1. **PURPOSE**

The purpose of this paper is to provide a progress report to Lanarkshire NHS Board on quality assurance, with a focus on risk management.

2. **MONTHLY REPORT TO THE BOARD ON QUALITY ASSURANCE**

2.1 **NHS Lanarkshire Quality Dashboard**

This paper includes the NHS Lanarkshire Quality Dashboard for September 2013 (Appendix 1). This shows data up to June 2013. Narrative comments have been inserted into the Dashboard.

The Clinical Governance Committee proposed at a meeting on 26 August 2013 that in future the Quality Dashboard should be considered in detail by the Clinical Governance Committee and issues highlighted as appropriate to the Board for consideration. The Board is requested to consider this proposal.

In addition, information in relation to the person centred care quality ambition will be considered in detail at the NHS Lanarkshire Care Assurance Board with issues highlighted as appropriate through the Clinical Governance Committee to the Board.

2.2 **Clinical Governance Committee**

At the meeting on 26 August 2013 the Clinical Governance Committee considered:

- A verbal update on the Local Unscheduled Care Action Plan and Medical Staffing
- A verbal progress report on the establishment of the Care Assurance Board
- An update on the Hospital Standardised Mortality Improvement Programme (further information on this is provided in section 2.3 of this paper)
- A report on Mental Health Learning Disability – the Prevention and Management of Suicide
- A report considering the relevance to Lanarkshire of the findings and recommendations of the Francis Inquiry into Mid-Staffordshire NHS Trust including an undertaking to refer actions required to established NHS Lanarkshire groups for implementation
- An update on NHS Lanarkshire’s improvement plan on the management of significant adverse events and preparations for the Healthcare Improvement Scotland to review on these arrangements
- The Nursing and Midwifery Council (NMC) Supervisory Authority Annual Report 2012-13 which reviews South East and West of Scotland Region Boards (including Lanarkshire) against the standards set within the NMC, midwives rules and standards (2004 and 2012)
• NHS Lanarkshire’s Information Assurance Workplan
• A Clinical Governance report including a focus on the activity of the Quality Hub, The Scottish Patient Safety Programme and the Quality Dashboard.

2.3 Hospital Standardised Mortality Ratio (HSMR)

NHS Lanarkshire has continued to prioritise its response to the on-going high mortality ratios across the three acute hospitals and in particular Monklands Hospital. This is being driven by the HSMR Improvement Programme which focuses on key areas for improvement, working to tight timescales.

A revised Programme Plan was ratified at the HSMR Improvement Programme Board meeting on 13 September 2013. This is a working document which is used to monitor progress across the four workstreams. Each workstream is in the process of finalising Project Initiation Documents which set out for the projects; project objectives, approach, deliverables and benefits, constraints, communications, milestones and risk assessment. The Programme Plan includes Gantt charts for each workstream which will be used by the workstream groups to monitor progress and provide highlight reports to the Programme Board.

At the Programme Board on 13 September 2013 the following main areas of progress were noted:

Deteriorating Patient / Sepsis
• A Clinical Observational Policy has been finalised and circulated throughout the acute hospitals utilising Safety Briefs. This will also be promoted on NHS Lanarkshire’s intranet site as a background graphic. In addition, “Safety Huddles” of clinical staff will be utilised in the acute hospitals to promote the policy and to support the deteriorating patient workstream.
• The monitoring tool for assuring the accuracy and frequency of modified early warning scoring (MEWS) has been changed and the tool will be tested on a sample of five patients per ward. The findings from this test will used to inform improvement activity.
• An improvement team has been agreed for each acute hospital and these teams are developing spread plans for improvement.
• Training on Clinical Support Worker Recognition Assessment Support and Help (CRASH) and The Acute Life Threatening Emergencies Recognition and Treatment (ALERT) Training is on-going for identified staff groups with dates in place for each acute hospital in September and October 2013.
• Planning has commenced to improve the effectiveness of intentional safety rounding as a means to anticipate care needs and increase patient safety.
• The workstream has commissioned a review of Lanarkshire’s Hospital Emergency Care Teams and Minor/Major Injury/Illness Nurse Treatment Service (MINTS).
• Work is ongoing on the implementation of the Patientrack pilot (an electronic recording, monitoring and escalation system for patients’ whose condition deteriorates) in five wards at Monklands Hospital. I-Pads have been sourced and the software installed and is being configured for NHS Lanarkshire. Detailed planning has taken place for the first rollout ward (ward 2).
• Ongoing implementation is taking place of Sepsis 6 (an evidenced based intervention to ensure early treatment of sepsis) this has been targeted initially
at high impact areas, as identified from local and national data, including accident and emergency departments and emergency admission units.

- A measurement plan for the workstream has been agreed.

End of Life Care

- As part of a test of change at Monklands Hospital to identify how Anticipatory Care Plans (ACPs) can be used to enhance patient care in Accident and Emergency Department, and where necessary through an acute setting, discussions have taken place about ensuring that ACP documentation is communicated on admission as part of the clerk-in process.

- In addition, staff groups are being identified from several wards and specialties within the hospital to be involved in the test of change. A survey will be undertaken of these staff to establish their knowledge of ACPs and to identify training needs. An existing ACP resource pack will be used which contains all the relevant educational materials.

- The electronic Key Information System (eKIS) will be used to communicate ACPs undertaken by General Practitioners. This allows information on ACPs to be accessed through emergency care summaries by acute hospital staff. eKIS is enabled in 76 general practices in Lanarkshire.

- The Lanarkshire Emergency Referral Centre has implemented a prompt question on ACP. If a patient is identified as having an ACP they or their carer are requested to bring this on attendance or if it is held on eKIS the Accident and Emergency Department is notified.

Information and Quality Reviews

- A very informative meeting took place on 11 September 2013 with Information Services Division leads on coding and the HSMR model. A range of actions were agreed and the meeting discussed the definition of an admission diagnosis / diagnosis at the end of the assessment episode of an inpatient stay as well as other issues.

- Actions have been progressed to improve coding of daycase and inpatient admissions including:
  - Testing a sticker to collect coding information from consultants. The sticker has been successfully used at Hairmyres Hospital for emergency medicine admissions and its use is being extended to care of the elderly and surgical admissions. The sticker has had one test at Wishaw Hospital and agreement has been reached to test the use of the sticker at Monklands Hospital.
  - The digital letter template used by consultants for discharge letters has been reviewed to support improved coding. The revised template is now live on digital dictation and its format has been communicated to all consultants as well as information on the coding “dos and don’ts”.
  - A prompt card has been agreed covering the content required in discharge letters. The design of this has been provided by medical illustration. Once produced, each consultant will be provided with this prompt card.
  - Information services have designed with medical records a report on outstanding discharge letters. The report is being validated and following this, an escalation process will be designed to performance manage the timely completion of good quality discharge letters.
− As a short term measure to improve the accuracy of the Hospital Standardised Mortality Ratio, consultants have reviewed the coding of admission and discharge diagnosis for all deaths relating to April – June 2013 quarter.

− A report of the mortality casenote review undertaken of a sample of cases from the October – December 2013 quarter was presented to the HSMR Improvement Programme. The learning from this review reinforced the actions already being undertaken as part of the HSMR Improvement Programme Plan.

− A proposal for taking forward a systematic approach to mortality and morbidity reviews was agreed by the Acute Clinical Governance and Risk Management Committee at its meeting on 30 August 2013 and a pilot is on-going at Hairmyres Hospital. Implementation of the standardised approach will be supported by agreeing leads at each acute hospital and through the development of standardised web based reporting. A visit is being arranged to view a system in use at Forth Valley Royal Hospital.

**Clinical Leadership**

− Planning on the development programme for clinical leaders managing acute admission areas has commenced. Discussion will be undertaken with potential participants to prioritise and fine tune content to their needs. Most of the resources needed to enable such a programme are available in-house and areas where external input may be required have been identified.

− The appointment of additional staff for Hairmyres and Monklands Hospitals emergency medical acute receiving units and accident and emergency departments has been pending, awaiting the outcome of a bid to the Scottish Government as part of the Local Unscheduled Care Action Plan.

− As mentioned above improvement teams comprising of Consultant, Senior Nurse and Service Manager have been established to take forward the deteriorating patient workstream on each of the hospital sites.

**NHS Lanarkshire Rapid Review Assessment**

On the 27 August 2013, Healthcare Improvement Scotland announced that it had been commissioned by the Scottish Government to further scrutinise the interventions taking place in NHS Lanarkshire hospitals in relation to their HSMRs. The review is to:

− Provide an independent expert diagnosis on the factors which may underlie the HSMR figures including: a rapid review assessment of any systemic factors which may be impacting on the safety and quality of care and treatment being provided to patients in NHS Lanarkshire’ s Acute Hospitals.

− Consider whether the existing action by NHS Lanarkshire to address any key issues identified in the diagnostic phase is adequate, and whether any additional steps should be taken.

− Advise of any additional support that should be made available to NHS Lanarkshire to help strengthen and accelerate their improvement programme.

− Advise on any areas that may require further action.

The review has commenced and NHS Lanarkshire is collaborating closely with Healthcare Improvement Scotland to ensure its progression.
3. RISK MANAGEMENT

3.1 Risk Management Strategy and Work Plan

Risk Management Guidance Review

As scheduled, a review was undertaken of four of the current Risk Management Guidance sections:
- Incident Recording
- Escalation of Significant Incidents
- Undertaking a Critical Incident Review Using Root Cause Analysis
- Report Writing

The review resulted in the production of a simplified, single integrated guidance section titled *Incident Management* incorporating the core principles from the previous individual sections.

In addition to the simplification, further improvements were considered and proposed by the review group and endorsed through the Risk Management Steering Group:
- Inclusion of working definitions for clinical incidents and near-miss
- Inclusion of commissioning criteria for undertaking a Critical Incident Review
- Additions to the operational roles and responsibilities, specifically, ensuring there is a nominated contact person for patients, families and/or carers affected by a significant adverse event (supported by newly developed patient/family/carer information leaflet on Critical Incident Reviews to be available for operational managers end of September 2013 following endorsement through the Clinical Governance Steering Group)
- Agreed letter templates supporting effective sharing of Critical Incident Reviews

The updated Risk Management Guidance *Incident Management August 2013* has been launched through the staff briefings and can be accessed through the risk management webpage on Firstport at:


Healthcare Improvement Scotland has just published “Learning from adverse events through reporting and review: A national framework for NHSScotland, September 2013”. The Board’s Incident Management Guidance will be further updated in light of this.

NHS Lanarkshire’s review by Healthcare Improvement Scotland in relation to the management of significant adverse events was expected to take place around October / November 2013. However, resulting from the priority of Health Improvement Scotland Review of the Hospital Standardised Mortality Rates (HSMR), the significant adverse event review has been postponed until early 2014, with a review date to be confirmed.
Risk Management Work Plan

The following continues to form the core areas of work to continuously improve Incident Management:

- Monitoring and improving the performance and the management of incident recording, grading, and commissioning of Critical Incident Reviews and the subsequent management actions.
- Development of a Learnpro module for Critical Incident Review
- Delivery of Critical Incident Review training May – October 2013
- Implementation of an electronic documentation library system for management and tracking of, and providing assurance on, effective management of Significant Adverse Incidents /Critical Incident Reviews

3.2 Risk Management Framework and Monitoring

The following section provides monitoring information on incident recording; risk register development, monitoring and review; grading of incidents and risks and critical incident review all of which are the core elements of the Risk Management Framework.

Incident Recording

Key Performance Indicators (KPI) for the reporting, verifying and closing of incidents are continuously monitored by the risk management team and reported on in Table 2 below.

All operational units have access to the Datix system to oversee and manage their incident data, reporting through their respective management and/or partnership and Health and Safety Groups. Access and support for users and managers is facilitated through the risk management team.

The Risk Management Steering Group receives a report on incident closure performance by grading at each meeting.

Risk Grading of Incidents

Grading of incidents recorded directly on to the Datix system is mandatory and is monitored by the risk management team. Some areas within Property and Support Services Department still record on a paper format, and then transfer the information to the electronic system.

For the period April 2013 – June 2013, there was a total of 3,815 incidents recorded and verified with grading outcomes as in Table 1.

Table 1: Grading Outcome of Incidents April 2013 – June 2013

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Very High</th>
<th>Not-graded</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>379</td>
<td>858</td>
<td>43</td>
<td>2</td>
<td>0</td>
<td>1282</td>
</tr>
<tr>
<td>Non-Clinical</td>
<td>1143</td>
<td>1376</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>2533</td>
</tr>
<tr>
<td>Totals</td>
<td>1522</td>
<td>2234</td>
<td>57</td>
<td>2</td>
<td>0</td>
<td>3815</td>
</tr>
</tbody>
</table>

There is no significant variance in the overall numbers over previous quarters.
Table 2: NHS Lanarkshire Performance for Closure of Incidents for period April – June 2013 with the target performance agreed as 65%

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Closed within 10 working days</th>
<th>Closed within 20 working days</th>
<th>Closed within 45 working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>1522</td>
<td>79%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>2234</td>
<td></td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>57</td>
<td></td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>Very High</td>
<td>2</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Totals:</td>
<td>3815</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Risk Registers**

The agreed Risk Register Key Performance Indicator is the *Number of Risks reviewed within agreed timescale as a percentage of number of risks on Register*. This is subject to quarterly reports with outcomes as at 1 September 2013 shown in Table 3.

Table 3 Number of Risks reviewed within agreed timescale

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of ‘Live’ Risks</th>
<th>Number of Risks past Review Date</th>
<th>Percentage Compliance Last Quarter</th>
<th>Percentage Compliance This Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall NHS Lanarkshire</td>
<td>352</td>
<td>117</td>
<td>71%</td>
<td>67%</td>
</tr>
<tr>
<td>NHS Lanarkshire Corporate Risk Register</td>
<td>26</td>
<td>0</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Corporate PSSD – All Risks</td>
<td>60</td>
<td>10</td>
<td>86%</td>
<td>84%</td>
</tr>
<tr>
<td>Corporate IM&amp;T – All Risks</td>
<td>12</td>
<td>10</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>Acute Division – All Risks</td>
<td>58</td>
<td>36</td>
<td>49%</td>
<td>38%</td>
</tr>
<tr>
<td>North CHP - All Risks</td>
<td>93</td>
<td>7</td>
<td>75%</td>
<td>93%</td>
</tr>
<tr>
<td>South CHP – All Risks</td>
<td>34</td>
<td>33</td>
<td>67%</td>
<td>3%</td>
</tr>
<tr>
<td>Others</td>
<td>69</td>
<td>56</td>
<td>73%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Out of the 352 live risks managed through the Datix system. At 1 September 2013, there were 117 risks overdue for review, with overall compliance down from 71% in the last quarter to 67% compliance for this reporting period.

From the 352 live risks, the distribution of current assessed level of risk is set out in Table 4.
Table 4 Distribution of Current Assessed Level of Risk

<table>
<thead>
<tr>
<th>Area</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Very High</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lanarkshire Corporate Risk Register</td>
<td>7</td>
<td>12</td>
<td>7</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Corporate PSSD – All Risks</td>
<td>19</td>
<td>35</td>
<td>6</td>
<td>0</td>
<td>60</td>
</tr>
<tr>
<td>Corporate IM&amp;T – All Risks</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Acute Division – All Risks</td>
<td>11</td>
<td>27</td>
<td>19</td>
<td>1</td>
<td>58</td>
</tr>
<tr>
<td>North CHP - All Risks</td>
<td>10</td>
<td>56</td>
<td>27</td>
<td>0</td>
<td>93</td>
</tr>
<tr>
<td>South CHP – All Risks</td>
<td>4</td>
<td>25</td>
<td>5</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td>Others (laboratories, clinical governance</td>
<td>3</td>
<td>41</td>
<td>25</td>
<td>0</td>
<td>69</td>
</tr>
<tr>
<td>and risk management functions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall NHS Lanarkshire</td>
<td>56</td>
<td>204</td>
<td>91</td>
<td>1</td>
<td>352</td>
</tr>
</tbody>
</table>

Risk Appetite and Risk Tolerance
The Risk Management Steering Group has overseen a risk identified within the agreed tolerance indicator of a Very High risk on a risk register with Uncertain or Inadequate controls.

This very high risk has been described within the Acute Operating Division:

*There is a risk that NHS Lanarkshire does not meet the 4 hour emergency care target that 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment because of the increasing emergency admissions and acuity of unwell patients, a consequence of this is the significant clinical risk/patient safety issues this presents, with patients waiting beyond 4, 8 and 12 hours and an increase in the number of ‘boarders’.*

This risk is being overseen through the Risk Management Steering Group with assurance reporting by the Director of Acute Services.

4. STRATEGIC FIT

<table>
<thead>
<tr>
<th>Linkage to Corporate Objectives</th>
<th>Creation of a quality culture characterised by safe, effective and person centred services on all occasions 1.1 Develop a corporate quality culture 1.2 Deliver person centred care 1.3 Improve safety 1.4 Delivery effective care 1.5 Improve infrastructure for quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution to Quality</td>
<td>Paper provides quality assurance and improvement information for the Board.</td>
</tr>
<tr>
<td>Fit with 'A Healthier Future' Strategic Planning Framework</td>
<td>In line with overall aim to improve quality of care (person centred, safe and effective).</td>
</tr>
<tr>
<td>Financial Consequences</td>
<td>No consequences.</td>
</tr>
</tbody>
</table>
**Equality and Diversity Impact Assessment**  
Paper has a neutral impact on the equality target groups.

**Risk Assessment/Management**  
HSMR is identified as a corporate risk and has been added to the Corporate Risk Register.

**Consultation and Engagement**  
Paper aims to provide accountability and transparency through effective quality assurance reporting for both internal and external stakeholders.

**Fit with Best Value Criteria**  
Monthly Clinical Governance report demonstrates “Executive and Non-Executive leadership ensure accountability and transparency through effective performance reporting for both internal and external stakeholders and that there is a willingness to be open to external scrutiny, for example, through formal external accreditation tools.”

5. **CONCLUSION**

The Board is requested to consider the proposal from the Clinical Governance Committee that in future the Quality Dashboard should be considered in detail by the Clinical Governance Committee and issues highlighted as appropriate to the Board for consideration.

The Board is asked to note the content of this paper.

6. **FURTHER INFORMATION**

For further information about any aspect of this paper, please contact:

**Name** Carol McGhee (for update on Risk Management)  
**Designation** Corporate Risk Manager, telephone 01698 858099

**Name** Pam Milliken (for update on Clinical Governance)  
**Designation** Head of Clinical Governance and Risk Management, telephone 01698 858100  
16 September 2013