EMBARGOED UNTIL DATE OF MEETING.

Greater Glasgow and Clyde NHS Board

Board Meeting

April 2011 **Board Paper No. 11/ 10**

Dr Brian Cowan, Board Medical Director
Andy Crawford, Head of Clinical Governance

Scottish Patient Safety Programme Update

Recommendation:

Members are asked to:
Review and comment on

- the ongoing progress achieved by NHS GG&C in implementing the Scottish Patient Safety Programme

NHS Greater Glasgow and Clyde Target statement

The overall NHS GG&C aim is to ensure the care we provide to every patient is safe and reliable and the local implementation of the Scottish Patient Safety Programme will contribute to this aim.
Our SPSP aim is to achieve full implementation of the core programme in ASD by the end of Dec 2012. (The core programme includes improved staff capability in all wards, creation of reliable processes for every relevant element in every ward.) We will also develop and fully describe SPSP style improvement programmes in Paediatrics and Mental Health services in 2010, then in Primary Care and Obstetrics in 2011.

Progress Points

a) We indicated in the previous report on SPSP implementation to the Board that NHS Greater Glasgow and Clyde believes we have now met the conditions for the next point on the assessment scale, level 3.5, and are asking the National SPSP team and IHI advisors to review and confirm the local assessment.

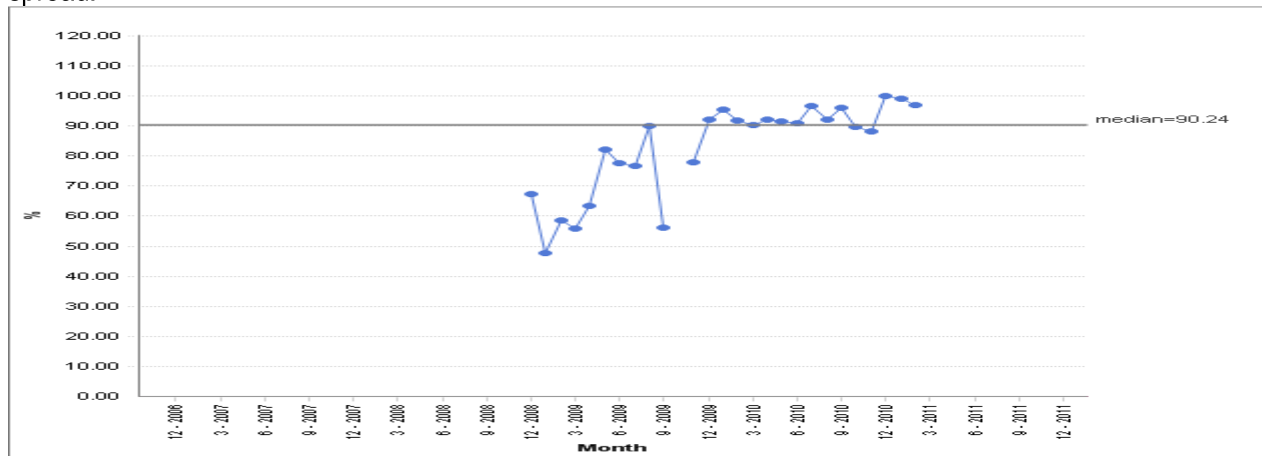
Level 3.5	Sustained improvement (three months without sliding backwards) is noted in process and outcome measures for pilot populations in all five work streams. Spread (including testing, training, communication, etc.) of all key changes is underway beyond the pilot populations.

The position has not been clarified so it is presumed we remain at level 3. More importantly we remain unclear as to the reasons why we have note satisfied the criteria. We still consider that we have met the requirements and are engaging with IHI advisors to resolve this uncertainty.

As the Board is aware we have demonstrated sustained reliability in a pilot population for all elements in the programme. The major challenge for the Board over the next two years is spreading the reliable practices to all applicable clinical teams.

b) We wished to highlight one of the areas we are working on, which is ensuring patients do not become cold prior to or during surgery i.e. sustaining normothermia (normal body temperature). The following chart is of the percentage of patients in the monthly samples where normothermia is maintained. This shows the work at Victoria Infirmary and the improvements generated then of sustained performance in excess of 90% reliability are clearly seen. What is not visible is that this now includes the New Victoria Hospital theatres as well as the

Victoria Infirmary. In the last two months the measurement samples have included in excess of 400 patients over the two sites and importantly continued to achieve high reliability. This is an example of very successful spread.



c) There continues to be good progress in developing reliability of medicines reconciliation at admission. Extending from initial success in Glasgow Royal Infirmary we are now seeing reliability emerge in other areas notably the Acute Medical Unit and Coronary Care Unit at Royal Alexandra Hospital and in Acute Medical Unit at Southern General Hospital.

d) Previous reports highlighted to the Board the Hospital Standardised Mortality ration (HSMR) for the combined adult services at Royal Alexandra Hospital (RAH) and Vale of Leven Hospital (VoL) had been flagged up, when compared to other Acute Hospitals in NHS Scotland, as having a HSMR that was not showing improvement in line with the expected SPSP aims. Although this does not necessarily mean that there are problems with the quality or safety of patient care at the hospital, we are using the HSMR as a starting point to explore areas of potential variation, worthy of further consideration, and to identify if any improvements might be possible or required. The updated version of Action Plan for improving the HSMR at Royal Alexandra Hospital/Vale of Leven has been shared again at the end of February, for external critical review, with colleagues in NHS QIS. This first version was positively received and we are expecting this to be the case with latest plan.

e) As we begin to look ahead to the end of the first five year phase of SPSP (December 2012) we recognise the importance of understanding how current progress matches expectations. A major review of internal predictions against the SPSP first phase milestones at December 2012 is underway and due to be presented to ASD CG forum at its April meeting. This will allow more detailed discussion on areas and means to accelerate programme implementation. At this point, after four waves of introduction to start teams up into programme we are working with 270 clinical teams from wards, theatres, critical care and high dependency. The final ten wards will be commencing in the next month, which means the original start-up plan, set in 2008, has been delivered four months ahead of schedule.

f) NHS GG&C has tried to make full use of the nationally supported developmental programmes. We have three graduates and two staff in the current cohort of the SPSP Fellowship – aimed at creating clinical leadership for quality improvement – and are actively promoting the next round of opportunities which is being advertised across the Board. In addition to the core programme in acute services we are hopeful that there will be interest from both primary care and mental health whose services are currently developing SPSP programmes.