Greater Glasgow and Clyde NHS Board

Board Meeting

24 February 2009 **Board Paper No. 09/16**

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NHS GG&C SPSP Update for NHS GG&C Board February 2009

Recommendation:

Members are asked to:

Review and comment on the progress achieved by NHS GG&C in implementing the Scottish Patient Safety Programme (SPSP)

1. Introduction

Safeguarding patients receiving care is a key strategic priority for NHSGG&C. NHS GG&C is demonstrating this commitment by a variety of means but a major element is its participation in the Scottish Patient Safety Programme (SPSP).

The Acute Service Division is currently supporting 31 pilot sites and this report provides an overview of progress to date within the programme.

3. Background

The SPSP approach focuses on improving safety by increasing the reliability of healthcare processes in Acute care. This is achieved by front line teams testing and establishing more consistent application of evidence based clinical or communication processes through four clinical work-stream packages. These packages are for Critical Care, General Ward, Peri-Operative and Medicines Management. The success of this activity is monitored through a measurement framework and supported by enhanced commitment to the priority of patient safety from organisational leadership. This is linked to an overarching set of improvement aims which are currently stated as follows;

- Hospital Mortality: 15% reduction
- Adverse Events: 30% reduction
- Ventilator Associated Pneumonia: Reduction
- Central Line Bloodstream Infection: Reduction
- Blood Sugars w/in Range (in ITU/HDU): 80% or > w/in range
- MRSA Bloodstream Infection: 50% reduction
- Crash Calls: 30% reduction
- Harm from Anti-coagulation: 50% reduction in Adverse Drug Events
- Surgical Site Infections: 50% reduction (clean)

The programme is planned and tracked around six component objectives (see also appendix one Programme Matrix). These are outlined in the following table and have been used to structure reporting on programme implementation.

Component Objectives: 1	To complete the pilot and spread of reliable designs for safety-crucial communication and care processes in the four clinical content areas
Component Objectives: 2	Provide the Leadership system to support the improvement of safety and quality outcomes in NHS GG&C
Component Objectives: 3	Deploy system of safety metrics that enables understanding and prompts actions that can improve safety and quality outcomes in NHS GG&C
Component Objectives: 4	Support a learning collaborative, internally and in SPSP events, to exchange experience and learning that enables improvement
Component Objectives: 5	Generate an evaluation framework that contributes to internal and national learning over the outputs, mechanisms and contextual dimensions necessary for improvement in safety and quality outcomes.
Component Objectives: 6	Delivery of all extensions to programme formally supported through NHS GG&C SPSP implementation programme base.

2. Reflections on Component Objectives

2.1.a Progress in Front Line Pilot Teams

NHS GG&C initiated its involvement with a first phase commencing January 2008 involving 9 front line teams (FLTs) in two hospitals. In general these FLTs are maintaining tempo that keeps NHS GG&C in line with the published SPSP timeline for the clinical work-streams. As we progress towards the summer and initiation of spread the confidence that pilots will have of complete testing and design of reliable process becomes crucial.

Two of the Phase One General Ward pilots are making good progress and there is reasonable confidence that milestone three will be met for all content areas.

The two Phase One Critical Care pilots have made good progress and there is reasonable confidence that milestone three will be met for all content areas.

The two Phase One Peri-operative pilots continue to experience problems with measurement and incomplete data that is limiting ability to consider whether reliable practice designs are in place. The teams own description and opinions suggest that a number of practices are now consistently in place.

The two Phase one Medicines Management pilots continue to experience difficulties around medicines reconciliation and although inhibiting factors are being addressed by leadership there is diminishing confidence over milestone 3 attainment in this area.

The following table is an extract from ASD monthly monitoring reports. It shows part of the reports from phase 1 pilots in applying general ward package. The Senior Management team can see where testing is occurring and what the data indicates about the reliability of the process. In this example we can see that for three of the elements in the General Ward package ward 11 at Glasgow Royal Infirmary have completed testing and implementation but also that the reliability of their design is very high.

Team	Earl Warning Scores	Safety Briefings	PVC Bundle
Phase 1 **GRI** Ward 6	Implementing to all patients	Implementing daily briefings	Small scale testing of new PVC care plan
	Compliance variable low- mid 80%	Compliance 67% for Oct/Nov	Measuring
Phase 1 **GRI** Ward 11	Implemented to all patients	Implemented twice daily briefings	Implemented to all patients
	Compliance steady 95-100% last 3 month	6 Run chart data points at 97% to 100%	Compliance at 100% for 2nd month

A second phase of programme was launched by ASD in June 2008 extending the programme to a further 21 wards. The Phase two pilots continue to make steady progress utilising the experience from phase one as they develop.

2.1.b Spread planning

The first stage in SPSP implementation involves demonstrating firstly the efficacy of safety methods in the local context and secondly the prototyping of reliable designs in the defined pilot sites. The second stage is the translation of methods and reliable designs across the rest of the organisation.

Drafting of the Spread Plan is advancing as an iterative process. An initial paper outlining key issues and basic configuration of phased spread was considered by November SMG. ASD directorates are currently completing the identification of candidate sites for phase 3. The most recent draft of the spread plan is attached as appendix two.

The target for each phase of spread is outlined in the following table.

Phase	Scale (number of locations)	Commencing	Completing	Cumulative total of sites showing reliability across work-stream at each year end
One	9	Feb 2008	Mid-2009	Zero by end of 2008
Two	22	June 2008	End-2009	31 by end of 2009
Three	60	Mid-2009	End-2010	90 by end of 2010
Four	90	Mid-2010	End-2011	180 by end of 2011
Five	120	Mid-2011	End-2012	300 by end of 2012

Recent meetings with the national programme leads from QIS and SGHD helped explore and confirm general acceptability of target numbers in an escalating spread model over next three years. The meeting also identify options for additional assistance to address scale of next phase especially at start up.

2.2.a Progress against SPSP national assessment scale

One of the key aims of the Leadership team is to maintain progress in line with the national parameters for programme implementation (see table below). The underlying position for Phase 1 has been agreed with SPSP appointed advisors (IHI) to have reached 2. We are one of the few Boards in NHS Scotland to have achieved this level.

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The projected performance against the assessment scale (table below) indicates that having recovered initial slippage. The ongoing problems with measurement in peri-operative workstream are confounding our ability to show underlying reliability of practice. This means we are likely to drop behind trajectory during 2009 but regain any loss by the end of the year when level 3.5 should be achieved on time. The criteria for levels beyond this are currently unclear requiring further discussion with SPSP.

National parameters for SPSP implementation

Score	Definition	SPSP target dates	NHS GG&C dates (Actual/ predicted)
0.5	Pre-work completed by due date and pilot populations and teams have been identified for all five work streams.	Jan 08	Met - on timescale
1.0	Testing in all work streams is underway. Measurement system is being developed and at least half of the process and outcome measures are being collected and reported on the Extranet	Apr 08	Met - August 08
1.5	Results on all outcome measures are being reported on the Extranet. In addition, all process measures relevant to the work currently underway are being reported on the Extranet. Improvement noted in process measures in pilot populations in at least two work streams. Initial plans for spread within each hospital are being developed.	July 08	Met – December 09
2.0	Improvement noted (using run chart rules) in process and/or outcome measures for pilot populations in three or more work streams.	Jan 09	Met - Jan 09
2.5	Improvement noted (using run chart rules) in process and/or outcome measures for pilot populations in all five work streams.	Apr 09	Predicted May 09
3.0	All key changes in all five work streams have been implemented in the pilot populations. Sustained improvement noted (using run chart rules) in process and outcome measures in one to three pilot populations.	Jul 09	Predicted Aug 09
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.	Jan 10	Predicted Jan 10
4.0	Spread (including testing, training, communication, etc.) of all key changes has been achieved in one to three (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas	Jan 11	Unclear
4.5	Spread (including testing, training, communication, etc.) of all key changes has been achieved in all (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas.	Jan 12	Unclear
5.0 .	Spread has been achieved in all five (breadth) work streams with 100% penetration (depth) into the applicable clinical areas and has been sustained (no backward slipping in the outcome measures) for a minimum of three months.	Dec 12	Unclear

2.2.b Leadership Action Plan

The Senior Management Team are given a specific set of challenges to address and make explicit the commitment to patient safety. These are outlined in the Leadership Action Plan (see appendix three). There are ten specific requirements provided and so far NHS GG&C has made very good progress and completed seven. A further requirement is completed when this report is reviewed by the Board as the first of the regular reporting scheme. The next requirement is to "place safety and quality issues at the top of senior leader meeting agendas". This is complete for a range of key groups but we need to clarify whether this should extend to NHS GG&C Board meetings, which will allow us to meet this requirement. The final aspect relates to the measurement scheme which is a maintenance requirement requiring ongoing attention for the duration of the programme.

2.2c Feedback following site visit

SPSP national team have conducted two formal site visits to review NHS GG&C. The most recent of which occurred in November 2008. The feedback report was recently received and is being shared with all those involved in the programme. The following is an extract from the report and indicates the sense that our progress to date is positively perceived.

Extract from SPSP NHS Greater Glasgow & Clyde – Site Visit Report November 2008

Leadership and General Observations

The team is clearly facing huge issues in relation to the size of the organization and the logistics of setting up and spreading the SPSP work across all sites. The infrastructure and operational plans developed by Andy Crawford and the team are providing the organization with a vital framework on which to build. Brian Cowan, Board Medical Director, clearly provides a great deal of leadership to this programme. He has a clear sense of the work, both the challenges and the opportunities. The individual work streams have identified executive champion and their own programme manager. That programme manager is responsible for spreading the work specific to the work stream across all sites. This role is vital in terms of connecting and sharing progress across teams/sites. The monthly report detailing progress is impressive and makes clear both the extent of the effort and the depth of the challenge facing a board of this size.

The spread plan clearly lays out how GG&C will complete the spread of changes within the five years of the project. It is very apparent how carefully thought out this work has been and how strategic its position in GG&C.

The entire leadership team attended the luncheon session. This is a remarkable achievement in itself given the demands on their time and attention. The leadership provided by this group sends a clear message to the teams concerning the importance of the safety work.

Walk-rounds have been conducted monthly a plan for the next year has been completed. Leaders shared that it would take two years to get back to sites for a second round of walk rounds. Increasing the visits to biweekly might be a viable approach to get back to units more quickly.
Impressive progress has been made since the last visit. Teams of frontline clinical staff turned up to share their progress and we really needed more time to have been able to speak to all these staff who were eager to discuss the work.

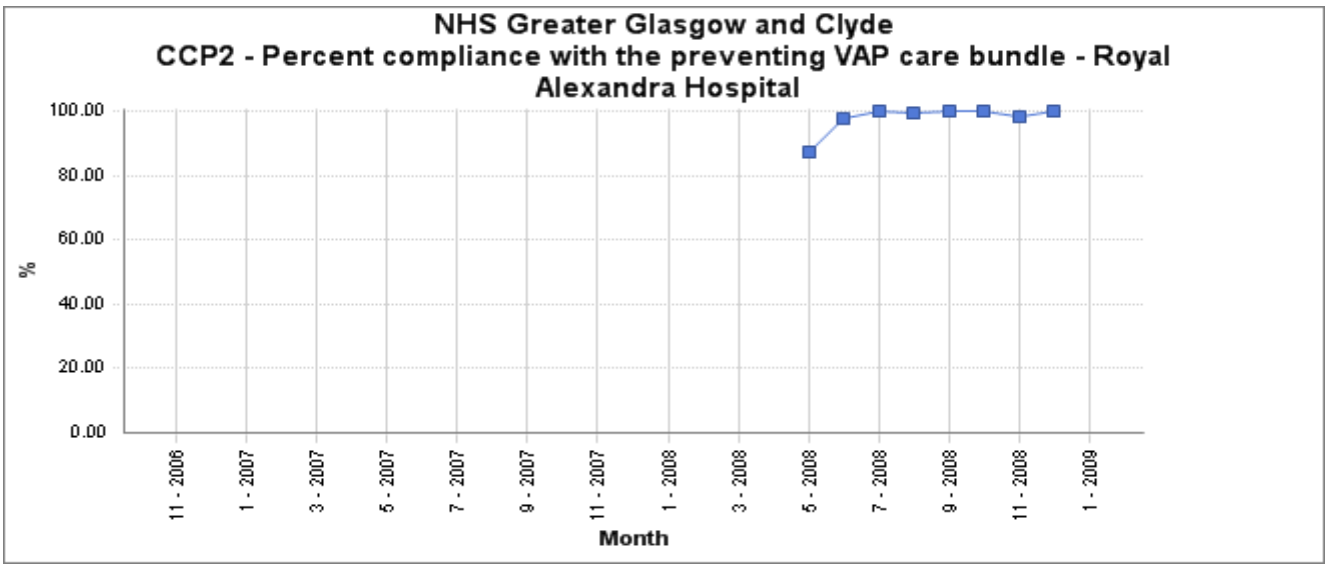
2.3 A system of safety metrics

Successful measurement is seen by SPSP as a cornerstone of successful improvement. Measurement is carefully constructed and viewed as an opportunity for learning and improvement. It is highly localized so that staff can see that they can effect change, and contrasts with measurement for judgment that is viewed as the NHS norm.

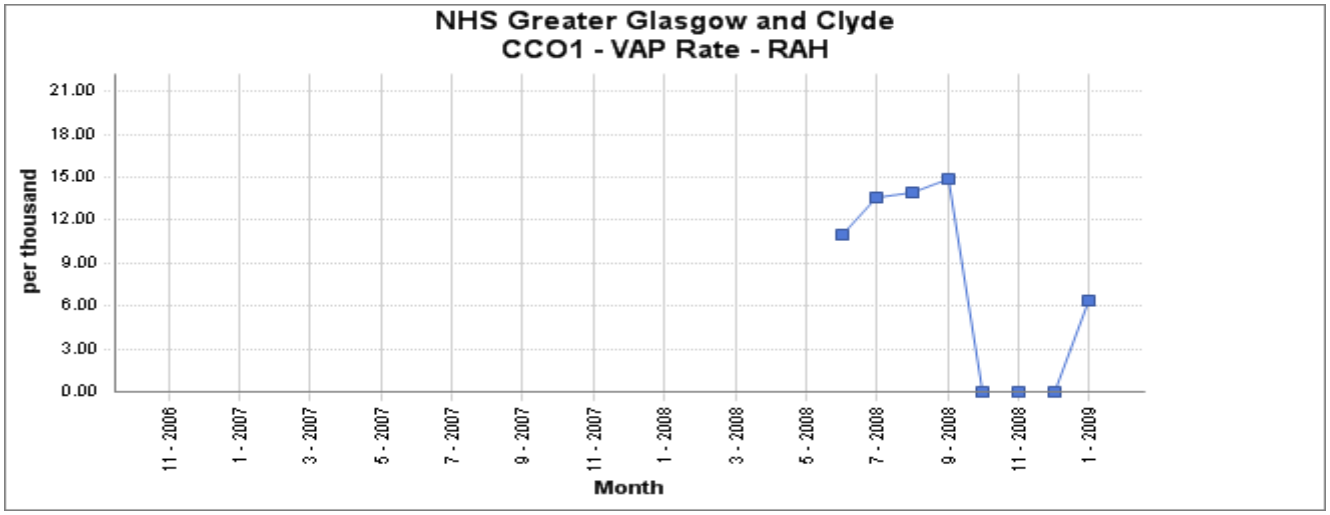
SPSP uses a measurement plan that extends across the programme and includes Outcome Measures, Process Measures and Balancing Measures (viewing system change to ensure no adverse consequences arise elsewhere). Data is viewed in annotated graphs so that staff can see the effect of changes they are making.

The first chart is an example of a run chart on one teams compliance with the prevention of Ventilator Associated Pneumonia. There are a number of practices that all need to be reliably performed for each

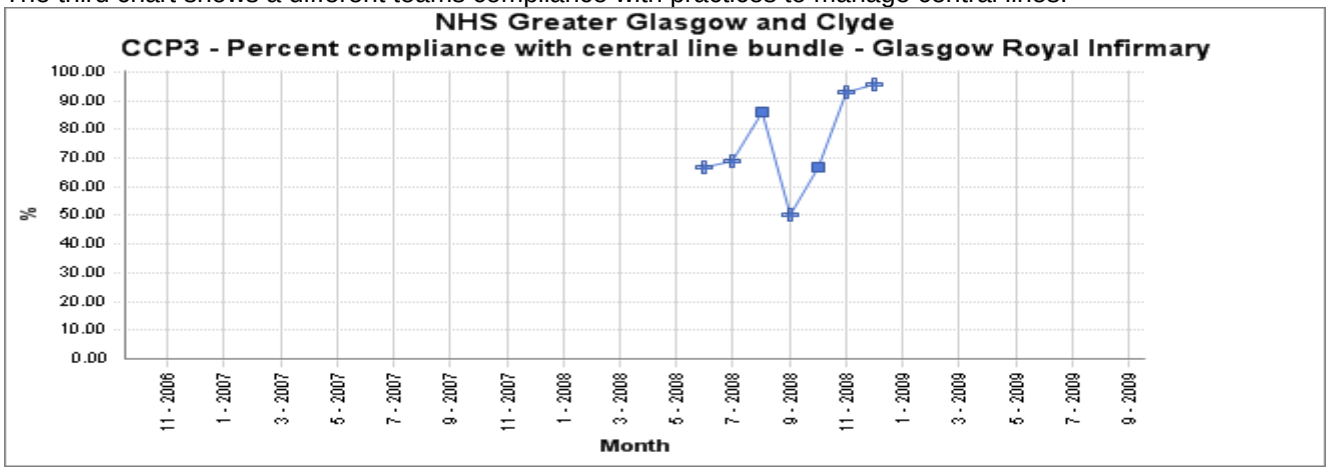
patient before compliance is achieved. Here in this chart we can see the team have found way to sustain high levels of reliability over a number of months. They were working on improvement before the measurement was in place but from comparable teams it is reasonable to expect that initial performance was of the order of 40-60%. (Note the x-axis extend before the start of the programme in NHS GG&C which was January 2008).



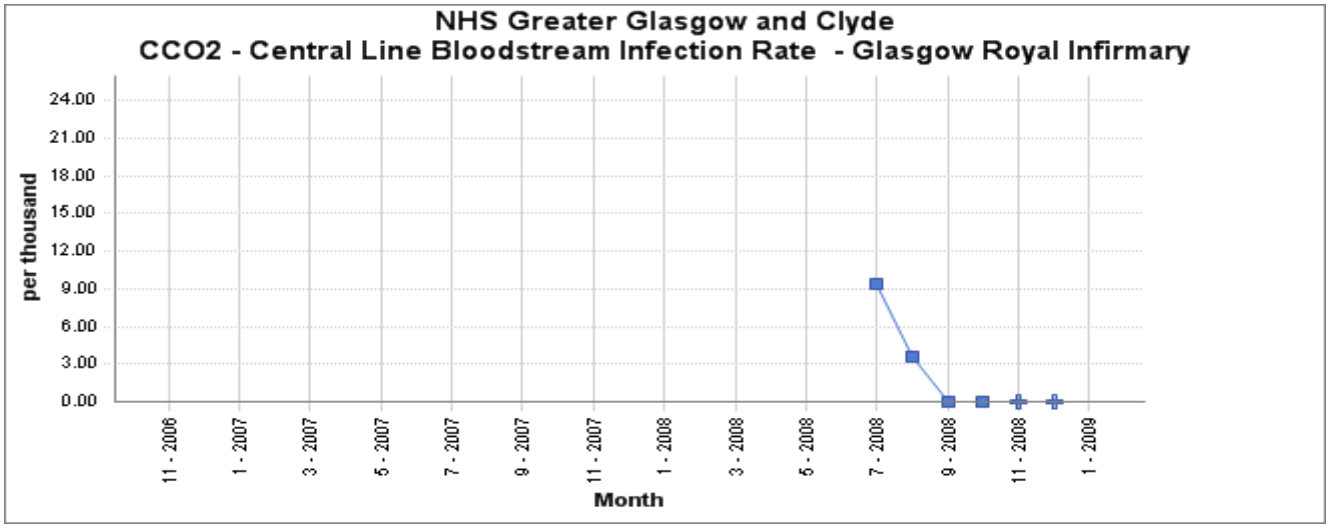
In this second chart we can see the impact of the teams work on patient safety through the rate of Ventilator Associated Pneumonia.



The third chart shows a different teams compliance with practices to manage central lines.



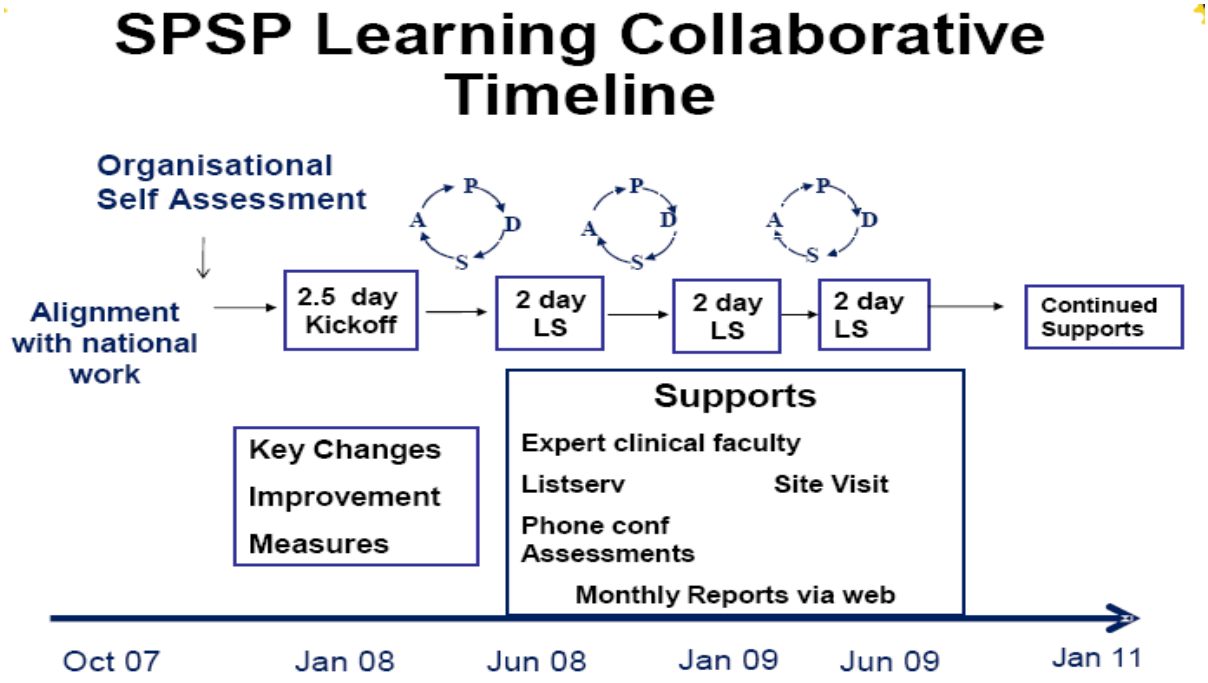
The fourth chart shows a reduction in their central line bloodstream infection rate.



NHS GG&C are now beginning to observe improvement in a number of areas across three of the four clinical work-streams. In the fourth the problems of maintaining data collection are proving a challenge. Whilst we do need further development of the measurement system and more time to be fully satisfied these improvements are genuine the early experience of the use of such charts is proving extremely encouraging.

2.4 Learning collaborative

SPSP has sustained an extensive network for supporting local programme frameworks. In addition to our own local meetings there are regular conference calls, feedback reports, site visits, and national conferences. This is outlined in the flowing chart.



Feedback from SPSP on our internal approach and our level of engagement with the various opportunities has been very positive. Two of the six places on the SPSP Fellowship were awarded to GG&C staff. Ten staff are currently attending a five day Patient Safety workshop being run by NES and SPSP. NHSA GG&C staff have been very prominent in facilitating workshops at national and regional events. More recently over 60 NHSGG&C staff attended the national SPSP event in Edinburgh during mid-January. The fourth national event for the SPSP will be on 19 and 20 May 2009 in the SECC.

2.5 Evaluation

There is as yet no national evaluation framework, though we understand this is in development. Progress in achieving process reliability or improvement in safety outcomes is built into the measurement scheme. We are however conscious that there are other impacts and in particular mindful of how staff capability for safety improvements may translate in future years from the core programme to other opportunities. This will be monitored through the Boards Patient Safety Group who have a remit for integrating the lessons from SPSP into the existing clinical risk management framework.

As part of the evaluation approach Acute Services Division is going to work with patient safety researchers at the University of Aberdeen who are conducting a survey of organisational safety culture in a sample of acute hospitals in Scotland. This will provide a measure of how clinical staff view aspects of their workplace that can influence the safety of patients. The short tem benefit will be a baseline on safety climate of our hospitals. Eventually this will lead to creation of a validated tool for NHS Scotland.

2.6 Extension of Core programme

The core programme focuses on four clinic areas (Critical Care, General Ward, Peri-Operative and Medicines Management) with an established set of elements in the work-stream package for each area. The current programme arrangements are keen not allow scope creep to jeopardise the ability of NHS GG&C to deliver but it is inevitable that staff will seek to exploit other opportunities. To ensure these are appropriately constructed some input will be required. There are three forms by which extension appears to be occurring.

There are likely to be extensions to the number of active elements in the work-stream packages. There are currently discussion between SPSP and NHS QIS on Coronary Heart Disease and it is expected this will be added in to the General Ward requirements.

There are likely to be developments of new packages or existing packages in new areas. Discussion is underway with Women and Children's Directorate on application of existing packages in a paediatric setting and on creation of an obstetric package.

There are likely to be adoption of individual elements of SPSP. The Global Trigger Tool is used to explore adverse events not normally detected by spontaneous reporting or significant clinical incident review arrangements. Yorkhill has recently engaged with a UK workgroup to create and run a GTT for paediatric hospitals. Other services such as mental health have expressed interest in GTT for their setting.

3.Conclusion

After the first challenging year supporting SPS implementation NHS GG&C has made good progress that has been positively evaluated from a national and local level. Acute Services Division has further major challenges in completing the first two phases and launching spread in this next year. The scale of spread is unique to NHS GG&C but the approach and commitment of staff is encouraging and we remain hopeful that progress will be sustained.

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Appendix one

NHSGG&C SPSP Implementation Programme Matrix (last update February 2009)

The following table outlines the high-level planning structure for programme management of SPSP implementation, exploring the relationships, verification and assumptions underpinning the programme Goals (the broader impact of programme participation), Purpose (the direct requirements and consequences of the programme) and Components (the necessary structure of activity and task sets necessary to realise the purpose and goal).

Plan Description	Indicators	Means of Verification	Assumptions
NHS GG&C Goal: To develop the application of quality improvement techniques that generate and sustain improvements in levels of clinical safety for the patients and of safety culture staff in NHS GG&C	1. SPSP programme outcome aims relating to 15% reductions in morbidity by 2012 and 30% reduction in GTT detected adverse events by 2012 for all acute hospitals in NHS GG&C 2. Reductions in frequency and forms of harm events 3. Feedback from staff 4. Feedback on patient experience 5. Results of Nationally sponsored evaluation framework	1. Internal data collected in line with SPSP measurement strategy 2. Other safety related sources e.g. RCA of significant events, targeted surveillance data 3. National Safety Culture survey, training needs & capability surveys (and possible narrative analysis to be established) 4. Better Together, PFPI developments (and patient involvement projects to be initiated through SPSP) 5. NHS QIS/SPSP reports	
Plan Description	**Indicators**	**Means of Verification**	**Assumptions**
Programme Purpose: To implement SPSP within NHS GG&C ensuring all specified requirements are met within parameters deemed to be acceptable to the NHS QIS National SPSP Steering Group and SGHD • reduce rate of Ventilator	1. NHS GG&C performance against the SPSP assessment scale and programme trajectory is maintained within accepted limits. 2. Spread across NHS GG&C is achieved at a sufficient rate to achieve full deployment through Acute Services Division	1. Internal data collected in line with SPSP measurement strategy both with respect to outcome and process measures and timeline for achieving results 2. Internal monthly assessment verified by SPSP Faculty feedback 3. Internal monthly	The aims of SPSP and application of its methods can be realised in the various organisational contexts within NHS GG&C SPSP can be synergistically integrated with existing or new patient safety and quality improvement programmes Political priority continues to reflect the

Associated Pneumonia • reduce rate of Central Line Bloodstream Infection • increase Blood Sugars w/in Range (ITU/HDU): 80% or > w/in range • reduce MRSA Bloodstream Infection by 50% • reduce Crash Calls by 30% • reduce harm from Anti-coagulation associated ADEs by 50% • reduce Surgical Site(clean) Infections by 50%	by December 2012 3. Process reliability and safety outcomes realised at SPSP expected levels	progress reports endorsed by NHS GG&C Executive Sponsor & Leadership team feedback 4. Tracking reports against spread plan 5. SPSP outcome and content area process measures as relating to work-streams, Directorates and Hospitals	underlying organisational, legal and moral imperatives to improve patient safety levels in NHS Scotland.
Plan Description	**Indicators**	**Means of Verification**	**Assumptions**
Component Objectives: 1 To complete the pilot and spread of reliable designs for safety-crucial communication and care processes in the four clinical content areas	1. Degree of reliability or safety achieved 2. Progress against SPSP timescales for pilot sites 3. Progress against timescales created in NHS GG&C Spread Plan	1. The monthly reports on the specific measures related to each content area 2. Programme management review in quarterly and monthly reports to ASD SMG	Reliability of clinical processes can be sustained at a rate sufficient to impact on overall safety levels The experience of progress and tempo from voluntary programmes is transferable to nationally sponsored mandatory programmes.
Plan Description	**Indicators**	**Means of Verification**	**Assumptions**
Component Objectives: 2 Provide the Leadership system to support the improvement of safety and quality outcomes in NHS GG&C	1. Completion of elements outlined in SPSP Leadership. 2. SPSP implementation progress within accepted parameters	1. NHS GG&C Leadership Development project plan 2. SPSP feedback on trajectory and process/outcome measurements 3. Staff feedback on	Three main challenges of capacity, capability and clinical engagement are adequately resolved. An adequate programme infrastructure can be developed and sustained in the face of

	3. Development of additional local aims/objectives to advance safety leadership	their perception as to the level of leadership commitment to patient safety. 4. Rates of completion of leadership walk-round and rate completion of actions committed to during walk-rounds.	prevailing resource constraints.
Plan Description	**Indicators**	**Means of Verification**	**Assumptions**
Component Objectives: 3 Deploy system of safety metrics that enables understanding and prompts actions that can improve safety and quality outcomes in NHS GG&C	1. Submission of all required measures to SPSP website 2. Emergent use of NHS GG&C custom measures 3. Review and display of charts at local level to drive design and improvement 4. Review of charts by leadership to drive system change	1. Programme management review in quarterly and monthly reports to ASD SMG 2. Programme management FLT assessments linked to monthly reporting arrangements	A sufficient data capture infrastructure can be sustained across pilots and spread sites. The principle of data for improvement not judgment can be preserved
Plan Description	**Indicators**	**Means of Verification**	**Assumptions**
Component Objectives: 4 Support a learning collaborative, internally and in SPSP events, to exchange experience and learning that enables improvement	1. Staff participation levels in collaborative mechanisms 2. Staff feedback on value and impact of opportunities	1. SPSP event evaluation reports 2. NHS GG&C event evaluation reports 3. Assessed levels of collaboration internally between implementation sites and with other NHS Boards	Resolution to local issues or barriers is accessible through this network There is sufficient organisational capacity to generate high levels of staff participation
Plan Description	**Indicators**	**Means of Verification**	**Assumptions**
Component Objectives: 5 Generate an evaluation framework that contributes to internal	1. There is an increasing level of NHS GG&C staff inputting to national and	1. Programme management review in quarterly and monthly reports to ASD	The methods can be deployed successfully and regarded as element in NHS GG&C ongoing approach to

and national learning over the outputs, mechanisms and contextual dimensions necessary for improvement in safety and quality outcomes.	organisational leadership 2. Awareness of methods is spreading across all staff with an associated emergence of local experts 3. Participation in nationally sponsored evaluation framework is at high levels	SMG 2. Staff knowledge and training needs assessment reports 3. SPSP feedback on programme implementation	quality improvement. The enhancement of capability at all levels is necessary to generate a stronger safety culture.
Plan Description	**Indicators**	**Means of Verification**	**Assumptions**
Component Objectives: 6 Delivery of all extensions to programme formally supported through NHS GG&C SPSP implementation programme base.	1. Delivery of design and testing on HPS CDAD treatment and measurement package.	1. Individual reports and feedback from sponsoring agencies	Additional developmental projects can enhance understanding without compromising the integrity of core programme objectives and aims.

Appendix Two

Spread Plan for SPSP implementation in NHS GG&C

(version 3 at January 2008)

The first stage in SPSP implementation involves demonstrating firstly the efficacy of safety methods in the local context and secondly the prototyping of reliable designs in the defined pilot sites. The second stage is the translation of methods and reliable designs across the rest of the organisation. This paper describes an approach to the second stage, referred to by SPSP as Spread, and is predicated on the assumption that the requirements for the first stage are met.

The first step in creating the plan for spread is to define an aim of what is to be achieved, for whom, by when and where. Then the spread plan should address "the "how" of spread and includes communication methods and channels to reach and engage the target population; a measurement system to assess progress in meeting the spread aims; and anticipation of the actions needed to embed the changes into the organization's operational systems".[1]

The NHS GG&C aim is:
To generate understanding of SPSP quality improvement methods amongst clinical staff and that they then demonstrate application of knowledge by creating reliable processes for at least one of the existing four clinical workstream packages in all clinical wards in NHS GG&C Acute Services Division by the end of 2012. Approved at December ASD SMG

Reflections on the aim

It is important to recognise that the NHS GG&C vision for on going implementation of SPSP extends beyond the universal performance of reliable clinical practice. It includes providing staff with the capability to sustain improvement through influencing and informing attitudes on safety and quality, giving access to and support in using tools/methods with the purpose of significantly augmenting the safety culture.

The aim is already out of date even within one month of approval as it is challenged by the SPSP National Steering Groups view on the programme aim as "everything everywhere". The aim needs to be expanded to include a commitment that all wards will progress beyond the initial work-stream package to implement all relevant content areas specified within the core programme. This revised aim will be presented for approval at February ASD SMT.

How to Spread

[1] Massoud MR, Nielsen GA, Nolan K, Nolan T, Schall MW, Sevin C. *A Framework for Spread:From Local Improvements to System-Wide Change*. IHI Innovation Series white paper. Cambridge,Massachusetts: Institute for Healthcare Improvement; 2006. (Available on www.IHI.org)

It is necessary to create phased approach to implementation. In considering the many management challenges faced by ASD in 2009 and the longer term benefits of other initiatives such as Senior Charge Nurse Review the scale of each yearly target has been incrementally adjusted. The basic model of implementation targets has been endorsed by ASD SMG. The plan has also been reviewed with SPSP senior staff from SGHD and QIS who expressed comfort around intentions offered support in launching next phases. The target for phases of spread are outlined in the following table.

Phase	Scale (number of locations)	Commencing	Completing	Cumulative total of sites showing reliability across work-stream at each year end
One	9	Feb 2008	Mid-2009	Zero by end of 2008
Two	22	June 2008	End-2009	31 by end of 2009
Three	60	Mid-2009	End-2010	90 by end of 2010
Four	90	Mid-2010	End-2011	180 by end of 2011
Five	120	Mid-2011	End-2012	300 by end of 2012

Identification of the specific locations for spread is being undertaken with individual Directors and their management teams. During this process other factors and specific Directorate requirements also need to be identified including potential no-go areas.

At this stage the Spread plan paper is more focused on the process of how we create the spread plan, recognising that over the coming months the content described in the paragraph above will be articulated in increasing detail.

Communication methods and channels

General awareness - There have been a number of events to develop awareness amongst staff and developments in the national marketing approach are expected to contribute further. However the challenge of creating large scale understanding is significant and though this will continue a more targeted approach is deemed necessary to support effective spread. Staff working in existing pilot sites have given a strong message that appreciation of SPSP in other teams and services is very limited.

Specific awareness in advance of implementation – It is recognised that leadership requirements are specific to each Directorate and to individual to each workstreams. In particular improving engagement at speciality level has been repeatedly highlighted. It is proposed that individual communication and awareness plans are established for each Directorate. One new aspect of the process is the intention to establish an assessment tool for exploring the pre-conditions for teams entry to programme with the aim of maximising the potential for success in the early implementers. We have recently identified benefits of linking middle management to more explicitly to each front line team. This is likely to lead to their inclusion in education and applying new model of engagement building on phase 1 and 2 experiences.

Stakeholder analysis - The GG&C SPSP programme staff have already been collaborating with ASD Organisational Development to scope out risks, benefits and learning points associated with the other major quality and service developments in NHS GG&C ASD. There has also been liaison with other colleagues and IHI staff to consider the required characteristics, scope and dimension of NHS GG&C's spread plan. Links have also been established with Senior Charge Review implementation arrangements, Resuscitation Committee, Practice Development. However there are likely to be other internal stakeholders with specific needs to be met.

Measurement system

The existing SPSP measurement strategy is expected to form the basis of ongoing measurement system, though as local experience develops this is expected to be refined. There is also an enhanced evaluation framework being developed at national level, which will inform local measurement of progress.

Actions

1. **Explore the Directorate needs and views regarding**
   - potential sites for early implementation and areas to be deliberately excluded
   - specific communication needs and methods for key groups in the Directorate
   - process for initial identification and recruitment

- Obj. 1 HoCG to meet all participating DMTs by end December 2008
  Outcome- complete
- Obj. 2 All participating DMTs to identify candidate spread locations and associated work-stream by 14 February.

2. **Initiate relationship with candidate sites/teams to create awareness, knowledge and commitment as prelude to programme becoming active in team**
   - Engagement plans tailored for each directorate are required

- Obj. 1 Establish outline engagement plans by 28 February

3. **Scope out criteria for suitability of future sites for implementation of SPSP**
   - Learning from pilot sites
   - Scope out conditions for success
   - Assessment of each sites and approval for inclusion in programme

4. **Undertake more detailed stakeholder analysis**
   - Clarify other stakeholders who need to be directly involved or advised e.g. Planning/HI&T/L&E

5. **More detailed analysis of organisational objectives and programme risks, especially associated with other major developments**
   - Mapping of other initiatives
   - Contingency in cases of pilots being unable to generate reliable design for spread
   - Expand programme risk register

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Appendix Three

NHS GG&C SPSP Leadership Development Project Plan (Last update mid-February 2009)

Outcome:- *Provide the Leadership System to support the Improvement of Safety and Quality Outcomes in your Board*		
Primary Drivers	**Secondary Drivers**	**Update**
1. Develop the infrastructure to support quality and safety improvement (note additional items 1z and 1y are not part of SPSP driver set)	a. Establish an SPSP Implementation Committee **Complete**	1a – <u>The SPSP Implementation Working Group is in place</u>. It is chaired by Medical Director, as SPSP Executive lead. The format has been revised to incorporate the higher number of pilots following on from phase two launch. Emerging issues are being linked to SMG feedback and routine reports. Fuller evaluation has been completed. Reaction positive but for review at next meeting and at SMG. **Next steps**- Test of meeting timing to take place in March exploring whether more or different staff are able to attend.
	b. Ensure a feedback mechanism for issues raised in Walk-rounds **Complete**	1b – <u>The feedback mechanism is in place</u>. The administrative approach has been based on experience from other sites more experienced in using this device. It has been tested and revised to include protocols for immediate feedback to wards, tracking of actions progress to completion and overall monitoring reports (including themes analysis) linked to ASD SMG. The deployment of agreed additional administrative resource is complete. An evaluation report is in preparation for review at next ASD SMG where both the emerging themes and possible improvements will be considered. **Next steps**- Identify further revisions to format in light of ongoing evaluation by end of March 2009.
	c. Ensure the development of a measurement system used to understand and drive patient care quality and safety indicators	1c - The measurement system is in place for phase 1 pilots sites and data is being reported to SPSP website. Deployment of the measurement scheme is well advanced for two pilots. Run charts for available data are now being linked in to SMG reports and have been shared with Board structures through reports and presentations. Pilot wards are also displaying local data for staff and RAH ITU has charts on public display **Next steps**- Complete the deployment of data collection arrangements for all process and outcome measures in phase 2 pilot locations by end of April 2009.
	d. Assign a senior leader to each improvement area **Complete** z. Maintain a communication plan that underpins awareness of all stakeholders in patient safety	1d. <u>Leadership assignments in place.</u> Each Director has assumed Sponsor role for work stream pilots in their own areas of responsibility. Additional thematic leadership is provided for Medicines issues and

	y. Create a strategy & plan to develop staff capability	Infection Control. 1z - Communication with stakeholders is a key domain in our local implementation plan. Pilot sites have direct support from SPSP, via Listserve and the IHI Extranet facilities, which is supplemented by local meetings and bulletins. In considering awareness of other groups a number of presentations/updates have occurred. The ASD middle managers are a key group who have received increased input to support their knowledge and awareness. Recent mechanisms include display and presentation at ASD OD event, article in Staff Newsletter and presentations to numerous management meetings. Patient and public involvement is growing slowly but there is a national communication strategy being developed that will support us in working with this key stakeholder set. **Next steps**- Aim for further article in April Staff Newsletter and internal marketing drive through Spring 1y – Front line teams in pilot, programme managers and leaders have attended national SPSP conferences. This personal development has been applied internally through coaching and educator roles. Two NHS GG&C staff were nominated and successful in securing SPSP Scottish Fellowship training places. 10 staff from NHS GG&C are attending the new NES/SPSP Patient Safety Course. Programme Managers have displayed knowledge and skills through support to national programme and network events. Ongoing work with OD team and support team for Senior Charge Nurse Review to map out issues and developments complimentary to SPSP ensuring a consistent approach to develop staff capability for safety and quality improvement. (Note this underpins spread plan)
Primary Driver Two	**Secondary Drivers**	**Update**
2. Provide oversight to programme	a. Meet with the Programme Manager remove Barriers **Complete**	2a – <u>Mechanisms to engage with Programme Managers are in place.</u> There are a number of mechanisms to identify and address barriers. Executive lead meets with Programme Lead each month. The leadership team meet with front line team leads at six weekly Implementation Working Group meetings. There are monthly reports by Programme Lead to ASD SMG to engage broader leadership arrangements in SPSP support. The programme managers meet regularly with teams then meet as a group fortnightly to identify progress and barriers. The Head of Clinical Governance as programme lead has also started to meet directly

	b. Meet regularly with the SPSP Implementation Committee to track progress and remove barriers **Complete** c. Display the Gantt chart that depicts progress toward SPSP goals **Complete**	with front line teams. A second faculty visit also took place in November and feedback was generally positive. 2b - <u>Meetings are in place.</u> The leaders are an integral part of SPSP Implementation Working Group and there are regular reports to ASD SMG. The information needs of the Directorate Senior Management Teams is being addressed through the submission of monthly updates. 2c - Monthly progress reports have been provided to SMG then used a basis for communication with internal stakeholders. A reporting format to represent progress against SPSP expected tempo has been developed through testing process and endorsed by IHI. Selected results are on display in the ASD Management team corridor.
Primary Driver Three	**Secondary Drivers**	**Update**
3. Promote the position of safety and quality in the organization	a. Ensure that the senior team participates in Walk-rounds <u>Local aim- complete over 50 walk-rounds by end 0f 2008</u> **Complete** b. Place safety and quality issues at the top of senior leader meeting agendas c. Add SPSP progress and outcomes to the Board Agenda	3a – <u>Senior Team Participation has been established and sustained</u>. **NHS GG&C local aim was met – by end of 2008** **NHS GG&C ASD completed 63 walk-rounds** 3b – <u>Prominence of safety priorities has been established in key meetings</u>. The Clinical Governance Committee have traditionally placed patient safety issues at the top of the agenda. The Clinical Governance Implementation Group and ASD SMG have also revised meeting arrangements and agenda. 3c – <u>SPSP progress and outcomes have been established as monthly agenda item for ASD SMG</u>. There are reporting lines to Board and corporate structures including seminars, reports to Clinical Governance Committee, updates to PPPG and personal reports to the Chief Executive and Chairman. **Next steps**- A report to the full public meeting of the Board is being established and will occur every two months from February 2009 onwards.