NHS FIFE
Report to NHS Fife Board, June 2015

THE SCOTTISH PATIENT SAFETY PROGRAMME (SPSP)
NHS FIFE UPDATE REPORT

1 SITUATION
The purpose of this report is to update the Board of the ongoing activity underway across NHS Fife to implement the Scottish Patient Safety Programme (SPSP). This report covers February to May 2015 and provides a brief overview of the programme.

2 BACKGROUND
The SPSP programme for acute hospitals was introduced in 2008 with the aim of reducing hospital standardised mortality (HSMR) by December 2012 and reducing “harm” by 30%. The second phase of the programme was launched in August 2013 with the overarching aim that 95% of all patients receiving acute care should be free from harms as identified by the Scottish Patient Safety Indicator (SPSI) and that the HSMR would be reduced by an additional 5% taking the overall reduction to 20%.

The SPSI Harms are:

- Cardiac arrests
- Falls
- Pressure ulcers

Catheter Associated Urinary Tract Infections (CAUTI) were part of the initial SPSI harms but were temporarily removed until a national definition could be agreed. A recent meeting in June reached a preliminary agreement on an outcome definition which will be tested before expected release in December.

The key aims of the programme were re-iterated in CEL 19 which instructed Boards to have robust mechanisms in place to ensure that the ten essentials of safety would be reliably delivered to every patient who could benefit from them. In May 2015, an additional letter from the Chief Executive of Health Improvement Scotland (HIS) advised Boards that they were no longer required to submit national reporting on the “ten essential” process data in recognition of the reliable local self-assurance and governance mechanisms that Boards had set in place to ensure that each of these processes were reliably implemented and sustained.

Healthcare Improvement Scotland has agreed with the Scottish Government that external assurance of the reliable implementation of the ten essentials should be sought via the new Quality of Care Reviews which are currently being designed, within the scope of the annual review processes and through ad hoc Minister updates.

The ten patient safety essentials are:

- Hand washing
- Leadership walkrounds
- Communications: surgical pause and brief
- Communications: general ward safety brief
- ICU daily goals
- VAP bundle
- Early warning scores
A self-assurance framework tool based on the Acute Adult Measurement Plan has been developed locally to assist Directorates within the Acute Hospitals and Community Services to support the self-monitoring process. The tool provides general guidance around “sustainability” and stepping down processes when improvement measures are truly embedded and are reflected in associated outcomes.

The development of the Clinical Dashboard across NHS Fife is being led by the Associate Director of Nursing in Acute Services and will provide an overview of the status of performance once all of the interventions have been migrated onto the system.

Ward based data will be entered onto LANQIP and exported onto the Clinical Dashboard.

A series of Standard Operating Procedures (SOP) are being developed to support the robust implementation of the ten essentials. The SOP design link process measures with outcomes and provide improvement guidance to staff whenever the required performance outcomes have not been achieved.

3. ASSESSMENT

HSMR

Chart 1

Chart 1 demonstrates NHS Fife's HSMR rate in comparison to NHSScotland performance
Chart 2 demonstrates NHS Fife’s HSMR with regression line.

The most recent HSMR data released at the end of April 2015 demonstrated a percentage reduction of 22.8% since Dec 2007 with a HSMR rate of 0.88. This has deteriorated since the previous HSMR data release at the end of February which demonstrated 23.7% reduction at that time with a HSMR rate of 0.75.

**CARDIAC ARRESTS**

Chart 3 demonstrates a rise in the number of cardiac arrest rates in the acute hospitals.

The Resuscitation Committee has reviewed all of the cardiac arrests that occurred during January 2015 due to the rise in the number of events that occurred at this time. The findings will be presented at the Quality Safety and Governance Group and outcomes will be added to the Reducing Harm Action Plan. The Reducing Harm Action Plan was developed a number of years ago as a vehicle to collate potential harms in the organisation that can then be actioned and learning shared.
Table 1 provides an overview of the individual SPSP programmes underway within NHS Fife.

The Acute Adult Programme was devised for Acute Hospitals but NHS Fife Community Services has implemented the ten essentials whenever it has been thought that patients may benefit.

An update report on the ten essentials for each of the Directorates within the Acute Hospitals will form part of the performance reports which are currently being implemented.

The ten essentials have been fairly well embedded within NHS Fife, but there remain some areas that have not reached sustained improvement with some of the process measures. Process performance is updated on a RAG status chart which provides a visual overview of compliance.

Peripheral Vascular Catheter
The Peripheral Vascular Catheter Maintenance Bundle has been widely implemented throughout the organisation and overall performance is good, but there are still areas that could improve their performance.

A recent rise in Staphaureus Bacteraemias occurred in June. PVC compliance and hand hygiene compliance will inform the Rapid Event Investigations which will take place for each of these events. An action plan will be developed to ensure any learning from these harms are identified and auctioned.
SPSI Harms

CAUTI

The Catheter Urinary Tract Infection Prevention Insertion and Maintenance bundles have been widely implemented in inpatient areas throughout the Acute Division and Community Services.

The Urinary Catheter Insertion and Maintenance Bundles and processes have been reviewed over the last two to three months in recognition of feedback received from staff. A Short Life Working Group convened to review the improvement processes and documentation used across both the Acute Hospitals and Community Services.

This is evolving into a wider stakeholder group led by the Associate Director of Nursing NHS Fife that will lead further improvement interventions to reduce the number of urinary catheter infections. The national CAUTI Short Life Working Group was reconvened in June with the aim of agreeing a national CAUTI definition. At the meeting the group agreed that the “signs and symptoms” definition was the best definition to drive improvement. The group also agreed that “catheter bed days” as a denominator was a useful measure to determine if the numbers of catheters inserted ultimately reduced.

CAUTI Definition:

- **Does the patient have a urethral urinary catheter insitu or has it been removed within the previous 48 hours**
  - CAUTI defined as: Temp <36°C or >37.9°C OR 1.5> baseline on 2 occasions in last 12 hours and 1 or more of the following:
    - Shaking chills (rigors)
    - New costovertebral (central lower back) tenderness
    - New onset or worsening delirium (confusion)
  - AND: on antibiotics for treatment of UTI

Falls

The improvement work around falls is being led by the Associate Director of Nursing in Acute Services. This work is linking to the Frailty interventions that are being led by Dr Sue Pound. The group have progressed a number of interventions which include:

- Development and implementation of a Falls Pathway across NHS Fife
- Falls care plan
- Comfort Round bundle
- Process measurement plan that is currently being tested

Cardiac Arrest /Deteriorating Patient

A review of cardiac arrests was undertaken by the Resuscitation Committee Leads following a rise in the number of arrests that had occurred to determine if “failure to rescue” had been identified during their care.

Patientrack has now been implemented (at some level) in fourteen wards within the Acute Division. The electronic system provides a standardised track and alerting system that identify patients at risk of deteriorating and then alerts the responsible Clinician so that a timely response is initiated. The sepsis bundle has been implemented in seven clinical areas.
Since the sepsis six bundle was implemented the screening tool has been used:

- 865 times in A & E since December 2012
- 381 time in AU1 since February 2013
- 28 times in AU2, 65 times in Ward 34 since May 2014

A mortality review of every death within Victoria Hospital was undertaken over an eighteen month period to determine if any organisation learning could be gleaned from the reviews to improve patient care.

The Scottish Structured Response tool has been implemented in one ward and is undergoing testing in another ward. The tool provides a standardised methodology for staff to escalate concerns and to promote a team approach to patient care management.

**Pressure Ulcers**

The improvement work around pressure ulcer care is being led by the Associate Director of Nursing/Head of Service Delivery GNEF. The group have progressed a number of interventions which include:

- Standardisation of the levels of harm and recording on Datix
- A Datix prompt to reduce duplicate pressure ulcer recording
- Implementation of a Patient Information Leaflet across NHS Fife
- NHS Fife-wide REI tool developed
- NHS Fife-wide approach to data measurement

**Capacity / Events**

Deteriorating Patient Learning Session 10th June 2015
McQIC Paediatric Network Event 11th June 2015
SPSP IA Networking Day 4th September 2015 and 4th February 2016
World Sepsis Day 10th September 2015
SPSP Acute Adult Regional Learning Session East 8th October 2015

**GOVERNANCE ARRANGEMENTS**

The reporting process is currently being reviewed.

4 **RECOMMENDATIONS**

The Board is asked to:

**Note** the overview of progress for each work stream.

**Advise** on aspects of the report that they found valuable and if they would value continuing reports in this format

Dr FRANCES ELLIOT  
Medical Director NHS Fife  
Executive Sponsor for SPSP  
16th June 2015

Mrs CATHY GILVEAR  
Patient Safety Programme Manager