Greater Glasgow and Clyde NHS Board

Board Meeting

October 2015 **Board Paper No. 15/49**

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 paper provides an update on the

- the developing national approach to the Scottish Patient Safety Programme (SPSP)
- SPSP for Mental Health,
- SPSP for Primary Care.

The SPSP approach aims to develop clinical processes through iterative testing so they are capable of operating with higher levels of reliability. The paper describes the scope of testing work, along with a brief outline of progress and challenges for each programme.

The Board of NHS GG&C is asked to:

- note the progress made by NHSGG&C Mental Health services in implementing the Scottish Patient Safety Programme,
- note the progress made by NHSGG&C Primary Care services in implementing the Scottish Patient Safety Programme.

3. SPSP Programme Approach

National Safety Conference

A conference is planned for the 9th November 2015 which will bring together all of the SPSP programmes in a celebration of the fantastic work carried out improving safety, and allowing delegates to learn from the experience of safety work across Scotland and beyond.

The aim of the event is to bring together a community to share learning and help drive safer care across Scotland.

By attending the conference it is expected delegates will have the opportunity to:

- Understand the role that compassion plays in the delivery of safer person centred care
- Connect with individuals and organisations to share experience and learning
- Increase awareness of the wider community that will help you and your team deliver safer care

NHS GG&C is currently confirming staff to attend and building a storyboard of our local work across all programmes to share with the rest of Scotland.

SPSP in 2016 and beyond

The timeline for the aims in the Acute Adult programme are set to conclude in December 2015. There is also a shift in emphasis of care delivery given the integration of health and social care. This has prompted Scottish Government Health Directorate (SGHD) and Healthcare Improvement Scotland (HIS) to initiate a review process prior a major refresh of SPSP envisaged for 2016. HIS have begun a 90 day review in which they will attempt to synthesise prevailing knowledge from literature and experience of implementation in NHS Boards. This will be used to frame a set of development proposals. During the early engagement of this exercise HIS have indicated a shift in focus to ensure greater local selection of priorities along with an expectation of inclusion of themes that reflect integration e.g. a programme theme of *frailty*. We are expecting that there will be good opportunity to support the review with our experience and will advertise information on the consultative process when it is provided.

4. Update on SPSP for Mental Health

Background

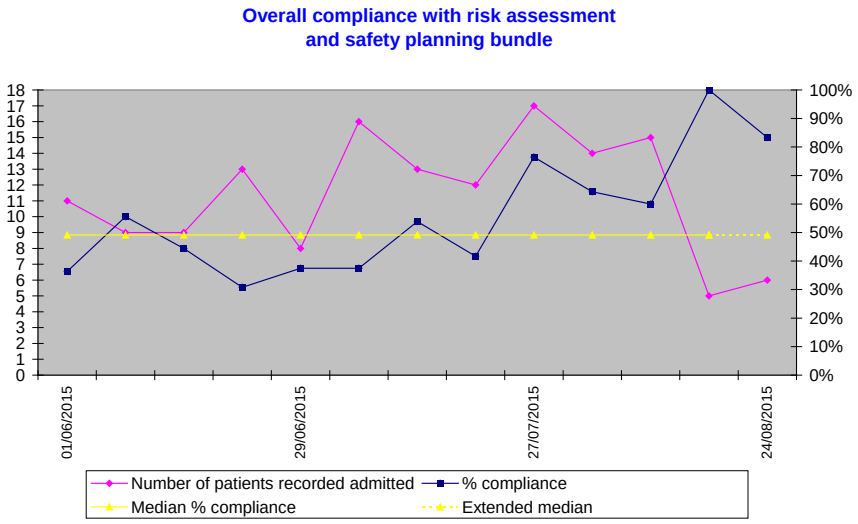
The Scottish Patient Safety Programme – Mental Health aims to systematically reduce harm experienced by people receiving care from mental health services in Scotland, by supporting clinical staff to test, gather real-time data and reliably implement interventions, before spreading across the NHS board area. The work is being delivered through a four year programme, running from September 2012 to September 2016. This report provides an update on progress across 14 wards implementing the Programme in NHS GG&C.

Summary of current position

There are currently 14 wards testing five work streams across NHS Greater Glasgow and Clyde. Each of these workstreams now has an identified lead who attends the SPSP MH Steering Group.

Risk Assessment and Safety Planning

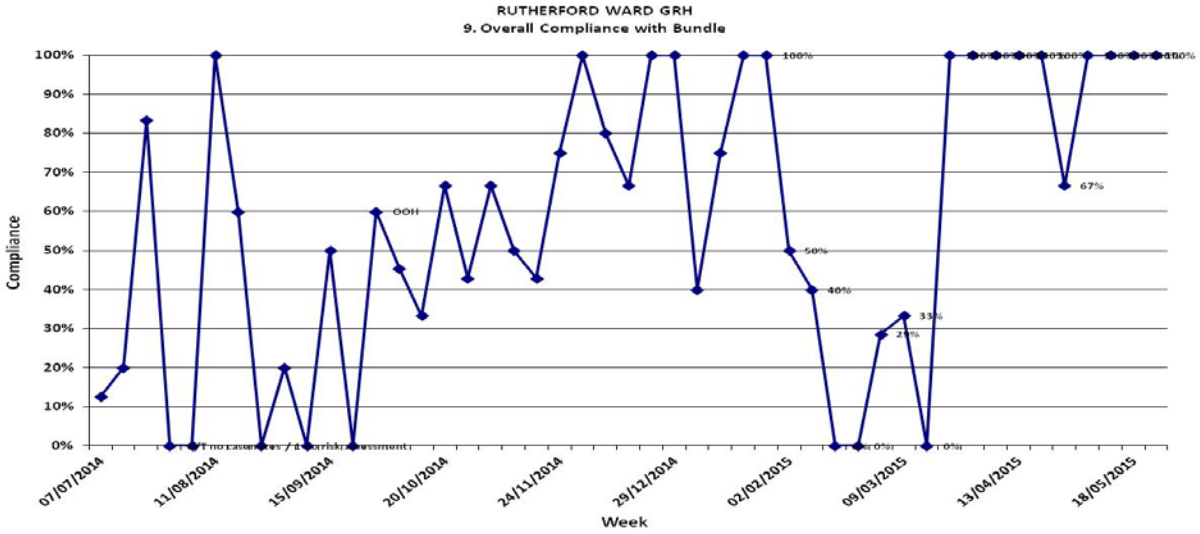
All 14 wards were asked to test a recently adapted risk assessment and safety bundle. The following chart describes progress from 1st June 2015, when the modified bundle was introduced. This chart is an aggregate from 8 wards who participated in the modified bundle.



This bundle requires an up to date risk assessment to be available within 2 hours of admission, developed with the service user and updated within 72 hours.

Communication at Key Transition

One ward has developed and is testing a communication on admissions bundle. This bundle looks at the quality of referral information. The chart below describes progress with the bundle. A recent local learning session highlighted the need to test safety briefs and huddles across all wards. Staff from a range of disciplines attend the safety huddle and in some areas have been occurring at the weekends. This encourages a team approach and hospital sites can prioritise where help is required across the site.



Safe and Effective Medicines Management

There are several interventions currently being tested within this work stream

- Medicines reconciliation in three wards.
- The national ‘as required’ psychotropic bundle is being tested in all 14 wards. A bundle is being developed in one ward which will support this work with the intention that the bundle can then be rolled out.
- A Clozapine Admissions Bundle designed to improve clozapine prescribing on admission is being tested.
- A Safer Prescribing Intervention is being tested in three wards. The aim is to ensure ward prescriptions sheets are written to the agreed standard to support safer medicines administration.

Restraint and Seclusion

One ward is currently developing a restraint and seclusion bundle.

Leadership and Culture

The leadership and culture work stream applies to all wards involved in the programme. The elements of the leadership and culture work stream are:

- Staff Safety Climate Tool – To date two wards have completed their third Staff Safety Climate Survey and 7 have repeated the survey. All 14 wards have completed the survey once. Additional wards are undertaking their repeat surveys at present.
- Patient Safety Climate Tool - All SPSP wards have now completed their Patient Safety Climate Tool and 10 wards have now repeated the survey. These wards have the new revamped report provided by Glasgow Mental Health Network (GMHN).
- Safety Conversations - At October 2015 all 14 wards will have taken part in a safety conversation. Actions from these visits are now being logged and followed up through the clinical governance support unit. The Steering group have agreed that these visits will occur annually. The Safety Conversation Guidance was updated in June 2015 and alterations were made to the original executive team membership, invitation process and the paperwork distributed to the executive team/ward staff prior to the visit.

Next Steps

At a recent regional event HIS advised that the programme would be extending and future work would be taken forward with children mental health services, older people's mental health, perinatal and community teams.

The local programme leads are concerned that a shift in focus will dilute existing efforts prior to our work reaching a reasonable conclusion. The local plan is to maintain a focus on agreed local deliverables. Currently these are:

- Full compliance with risk assessment bundle and evidence of improved and safer care as a result. Early indications suggest that there has been some confusion regarding clarity of data definitions, which has been confirmed by visits to each ward and analysis of the data.
- Full compliance with the "as required" bundle with evidence of improved care and safety as a result.

On confirmation of these priorities there will be a refresh of the testing and implementation plan for wards across Mental Health Services.

5. Update on SPSP for Primary Care

Background

The aim of the SPSP-PC is to reduce the number of events which could cause avoidable harm from healthcare delivered in any primary care setting. The range of activity within Primary Care NHSGGC involving collaborations with Pharmacists, GPs, District Nurses amongst others highlights the interest and determination to improve patient safety within the Primary Care setting.

Workstream Updates

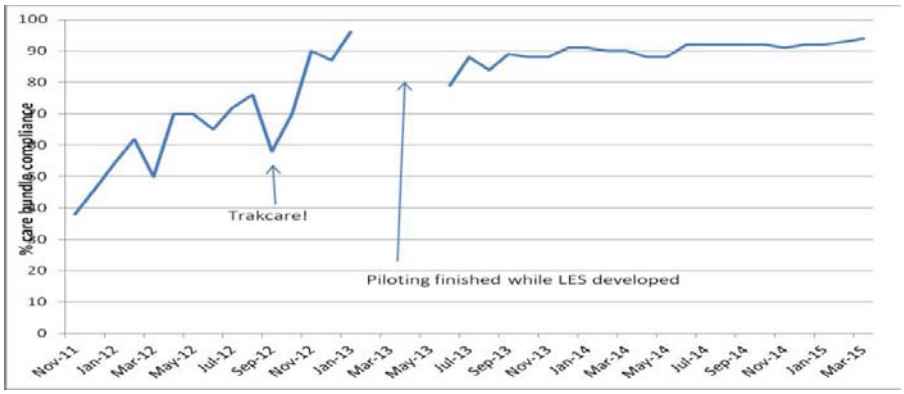
Medicines reconciliation GP Practices

The medicines reconciliation care bundle forms part of the "safer medicines" workstream in the Scottish Patient Safety Programme (SPSP) in Primary Care. Since the first polypharmacy Locally Enhanced Service (LES) submission in June 2013 to March 2015 involving 217 GP practices, there has been an increase in care bundle compliance by from 79% to 94%, just falling short of the 95% target (chart 1).

GP's have also completed medicine reconciliation reflection sheets and over the 2014/15 period they state that

- **85%** think carrying out the medicines reconciliation care bundle in their GP practice has improved patient safety or has the potential to improve patient safety
- **80%** think carrying out the medicines reconciliation care bundle in their practice has improved their practice processes
- **58%** have used their monthly data to identify areas for improvement
- **90%** reported an increased workload as a result of the medicines reconciliation care bundle
  A rewarding outcome of medicines reconciliation is that the patients have really appreciated receiving a call from their GP after their discharge from hospital and this has proven positive for both the patient and staff and provided opportunity to ensure accurate and safe prescribing.

Chart 1



Pharmacy in Primary Care Collaborative

The pharmacy in primary care collaborative started in July 2014 and will run for two years, supported by funding from the Health Foundation's Closing the Gap in Patient Safety Programme. NHSGGC is one of four Scottish Health Boards chosen to participate in the SPSP Pharmacy in Primary Care Collaborative.

Progress has been made on all of the work streams of the collaborative i.e.

- To pilot high risk medicine care bundles
- To develop a safety climate survey and supporting materials
- To develop learning sessions for participating pharmacies.
- To develop a Medicines Reconciliation Driver Diagram

As part of this collaborative NHSGGC developed an NSAID Care Bundle, the aim of which is to reduce the co-prescribing of High Risk Drug Combinations (NSAIDS and other medication) by 90% by 30th June 2016. 10 community pharmacies are involved in this pilot and have been submitting data on a monthly basis since January 2015.

Shared learning is an important part of the collaborative and also inclusion of public representatives. NHSGGC has already hosted a local learning session on the 3rd March and at the end of October will be contributing to the planning for the next National Learning Session is planned for the 25 & 26 November 2015.

High Risk Medicines

Small scale testing for the Disease Modifying Anti-Rheumatic Drugs (DMARDs) bundle was undertaken as a pilot in 2014. The pilot results highlighted improvements through

- Tighter prescribing methods
- Patient identification
- Alert recall systems

- Assurance of robust process for DMARDs management.

DMARDs is now managed through the Local Enhanced Service (LES) with 202 GP practices involved. There has been a gradual increase in compliance with the DMARD bundle which is currently at 50.9% (Chart 2) This suggests that there is progress towards the overall target of 100%. Work is underway to consider how to improve and support compliance with those GP practices that are not meeting the bundle requirements.

Chart 2

Measure	**DMARDS Bundle**					
Description	**All Available data**					
Name	**NHS Greater Glasgow & Clyde**					
Chart type	Board		Spread			
Month	number of patients with bundle complete	number of patients reviewed	# areas engaged	# in LES	Month	% Attainment
Apr 15					#N/A	#N/A
May 15	290	807	93	202	May 15	35.9
Jun 15	638	1570	155	202	Jun 15	40.6
Jul 15	808	1615	153	202	Jul 15	50.0
Aug 15	787	1546	150	202	Aug 15	50.9

Results Handling

In a review of Significant Event Analyses (SEA) in general practice in Scotland (2009) 20% of SEAs related to results handling systems. A 2014 survey of practice receptionists across NHS Scotland revealed that according to receptionists:

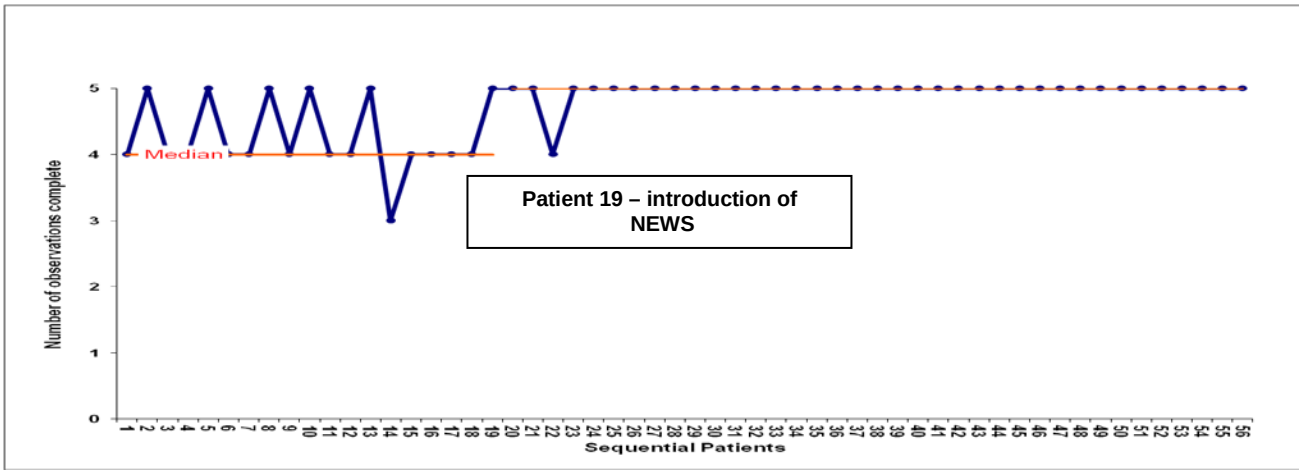
- systems for tracking and reconciling are variable, problematic and need improved, and
- communication from doctors can lack clarity causing frustration and unnecessary workload.

Eighteen months ago, through the small testing approach, a bundle for Results Handling was developed by NHSGGC practices, in collaboration with Grampian colleagues. This has now been adopted nationally by HIS and rolled out to all other boards. Currently in NHSGGC 9 GPs are involved in the Results Handling workstream. The overall compliance rate amongst the 9 GP Practices sits at 82%. Data is submitted to the CGSU and analysis is shared back to the practice. Planned visits are being arranged with the participating practices to increase compliance and a session is being considered to promote shared learning between participants and highlight good practice examples.

Sepsis

Within the NHSGGC Out of Hours GP Service (OOH) there has been some exploratory work undertaken to develop a bundle for the early detection of Sepsis. As part of this exploratory work GPs have been testing the use of the National Early Warning Score (NEWS) which aims to standardise an approach for efficiently identifying and responding to patients who present with or develop acute illness. Chart 3 highlights the use of the news score amongst the participating 7 GPs.

Chart 3: the use of a National Early Warning Scoring System (NEWS) in Greater Glasgow and Clyde Out of Hours Service.



At a recent Sepsis Learning Event on October 1st 2015, OOH GPs attended the learning event and agreed to continue participation in the Sepsis pilot. On the evening the patient cohort was agreed as: 'Patients who have been identified for admission to hospital with suspected sepsis'.
The bundle questions were agreed as follows:

1. Was a NEWS score carried out? Yes/No
2.Was antibiotics considered as per NHSGGC prescribing guidelines? Yes/No
3. Was the most appropriate priority ambulance ordered? Yes/No
4. Was the NEWS score communicated to the admitting hospital? Yes/No
5. Was the diagnosis documented? Yes/No
6. Have all the elements of the bundle been met? Yes/No

Staff in the CGSU are supporting this work with the Programme Lead (Dr Stephen Mclaughlin) and are in discussion about the data recording/retrieval and analysis.

Pressure Ulcer Care

District Nursing staff continue to build on their success of achieving 100% compliance with the Pressure Ulcer Prevention bundle. Currently they have worked with the Information Technology (IT) Department to develop a 'Dashboard' IT system through Micro-Strategy. This allows data to be more effectively collated and reported on. The dashboard and training is ready to roll out to all District Nurses. Compliance with the bundle is being measured as 'compliant' 'partly compliant' and 'not compliant'.

Reflections

The range of activity within Primary Care reflects the desire to improve patient care through safe and effective practices and processes. An SPS-PC learning event is planned for the end of January 2016 which will provide an opportunity to bring all the workstreams together for shared learning. There are particular challenges with data recording for all the projects however the approach taken by the District Nursing team using the 'Dashboard' may potentially provide a solution for other work streams.

Currently HIS are embarking on a consultation period for the next round of SPSP –PC initiatives, which will likely add to the portfolio of work in Primary Care. SPSP are also seeking applications for involvement in the Dentistry in Primary Care Improvement Collaborative with NHSGGC and Oral Health likely to submit a bid for the programme.

Appendix One
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
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