions to assess their priorities. Being able to start this engagement earlier this year, will allow more time for actions to be completed as the current action plan was not agreed until later in 2023-24 due to this being the first year of the strategy.

At time of writing it is anticipated that most of the actions of the 23/24 plan will be completed at the end of March with some slightly delayed due to capacity issues in the system. The Healthcare Quality Assurance and Improvement Committee will receive the final quarter report in April.

1. Assurance of Quality

1.1 Duty of Candour

All adverse events that meet the criteria for duty of candour are investigated as a significant adverse event review (SAER) which has a specific process and report template to follow. SAERs are tracked to establish which events are Duty of Candour, and these are monitored to ensure all aspects of the legislation have been followed and causation codes have been recorded.

At the time of reporting (8th March 2024), there were 121 Significant Adverse Event Reviews (SAERs) commissioned between January and December 2023.

In the most recent quarter (Q3: October - December 2023) there were 22 SAERs commissioned, 7 of which were retrospectively recorded incidents, occurring in May 2022, August, and September 2023. These retrospectively reported incidents were recorded as pressure ulcer, radiation/imaging, self-harm, theatre processes, treatment, and unexplained injury.

Currently 35% (42 of the 121) significant adverse events have been recorded as triggering the legislation for Duty of Candour. 95 SAERs have concluded and 26 remain open and on-going.

It is unknown currently if the 26 open SAERs trigger the Duty of Candour legislation, due to the investigation not yet being complete, which is acceptable.

For the 95 SAERs that have concluded:

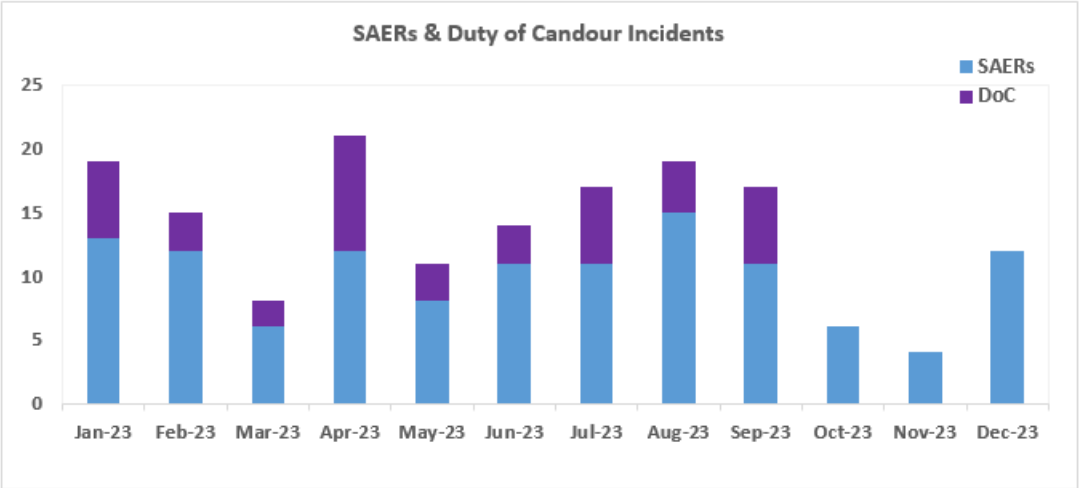
- 53 cases have been recorded as not meeting the Duty of Candour legislation
- 42 are recorded as meeting Duty of Candour legislation

All 42 cases that were recorded as triggering the legislation were assessed for compliance with the following elements of the regulations:

- *Apology given*
- *Patient or Relative informed of the adverse event*
- *Robust review undertaken*
- *Patient or Relative invited to participate in review*
- *Patient or Relative informed of the results of the review*
- *Staff involved supported*

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. Full compliance was achieved for all concluded incidents.

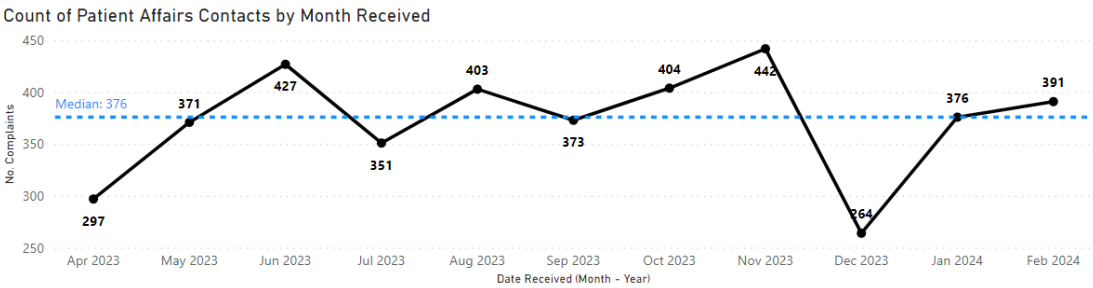
The chart below shows the overall number of SAERs reported from the three divisions along with the number of incidents triggering duty of candour legislation, over January to December 2023.



The annual Duty of Candour report will be prepared in April and will be presented at the Healthcare Quality Assurance and Improvement Committee Annual Report meeting in May. As there are likely to be reviews that remain open at that time, an addendum will be added when the last case of 23/24 has closed providing a complete account.

1.2 Complaints

As anticipated, following a dip in December, there was a post-festive period increase in activity received. This followed the trajectory from preceding years.



Date Received (Month - Year)	Access to records	Compliment	Concerns	Enquiry	Stage 1 Complaint	Stage 2 Complaint	Stage 2 Complaint Escalated from Stage 1	Suggestions & Comments	Total
Apr 2023	1	19	6	91	134	31	15		**297**
May 2023	8	29	4	120	143	44	18	5	**371**
Jun 2023	1	22	9	136	195	34	20	10	**427**
Jul 2023	1	12	7	116	157	32	23	3	**351**
Aug 2023	3	11	15	150	178	29	17		**403**
Sep 2023	2	11	10	141	141	39	26	3	**373**
Oct 2023	2	19	7	145	161	47	18	5	**404**
Nov 2023	1	97	4	136	156	36	12		**442**
Dec 2023	1	12	6	100	108	26	10	1	**264**
Jan 2024	3	15	7	166	132	40	13		**376**
Feb 2024	2	17	7	166	160	32	7		**391**
Total	**25**	**264**	**82**	**1467**	**1665**	**390**	**179**	**27**	**4099**

Complaint performance measures and commentary are included in the Integrated Performance & Quality Report (IPQR). Headline data below:

At the time of writing (7th March 2024), February 2024 performance on **closed** activity information is available:

- **74%** of complaints closed at stage 1 (exceeding local target of 65%)
- **28 days** is the average stage 2 response time (not meeting Q4 local target of <20 days)
- **56%** of stage 2 complaints closed within 20 working days (not meeting Q4 local target of 75%)

There has been continuous quarterly improvement in the % of stage 2 complaints closed within 20 working days over the last 3 quarters:

Q4 2022/23	**Q1 2023/24**	**Q2 2023/24**	**Q3 2023/24**
14% (27/199)	23% (43/188)	42% (70/168)	48% (83/173)

Cumulative Scottish Public Service Ombudsman (SPSO) NHS Lanarkshire healthcare complaint determinations for Quarter 1, Quarter 2 and Quarter 3 2023-2024 are detailed below. There is a continuing high percentage of complaints not proceeding to full investigation. This correlates with the quality of complaint responses. For example, if the SPSO think they can add nothing further to the board's investigation and learning, they are less likely to proceed to investigation.

Outcome	University Hospital Hairmyres	University Hospital Monklands	University Hospital Wishaw	Maternity & Neonates	University Health & Social Care North Lanarkshire	South Lanarkshire University Health & Social Care	Corporate Services	*Total*	%
Upheld	1	0	3	0	0	0	0	**4**	**7%**
Partially upheld	1	0	1	0	0	0	0	**2**	**4%**
Not upheld	0	3	1	0	0	1	0	**5**	**9%**
Not proceeding	9	12	8	3	6	1	3	**42**	**75%**
Other*	2	0	0	0	1	0	0	**3**	**5%**
Total	**13**	**15**	**13**	**3**	**7**	**2**	**3**	**56**	**100**

**Resolved as complainant chose not to engage with the SPSO*

Resolution of complaints at Stage 1 continues to be encouraged by promoting our stage 1 guidance and animation which outlines the benefits for complainant, organisation and staff involved. Resolving complaints at Stage 1 wherever possible avoids a lengthy and potentially protracted Stage 2 investigation. Success of this approach is monitored through IPQR measure 1.

For Stage 2 complaints, we are continuing to promote the motto of:

Robust Timescales + Quality = Person Centred Complaint Handling.

The Stage 2 Escalation 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 delivery of Key Performance Indicators.

A short animation on writing Stage 2 complaint comments has been developed. This is shared with staff when comments are requested for Stage 2 investigations, with the aim of improving the quality of comments returned.

NHS Lanarkshire's Patient Affairs and Complaints Lead participated on a panel at the SPSO conference in November, outlining best-practice on creating a learning and improvement focused complaints process and culture. The presentation from Carolyn Hirst on complaint handling and staff wellbeing has been published. This includes useful narrative on many of the recent discussions across NHSL, for example, quantitative and qualitative measures of good complaint handling. Carolyn has agreed to participate in NHS Lanarkshire Quality Week 2024 by presenting a session. She has worked as an independent mediator since 2006. As well as providing mediation services she is a conflict coach, carries out research relating to conflict and delivers conflict-related training and education. Carolyn is a former Deputy Public Services Ombudsman, has been a University Lecturer in Ombudsman and Complaint Handling Practice and before that worked for nearly 20 years in social housing. She is an experienced Non-Executive Director, most recently with NHS Lothian and Midlothian Integration Joint Board.

The NHS Lanarkshire Patient Affairs and Complaints Lead has been working with a member of NHS Forth Valley to review national Complaints and Feedback training resources. A draft report has been completed and submitted to National Education Scotland (NES), providing recommendations on improvements to the national training approach. This work will influence our local approach to complaints education.

A review of mental health complaints using the healthcare complaints analysis tool (HCAT) has been concluded and a thematic report has been shared with senior staff. Although there are several requests for this type of thematic review, current resources restrict significant scale-up of this approach as this was financed with previous underspend. Work has progressed with reviewing prison and out of hours' complaints.

We are continuing to develop and evaluate approaches on learning and themes from complaints through LanQIP, including developing a dashboard for AHP complaint themes.

NHS Lanarkshire responded to a consultation on the SPSO child friendly complaints principles in March 2024. SPSO are currently making amendments based on consultation responses (220 received), before seeking parliamentary approval prior to publication. Following publication (from 16 July 2024), SPSO will expect all organisations under its jurisdiction to have due regard for the principles in the way we handle complaints involving children.

SPSO have commenced preparatory work on development of a child friendly complaints procedure. For NHS organisations, the new procedure will be issued as a good practice toolkit, as the model Complaint Handling Procedure has not been updated for the NHS sector. When this is received (anticipated end of March), arrangements will be made for further local preparatory work. The SPSO have been asked to participate in NHS Lanarkshire's Quality week to provide an information session on child friendly complaints.

1.3 Hospital Standardised Mortality Rate (HSMR)

The latest release of HSMR data was published by ISD on 13th February 2024.

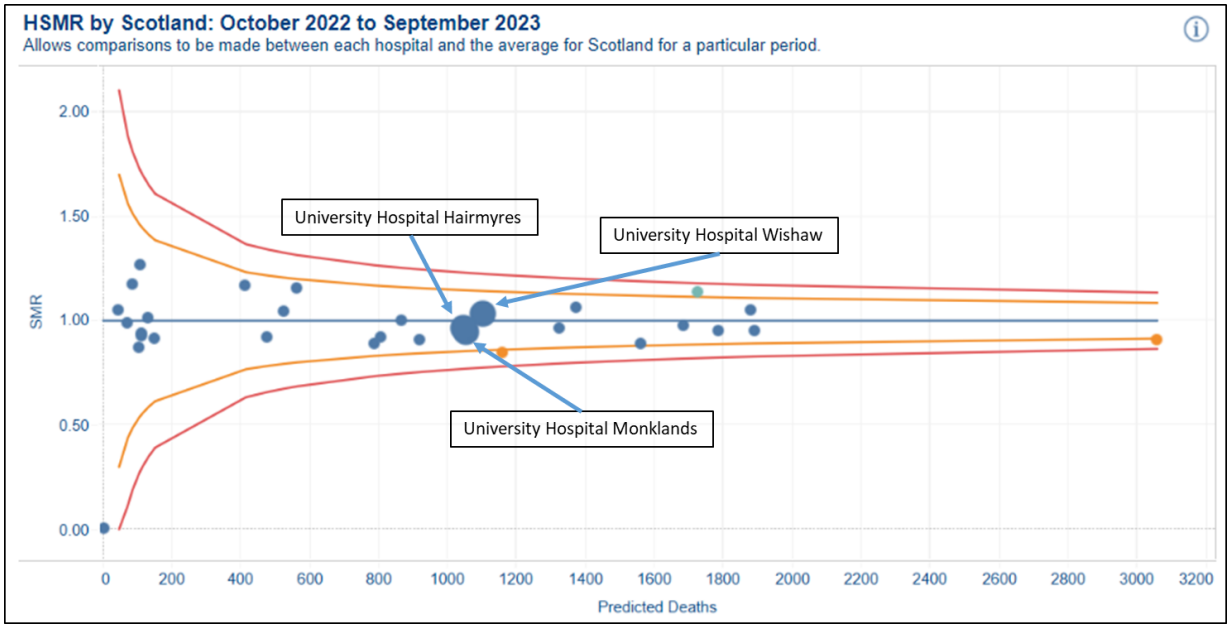
The data includes case-mix adjusted 30-day mortality on admissions from **October 2022 to** September 2023.

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.

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 the HQAIC.

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

The 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: October 2022 to September 2023

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR	Comparison to Scotland on the chart
Scotland	**27,869**	**27,869**	**653,274**	**4.3%**	**1.00**	**n/a**
NHS Lanarkshire	3,138	3,203	69,671	4.5%	0.98	**n/a**
University Hospital Hairmyres	1,007	1,046	22,566	4.5%	0.96	●
University Hospital Monklands	997	1,053	19,713	5.1%	0.95	●
University Hospital Wishaw	1,134	1,104	27,392	4.1%	1.03	●

1.4 Data & Measurement

During 2023-2024 the Data & Measurement team provided ongoing support and maintenance for all the Quality and Safety dashboards developed and managed by the team. This involved:

- Weekly and monthly refresh and review of quality measures
- Providing narrative and insights on the data
- Meeting dashboard stakeholders to review performance of Key Quality Indicators
- Further drilldown analysis to inform process improvement when quality indicator data displays non-random variation
- Frequent liaison with multidisciplinary teams to review and update dashboard content, ensuring ongoing alignment with priorities

The established Quality & Safety Dashboards receiving this level of support included:

- Corporate Quality and Safety dashboard
- University Hospital Hairmyres Quality and Safety dashboard

- University Hospital Monklands Quality and Safety dashboard
- University Hospital Wishaw Quality and Safety dashboard
- Child Health dashboard

Four new dashboards were designed and developed in the reporting period:

- NHS Lanarkshire Staff Health & Wellbeing (SHWB) dashboard to support measurement of the SHWB strategy objectives
- Cardiac Arrest Dashboard, which reports on key measures such as Cardiac Arrest rate, outcome of arrest, use of debriefings and NEWS. This will be used to support decision making at the Pan Lanarkshire Resuscitation Committee
- University Health & Social Care North Lanarkshire & South Lanarkshire University Health & Social Care Partnerships Quality and Safety dashboards were finalised for distribution, with work ongoing to further develop these

Four existing dashboards were reviewed and enhanced in the reporting period:

- Public Health COVID-19 dashboard was updated to include latest vaccination criteria (autumn and winter booster) as well as Length of Stay measures
- Public Health Influenza Surveillance dashboard was updated to include review by Scottish Index of Multiple Deprivation codes (SIMD), latest vaccination criteria and Length of Stay measures
- Psychological Services Record Keeping Audit dashboard was updated to improve the functionality of review by individual teams
- Maternal and Infant Nutrition: Vitamin Distribution dashboard was updated to increase the number of locations for review

In addition, the following new areas of work were supported by the team during 2023-2024:

- Development and ongoing maintenance of new corporate level performance reporting to the Corporate Management Team (CMT) through the Balanced Scorecard which is updated on a weekly/monthly basis
- Updating monthly Clinical Governance and Corporate measures included in the new Integrated Performance & Quality Report (IPQR) sections
- Implementing a new quarterly review process and highlight report approach for the partnership dashboards to ensure the data can be disseminated to Governance Groups
- Data analysis support to the Healthcare Improvement Scotland (HIS) Scottish Patient Safety Programme (SPSP): Acute Adult Collaborative, with a focus on reducing falls, and early recognition and timely intervention of deteriorating patient
- Data analysis support to the Healthcare Improvement Scotland (HIS) Scottish Patient Safety Programme (SPSP): Paediatric Collaborative, with a focus on the scoring and reliable use of PEWS observations.
- Working with HIS representatives to review performance of Key Quality Indicators associated with the collaborative, undertaking further drilldown analysis to assist in process improvement
- Review of Staff Safety Culture Card performance in greater depth to inform the Staff Health & Wellbeing dashboard

The team delivered 3 virtual Data & Measurement Masterclasses during 2023-2024, to over 70 NHS Lanarkshire staff members across a variety of disciplines. These masterclasses provide education in data interpretation, variation, presentation, data formatting and visualisation, in line with the NHS Lanarkshire Data & Measurement framework. Further sessions are scheduled to be held during Quality Week 2024.

2. Quality Improvement

2.1 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.

Using QI methods and tools help frontline staff to identify areas of waste, non-value adding steps and constraints and bottlenecks within the healthcare system. QI can support improvements in quality and safety when staff are trained in the correct approaches to use.

It enables participants to learn about and practice using QI methods. Enabling staff to move from having 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.

By completing the programme staff are able to:

- Describe what quality improvement is and why it is important
- Describe commonly used improvement science concepts and tools
- Demonstrate how to practically apply key quality improvement concepts to a small improvement project
- Apply the concepts and tools to contribute to team improvement initiatives

The programme is delivered via MS Teams and currently takes place over 4 two hour sessions. There are general cohorts available to staff across a range of roles and we also deliver bespoke cohorts targeting a specific group. For example; a bespoke cohort was available to staff working on the Infection Prevention & Control Collaborative. Additionally, there will be a cohort in May 2024 specifically for Senior Leadership roles.

During this year there have been 4 cohorts of the programme with a total of 121 staff taking part. Participants range from a variety of professions, roles and areas with NHS Lanarkshire.

To support implementation of their learning participants are asked to apply the QI theory and practical skills they are learning to an area of their own work where quality and safety could be improved.

This feedback is from a Service Manager who has undertaken the programme, has applied the learning to various aspects of work as well as providing support and guidance to others in QI methodology:

> *"Since completing the aEQUIP course last year I have been able to utilise the knowledge, skills and tools in a number of pieces of work I have either assisted with or led on for NHSL and South Lanarkshire Health & Social Care. The most apparent benefit of the course has been utilised while supporting the staff and mainly team leaders that I manage in carrying out improvement work and guiding those staff with improvement methodology and outlining the key data for collection in order to assist in evidencing improvement and utilising for future key projects. Examples of these projects would include the delivery of the Blood & Go Service within Cambuslang & Rutherglen Treatment Rooms. This work has resulted in higher levels of patient satisfaction, reduced waiting times for GP accessing blood results and more recently a reduction in the number of hospital outpatient appointments". (Service Manager)*

This QI programme not only supports improvements to quality and safety for patients it also supports staff development and career progression. Several members of staff have used their new knowledge to support the SPSP Paediatric Collaborative improvement work on using the Paediatric Early Warning Score within the children's wards at University Hospital Wishaw. One of the Senior Charge Nurses within Paediatrics is now progressing their QI knowledge learned on aEQUIP and will complete a National Programme.

Two nurses from University Hospital Monklands credit the aEQUIP programme for their promotions into new leadership roles. One into a Band 8 role in the FLOW team and the other into a specialist role in the diabetic service.

Participants are asked to provide detailed feedback relating to each aspect of the programme content so that we can continually improve it. Some of the overall feedback received was:

- "An excellent course that was very well organised".
- "Thank you for giving me the confidence to start".
- "Thank you so much, all really interesting and useful, great to know the team are available".
- "This is amazing feedback [on homework] and really helpful. I wasn't expecting individualised feedback so thank you so much. Your points make sense and I'll start integrating them".

2.2 Leadership Quality Walkrounds

Leadership Quality Walkrounds (referred to hereafter as walkrounds) are part of the organisation's programme of work to improve our quality and safety culture and outcomes. Walkrounds also support the organisation to achieve the implementation of the 'Patient Safety Essentials' (CEL 19, 2013).

Walkrounds involving senior leaders and Non-Executive Directors have been undertaken in NHS Lanarkshire since 2014. These initially focused on patient safety in acute hospital wards and departments, subsequently extending to quality and safety in all sites including community hospitals and Health Centres and in 2023/24 extending again to include non-clinical teams and areas e.g. laundry.

Walkrounds are a key component of the NHS Lanarkshire Quality Strategy and by providing an approach to support Board members to engage with frontline staff it plays a key part in supporting a number of its True North Statements:

The walkrounds also demonstrate compliance with the Blueprint for Good Governance in NHS Scotland by creating opportunities for engagement and visibility of Board Members.

The Leadership Quality Walkround is not an inspection, audit or 'Back to the floor' exercise, it is an opportunity for frontline staff to:

- Discuss healthcare quality and safety issues openly and honestly
- Provide the opportunity to describe what they have done to improve quality and safety in their area.
- Celebrate success achieved through improvement initiatives
- Promote a quality culture of improvement and encourage reporting of and learning from adverse events
- Provide visible, listening leadership to identify actions to improve quality

A full review of the walkround process and outcomes was carried out in 2022/23. For year 2023-24 it was agreed that based on the feedback from approx. 70 stakeholders that changes would be made to the process including:

- Walkround teams should be limited to a maximum of 4 people (Executive Director, Non-Executive Director, Clinical Lead and Quality Lead). Frontline staff stated that a larger number of people visiting was not appropriate as this can be disruptive to the area.
- Where possible, walkrounds should be conducted primarily in the afternoons as feedback from frontline staff suggested this was a more settled time for services and for patients. Staff did not want to have walkrounds taking place in the evenings or weekends when they had less staff available and therefore less time to spend with the walkround team.
- Pre walkround documentation about the area being visited is now optional as staff demands and workload pressures do not always leave time for this and this reduces additional pressure on NHSL staff.
- Improvement Team will allocate Non-Executive Directors to walkrounds based on their availability and to ensure an even spread and equal representation of Non-Executive Directors across the year.

From April 2023 to March 2024 there have been 62 walkrounds with the following areas visited; 16 teams in University Hospital Monklands, 13 teams in University Hospital Hairmyres, 14 teams in University Hospital Wishaw, 10 teams in North Health and Social Care Partnership and 9 teams in South Health and Social Care Partnership)

During the walkround frontline staff raise areas of improvement and good practice which they have carried out and wish to celebrate and highlight. This provides them with an opportunity to share their good work and their sense of pride and achievement. It enables the Board members and others to listen to staff and provide immediate visible and compassionate leadership. Some of the many examples of great practice shared during walkrounds include:

- Many acute ward areas like ward 21 University Hospital Wishaw, report being proud of staff retention throughout challenging times (COVID and the recovery period) demonstrating a strong team dynamic and continuity within the team.
- Staff Wellbeing- Leaders from many areas report feedback that staff in their teams feel listened to, a feeling of camaraderie and some have made a conscious effort to focus on improving wellbeing by introducing new opportunities e.g. Emergency Department, University Hospital Monklands- team bonding sessions.
- Being innovative with managing waiting times and waiting lists e.g. Vaccination clinics now overbook appointments by the volume of DNAs they observe through data analysis leading to a more responsive service who maximise resource.
- Using digital solutions to improve communication across teams or MDTs- e.g. An AHP team in Camglen now use teams for daily MDTs and huddles to avoid duplication and share learning to improve patient experience and deliver a more joined care pathway.

It is also an opportunity for staff to raise any areas of concern they have that has not been resolved at an operational management level or raise issues which they feel Board members should know about. Any areas raised are noted in the form of an action and are recorded at the time of the walkround with a nominated lead to take forward progressing the action.

An example of issues highlighted during walkrounds in 2023/24 were:

- Providing clarity and feedback on staffing challenges
- Use of the workforce tool
- Opportunities to utilise staff differently (band 4/5 role)
- Availability of IT programmes and accessibility issues
- Challenges with space and layout of spaces in primarily acute areas
- Opportunities for staff training and learning opportunities.

The issues are discussed with the management team for the area visited and actions are created to address the issues highlighted by staff on the walkround.
In total 120 actions were recorded following Leadership Walkrounds in 2023/24 and approx. a third of these have now been completed and signed off. Two thirds are still outstanding and will now be escalated in March 2024 to ensure that the staff who raised the initial issue receive feedback on what progress has been made with it.

Walkrounds are welcomed by frontline staff and by members of the 12 visiting teams. Feedback from the host teams visited continues to be very positive. All host area leads agreed that they felt Walkrounds to be a positive and engaging experience.

"The walkround fostered good discussions". (Senior Charge Nurse)

"The leadership team appeared genuinely interested in the service". (Senior Charge Nurse)

"A supportive discussion with the team". (Senior Charge Nurse)

"The walkround was a great experience, thank you very much for giving us the chance to discuss and feedback on all our efforts and any issues". (Senior Charge Nurse)

"A really rewarding experience. I think both the leadership team and the staff in the areas visited got a lot from it. The departmental staff genuinely seemed to appreciate that the leadership team and the Board were taking time out to meet them, actively listen to them and thank them in person for their commitment over the last few difficult years". (Non-Executive Director)

"I found the pre-visit reading and reports extremely helpful and they informed discussions. The presentation and discussions with the Senior Nurse were excellent. I was really impressed with his leadership passion and drive for quality improvement and safety." (Child Health Commissioner)

"It was a very enlightening visit and so important to prioritise. The staff are fantastic people and their care and compassion really shone though the busyness". (Senior AHP Lead)

"I thought it was great- I was struck by the positivity despite the huge challenges." (Divisional Medical Director)

"I personally found the visit really rewarding. It is great to gain exposure to the services across the whole system and reminds us that we all need to work together to meet the needs of people in our communities, who just happen to be in a hospital bed. The staff were fantastic but very open and honest about the challenges". (Nurse Director)

3. Evidence for Quality

The latest Corporate Policy CMT Report which demonstrates if policies have been reviewed within the review timescale, shows the compliance percentage is above the 95% tolerance level (97.5%) in February, with four policies lapsed (2.5%). The CMT Report has been updated to give a clearer and more succinct overview of the status of corporate policies in NHSL. It outlines the total number of policies, the number of lapsed policies and relevant information. In addition, the new report enables us to highlight any risks, issues, or actions planned for the next reporting period. It is also now sent to the Audit and Risk Committee for noting.

To help staff with the growing number of national policies, the Corporate Policies team have worked alongside the Lead Web and Digital Officer to update the corporate policies public pages. The team have now added a separate section for NHS Scotland HR Policies, as the number of national policies, and links to these pages continues to grow.

We are still seeking a replacement for the existing system managed through the Access database and this will continue to be a risk until a new system has been agreed.

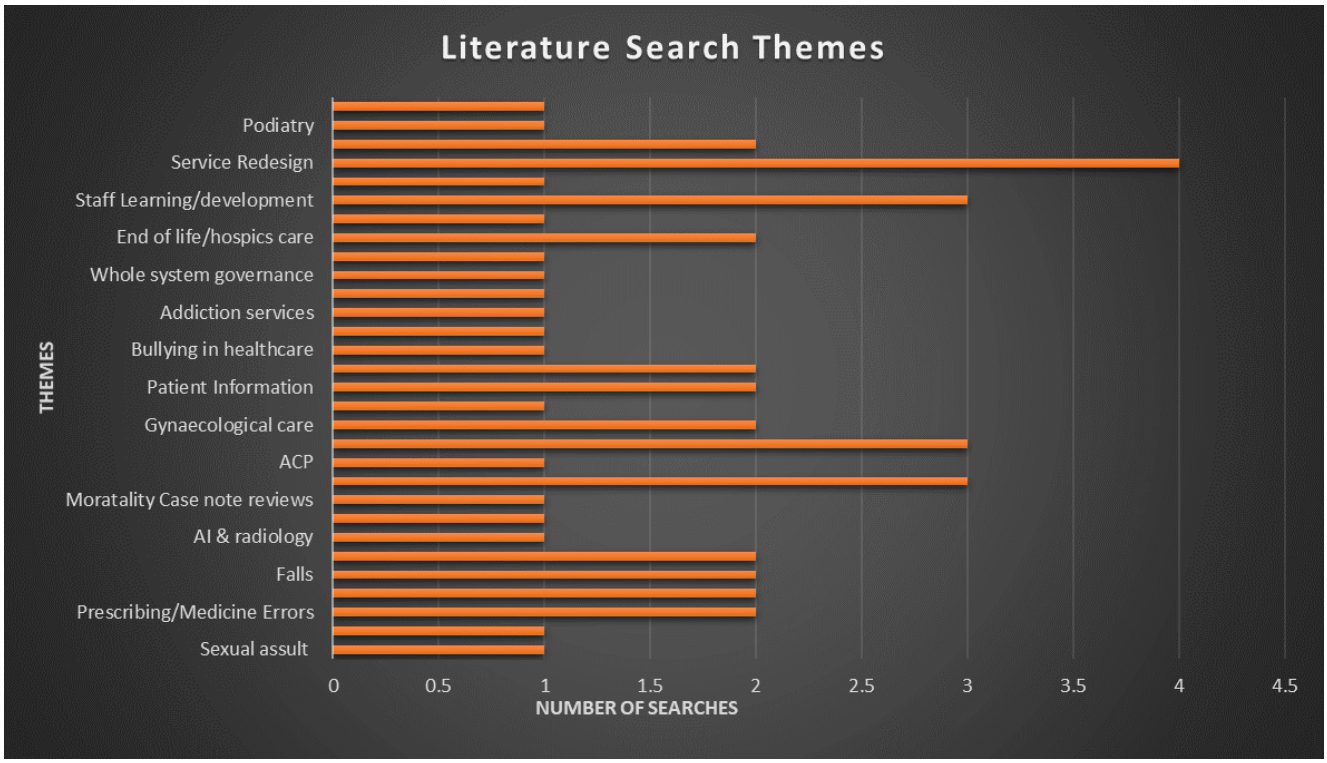
3.2 Literature Searching

This reporting period covers the period September 23- February 24.

In that period there were:

- Copyright Requests – **14**
- Literature searches – **53**
- MPR Searches – **6**

The themes for the searches in that period were:



3.3 New Process for National Standards

Work has commenced on a new process to ensure improved awareness and implementation of national clinical standards within in the board. The existing process has been in place for some time and while helpful as information was shared with clinical teams for self-assessment, there was a lack of corporate oversight and assurance that the standards were being implemented. The new process will identify any gaps and the formation of improvement action plans where required.

There are 2 recently published standards that will be used to test the new process:

1. Congenital Heart Disease
2. Cataract Surgery

This process has been presented at the Clinical Effectiveness meeting in February. Initial feedback on the process was positive with an acknowledgment of the need to be consistent in what is required back in terms of reporting and consideration of staffing pressures in particular teams. Leads will complete the test by April and results presented at the next Clinical Effectiveness meeting before being presented at QPPG.

Dr C Deighan
Board Executive Medical Director
March 2024