EMBARGOED UNTIL DATE OF MEETING.

Greater Glasgow and Clyde NHS Board

Board Meeting

26 June 2012 **Board Paper No. 12/19**

Board Medical Director
Head of Clinical Governance

Scottish Patient Safety Programme Update

1. Summary of Actions for Board Members

Members are asked to:

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

2. Purpose of the paper

NHS Greater Glasgow and Clyde Aim 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 (SPSP) will contribute to this aim.
Our SPSP aim is to achieve full implementation of the core programme in NHS GG&C Acute Services Division by the end of December 2012. (The core programme includes improved staff capability in all wards, creation of reliable processes for every relevant element in every ward.) We will achieve implementation of Paediatric SPSP meeting the national medium term goals by March 2012. We will also develop and fully describe SPSP style improvement programmes in Primary Care, Mental Health services and Obstetrics in 2011/2012.

N.B. we have confirmed with Acute Services Division, and previously reported to the NHS Board, that we will not achieve the creation of reliable processes for 8 of the18 relevant elements in every applicable ward/team by the end of December 2012.

This report provides an update report on key headlines linked to the SPSP programme implementation.

The Board is asked to note the ongoing successes in sustaining and extending SPSP implementation as it relates to the Acute Services Division.

3. Key Headlines

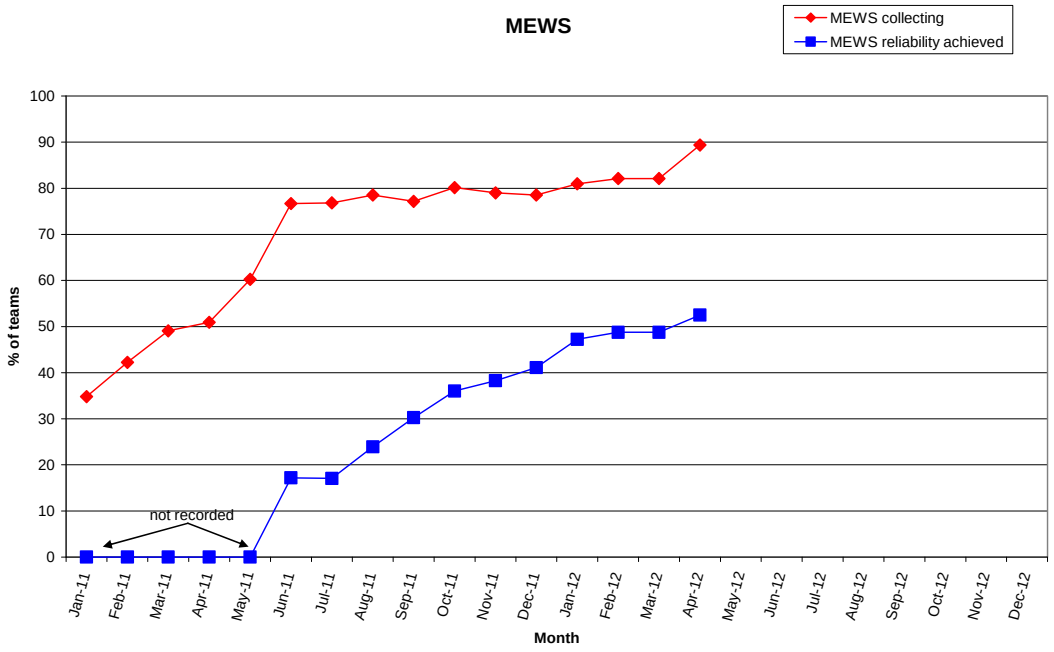
Cabinet Secretary Visit to RAH (18 June 2012)

The RAH ICU hosted a recent visit for the Cabinet Secretary. A number of programme achievements were showcase and well received but the main focus was on the brilliant results from the RAH ICU. These included reductions in average length of stay and mortality.

Early Warning Score (EWS)

There are a variety of illnesses that rapidly progress putting patients a risk of cardio-respiratory failure and death. Clinical observation is important in detecting those patients at risk of rapid and significant deterioration to ensure early and effective intervention. The EWS chart records a range of physiological parameters, linked to a clinical decision aid, which assists staff on decisions about escalating concerns for patients whose condition is deteriorating. Reliable implementation of the EWS is an element of the SPSP general ward work-stream. In previous programme assessments it was highlighted as an element at risk of not achieving full spread aim of more than 90% of clinical teams achieve reliability by December 2012.

This chart (titles MEWS) provides an update on the current position in relation to the spread of this work.



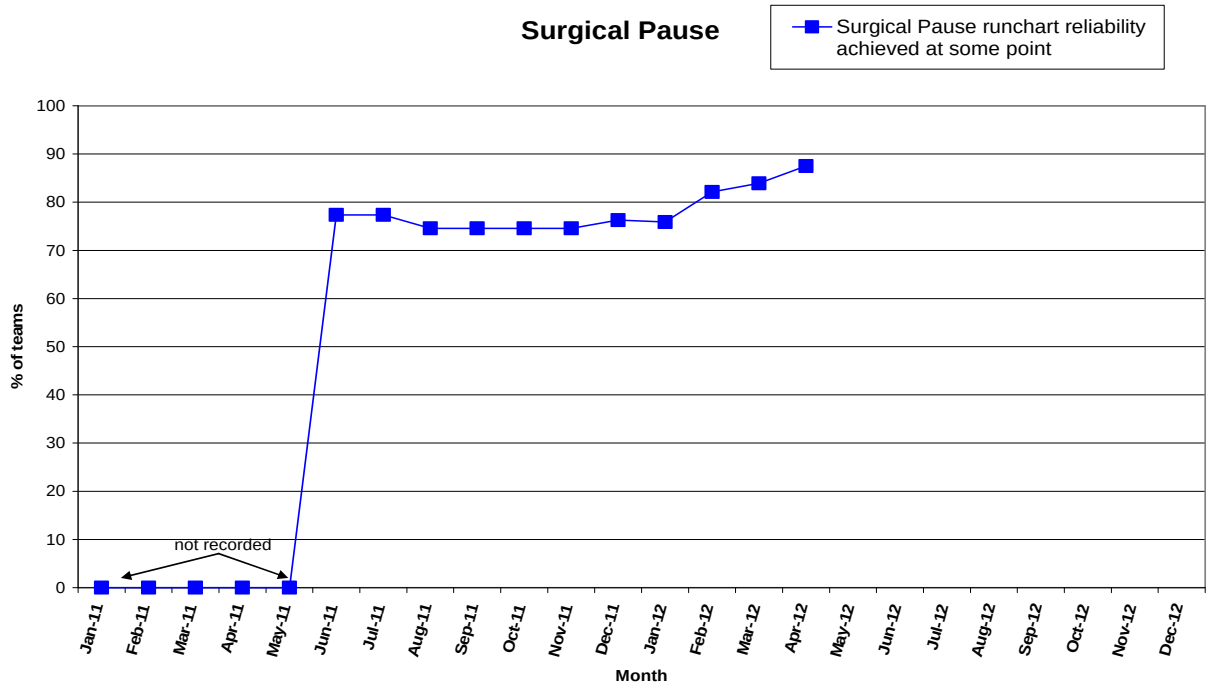
We can see the existing trajectory falls short of the spread aim. However there are a number of new factors that suggest we should revise the prediction to one of *likely to achieve the spread aim*. These are; the number of teams actively working on and measuring reliability, the completion of pilot work on a new, standardised Early Warning Score chart and the focus on improving recognition and management of patients with sepsis. The combination of effects is likely to increase significantly the focus on EWS implementation and accelerate the spread.

Critical Care Workstream

It would appear that we have reached a notable SPSP landmark for this workstream . all of the ITU areas have achieved the SPSP aim of a period 300 days between Central Line Related Blood Stream Infection. The two final areas of SGH Surgical and Neuro ITU have just been confirmed as reaching the target level. The time between such infections indicates a major reduction in their frequency

SPSP peri-operative work-stream: Surgical pause

One of the key areas of implementation in the peri-operative work-stream is the surgical brief and pause. The data reported from teams confirms notable success in achieving reliable implementation of the surgical pause. (See next chart)



It is difficult to understand the benefits of this level of reliable implementation. We have been tracking this locally through a clinical risk management development (Avoiding Significant Events Monitoring) where reporting of certain events is mandatory. This set of metrics allows us to explore the success and benefits of our safety strategies. This data shows a marked reduction in the frequency of operations on the wrong body part. There were three cases in 2010 and only one in the last 18 months. We attribute this in part to the level of reliability of the surgical pause. The most recent case is interesting in that it framed a very exceptional risk - that of a first bilateral operation preceding a second lateral operation so normal marking of the operating site on the patient are not the normal safeguard. This case also highlighted the benefits of the pause. Although the lateral operation commenced it was quickly halted by a nurse who identified that at the pause the report had been for the operation on the other side. So although we counted the event as occurring the pause did prevent significant harm being done to the patient.

Sepsis and Venous ThromboEmbolism (VTE)

A joint Sepsis/ VTE collaborative event was held on 11th June 2012, which was well attended by GG&C and the Board Medical Director presented the key note speech, illustrating some of the work done to date in GG&C.

Within the Sepsis work stream there are now 4 active teams within medical receiving unit who have now started collecting data, with 2 of these areas submitting their data to the Extranet. An additional 2 teams have been identified with the aim to have an active team on each main hospital site, supported by a GG&C Sepsis virtual network which has been established. We observe that this work stream is benefiting from strong levels of medical engagement and commitment.

With regards VTE work, 13 pilot sites have been identified in May 2012 across a range of specialities and hospital sites, and will begin testing in July 2012. The SPSP Collaborative for VTE Prevention is driven through and progress monitored by the NHS GG&C Thrombosis Committee. A risk assessment tool has been developed in line with SIGN recommendations and this will be the focus of the initial testing.

Although VTE prophylaxis has been a component of the Peri-op work stream it is not measured in the same depth as the VTE work stream which also includes looking at the quality of the VTE risk assessment. Although good progress has been made within the Peri-Op work stream some areas will find there is more to be done to meet the additional goals of the VTE work stream. Therefore when a ward commences the VTE work stream this will supersede the Peri-op VTE element.
Dr Beattie, AMD of W&C Directorate has recently taken over as co-chair of the national paediatric Advisory Group which reports into the national Safe Ambitions Steering Group.

Medicines Reconciliation

Following discussion at the Acute Clinical Governance Forum medicines reconciliation (MedRec) has been agreed as an area of major priority. There has been significant review of existing approaches and priorities. All Directorates have been developing accelerated spread plans for submission to the next meeting of the ASD Clinical Governance Forum. ECMS Directorate, where the initial pilot work was focused, now have plans in place to ensure all direct admission wards are active in MedRec. S&A Directorate have established a MedRec Steering Group and are developing a larger implementation plan to commence in July. Regional services have a established plan in place to begin MedRec in wards directly admitting patients targeting the Beatson, Neurology, Renal and Plastics. R&A Directorate currently have 7 active teams although these areas do not directly admit and discussions are underway to commence work in the stroke admission ward.

The electronic Medicines Reconciliation form will ease the clinical work flow and will be available to all teams from July onwards. This is completed as part of the admission process, but is an important source of information for completing discharge prescriptions/letters.