Item Number 11.3

BOARD33/2014
Tayside NHS Board
24 June 2014

NHS TAYSIDE PATIENT SAFETY NETWORK – DEVELOPING A SYSTEMATIC APPROACH

1. SITUATION AND BACKGROUND

The fundamental aim of the Scottish Patient Safety Programme (SPSP) is to reduce avoidable harm to patients by improving the safety of patient care at all points of care delivery. At its outset, SPSP focused on acute (hospital based) care but, in subsequent years, its remit extended and now includes the following areas; Acute Adult, Maternity and Children, Mental Health and Primary Care.

Following the Scottish Patient Safety Programme Update Report presented to the Board on 27th August 2013 it was proposed and approved NHS Tayside would develop a more systematic approach to improving patient safety where it is seen as more than a range of national programmes, with improvements that address local safety priorities identified by frontline clinicians and the voice of patients and carers. This approach and future actions would reflect the recommendations of recent NHS England reports, those of Francis, Keogh and most recently by the National Advisory Group Report 'A promise to learn, a commitment to act'.

To achieve this we are developing a new patient safety network to support NHS Tayside's patient safety agenda. Building on the various national programmes the Patient Safety Network in Tayside will bring together and support multidisciplinary team members from across organisational and professional boundaries to improve the safety of care across the whole patient pathway.

Network Aims

- The network will create the conditions for improvement in patient safety across NHS Tayside by providing a forum for staff; developing staff, creating knowledge, exchanging information and spreading good practice within and across multidisciplinary teams in all specialities.

- It will provide the opportunity for staff to develop their Quality Improvement Skills and to move forward Patient Safety activities within their service with a curriculum of topics delivered to support this.

Following consultation across the organisation, including primary and secondary care the following three areas have been identified as NHS Tayside priorities for patient safety; multidisciplinary team communication, the deteriorating patient and medicines safety. These will form the three workstreams of the network and will collectively support the individual aims of each national patient safety programme, more details of which can be found at;

http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes

Work is now underway to launch the network on the 27th August 2014 and we are currently in the process of liaising with each directorate's clinical governance leads to identify appropriate core members for each workstream.

2. ASSESSMENT

Following the identification of the three workstreams, work has continued to describe these priority areas in more detail and a workplan (illustrated in Figure 1) below has been agreed for 2014-2016;

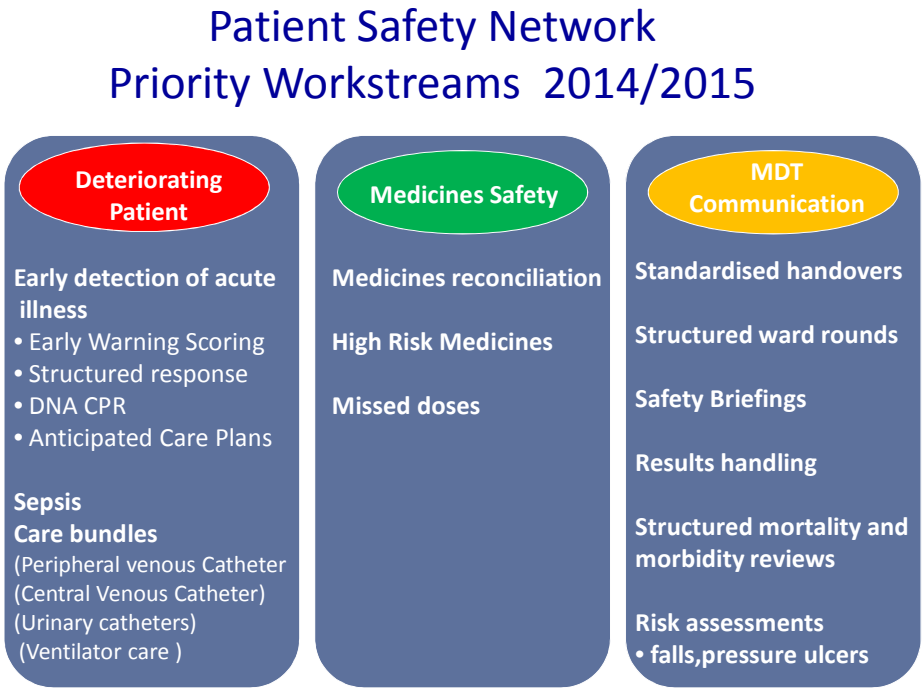


Figure 1

The network will bring together staff from across organisational and professional boundaries around common and credible aims. A robust communication plan has been developed in partnership with the communications team to ensure that all staff, patients and the public are aware of why the networks exists and what it hopes to achieve.

The following describes the steps that are currently being taken to build this new network and help ensure that we have the structure and tools in place to achieve its success.

Developing a cooperative structure

Strong and visible leadership will be critical and the Associate Director for Patient Safety reporting to the Board Nurse Director and Medical Director will take a lead role for this. We recognise that the network will require to be developed within existing resources. NHS Tayside has a dedicated patient safety team, working together with NHS Tayside staff including colleagues from the Centre for Organisational Effectiveness colleagues, Business Unit, Nursing Directorate, Quality, Clinical Governance and Risk Management and Infection Control, we will create and support the network to strengthen NHS Tayside's reputation as a learning organisation in particular training on such topics as safety science and quality improvement methods.

Building a critical mass

The network will offer a unique opportunity for staff to connect across traditional organisational and professional boundaries strengthening the sense of 'peerness'. The network will facilitate debate, coach and secure commitment to improvement, and support multidisciplinary groups to work together and make improvements across complex care pathways where they have perhaps failed previously. For example, recent efforts to improve medicine reconciliation have taken place separately within primary and secondary care without addressing the interface issues that contribute to this process being unreliable. Through the network it will be possible to connect wards and practices to test interventions, share ideas and measure collectively.

Recruiting members to the network has not been straightforward and we have decided to use our existing clinical governance structures to do this with the key principle that care needs to be taken to ensure appropriate representation and inclusion across all clinical teams.

The network is based on a collaborative learning model and active participation in, and support of, one another throughout the network action groups, conference calls/WebEx sessions, etc. is expected. The spirit of "All Teach, All Learn'' is a central driver for this network.

Beyond this, the network aims to draw in often neglected groups such as management, clerical and IT staff who have particular experience, skills to drive and influence to make change happen.

In addition, we continue to work with Dundee University Medical School around the education in Quality Improvement and Patient Safety for Medical students. Approximately thirty 5th year Medical Students each year participate in Quality Improvement and Patient Safety work participating in SPSP key objectives, working with local clinical teams to improve an area of practice. The network will give further support and opportunities to other students including nursing and dentistry to work alongside clinical teams undertaking e-Learning modules as well as face to face small group teaching.

Maximising collective intelligence

Figure 2 illustrates the network that will be easy and convenient for all to use. It will provide opportunities such as; teleconference calls for teams, a listserve, newsletters, and a webpage to discuss their concerns, clarify expectations, and establish a shared understanding of the aims of the network. Face-to-face meetings are, however, often critical to success and the workstream action groups will provide improvement educational sessions and facilitated discussions to foster team spirit and hear about others' experiences of making changes, convincing people that change is possible.

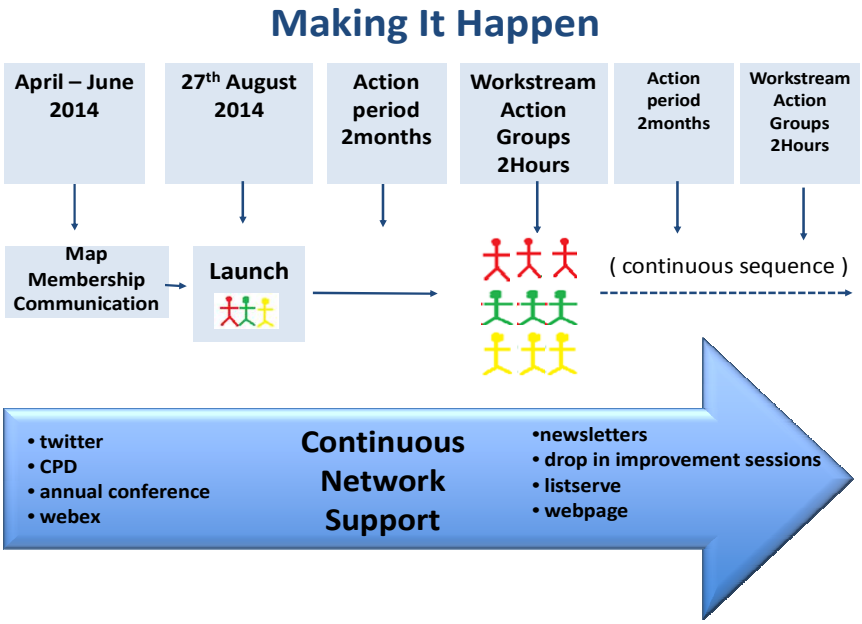


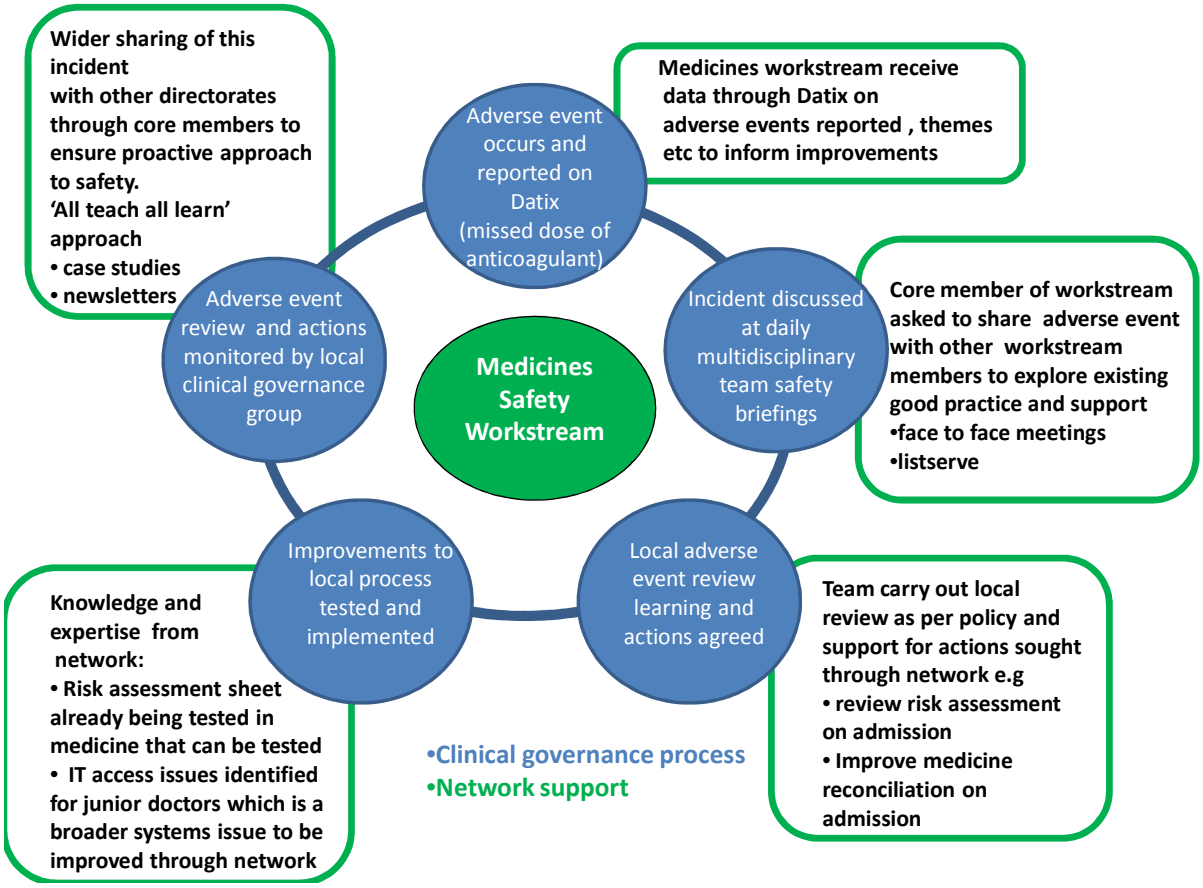
Figure 2

Reporting and assurance

Members of the network will have a responsibility to contribute effectively to the network objectives and through an engaging leadership style raise the profile of patient safety both within their local teams and beyond.

A robust and clearly defined measurement framework already exists through the national programmes to support the three workstreams and will be used to coordinate and monitor progress across the organisation. Reporting against this framework will be embedded within the existing clinical governance reporting structures and patient to Board information as outlined in the Board paper 'NHS Tayside's Clinical Governance Measurement and Monitoring Framework' on the 5th December 2013.

An example of how the network could support a clinical team make improvements to patient safety is detailed below and provides a more granular illustration of how it will support NHS Tayside's whole system of good clinical governance;



3. RECOMMENDATIONS

The Board are asked to confirm support to the development of a Patient safety Network and note the progress and development of the network to date.

4. REPORT SIGN OFF

Dr M McGuire
Nurse Director

Ms L McLay
Chief Executive

Dr A Russell
Medical Director

June 2014