## Greater Glasgow and Clyde NHS Board

## Board Meeting

**February 2015** **Board Paper No. 15/03**

**Board Nurse Director**

# Scottish Patient Safety Programme Update

### 1. Background

The Scottish Patient Safety Programme (SPSP) is one of the family of national improvement programmes, developed over recent years in relation to the national Healthcare Quality Strategy. These programmes draw on improvement methods advocated by the Institute for Healthcare Improvement. SPSP now contains a number of distinctly identified programmes as follows:

- Acute Adult Care
- Primary Care
- Mental Health
- MCQIC (incorporating Paediatrics, Maternal Care & Neonates)

### 2. Purpose of Paper

This is a high level overview report to update the Board on the Maternity and Children Quality Improvement Collaborative (MCQIC). MCQIC encompasses the clinical improvement activity of the Scottish Patient Safety Programme's maternity, neonatal and paediatric strands, whose overall aim is to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families in Scotland. MCQIC was launched formally as a collaborative in March 2013 (paediatric work stream had been active previous to this) and is a programme of quality improvement that will run until December 2015.

This report is presented to Board for information and approval. In particular the Board is asked to:

- Note the updates in each of the three work-streams, in terms of current activity, key areas of progress, or key issues to note.

## 2. MCQIC Key Events

### GG&C MCQIC Site Visit 24th October 2014

On Friday 24th October the board received a site visit from the HIS national team, this was a test by the national team combining all three work streams of MCQIC into one site visit. The visiting team consisted of HIS Improvement Staff and the national leads for the maternal care and paediatric work streams. The visit involved a morning leadership session with Executive and Directorate leads and representation from service improvement leads. To support interaction with frontline staff the visit was aligned with the local MCQIC event which allowed the national team an opportunity to address the staff as part of the programme and then to participate in the event with staff involved in the workshop discussion.

Feedback from HIS on the day was positive and they have prepared an SBAR report summarising the visit and highlighting key opportunities and challenges, this is in the process of being finalised with HIS. The final report will be shared with the HPN and O&G SPSP Monitoring Groups for them to review and consider the issues highlighted and any actions that may be taken.

### GG&C MCQIC Local Learning Event 24th October 2014

The local learning event, a follow up to the event in April, was a half day on the afternoon which featured presentations from each of the work streams highlighting work to date and also feedback from the prize winners from the previous event in April and learning from their attendance at the Paris Quality Forum. In a change from the previous event and to encourage sharing across the work streams the workshops focused on the deteriorating patient including sepsis, safety briefs and huddles, human factors in QI and improvement methods.

The formal evaluation is included in the appendix, overall it was deemed a success. Attendees highlighted that they they would have liked more workshop sessions and the opportunity to have attended all the workshop sessions. The decision to mix the three work streams instead of having work stream specific workshops has been well received and seen as an invaluable opportunity to share knowledge between the work streams. The team organising the event had considered omitting a session on the 'Theory of Improvement' as it was recognised that this has been covered at previous events. However this session was well evaluated and attendees felt that it gave them an opportunity to refresh their knowledge. Discussion on future events is welcomed.

### National MCQIC Learning Session 30th September 2014

The latest national learning event was held at Dunblane Hydro on 30th September, a variety of topics were covered with breakout workshops on QI methods and also for each discipline to discuss national priorities and take forward activity within their service. GG&C were well represented in attendance and storyboards from each of the work streams and one for each maternity site led by the MCQIC champions. The neonatal service won a prize for Best Story Board in their breakout session.

The neonatal and paediatric work streams received details of a change in the reporting with new national toolkits aligned to the updated measurement strategies; these will be discussed at the next HPN SPSP Monitoring Group as changes are required to the current system to align with these.

### National MCQIC Learning Session 2nd February 2015

A further event is being held in Glasgow on the 2nd February; we have a very good level of interest with additional places sought to support attendance and storyboard submissions. Exact agenda is still to be shared but expected to be similar to that of previous events with a mix of QI methods and work stream focused discussion.

## 3. Update on Maternity Workstream

### 3.1 Aim

The Maternity Care strand aims to support clinical teams in NHSGGC to improve the quality and safety of maternity healthcare. The overall aims of the Maternity Care strand are to:

- Increase the percentage of women satisfied with their experience of maternity care to > 95% by 2015, and
- Reduce the incidence of avoidable harm in women and babies by 30% by 2015.

Avoidable harm is defined by the further sub aims to:

- Reduce stillbirths and neonatal mortality by 15%
- Reduce severe post-partum haemorrhage (PPH) by 30%
- Reduce the incidence of non-medically indicated elective deliveries prior to 39 weeks gestation by 30%
- Offer all women carbon monoxide (CO) monitoring at the booking for antenatal care appointment
- Refer 90% of women who have raised CO levels or who are smokers to smoking cessation services,
- Provide a tailored package of antenatal care to all women who continue to smoke during pregnancy.

### 3.2 Current Position - Overview

There three major obstetric care sites within NHSGGC continue to make good progress in implementing the programme. The MCQIC midwifery champion roles are nationally funded and this funding ends in July 2015; a review of the support arrangements to consider the post champion model is underway. The Directorate are also undergoing a revision of their governance structures within obstetrics and the role of MCQIC is a key feature of this. Highlighted below are some examples of the progress since the last report, the table on the following page updates on the progress against individual measures for each site.

### 3.3 Examples of Current Position

**SGH**

- The SGH team are reporting greater staff engagement with more teams taking on board some of the data collection for measures which is key to local ownership of the improvement processes and reduces person dependency.
- Testing of a safety brief at 9am & 3pm daily continues with the focus on further testing of the reporting template.
- They have shown improvement around discussion about reduced fetal movement focus is now on sustaining this improvement.

**RAH**

- The work has spread to the midwifery unit at the IRH with daily safety briefings established with this team.
- There are daily surgical briefings for all elective cases at the RAH with reliability demonstrated and almost sustained.
- The RAH has also demonstrated sustained reliability in relation to documentation of discussion on reduced fetal movements.

**PRMH**

- Demonstrated sustained reliability in relation to escalation and intervention of MEWS and also in relation to normothermic babies leaving Labour Ward.
- The site has also started testing on PPH prevention and management following some scoping work locally to assess the bundles which was very positive and presented at the recent local event. This includes a list of risk factors for PPH which are considered on admission to labour ward and used to help identify those at higher risk.

| Measure reference | Measure Name | SGH | RAH | GRI (PRM) |
|---|---|---|---|---|
| Key Measures | | | | |
| Person Centred Care | | | | |
| MP04 | % of birth plans signed and dated by the woman and midwife | Data developing | Measuring | Data developing |
| Leadership and Culture | | | | |
| MP05 | Number of safety walkrounds | Measuring | Measuring | Measuring |
| MP06 | % of actionable items being completed each month | Measuring | Data developing | Measuring |
| MP07 | Safety Culture Survey | Data developing | Data developing | Data developing |
| Teamwork, Communication and Collaboration | | | | |
| MP08 | % compliance with the daily safety brief bundle | Measuring | Measuring | Measuring |
| MP09 | % compliance with surgical briefing | Data developing | Measuring | Measuring |
| MP10 | % of exchanges that use a high quality SBAR | Measuring | Measuring | Measuring |
| MP11 | % compliance with the significant event debrief bundle | Data developing | Data developing | Data developing |
| MP12 | % compliance with team huddles | Data developing | Measuring | Measuring |
| Safe, Effective and Reliable Care | | | | |
| MP13 | % compliance with the MEWS bundle | Measuring | Measuring | Measuring |
| MP14 | % of observations identified as at risk that have appropriate interventions undertaken in terms of their management as categorised by MEWS | Measuring | Measuring | Measuring |
| MP15 | % compliance with the sepsis 6 bundle | Data developing | Measuring | Measuring |
| MP16 | % compliance with the PPH prevention bundle | Data developing | Measuring | Measuring |
| MP17 | % compliance with the PPH management bundle | Data developing | Measuring | Measuring |
| MB01 | % of normothermic newborn babies at the point of discharge from labour suite | Measuring | Measuring | Measuring |
| MP18 | % of women with a documented discussion regarding fetal movements | Measuring | Measuring | Measuring |
| MP19 | % compliance with the stillbirth bundle | Data developing | Data developing | Data developing |
| MP20 | % compliance with VTE bundle | Data developing | Measuring | Data developing |
| Outcome Measures | | | | |
| MO01 | Rate of stillbirths | Measuring | Measuring | Measuring |
| MO02 | Rate of neonatal deaths | Measuring | Measuring | Measuring |
| MO03 | Rate of severe post-partum haemorrhages | Measuring | Measuring | Measuring |
| MO04 | % of non-medically indicated deliveries prior to 39 weeks gestation | Measuring | Measuring | Measuring |
| MO05 | % of women satisfied with the care they received | Measuring | Data developing | Data developing |
| MP01 | % of pregnant women offered CO monitoring at booking | Universal implementation | Universal implementation | Universal implementation |
| MP02 | % of pregnant women with a CO level ≥ 4 ppm (or who say they are current or recent smokers) that are referred to smoking cessation services | Universal implementation | Universal implementation | Universal implementation |
| MP03 | % of pregnant women who continue to smoke who are provided with a tailored package of antenatal care | Data developing | Measuring | Data developing |

### 3.4 Comparative data on maternal care

When the MCQIC report was last presented to the Board the ensuing discussion produced a request for comparative data, to explore if we could benchmark reliability and outcomes in NHS GG&C services with other NHS Boards. There is no longer a shared national repository of the SPSP data so we approached Healthcare Improvement Scotland with a request for a national overview. They indicated that they saw this as beneficial but would need to approach each Board to secure agreement for use of their data. They agreed in principle to take the proposal forward. At a informal meeting on Friday 6 February it was agreed a national overview report would be shared, which would allow this kind of comparison. We will link this into local governance groups and ensure it is referenced in the next Board SPSP report for MCQIC.

## 4. Update on Paediatric and Neonatal Workstream

### 4.1 Aim

Achieve a 30% reduction in adverse events that contribute to avoidable harm in Neonatal and Paediatric Services by December 2015.

### 4.2 Summary of Current Position

There are currently 20 teams supported across Paediatric and Neonatal services.

HPN SPSP Monitoring Group

The service have recently established an SPSP HPN Monitoring Group which is chaired by the HPN General Manager, with the second meeting taking place early 2015. With membership from management and clinical this group has a remit to support the SPSP and wider QI work in the HPN service including setting the priorities for the work and revising progress against to support barriers where possible. The need to make links to the New Children's Hospital and the planned introduction of Ward Accreditation Standards has been acknowledged by this group and work is underway to do this.

The national team have introduced a new toolkit to support reporting along with a quarterly SBAR submission with an assessment of progress. The CGU support team are linking with service to consider how best to implement this and align to the current frontline team methods for data collection and reporting. It has been agreed that the Monitoring Group will review and sign off the quarterly SBAR reports prior to submission.

Paediatrics

Within paediatric wards the areas of work are hand hygiene, CEWS, Safety Briefs, SBAR, PVC and CVC maintenance which is being spread from PICU. All teams have shown reliability in all elements with a further 3 teams identified as having sustained reliability in all applicable element. For those who have not yet achieved the sustained reliability the Clinical Improvement Co-ordinator continues to link to provide support and maintain focus. The CVC maintenance has spread to two areas with reliability established in one, a third area is set to commence testing this month. The plan for spread is currently being reviewed alongside the migration plan to ensure spread to all high risk areas.

PICU have begun testing of a Safety Huddle and have in December begun submission of their VAP rate which is a key outcome measure. Dr Neil Spencely is in the current cohort of SPSP fellows and will be using the PICU work as part of his project. Lesley McFarlane, who studied on the Improvement Advisor course has been seconded to HIS as an Associate Improvement Advisor and will be working on the paediatric work stream nationally.

Neonates

Neonatal teams are progressing well and have expanded work being the initial 3 priorities identified for each site. Local initiatives linked to local properties are the Extubation Pause and WARM bundle, at PRM and SGH respectively. Similar agreement is needed to ensure the neonatal data and SBAR reporting is set up.

**Table 2: Paediatric & Neonatal Teams At a Glance (5 indicates reliability achieved)**

| Team | Hand Hygiene | VAP bundle | Cent Line Insert | CVC maint | MDR | MDR & DG | PVC Maint | Safety Brief | SBAR |
|---|---|---|---|---|---|---|---|---|---|
| RHSC-PICU/ITU | **5** | **4.5 Grn** | **4.5 Grn** | **5** | **5** | | **5** | **5** | **-** |

| Team | HH | EWS | Safety Brief | SBAR Use | SBAR quality | PVC Maint | PVC Insert | CVC maint |
|---|---|---|---|---|---|---|---|---|
| RAH-15 | **5** | **5** | **5** | **5** | **5** | **5** | n/a | n/a |
| RHSC-01c | **5** | **3 Grn** | **4.5 Grn** | **3 Grn** | **3 Grn** | n/a | **3 Grn** | n/a |
| RHSC-03a | **5** | **5** | **5** | **5** | **5** | **5** | n/a | n/a |
| RHSC-03b | **5** | n/a | **5** | **5** | **5** | **5** | n/a | n/a |
| RHSC-04a | **5** | **5** | **5** | **5** | **5** | **4.5 Red** | n/a | n/a |
| RHSC-04b | **5** | **5** | **5** | **5** | **5** | **5** | n/a | n/a |
| RHSC-05a | **5** | **5** | **5** | **5** | **5** | **2 Red** | n/a | n/a |
| RHSC-06a | **5** | **5** | **5** | **5** | **5** | **5** | n/a | **4 Grn** |
| RHSC-07a | **5** | **5** | **4.5 Grn** | **4.5 Grn** | **4.5 Grn** | **5** | n/a | n/a |
| RHSC-07b | **5** | **5** | **3 Grn** | **4 Grn** | **4 Grn** | **5** | n/a | n/a |
| RHSC-DSU | **5** | **5** | **5** | **4.5 Grn** | **4.5 Grn** | n/a | n/a | n/a |
| RHSC-Schiehallion DC | **5** | **4.5 Grn** | **5** | **4.5 Grn** | **4.5 Grn** | n/a | **4.5 Grn** | **3 Grn** |
| RHSC-Schiehallion - 01a | **5** | **5** | **5** | **5** | **5** | **5** | n/a | **0.5 Grn** |
| RHSC-Emergency Dept | **5** | **5** | **5** | **4.5 Grn** | **4.5 Grn** | n/a | **4.5 Grn** | n/a |

**Table 3: Neonatal Teams**

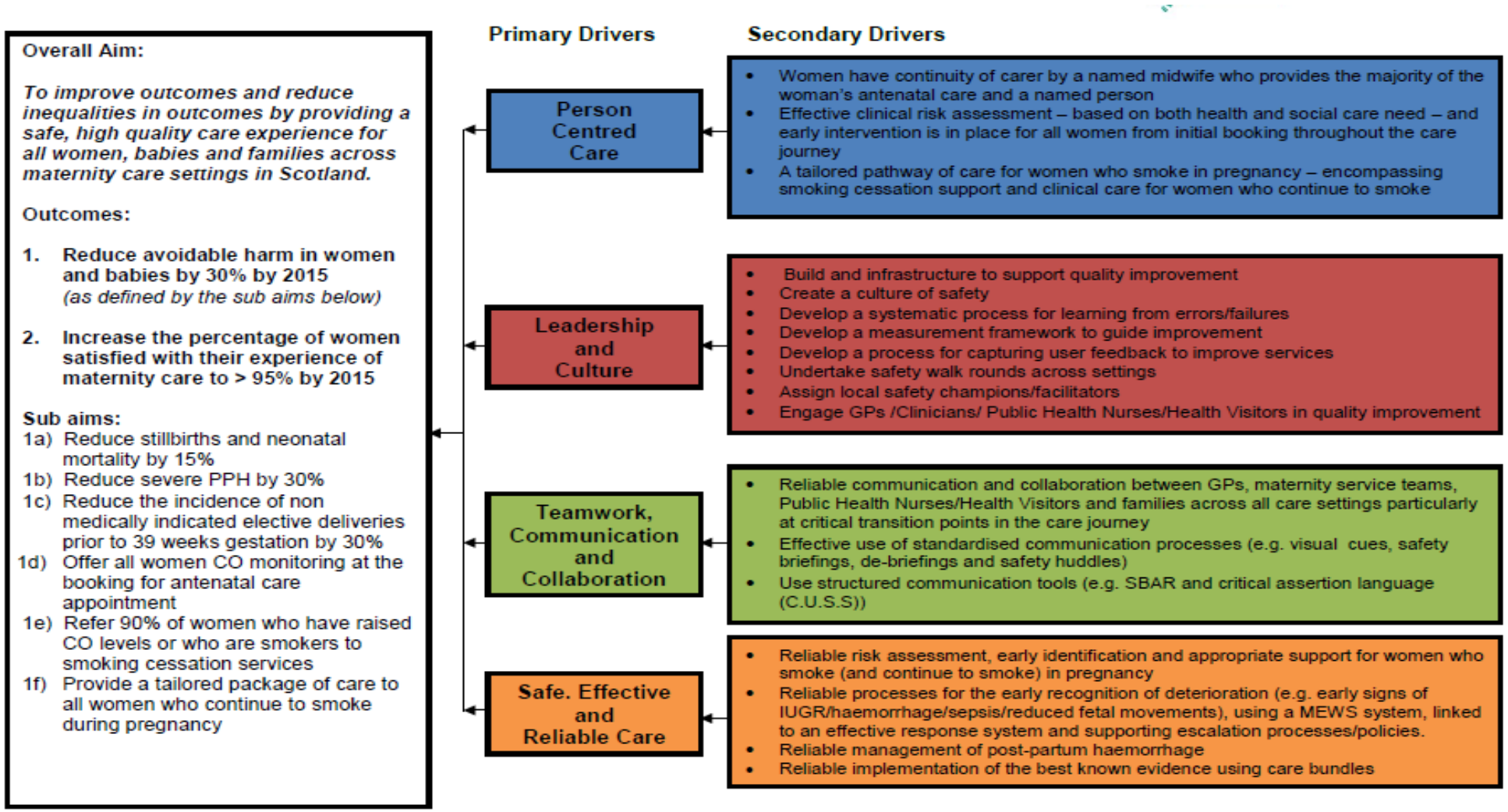
| Team | Hand Hygiene | Cent Line Insert | CVC Maint | PVC Maint | Safety Brief | SBAR | Gentamicin |
|---|---|---|---|---|---|---|---|
| PRMH-Neonatal | **5** | **3 Amb** | **3 Amb** | - | **4 Green** | **-** | **3 Amb** |
| RAH-Neonatal | **5** | - | **4 Green** | **4 Green** | **3 Green** | **0.5 Green** | **3 Amb** |
| RHSC-Neonatal | **5** | - | **3 Green** | - | **5 Green** | **-** | **5** |
| SGH-Neonatal | **5** | **3 Amb** | **3 Amb** | - | **4 Green** | **0.5 Green** | **4 Green** |

The RHSC Theatres team in Table 4 below has achieved success in most measures, although additional support is required to enable further progress with the Post-List debrief measure.

**Table 4: Peri-operative Teams**

| Team | Pre-list Team Brief | Surgical Pause | Antibiotics | PVC Insert | Sign Out | Post-list De-Brief |
|---|---|---|---|---|---|---|
| RHSC-Theatres | **5** | **5** | **5** | **3 Amb** | **4.5 Amb** | **2.5 Red** |

## Appendix 1: Maternity Workstream Driver Diagram



## Appendix 2: Scottish Patient Safety Programme: Glossary of Terms

| | |
|---|---|
| **SPSP** | Scottish Patient Safety Programme |
| **SPSP-MH** | Scottish Patient Safety Programme – Mental Health |
| **SPSP – PC** | Scottish Patient Safety Programme – Primary Care |
| **SPSPP** | Scottish Patient Safety Paediatric Programme |
| **CVC** | Central Venous Catheter |
| **CAUTI** | Catheter Associated Urinary Tract Infection |
| **DMARDs** | Disease Modifying Anti Rheumatic Drugs |
| **EWS** | Early Warning Scoring |
| **HAI** | Healthcare Associated Infection |
| **HDU** | High Dependency Unit |
| **HIS** | Healthcare Improvement Scotland |
| **HSMR** | Hospital Standardised Mortality Ratio |
| **IHI** | Institute for Healthcare Improvement |
| **ITU** | Intensive Care Unit |
| **ISD** | Information Services Division |

| | |
|---|---|
| **LES** | Local Enhanced Service |
| **LVSD** | Left Ventricular Systolic Dysfunction (heart failure) |
| **MCQIC** | Maternal Quality Care Improvement Collaborative |
| **MEWS** | Maternity Early Warning Score |
| **MDT** | Multi Disciplinary Team |
| **NEWS** | National Early Warning Scoring |
| **PDSA** | Plan, Do, Study, Act (small scale, rapid, reflective tests used to try out ideas for improvement) |
| **PVC** | Peripheral Venous Cannula |
| **QOF** | Quality Outcomes Framework |
| **SBAR** | Situation, Background, Assessment, Recommendation (a structured method for communicating critical information that requires immediate attention and action; can also be used effectively to enhance handovers between shifts or between staff in the same or different clinical areas. |
| **SMR** | Standardised Mortality Ratio |
| **SSI** | Surgical Site Infection |
| **SUM** | Safer Use of Medicines |
| **Surgical Briefing** | A pre-operative list briefing designed to ensure entire team understand expectations for the list and each procedure. |

| | |
|---|---|
| **Surgical Pause** | A pre-operative pause as an opportunity to cover surgical checklist and act as final reminder of items that must be completed prior to commencement of the operation. |
| **Trigger Tool** | A case note audit process designed to find examples where the care plan has not progressed as expected |
| **VAP** | Ventilator Associated Pneumonia |
| **VTE** | Venous Thromboembolism |