NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Monday 12 August 2024**
Title:	**Quality and Safety - Acute Services Update**
Responsible Director:	**Jennifer Wilson, Nurse Director**
Report Authors:	**Stephanie Frearson, Acute QI Lead** **Nina McGinley, Board Excellence in Care Clinical Lead & Lead for Practice Development** **Gillian Biggans, Resuscitation Service Lead** **Linda Robertson, QI Lead Nurse Professional Development FFN**

1. Purpose

This is presented to the Board for:

- Discussion

This paper relates to:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2. Report summary

2.1 Situation

This paper outlines Scottish Patient Safety Programme (SPSP) progress in alignment with Excellence in Care (EiC) locally and describes to members the current status and plans going forward in relation to local on-going patient safety measures including:

- Falls
- Falls with harm (FWH)
- Pressure Ulcers (PU)
- Cardiac Arrest
- National Early Warning Score (NEWS)
- Food Fluid and Nutrition (FFN)

2.2 Background

SPSP is a longstanding national initiative that aims to support and improve the safety and reliability of health and social care and reduce harm, whenever care is delivered. EiC is a national assurance programme which aims to ensure people have confidence they will receive a consistent standard of high-quality of care no matter where they receive treatment in NHS Scotland, providing consistent, robust processes and systems for measuring, assuring, and reporting on the quality of care and practice.

2.3 Assessment

As part of the SPSP Acute Adult Portfolio, all Scottish Health Boards are invited to report Falls, FWH and Cardiac Arrest data nationally to Healthcare Improvement Scotland (HIS). As part of the EiC programme, data for Falls and PUs are also submitted monthly to Public Health Scotland (PHS) via a data extract from Datix and the Patient Management System. Food, Fluid and Nutrition MUST scoring information is collated monthly and forms part of the national Excellence in Care report.

Locally, clinical staff report adverse advents such as Falls, FWH, PUs, FFN and Cardiac Arrest via Datix. Recently within Acute Services an exercise to review all active process measures has been carried out. This has enabled a reduction in the number of process measures being input resulting in staff reporting these in a more relevant and meaningful way and additionally, reducing data burden. The recently introduced Quality and Safety Framework sets out a structure which provides clear staff guidance around agreed measures and roles/responsibilities for collecting and reporting data.

Full details of all QI incentives and progress against these measures are included in Appendix 1.

2.3.1 Quality/patient care

Participation in both SPSP and EiC programmes enables us locally to provide an evidence base which supports objective measurement and provide assurance around the quality of patient care. This is valuable to both enabling areas of improvement and celebration of success.

2.3.2 Workforce

Attaining sustainable improvement is only achievable when all staff are fully invested and empowered**.** There is a requirement for staff to participate in both SPSP/EiC programmes to benefit patient experience, care and outcomes**.** At times operational pressures that the organisation continue to face may impact on staff ability to engage with QI incentives.

2.3.3 Financial

It should be noted that reduced performance in relation to SPSP and EiC measures may have a financial impact, for example potential for increased length of stay due to experiencing a fall with harm or PU.

2.3.4 Risk assessment/management

Failure to comply with national/local improvement programmes may impact on:

- Patient harm(s)
- Patient/Staff experience and wellbeing
- Complaints
- Litigation and adverse publicity

2.3.5 Equality and diversity, including health inequalities

An impact assessment has not been completed to support either the SPSP or EiC programmes. Participation and implementation of both these programmes of improvement/assurance work impacts positively on all patients and service users regardless of health inequalities.

2.3.6 Other impacts

- Best value
- Vision and Leadership
- Governance and accountability
- Compliance with Corporate, NMAHP and Quality Strategy Objectives

2.3.7 Communication, involvement, engagement and consultation

Both SPSP and EiC programmes require ongoing communication, involvement, engagement and consultation with all stakeholders. To date this has included:

- Updates to relevant Governance/Improvement groups
- Engagement in SPSP/EiC learning sessions (local and national)
- Improvement advisor alignment to support triumvirate structure
- Access to local and site data

2.3.8 Route to the meeting

This paper has been tabled at Healthcare Governance Committee on Monday 29th July 2024 prior to presentation to Board.

2.4 Recommendation

For discussion. Members are asked to receive and discuss this report which provides an overview of performance, assurance and QI activity in support of local and national improvement initiatives.

3. List of appendices

The following appendices are included with this report:

Appendix 1 – Acute Services Quality and Safety Update

Appendix 1

Acute Services Quality and Safety Update

1. Introduction

The Scottish Patient Safety Programme (SPSP) is a longstanding national initiative that aims to support and improve the safety and reliability of health and social care and reduce harm, whenever care is delivered. As part of SPSP, all Scottish Health Boards were historically invited to report Falls, Falls with Harm (FWH), Pressure Ulcers (PU) and Cardiac Arrest rates to Healthcare Improvement Scotland (HIS) SPSP/Acute Adult Portfolio quarterly. Following a pause during the COVID pandemic, data submission from NHS Ayrshire and Arran (NHSAA) recommenced in November 2021 however PU data was no longer requested and/or submitted.

Commissioned by the *Scottish Government* in response to the Vale of Leven Hospital Inquiry, Excellence in Care *(EiC)* is *Scotland's* approach to assuring and improving nursing and midwifery care. As part of the EiC programme in acute services, data for Falls, PU, National Early Warning Score (NEWS), Food, Fluid and Nutrition (FFN), Workforce Variance and Student Experience is currently submitted monthly to Public Health Scotland (PHS) via a data extract from Datix, Quality Improvement (QI) Portal, Scottish Standard Time System, Quality Management of the Practice Learning Environment and the Patient Management System. EiC data submission from NHSAA to PHS has been on-going since October 2020.

This paper outlines SPSP progress in alignment with EiC locally and describes to the group members progress and plans going forward in relation to patient safety measures including:

- Falls
- Falls with harm
- Pressure Ulcers
- Cardiac Arrest
- National Early Warning Score
- Food Fluid and Nutrition

2. Data Surveillance

Within NHSAA a monthly surveillance programme has been successfully introduced, supported by the QI team, Pressure Ulcer Improvement Nurses (PUIN) and the Falls Co-ordinators (FC). A locally developed data dashboard that gives an ‘at a glance’ overview of performance (reportable harms) on both acute sites was developed and introduced on the TEAMs platform. Access to the TEAMs channel has been offered to all management and Senior Nursing staff to enable a complete data overview of SPSP reportable harms and identify areas who may require QI support on a monthly basis. Currently Falls, FWH and PU data is displayed with plans to add cardiac arrest data in the near future.

The TEAMs channel displays data over the last 2 years from both acute hospital in-patient areas. Using QI methodology, run-chart rules are applied and areas with an increase or decrease in median rates of Falls/FWH and/or PUs are identified. Where data demonstrates an increasing rate of harm, clinical teams are contacted to discuss and understand the data, identify improvements and are offered a supported QI action plan. The QI team also reach out to areas displaying decreased rates of harms to celebrate success and enable shared learning throughout the organisation. Recently conversations have taken place to discuss

and explore how the dashboard data can be more widely shared and understood by all members of staff.

On a monthly basis the EiC team review the EiC Measures on the national dashboard; Care Assurance Improvement Resource (CAIR) and Business Objects to identify the areas that have less than 80% compliance. The EiC team highlights to the Clinical Nurse Managers the compliance and aspects of the process measures that they need to improve.

NHSAA EiC Team are required to report to Scottish Government quarterly. This report is also presented to Professional Leadership Group (PLG) chaired by the Executive Nurse Director. This includes both EiC Board Level Data and outcomes from Care Assurance Tool audits. The overarching aim of this approach is to provide local assurance and impact of EIC within NHSAAwhilst identifying key risks and actions where required.

3. Falls/Falls with Harm (Acute sites)

From September 2021 to March 2024, NHSAA have been part of the SPSP Acute Adult Collaborative which had a particular focus on:

- Reduction of inpatient falls and falls with harm (FWH).
- Reduction in Cardiopulmonary Resuscitation Rates (CPR)

As part of this programme a falls reduction change package was developed and shared for use locally. This enabled us to benchmark current practice and prioritise and identify areas for falls improvement. With regard to a FWH definition, following extensive consultation with all stakeholders, a nationally agreed definition has now been agreed. This awaits final endorsement and roll-out at board level.

The falls and FWH rates across both sites and individually at both UHC and UHA are detailed below. All charts have been annotated to describe the change ideas implemented across this timeline while NHSAA were taking part in the SPSP Falls Collaborative.

3.1 Falls/Falls with Harm – Acute Sites (All)

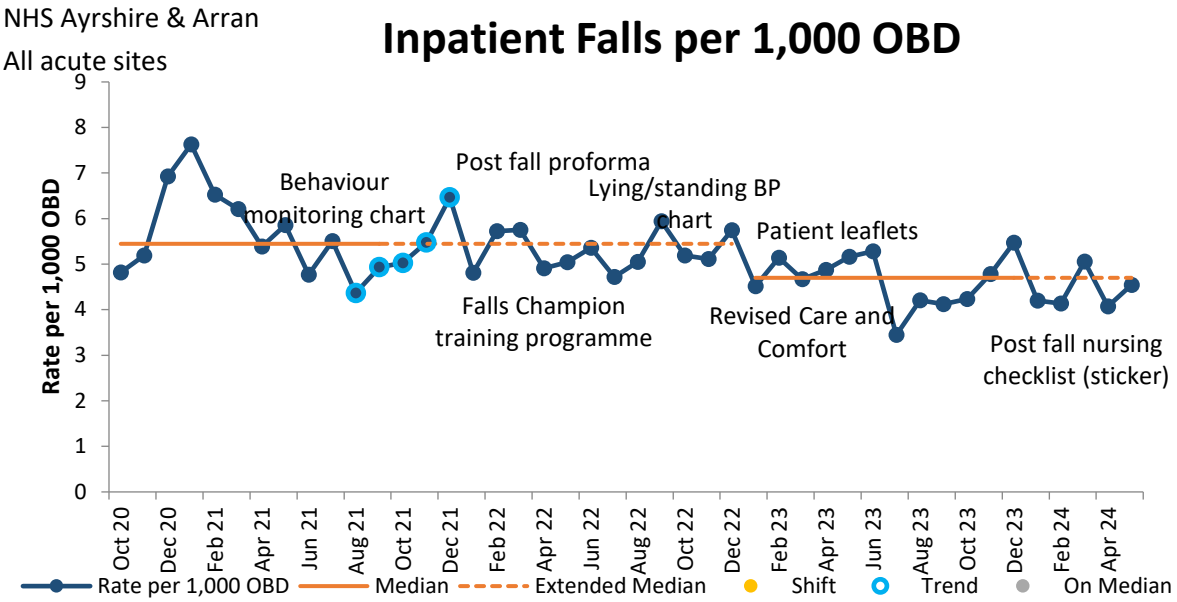


Chart 1. All Falls rate for All Acute Sites

Chart 1 outlines the rate of falls within adult inpatient wards on both acute hospital sites. In January 2024 the median was re-phased to reflect the new lower median of 4.7 (per 1000 OBD) which equates to a 14% decrease in the rate of falls reported.

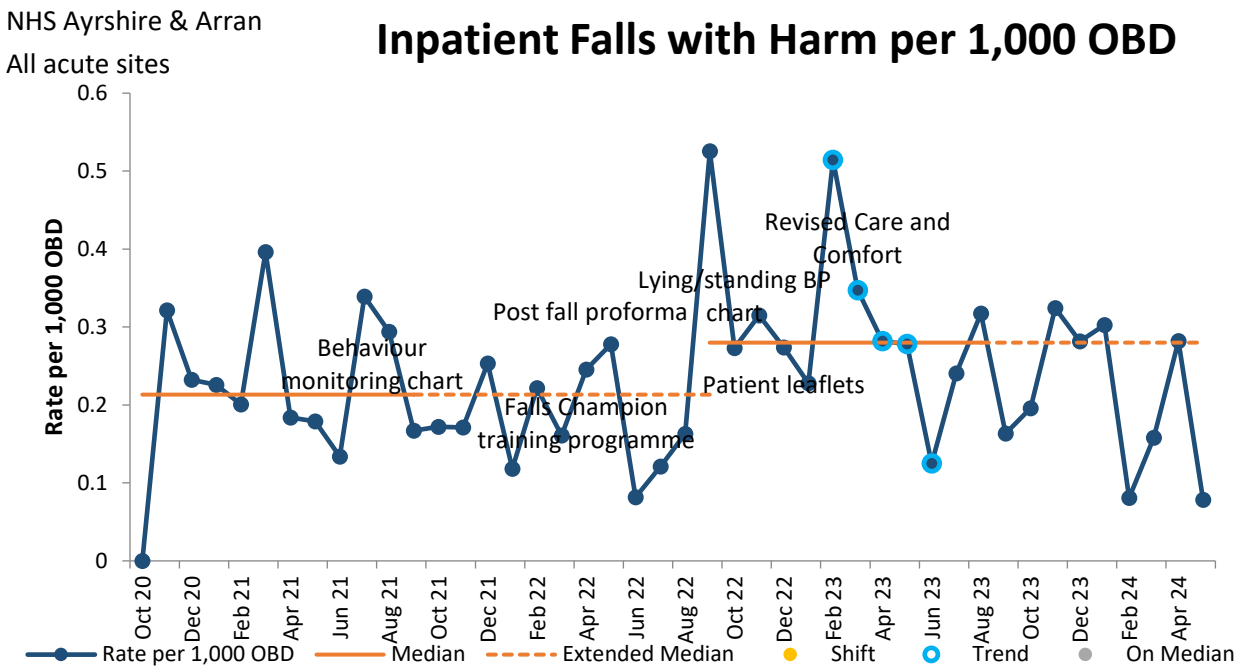


Chart 2. Fall with harm rate All Acute Sites

Chart 2 outlines the rate of FWH within adult inpatient wards across both acute hospital sites. In August 2023, the median was re-phased to reflect the new higher median of 0.28 (rate per 1000 OBD).

3.2 Falls/Falls with Harm – UHC Site

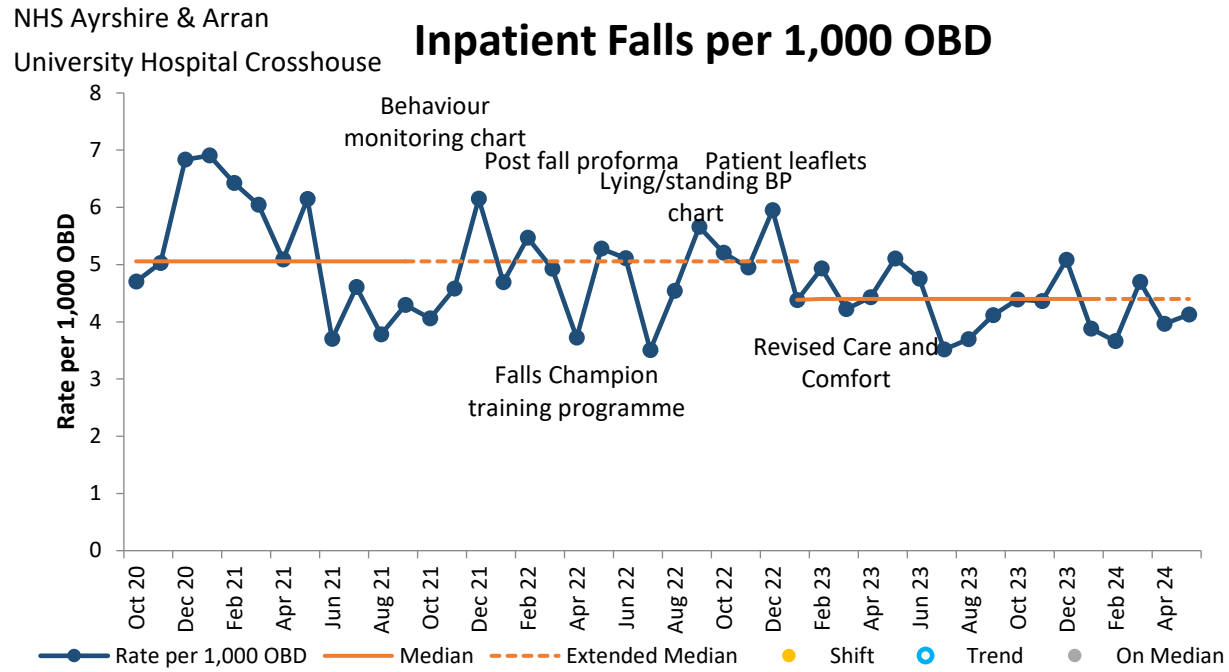


Chart 3. All Falls rate UHC

Chart 3 outlines the rate of falls within adult inpatient wards on UHC site. In January 2024, the median was re-phased to reflect the new lower median of 4.4 (rate per 1000 OBD). This represents a 15% decrease in the rate of falls reported.

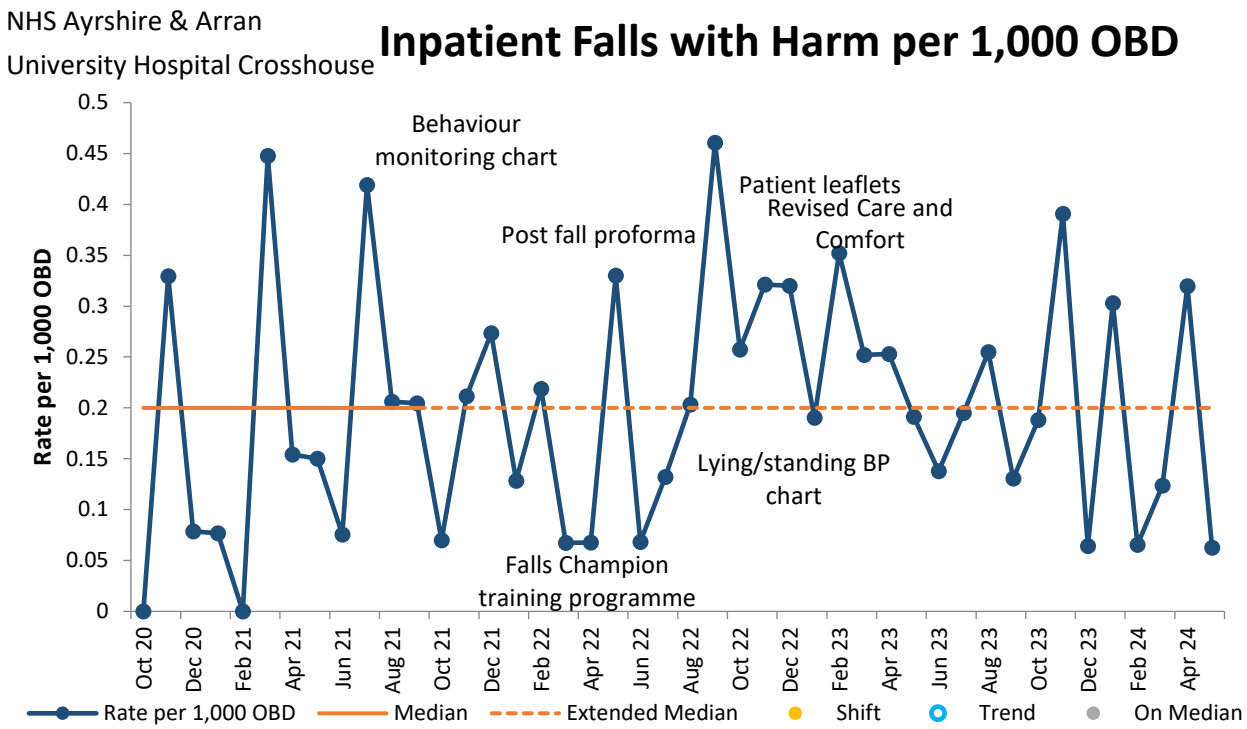


Chart 4. Fall with harm rate UHC

Chart 4 outlines the rate of FWH within adult inpatient wards on UHC site.

3.3 Falls/Falls with Harm – UHA Site

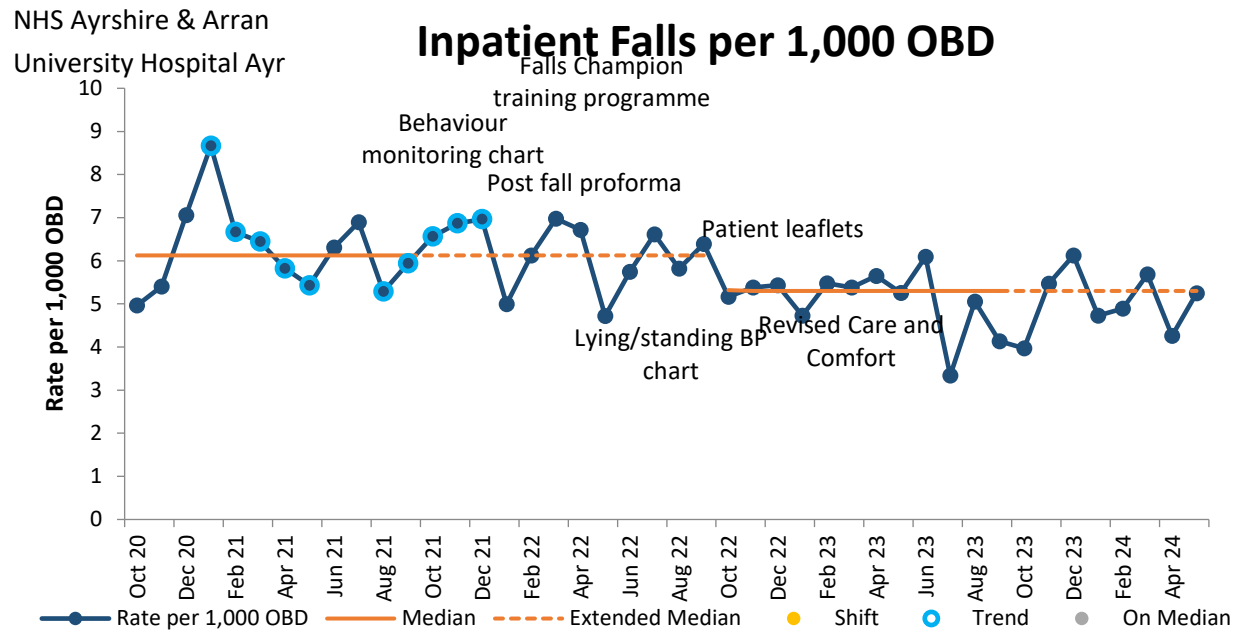


Chart 5. All Falls rate UHA

Chart 5 outlines the rate of falls within adult inpatient wards on UHA site. In September 2023, the median was re-phased to reflect the new lower median of 5.3 (rate per 1000 OBD) this represents a 14% decrease in the rate of falls reported.

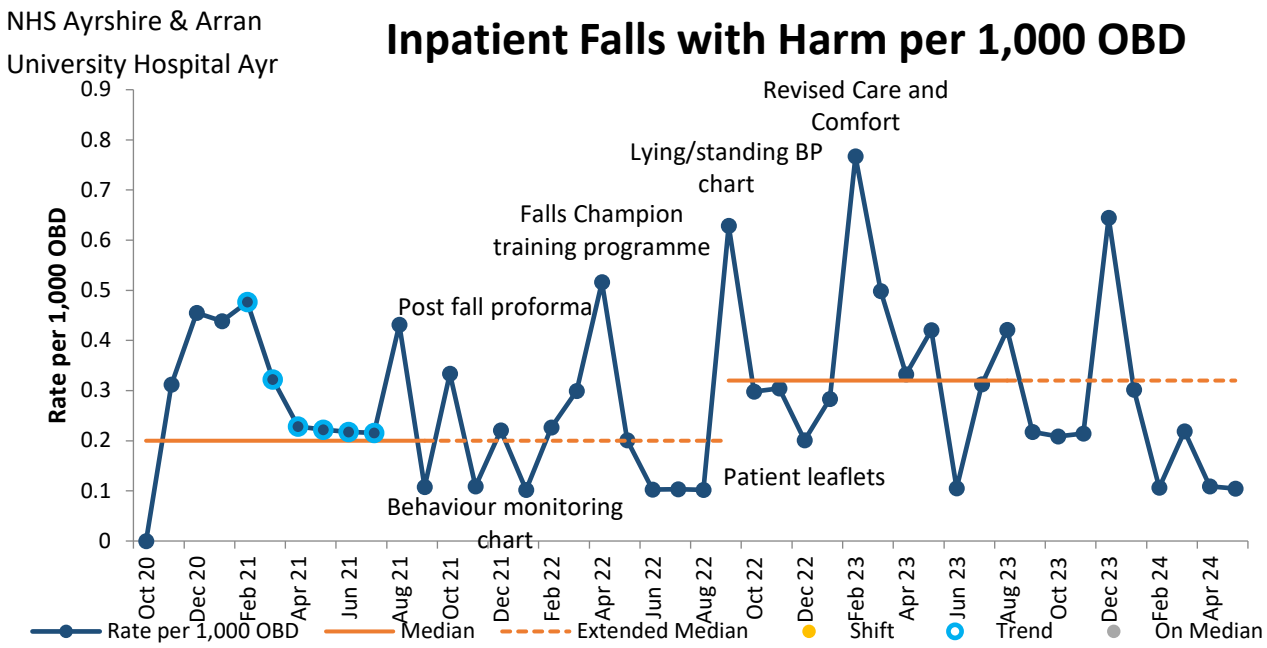


Chart 6. FWH UHA

Chart 6 outlines the rate of FWH within adult inpatient within UHA. In August 2023 the median was re-phased to reflect the new higher median of 0.32 (per 1000 OBD).

3.4 Falls Co-ordinator (Acute Services)

The National SPSP Falls collaborative has recently come to an end however at a local level the team continue to support and empower clinical teams to progress falls improvement and prevention. This has included testing of a dedicated falls support programme in collaboration with the QI team for 'hot spot' wards or those who are having regular and frequent FWH. The programme incorporates an initial audit of environment and processes (risk assessment, care planning and implementation of falls prevention interventions), which is then followed up with discussion of findings and an agreed and supported action plan with Senior Charge Nurse (SCN) over a period of months. Of the wards involved in this test of change 4/7 (57%) have demonstrated reduction or sustained reduction in all falls rates. The FC/QI team plan to explore and develop this programme of support further with a view to offering this service to additional wards. Additionally, to date, 96 staff have undertaken Falls Champion training with additional sessions planned for the coming months.

In recognition of the progress and success being made locally, the FC/QI team presented at the SPSP Acute Adult Collaborative celebration event in March 2024.

4. Pressure Ulcers

In 2021 local PU data from both acute sites, indicated early signals of an increase in PU's therefore, under the direction of the Executive Nurse Director and Acute Clinical Governance (ACG) Group an action plan was developed which included the development and launch in December 2022 of an NHSAA PU 'breakthrough series' collaborative. Further support was provided by a 2-year seconded post for a PUIN for Acute Services from March 2022.

4.1 Pressure Ulcer Collaborative Update

The PU Collaborative was launched in January 2022 with a clear focus on driving improvements around prevention of PU's across both acute sites, with 4 initial acute wards taking part and an additional 4 acute and 3 community hospital wards added at a later date. The agreed breakthrough series timeline has been challenged with delays due to system pressures resulting in difficulties with staff supporting and engaging in the collaborative. The collaborative has now reached its final action period with the working group currently identifying potential areas for scale up and spread. Within UHA a reduction has been observed with the total number of acquired PU's (count) however a 72 % increase is noted within UHC site. A future workshop has been provisionally planned for next month with key stakeholders to understand learning from the collaborative and plan next steps for pressure ulcer improvement work.

The PU rates across both sites and individually at both UHC and UHA are detailed below. Chart annotations describe the change ideas tested and/or implemented across this timeline as part of the role of the Pressure Ulcer Improvement Nurse and/or NHSAA Pressure Ulcer Improvement Collaborative.

4.1 Pressure Ulcers - Acute Sites (All)

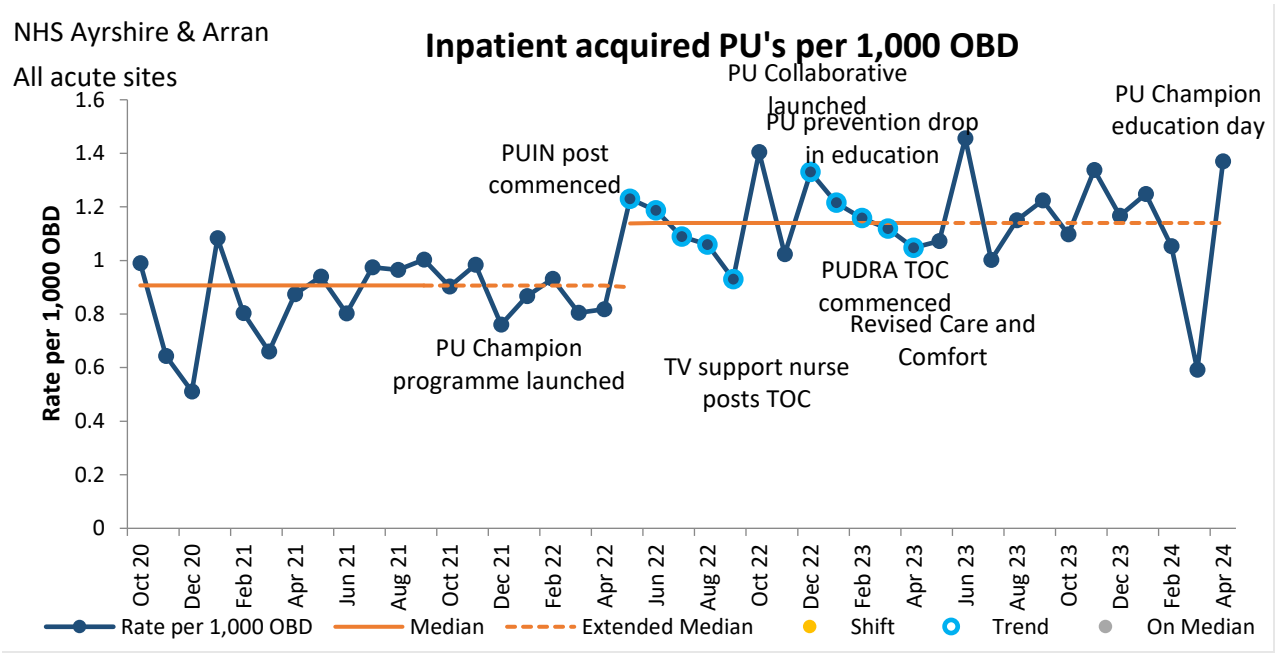


Chart 7. PUs All Acute Sites

Chart 7 outlines the rate of acquired PU's within adult inpatient wards on all acute sites. In May 2023, the median was re-phased to reflect the new higher baseline median of 1.1 (rate per 1000 OBD).

4.2 Pressure Ulcers – UHC

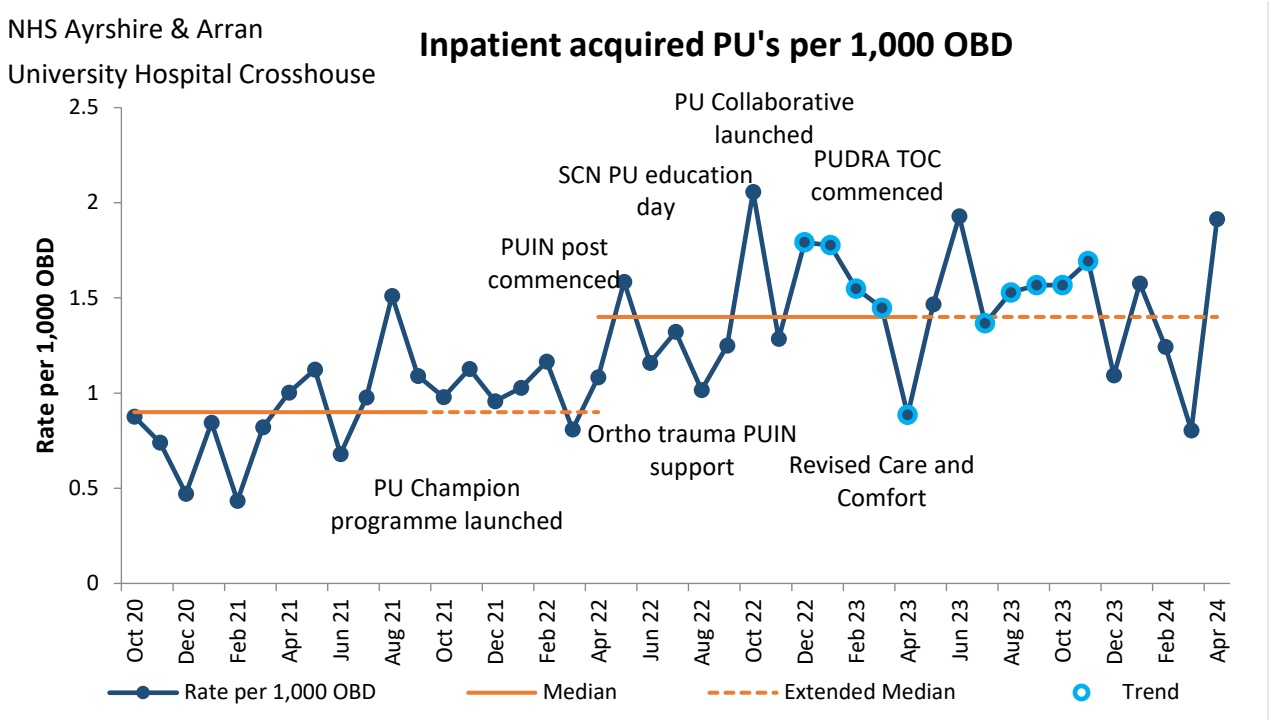


Chart 8. PUs - UHC

Chart 8 outlines the rate of acquired PU's within adult inpatient wards on UHC site. In March 2023, the median was re-phased to reflect the new higher median of 1.4 (rate per 1000 OBD) which represents a 55% increase in the rate of acquired pressure ulcers reported.

4.3 Pressure Ulcers – UHA

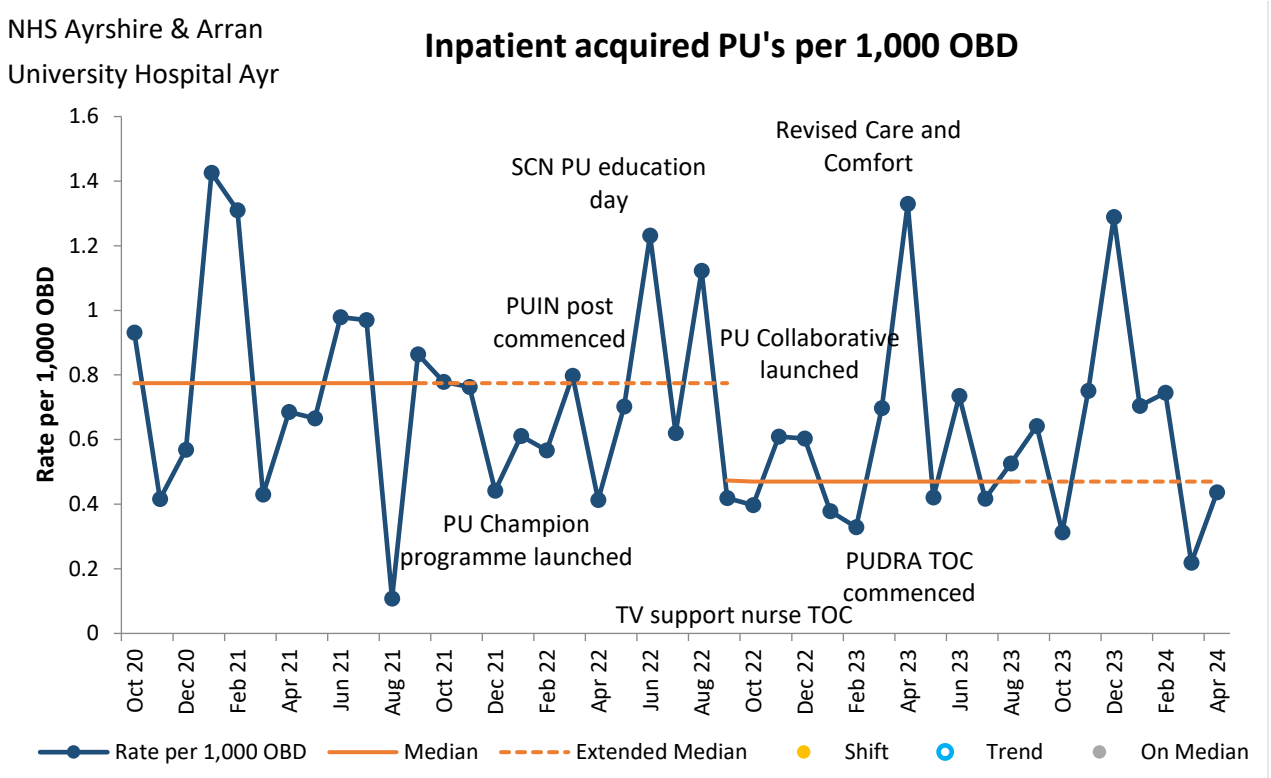


Chart 9. PUs - UHA

Chart 9 outlines the rate of acquired PU's within adult inpatient wards on UHA site. In March 2023, the median was re-phased to reflect the new lower median of 0.5 (per 1000 OBD), which represents a 37% decrease in rate of reported acquired pressure ulcers.

4.4 Pressure Ulcer Improvement Nurse

Funding from HIS was utilised in 2022 to fund 1.0 WTE PUIN. These seconded posts ended on the 31st March 2024, extension has been agreed until the end of August 2024. Using the same model as the Falls Co-ordinator role, the aim of the PUIN role was to be based within the acute QI team and use a collaborative approach employing QI methodology to identify and support change in areas with increasing incidence of acquired PUs. In addition to supporting the collaborative improvement initiatives annotated on the PU data above the following priorities and work plan was agreed:

- Monitor acute sites, collect data, investigate Grade 3 and above PUs
- Monthly identification of high-risk areas/wards (Grade 4/5)
- Support Adverse Event Review Group (AERG) process
- Ensuring accuracy of DATIX information

To date 81 PU champions have been trained across both acute sites with a further 24 nominated and awaiting dates for assessment. The PUIN has also undertaken a review of the process of all consequence 4/5 PU harms reported to the AERG. This resulted in the development and testing of a consequence 4/5 harm pathway for pressure ulcers that has recently been introduced to the AERG.

5. Deteriorating Patient

Deteriorating patient work stream progress since last reporting:

- Emergency Response Team relaunch work commenced with 3 pilot wards (4D, 2A and Station 2) educational roll out completed and in testing phase, evaluation and plan for further spread scheduled for end of July. This work is supported by Advanced Nurse Practitioner Team and Quality Improvement team
- Further quarterly multidisciplinary team (MDT) reviews of Combined Assessment Unit (CAU) true cardiac arrest in both UHA and UHC sites carried out with positive feedback from MDT, agreed learning points and plan for sharing learning with wider CAU team. CAU both sites are our hotspot areas for Cardiac Arrest.
- Ongoing and improved reliability (>95%) in collation of all true cardiac arrests via Datix, with progress made to extract this directly to enable more reliable and streamlined reporting to HIS.
- Local agreement through Deteriorating Patient and Resuscitation Group (DPRG) to aim locally for a 10% reduction in true cardiac arrest rate by January 2025 across both acute sites.
- SPSP sepsis change package presented at DPRG by clinical lead, request for support in devising a steering group to agree local approach to necessary implementation of changes.

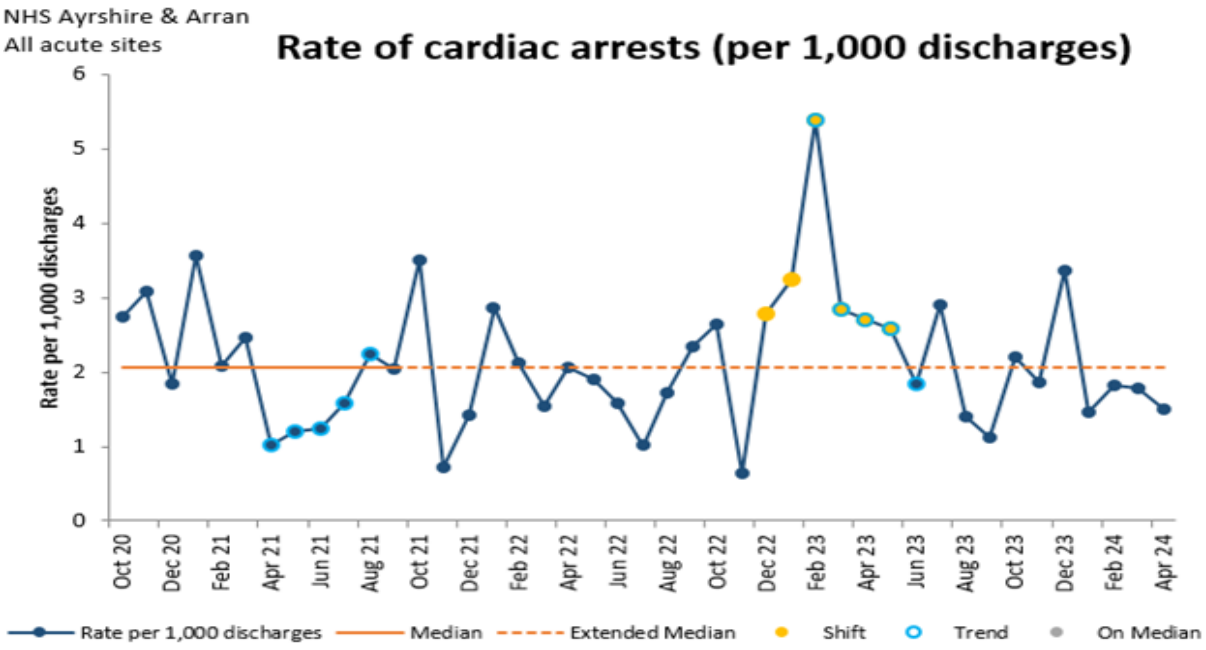


Chart 10. Rate of Cardiac Arrests per 1000 discharges.

Despite potential downward trend in data from February 23-September 23, data has been variable since. NHSAA cross-site median is currently sitting at 2.1, it should be noted that the national median is 1.42.

Ongoing theme around lack of Treatment Escalation Plan (TEP) and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision making, progress since last report with this;

- Deteriorating patient and resuscitation courses reviewed and adapted to include TEP/DNACPR education.
- Resuscitation Service Lead and deteriorating patient clinical lead have attended medical lunchtime meetings to highlight importance of good medical documentation especially around End-of-life decision making and communication of this with patient and family.
- This information has also been shared at high level Acute Quality and Safety Oversight meeting as well as Lead Nurse meeting and ACG meeting.
- Plan to share data and source support for improvement work at divisional governance meetings.
- A local steering group to be established to develop this programme of work.
- Collaboration with QI team to support QI methodology around TEP/DNACPR project.
- Resuscitation team will develop an overarching deteriorating patient driver diagram and subset of driver diagrams for aligned work.
- Electronic ReSPECT initial test phase has been evaluated. Significant IT barriers have resulted in slower progress than expected and therefore testing will continue with the addition of only one other ward.
- Most recent quarterly report from National Cardiac Arrest Audit (NCAA) for UHC on chart 11 as below demonstrates a 6.5% survival to discharge rate. Last year's National annual report data highlighted a 23.7% survival to discharge rate. This disparity is likely to be reflective of our clear theme of resuscitating patients who are unlikely to benefit from CPR.

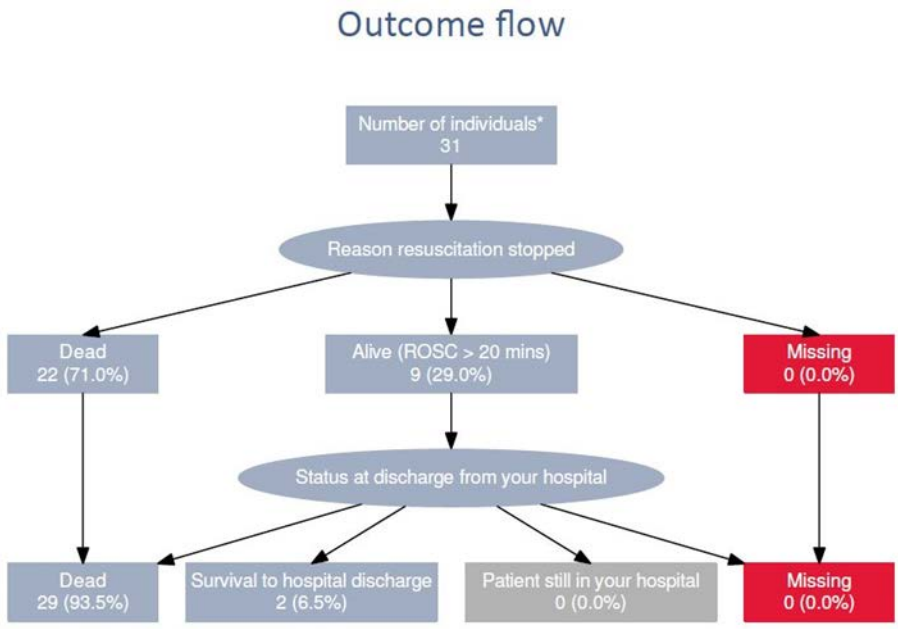


Chart 11. NCAA Cardiac Arrest Outcomes – UHC

Chart 12, allows for a National comparison with similar hospitals of our survival to discharge rate. UHC is shown to have the lowest survival to discharge rate. As a clear outlier it is important that we seek to better understand our data, through continuing to review and learn where best to focus our improvements.

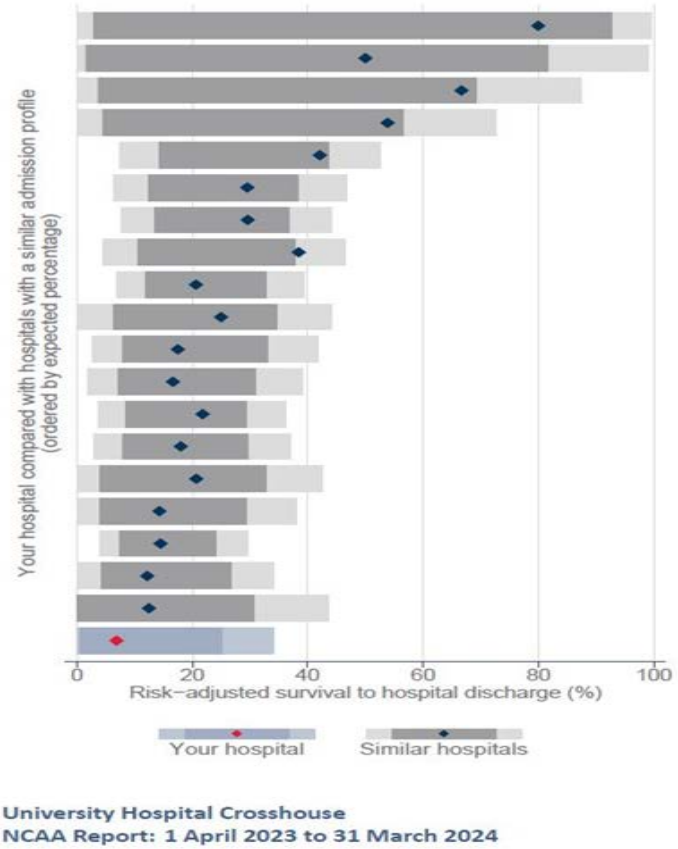


Chart 12. NCAA survival to discharge comparison with similar hospitals

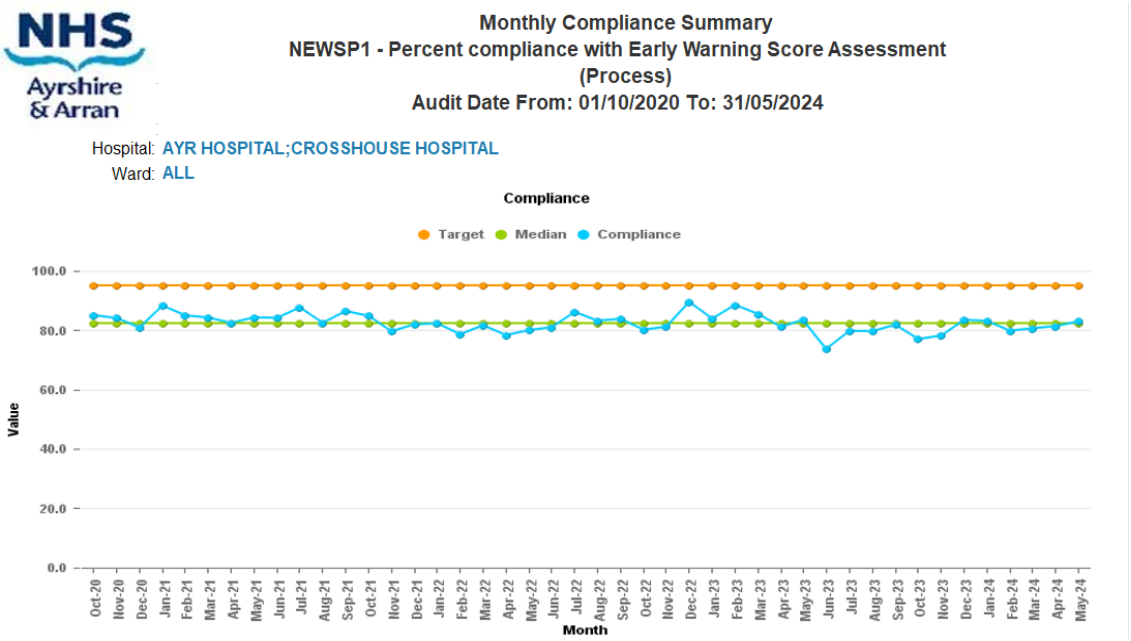


Chart 13. NEWS2 compliance - All Acute Sites

Chart 13 outlines the NEWS2 compliance across both acute sites. The median from October 2020 – May 2024 is 82.5% compliance. The main aspect of the bundle that is impacting on compliance is the frequency of NEWS not being completed within the allocated time.

Resuscitation and Deteriorating Patient Services undertook their own NEWS audit in March and April 2024 to gain an understanding of current processes at ward level across both Acute Sites. The audit highlighted a 70% cross site compliance with correct frequency of NEWS and 86% cross site compliance with correct action taken according to NEWS. This is further reflected in the latest annual data from cardiac arrest reviews. 100% of true cardiac arrest from January to December 2023 were reviewed with NEWS compliance analysed for each site as below in chart 14 and chart 15:

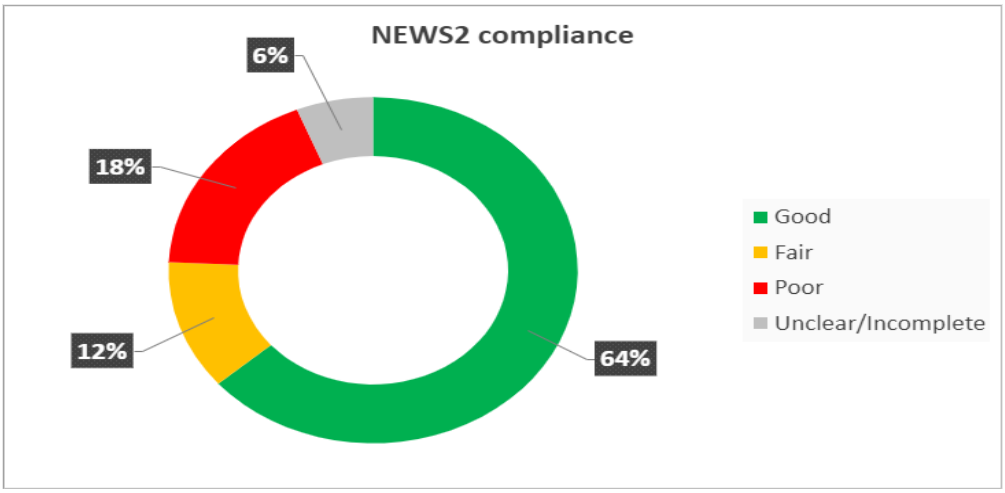


Chart 14 - UHC NEWS Compliance Data from true cardiac arrest reviews January to December 2023

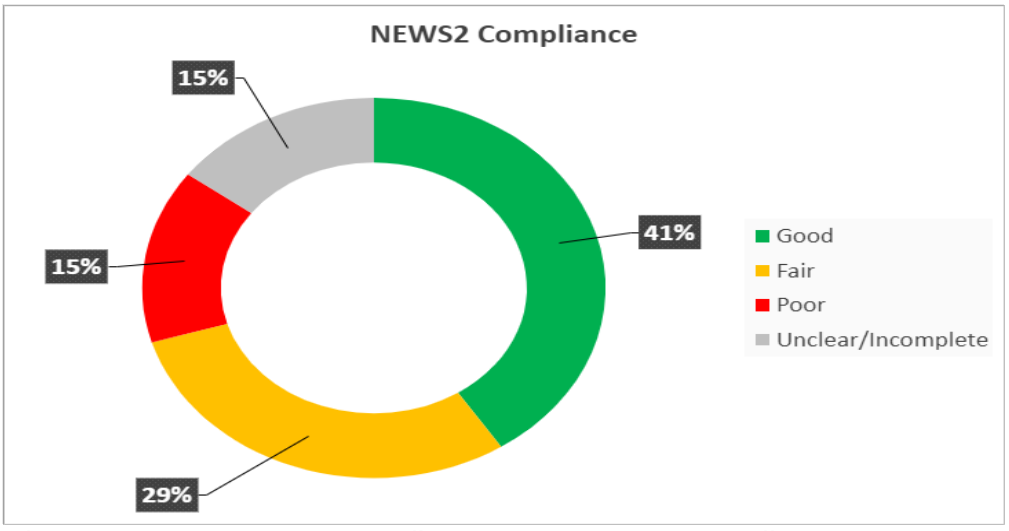


Chart 15 – UHA NEWS compliance Data from true cardiac arrest reviews January to December 2023

It has been identified that there is no local or national operational definition for what constitutes time compliance with NEWS. There is a need to standardise the margin of frequency around NEWS. In collaboration with the EIC team, Resuscitation and Deteriorating Patient Service are benchmarking with other NHS Scotland Health Boards around margins of timings for NEWS frequency compliance audits. It has been tabled locally at DPRG and Acute Quality & Safety Meeting and required to be discussed with the national EIC & SPSP teams. A way forward has still to be agreed.

EIC and Resuscitation Services will continue to collaboratively work towards an agreed margin for frequency of NEWS to support a realistic approach to audit. Resuscitation services will amend resuscitation and deteriorating patient training to include more education around NEWS and highlight the importance of NEWS compliance in the recognition of the deteriorating patient. Learning from cardiac arrest reviews to be cascaded widely throughout the organisation.

6. Food Fluid and Nutrition (FFN)

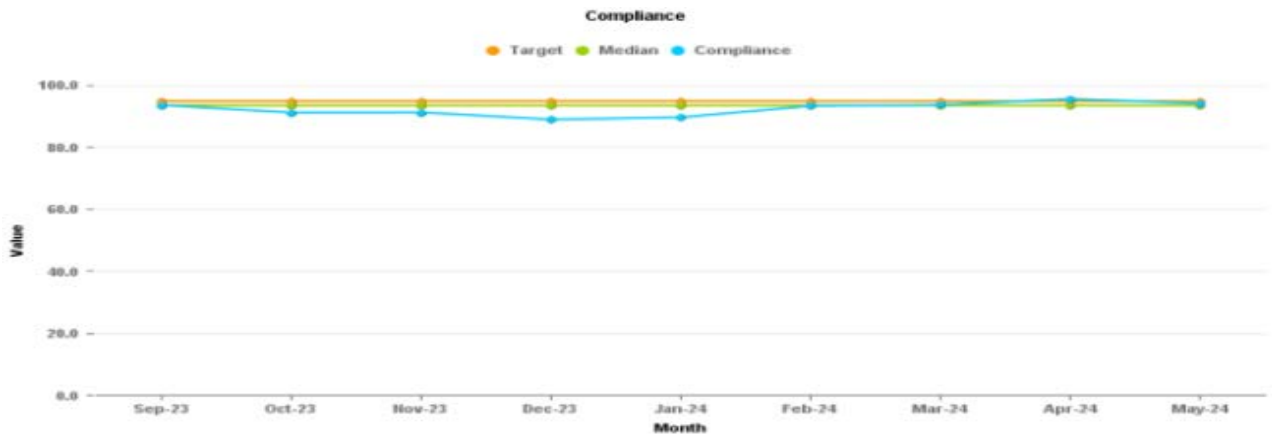
FFN standards data is collected monthly from 35 inpatient wards across both Acute sites. Staff can use the Food, Fluid and Nutrition Measurement Tool as a tool to understand, measure, monitor and improve the quality of Nutritional care in their clinical setting and to make and implement improvements in their process, and subsequent the care that is delivered.

The results from EiC MUST measurement continue to be reported monthly. Reports of data outputs are shared with local teams and senior nursing staff for review and action monthly by Business Objects. Information is also shared at the Acute Quality and Safety Oversight Group meeting bi-monthly to appraise any necessary actions of improvement required.

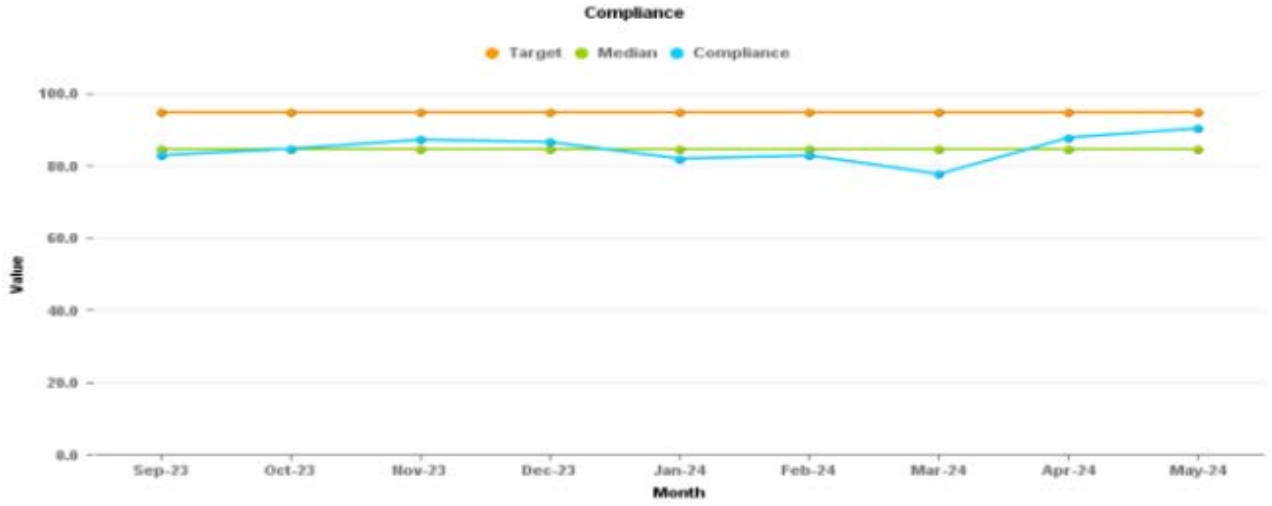
The Mealtime Coordinator audit tool has been revised, alongside role descriptors and new suite of Food, Fluid and Nutritional posters. This has been undertaken in collaboration with EiC lead, Senior Health & Safety advisor and Clinical staff. This updated tool has considered a human factors approach. Data sharing is included within the suite of reports from Business Objects.

FFN – MUST Score Compliance across UHA & UHC remains variable with the compliance per site for past 9 months shown on charts below:

Ayr Hospital Sept 2023 – May 2024



Crosshouse Hospital Sept 2023 – May 2024



6.1 FFN Education

Update modules for nursing, catering and facilities staff are now in place on the Learn Pro platform, these modules are aligned to eating, drinking and swallowing framework level 1 – 3. Additional modules are in place for chefs and cooks. See table below;

Dysphagia LearnPro module completion numbers until end Jun 2024

EDSF level Completed numbers Total Staff Numbers

	UHC	UHA	
Level 1	118	130	Registered Nurses and HCSW
Level 2	69	106	Registered Nurses and HCSW
Level 3	34	47	Registered nurses

Educational competency framework has been developed for nursing, HCSW (Healthcare Support Workers), facilities and catering staff. This will be launched July 2024. Update information has been developed on Roles and Responsibilities of all staff around Protected Mealtime, Nutritional Roles and responsibilities for IV Fluids, Hydration and nutrition and Mealtime coordinator role.

Multi-disciplinary Nutrition and Hydration awareness sessions are taking place at Crosshouse Hospital, Ayr Hospital, Ayrshire Central and Biggart Hospital at the end June 2024.

The Food, Fluid and Nutrition team continue to support the work to meet Food, Fluid and Nutritional Standards and Food in Hospital Standards as well as Health & Safety Executive Action plan

7. Quality and Safety Oversight Group

The introduction of monthly Quality and Safety Oversight Group in 2023 has provided a robust approach to the monitoring and scrutiny of Quality and Assurance process, outcome data and service improvement activity. Group membership is inclusive of Acute Services Senior Nursing Leadership, Site Directors, Quality and Care Governance, Excellence in Care and Health and Safety, with bi-monthly outcome reporting by Resuscitation Services, Pharmacy and Food Fluid and Nutrition Leads.
Data scrutiny has supported the identification of areas of excellence and areas for improvement. Most recently, a focus on monthly compliance of quality process measures and audit data submission has seen an increase in activity and process compliance percentage within Acute Services. The group remains in its' infancy set-up period and further development of the group is forecasted to further improve assurance and data scrutiny of safe, effective and person-centred care delivery within Acute Services.

8. Summary

Members are asked to receive and discuss this report which an overview of performance and activity in terms of SPSP Acute Adult Portfolio and local improvement initiatives in alignment with the EiC programme within Acute Services NHSAA.