Greater Glasgow and Clyde NHS Board

Board Meeting

15 December 2009 **Board Paper No. 09/ 66**

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Scottish Patient Safety Programme Update

Recommendation:

Members are asked to:

Review and comment on

- the progress achieved by NHS GG&C in implementing the Scottish Patient Safety Programme
- the need to create an endorsed SPSP aim at Board level

1. Introduction

Safeguarding patients receiving care is a key strategic priority for NHSGG&C. As part of the way NHS GG&C will demonstrate this commitment it is participating in the Scottish Patient Safety Programme (SPSP).

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 clinical or communication processes. The success of this activity is monitored through a measurement framework and supported by a visible commitment to safety from organisational leadership. This is linked to an overarching set of improvement aims which are currently stated as follows;

• Mortality: 15% reduction
• Adverse Events: 30% reduction

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

The Board will note that following implementation aim relates to the core programme and has been specifically approved by the Acute Services Division. As the programme extends into Primary Care and Mental Health settings the question as to whether the Board should establish and endorse an overall Board aim emerges.

In implementing SPSP 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 relevant clinical work-stream packages, and all relevant elements from other work-stream packages, in all clinical wards in NHS GG&C Acute Services Division by the end of 2012. Approved at ASD SMG February 2009

2. Key Points for attention

2.1 Progress against the national SPSP assessment scale for Boards

The NHS GG&C progress is currently assessed as level 2.5 by the national SPSP team. Level three requires that –
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.
There has been good progress in implementing all key changes in the pilot populations. A phase one General Ward pilot team has completed reliable implementation of three out of five of the elements in their work-stream. A phase one Critical Care team has completed reliable implementation of four out of eight of the elements in respective work-stream. A Peri-operative team has completed reliable implementation of five of seven elements in their work stream. Overall improvement, using run chart rules, has been observed in over three quarters of the measures across all work streams.

However the Boards progress towards the next level in the scale is not likely to secured be until next year due to challenges around demonstrating reliable process design in medicines reconciliation and limitations in connecting process improvement at the level a few wards and hospital data quality associated with outcome measures. The national team and the national SPSP Steering Group have been advised of this situation.

2.2 Examples of Specific Progress Showing Link Between Process Reliability and Outcome

The most significant results in terms of process reliability and outcome improvements has been observed in critical care. The team at the Royal Alexandra Hospital ITU have maintained process reliability for the central line bundle at 100% for over six months. This was associated with a period of 379 days without a any central line bloodstream infections. The team at Glasgow Royal Infirmary ITU have maintained process reliability for the ventilator associated pneumonia (VAP) bundle at above 90% for over six months. This was associated with reduction in VAP and it is now 334 days since one has occurred in the unit.

2.3 Spread plan

ASD reached its target of 60 new teams formally commencing in the programme during 2009. The process of working with each Directorate is now underway, to agree next wards for inclusion and how best to undertake their preparation and launch. There is a challenge in building an adequate support structure, given the prevailing economic conditions, that will be needed for what is a doubling of the scale of the programme in ASD along with new work areas being launched in mental health and primary care.

A programme for implementation of a Paediatric work-stream has been progressing in Women and Children's Services linked to a dedicated national steering group. Following a recent meeting it is expected that this will now progress formally and is already being supported from the ASD SPSP

programme team. Early discussions on SPSP in Mental Health have taken place with the idea of applying methods to generate reliable implementation of safety crucial aspects of the Mental Health Integrated Care Pathway being developed.

2.4 Learning collaborative

The recent visit by SPSP national team to GG&C was deemed as positive by staff and the visitors. Some local pointers were provided to the front line teams visited and a discussion on Global Trigger Tool led to commitment for a joint summit in February, but overall the visitors were very encouraging about the programme progress in GG&C. (Note - The Global Trigger Tool is a method of detecting adverse events, advocated by the Institute for Healthcare Improvement) that can in theory generate a hospital level measure showing improvements through in overall safety levels)

The fifth national SPSP conference has just concluded. On the bass of staff feedback at the preceding conferences we focussed attendance on new staff or teams. This resulted in more positive feedback about the benefits with many staff reporting informally they gained from the experience. The key strategic message was on developing senior leadership support through improved governance of patient safety and the need to create a clearer response to patient involvement and person focussed care in the programme.

2.5 Progressing the high level aims

SPSP has two high level aims – to generate a 15% reduction in hospital mortality rates and to generate a 30% reduction on adverse event rates. There has not been a viable measure of hospital mortality available to date. We have now received confirmation that ISD will routinely be providing access to Hospital Standardised Morality Ration for GG&C acute hospitals. We have also experienced a major difficulty in detecting adverse events using the Global Trigger Tool linked to the second aim. However a further review of Global Trigger Tool process has just been completed that identify a number of factors that would explain the poor detection of adverse events in the local reviews.

3. Key Actions for Next Period

Actions	**Responsible**	**Completed**
Engage with Directorates to establish identity of wards to commence in programme in 2010 (NB Phase four target is 90 additional wards)	HoCG	February 2010
Identify resource model to support implementation of phase four of programme	Medical Director	February 2010
Engage with teams and Directorate management to design a new model of collaborative learning linked to implementation group functions and leadership	HoCG	January 2010
Complete a full review of GTT process	HoCG	February 2010
Revise reporting formats, ensuring they create visibility of issues and progress for individual Directorates	HoCG	February 2010
Ensure local implementation plan for Paediatrics is developed and can be supported	HoCG/AMD W&CSD	January 2010