Borders NHS Board

PATIENT SAFETY & QUALITY: SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

Aim

The purpose of this paper is to inform the NHS Board of:

1. The Strategic Lead Patient Safety & Quality role
2. Overview of the National Scottish Patient Safety Programme (SPSP)
3. Highlight current local progress
4. Inform the Board of future plans and expected outcomes

Background

1. Strategic Lead Patient Safety & Quality role

This post will undertake a portfolio of responsibilities primarily in relation to the successful implementation and delivery of NHS in Scotland Quality Initiatives including the Scottish Patient Safety Programme and the Quality Strategy across NHS Borders, which will focus on patient safety, clinical effectiveness and person centeredness. The post is based in the Nursing and Midwifery Directorate but within a multi-professional context. The post has a strategic leadership function for patient safety in its broadest sense, including the SPSP, and quality initiatives mainly in relation to the quality improvement agenda.

2. Overview of the National Scottish Patient Safety Programme (SPSP)

The Scottish Patient Safety Programme (SPSP) is the first major work stream of the Scottish Patient Safety Alliance. The key objective of the SPSP is to steadily improve the safety of hospital care across the country. This is being achieved by using evidence-based tools and techniques in defined areas of clinical practice aimed to improve the reliability and safety of everyday health care systems and processes. Supported by the SPSP Programme Manager, real-time data is being gathered unit-by-unit, and frontline staff caring directly for patients undertake the improvement work that is required to achieve the aims of the Programme. Since January 2008 all acute hospitals (32) in all 15 Boards are taking part in the Scottish Patient Safety Programme**.**

The Programme recognises the complexities involved in delivering modern healthcare, and has been designed to standardise approaches to care. Drawing on national and international evidence, a series of interventions will be delivered to every patient, every time, under five work streams, namely:

- Leadership,
- Medicines Management
- General Ward
- Critical Care
- Peri-operative

There is good research to show which interventions make a difference when it comes to enhancing patient safety, and these are currently being implemented in all acute hospitals across Scotland. The Scottish Patient Safety **Paediatric** Programme has been launched nationally and local implementation will commence this month. National roll out of SPSP in **Mental Health** and **Primary and Community Services** is awaited.
During the five year period 2008-2013, steps are being taken to:

- Ensure early interventions for deteriorating patients
- Deliver evidence-based care to prevent deaths from heart attack
- Prevent adverse drug events
- Prevent central line infections
- Prevent surgical site infections
- Prevent ventilator associated pneumonia
- Prevent pressure ulcers
- Reduce staphylococcus aureus (MRSA plus MSSA) infection
- Prevent harm from high alert medications
- Reduce surgical complications
- Deliver evidence-based care for congestive heart failure
- Drive a change in the safety culture in NHS organisations

3. Current local progress
Thus far, there has been considerable progress in the Borders General Hospital across all clinical areas, which are actively testing and implementing in all work streams.

Leadership work-stream
Executive safety walk rounds and executive sponsors for each work-stream have been established, these provide an opportunity for the Executive Team to talk directly to the front line staff about patient safety matters and allows the Executives to offer help and support in the management of safety for patients. In addition, there are now executive sponsors linked to all of the 5 work-streams

General Ward work-stream
Substantial progress has been made in implementing processes which help to improve safety in the General Ward work-stream. One example is the safety briefings, when all staff gather together for 5 minutes and are briefed on any high risk situations within the ward. This method of communicating safety matters has reduced the number of adverse events and near miss situations in the wards. Examples include infection control issues, specifics about disorientated patients, special instructions for patients on certain types of treatments and patients with same names.

Peri-operative work-stream
The main focus of the Peri-operative work stream is on improving outcomes for patients who have had surgery. All theatres now have a system in place whereby all staff run through a full checklist in theatre prior to the commencement of any operation. This is a system which is designed to reduce the likelihood of any adverse events occurring and there has been a positive impact on patient outcomes. There has been minimal surgical site infection in orthopaedics and we are now extending this work to breast surgery.

Medicines Management work-stream
Medical staff engagement is increasing which has been significant in embedding the processes used to improve the management of patients medications from admission through to discharge, the intention being to reduce any adverse drug events.

Critical Care work-stream
Our local Critical Care work stream has been acknowledged by the SPSP Faculty team nationally as the gold standard for example there have been no infections in patients who have had a central line (a catheter which is introduced into a core body part) for over a year, the last infection was in June 2009. The Critical Care team always use the data resulting from the programme activities to examine the way that they deliver care, investigate when they do have any unexpected results and sustain the changes that they have introduced using the Model for Improvement.

Progress on the implementation of the SPSP programme is measured through a range of outcome and process measures. An **outcome measure** demonstrates the impact on the patient for example, the number of days gone by without an infection in patients who are on a ventilator. A **process measure** addresses the parts/steps in the processes that have been implemented, it measures whether the process is performing as planned. Hand Hygiene for example is a process. Another such process is the Ventilator Associated Pneumonia Bundle. A **'bundle'** is simply a series of research evidenced based interventions which have been proven to be of benefit to the patient and, if collectively implemented, provide a standardised process of care.
The following table summarises the measurement of the changes being tested and implemented across all work streams

Table 1

Team	Type of Measure	Number to be completed	Current Status
Critical Care	Outcome	9	9
	Process	9	9
General Ward	Outcome	5	5
	Process	9	7*
Medicines Management	Process	3	3
Peri-operative	Outcome	1	1
	Process	7	6
Leadership	Outcome	1	1
	Process	1	1

Key Red – Underperforming
Amber – Current performance moderately below the trajectory set
Yellow – Meeting trajectory

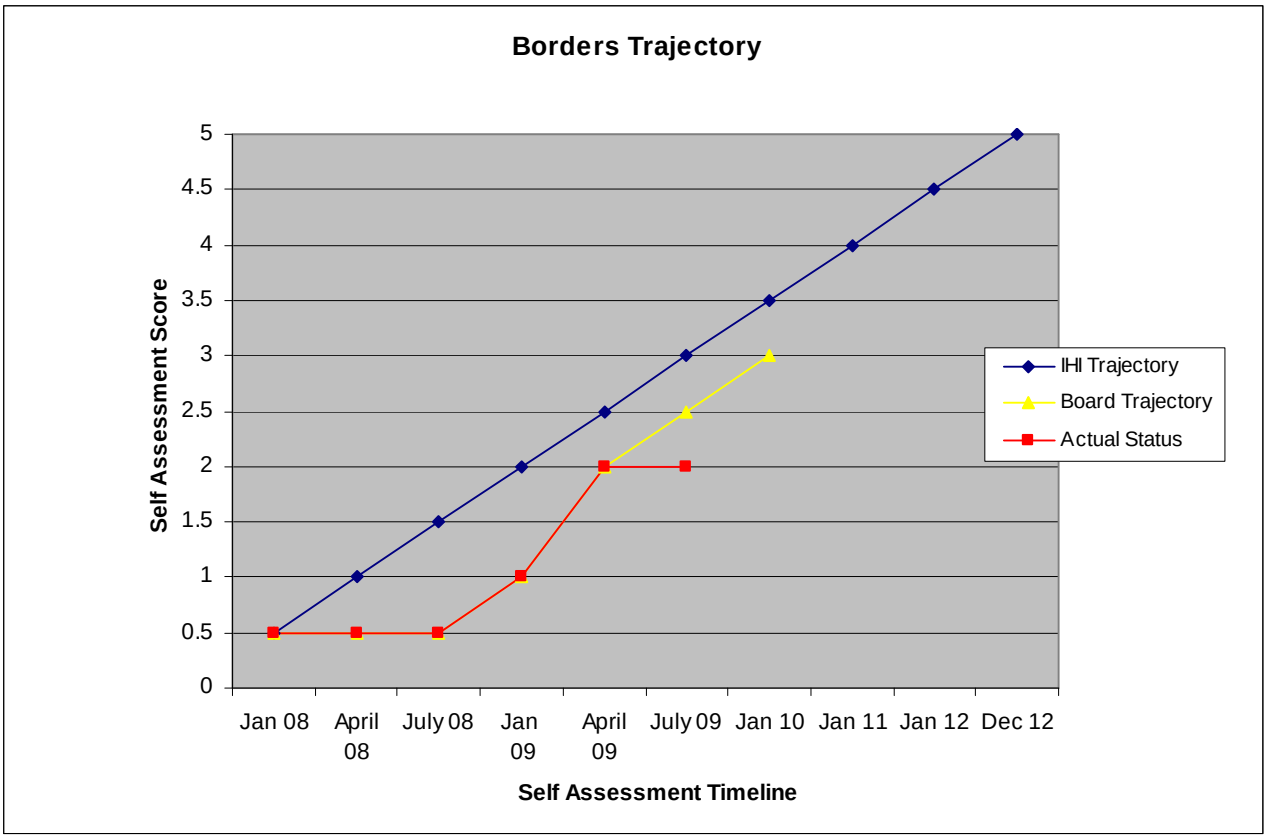
*In the General Ward work stream, two of the process measures are sub divided into three separate measures

4. Future plans and expected outcomes
The performance of each Board is measured by the (IHI) using an assessment scale which is graded between 0.5 up to 5 (see trajectory below). Each stage requires demonstration of progression within the pilot areas gradually building up from testing

changes through to evidencing sustained improvement. This applies to all measures in all work streams. As we still have some measures not fully established, we have not yet reached our target.

One Board (Tayside) has achieved point 3 on the scale, nine Boards have achieved a 2.5 Borders is currently at **2.0**, and expected to achieve **2.5** by September 2010 and **3.0** by the end of December 2010.

NHS Borders Trajectory



Risks

Continuing education in the methodology for implementing the programme is essential. Spreading the activities throughout the BGH is continuing however, it is difficult to ensure that staff in clinical areas new to the Model for Improvement and using the 'Plan Do Study Act' cycle have sufficient awareness and understanding of the model and its application. This is a significant risk to the continuous evolvement and correct adoption of the programme as reliable processes and data are paramount. A new 'Bundle' is being introduced this month on Heart Failure this, together with consideration of the roll out to Paediatrics, Mental Health and Primary Care remain the highest risks to the successful implementation of the SPSP across NHS Borders. This is partially addressed by the current national education programmes to build local capabilities in improvement skills.

A further risk to the delivery of the programme across the whole of the Board, is the likelihood of the withdrawal of the (IHI) as our full time technical experts and the current SPSP reporting computer system will no longer be available. This is being addressed nationally by Scottish Government.

Summary

Local SPSP expected outcomes 2010/11

- Integration and implementation of SPSP from point of care to Board
- Building a **sustainable** infrastructure **embedding** SPSP methodologies
- **Physician** and **Executive** engagement
- Making improvement 'business as usual'
- **Building** further **capacity** and **capability** in Improvement skills
- **Integrated** work programmes and measurement strategies
- **Increase % compliance** with e.g. hand hygiene, peripheral venous cannulation and daily safety briefings
- Developing **a Safety Culture**; Teamwork and communication, Education in the human factors, which influence behaviour at work effecting patient safety, use of the Situation, Background, Assessment, Recommendation (SBAR) tool, ward patient safety briefings and roll out of the RCN Patient Safety Climate Culture Tool

Recommendation

The Board is asked to **note** this SPSP update and **approve** future plans and expected outcomes.

Policy/Strategy Implications	This report is in line with the NHS Healthcare Quality Strategy (SGHD 2010)
Consultation	Not applicable
Consultation with Professional Committees	Not applicable
Risk Assessment	Not applicable
Compliance with Board Policy requirements on Equality and Diversity	Yes
Resource/Staffing Implications	None identified.

Approved by

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