NHS Greater Glasgow & Clyde

Quality & Performance Committee   18 March 2014

Report of the Medical Director   **Paper No: 14/26**

Scottish Patient Safety Programme Report

Recommendation:
The Quality and Performance Committee is asked to consider the
- Update and progress in meeting CEL 19 (2013) as it relates to the safety essentials
- Note a brief and provisional update on recent review visit from Healthcare Improvement Scotland and the National Clinical Lead for Safety

Purpose of Paper
This paper sets out the current position on the progress and ongoing monitoring of the ten Safety Essentials arsing from Chief Executive Letter CEL 19 (2013).

Key Issues to be Considered
The Acute Services Division has made good progress in spreading the ten safety essentials across all relevant teams. This creates the opportunity for transition of monitoring to routine operational delivery mechanisms and the refocusing of energies into prevailing safety priorities.

Any Patient Safety /Patient Experience Issues
Yes, a range of patient safety issues and improvements are described.

Any Financial Implications from this Paper
Yes, please see the business case for healthcare quality but not quantified in our Board context.

Any Staffing Implications from this Paper
None specified

Any Equality Implications from this Paper
None specified

Any Health Inequalities Implications from this Paper
None specified

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Scottish Patient Safety Programme Report

1.	**Background**

The Scottish Patient Safety Programme (SPSP) is one of the family of the national improvement programmes, developed over recent years in relation to the national Healthcare Quality Strategy, which draws on improvement methods advocated by the Institute for Healthcare Improvement.

SPSP now contains a number of distinctly identified programmes as follows:
- Acute Adult Care
- Paediatrics
- Sepsis
- Venous Thromboembolism
- Primary Care
- Mental Health
- Neonates
- Maternal Care

2.	**Summary & actions for Q&P Committee members**

This paper sets out a full update on the treatment of the ten Safety Essentials described in the Chief Executive Letter CEL 19 (2013).

The Quality and Performance Committee is asked to
- Consider the update and progress in meeting CEL 19 (2013) as it relates to the safety essentials
- Note a brief and provisional update on recent review visit from Healthcare Improvement Scotland and the National Clinical Lead for Safety

3.	**Safety Essentials**

3.1   Summary

This section presents a summary of the current position with the 10 Scottish Patient Safety Programme measures identified as essential to patient safety.

We have previously reported on the significant shift in the national strategy approach to evolving the Acute Adult Care programme within SPSP announced in a Chief Executive Letter CEL 19 (2013).
The key message being that our emphasis around the patient safety essentials should now "shift from testing and spread towards one of sustainable universal implementation which requires different approaches to ensuring and assuring the continued provision of these interventions as standard work in all clinical areas". The 10 Safety Essentials are deemed to be evidence based processes that have achieved a level of spread and reliability across acute hospitals in Scotland since the launch of SPSP in 2008. They are described

- Ventilator Associated Pneumonia (in ITU)

- Central Venous Catheter Insertion (in ITU)
- Central Venous Catheter Maintenance (in ITU)
- Daily Goal Setting (in ITU)
- Surgical Brief & Pause
- Hand Hygiene
- Early Warning Score
- Safety Brief
- Peripheral Vascular Catheters
- Leadership Walkrounds

In the last update we reported that good progress has been made towards high levels of spread of the ten patient safety essentials across the Acute Services Division. It was agreed that the CEL (19) was in line with our established plans for the transfer of ongoing responsibility for maintaining process reliability to routine operational delivery mechanisms within each Directorate's management structures. It has been emphasised that in this new arrangement the Division's clinical governance arrangements will retain periodic oversight to ensure any requirements of the national programme were being maintained.

The following section provides an update on current spread levels and the ongoing plans for transfer of responsibilities around the ten patient safety essentials.

3.2   Current Position

The first four safety essentials relate to the critical care work-stream which applies to ITU settings. The ITUs have an advantage in that they have process for recording infection rates linked to the clinical care processes. This means that the reliability and effectiveness of the clinical process can be tracked through outcomes monitoring, which has already been established and adopted as responsibility by local management.

The surgical brief and pause are related to the peri-operative workstream. This practice is now well established in all theatre areas. There is no outcome measure but we are stopping formal collection of process data on1st April 2014 to be replaced with 6 monthly qualitative observational audits performed by peers. This will not only highlight that the brief and pause are occurring but is designed to extend the review to consider the quality of the process i.e. information content, who is present etc.

The next four elements relate to the General Ward workstream. The monitoring of patient's condition through Early Warning Score charts has achieved a high level of spread. It is however embedded in the ongoing work around Deteriorating Patients and linked to a differing set of requirements in the new National Measurement Plan for SPSP. This element will not therefore be transferred to local management. The General Ward Safety has now been spread reliably across the Division at scale. Plans to transfer responsibility are now being made but likely to be modelled on observational audits to verify they continue to take place and are of an appropriate quality. Hand hygiene and peripheral venous cannula (PVC) both relate to infection control requirements that have drivers outside SPSP so discussion is ongoing as to where overall responsibility sits with regards to the continued monitoring and reporting at an aggregated level. PVC use and care has also been the subject of a recent internal audit report and this SPSP discussion will maintain those action plan requirements to reinforce a single leadership arrangement to ensure consistency of policy practice and measurement.

Leadership walkrounds are an ongoing and routine activity supported by senior leads in the Acute Services Division and by Non-Executive Directors. As this is a cross-system arrangement it is expected that they would remain a feature of the regular reporting framework so that we are assured they are being maintained and effective.

The current position in spreading each process across target teams is as follows for each safety essential (with data on Leadership Walkrounds included). This confirmed the high level of spread achieved in Acute Services Division.

Ventilator Associated Pneumonia Bundle:

Measure	Target Teams	Measuring	Demonstrated a reliable process by February 2014	%
VAP Bundle	7	100%	7	**100%**

Central Venous Catheter Insertion Bundle:

Measure	Target Teams	Measuring	Demonstrated a reliable process by February 2014	%
CVC Insertion	7	100%	7	**100%**

Central Venous Catheter Maintenance Bundle:

Measure	Target Teams	Measuring	Demonstrated a reliable process by February 2014	%
CVC Insertion	7	100%	7	**100%**

Note: Central line maintenance has been spread to HDU – 7/9 HDU teams have achieved reliability.

Intensive Care Unit (ICU) Daily Goals:

Measure	Target Teams	Measuring	Demonstrated a reliable process by February 2014	%
ICU Daily Goals	7	100%	7	**100%**

Note: Different model is required for HDU Daily Goals. 7/9 HDU teams have achieved reliability.

Surgical Brief and Pause:

Measure	Target Teams	Measuring	Demonstrated a reliable process by February 2014	%
Brief & Pause	52	100%	52	**100%**

Early Warning Scoring:

Measure	Target Teams	Measuring	Demonstrated a reliable process by February 2014	%
EWS	169	100%	166	**98%**

General Ward Safety Brief:

Measure	Target Teams	Measuring	Demonstrated a reliable process by February 2014	%
Safety Brief	209	100%	196	**94%**

Peripheral Venous Cannulla:

Measure	Target Teams	Measuring	Demonstrated a reliable process by February 2014	%
PVC	148	100%	131	**89%**

Hand Hygiene:

Measure	Target Teams	Measuring	Demonstrated a reliable process by February 2014	%
Hand Hygiene	209	100%	209	**100%**

Leadership Walkrounds:

Measure	Number of Walkrounds	Actions	Actions Completed	%
Leadership Walkrounds	400	1103	839	**76%**

4. Review visit and reflections on Points of Care implementation

The Board recently hosted a review visit from Healthcare Improvement Scotland and the National Clinical Lead for Safety. The visitors will provide a report of their views and we intend to share this, to frame a fuller update on the Points of Care Priorities, at the next Q&P meeting.

CEL 19 (2013) also set out the next set of major improvement ambitions for SPSP described as Point of Care Priorities, which are as follows:

- Deteriorating patients*
- Sepsis*
- Venous thromboembolism*
- Heart failure*
- Safer medicines*
- Pressure ulcers
- Surgical site infections
- Catheter associated urinary tract infections
- Falls with harm

This set is deemed safety critical for patients but known to require further rigorous testing, spread and reliable implementation using the quality improvement methodology familiar to those involved with the safety programme. Four of the nine point of care priorities (those marked with *) are already a focus of work within the programme, with the Acute Services Division recognising this is an opportunity to re-invigorate the current approach and priorities.

Reflecting on the discussions it appeared that the visitors affirmed the strategic implementation plan was an appropriate approach. In particular the high priority attached to deteriorating patients and medicines reconciliation along with integration of responsibilities into existing arrangements were commended. They shared our concerns that measurement support for clinical care teams required a more effective solution and would benefit from clearer national leadership. They also

acknowledged that areas of the national measurement plan remained problematic and invited further feedback on how we adapted local measurement approaches to more effective forms.

Overall it appeared the outline of our approach and progress was well received but we await the written feedback for a full confirmation of our visitor's opinion.