Safe Care Workstream

February 2011

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Clinical Lead: TBC (interim Kathy Mclean)

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Case for change

- The purpose of this workstream is to ensure every health organisation in the East Midlands is adding value through sharing best practice and using evidence appropriately to ensure patient safety. The initial focus areas (sub-projects) of this workstream were:
- **Venous Thromboembolism (VTE) Prevention**
- **Junior Doctor Engagement in Patient Safety**
- **Safer Surgery Checklist**
- **'High Risk' Medication Error Reduction**
- The focus of the workstream was extended to include some of the **High Impact Actions for Nursing** and the **Safety Express Project**. The latter is a DH led programme designed to support clinical teams from host organisations through a safety improvement programme focused on reducing the incidence of patients' suffering Pressure Ulcers, Falls, Venous Thromboembolism and/or Catheter Acquired Urinary Tract Infections.
- **Improving safety in any or all of the above areas means better care/outcomes for patients;** with this improvement comes substantial associated financial savings.

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Cost of Doing Nothing

NHS

In the East Midlands

~ 2500 potentially preventable VTE deaths per year

Limited involvement of Junior Doctors in initiatives to improve patient safety! & 3400 doctors in training in the East Midlands

Doubled hospital costs for patients with a surgical site infection

~ 4000 medication incidents (reported) *(>£1.5 million per large teaching hospital per year)*

> £ 125 million Pressure Ulcer Treatment per year

~ £1 million worth of excess bed days for falls

~ Hospital Acquired Infection for 8% of our patients

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Facts

Some Examples:

- **VTE** - hospital-associated VTE leads to about 40,000 deaths in England per year, 25,000 of which may be preventable through proper risk management and care.

  (National CQUIN 2011/2012 – adherence to NICE guidance)

- **Junior Doctor Engagement in Safety** – Junior Doctors are often best placed to identify patient safety issues & how safety could be improved for their patients. Important to increase their knowledge, awareness & involvement in Patient Safety.

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Facts

- **Safer Surgery Checklist –** use of the checklist contributes to significant reductions in death rate and inpatient complications (Haynes et al. 2009). (eg. patients with an Surgical Site Infection require on average an additional hospital stay of 6.5 days and their hospital costs are at least doubled).

- **High Risk Medication Error Reduction** – approx. 40,000 medication incidents reported to NPSA per year. Medicine Groups most likely associated with severe harm are Anticoagulants, Injectable Sedatives, Opiates & Insulin.

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Facts

- **Pressure Ulcer Reduction –** approx**.** one in ten patients admitted to acute hospitals either has or gets a pressure ulcer. Treatment of these costs the NHS £2.4 billion per year. (ref: 1000 Lives Campaign – Wales).

- **Falls Reduction –** as per previous presentation

- **Prevention of Infection (Catheter Acquired UTI)** – overall burden of Hospital Acquired Infection (HCAI) in England found to be 8.4% of adult in-patients in 2006. Estimated cost to NHS is at least £1 billion per year. Urinary infection associated with a urinary catheter is one of the commonest HCAIs.

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Outputs & documents for sharing

Project	Detail
VTE Project National CQUIN 2011/2012 – adherence to NICE guidance	Clinical Leads from all Acute Trusts & industry support
1. Regional Trust VTE Leads Network	
2. Agreed Cohort List for VTE Risk Assessment	Exclusions agreed for the region
3. Guidance on Achieving Exemplar Status	Circulated to all relevant providers
4. Shared Trust RCA Templates for VTE incidents	To be available via TE website
Junior Doctor Engagement	
1. Safety Culture Assessment Tool for Junior Doctors	200 junior doctors have completed this to date
2. Patient Safety Teaching Modules for incorporation into local trainee teaching programmes.	Work underway with Deanery
3. Regional Network of Linked Junior Doctor Patient Safety Forums	To be piloted in volunteer Trusts as adjunct to M&M meetings
4. Junior Doctor Event to showcase activities from Junior Doctor BASIS Programme & Patient Safety Forums	Junior Doctor Innovation for Safety Event with £1000 award for best.

Outputs & documents for sharing

Safer Surgery Checklist	Detail
1. Regional Trust Safer Surgery Leads Network - to ensure Trust compliance with Safer Surgery Checklist/Alert	Acute Trust Safer Surgery Leads
2. Audit tool to measure compliance & quality of compliance with the 5 stages of the checklist & Surgery Site Infection bundle	Via Network
High Risk Medication Harm Reduction	
1. Regional Pharmacist Patient Safety Network	Established
2. Template Risk Assessment Tool for use on admission to acute settings	
3. High Risk Medicine CQUIN	
4. Warfarin Metric Tool (INR >6)	
5. Sharing of Top Initiatives Across Region	To be available via TE website
4. High Risk Medicine Assessment Pamphlet	To be available via TE website

Outputs & Documents for Sharing

Project
High Impact Actions for Nursing
1. As this is a national project with local implementation the main products are through the national work via : http://www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefnursingofficer/Energiseforexcellence/index.htm This web site contains: E4E Cycle of Continuous Improvement and development Overarching approach – umbrella Social movement thinking E4E Narrative
2. http://www.institute.nhs.uk/building_capability/general/aims/ This web site has a number of presentations for each of the HIA High Impact Actions for Nursing and Midwifery Essential Collection Pack (need to be registered on website to download a full pack) Guidance on each of the HIAs Call to action commitment cards Opportunity Estimator Evaluation of the use of HIA nationally (the institute is currently collating this)
3. www.aukuh.org.uk The AUKUH Nurse Sensitive Indicators Implementation Resource Pack The Nurse Sensitive Outcome Indictors for NHS Provided Care -
4. High Impact Actions Dashboard

Next steps for Commissioners

- Ensure these work programmes are being targeted by their providers – ‘safe services’
- Multi-disciplinary team involvement in Patient Safety Initiatives not just ‘top down’ – under-represented groups involved eg. Junior Doctors
- Cost improvements re: reduced ‘recovery’ treatments, reduced lengths of stay, reduced complaints, reduced litigation.
- Health economy issues – action them as such
- Additional assurance measures: Providers demonstrating commitment to Patient Safety Improvement
- Seek evidence > observe >ask > role-model

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Conclusion

- Important Focus Areas chosen by East Midlands Trusts
- The ‘Right Thing’ to do for our Patients anyway. From a quality perspective are essential.
- Cost benefits of doing the Right Thing are substantial.
- *Include County Work re: these programmes in SOPs*

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Key contacts

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County Leads for Safe Care:

Lynn Woods (Derbys County)
? - previously Gill Collinson (Derby City)
Liz Rowbotham (Leics City)
Mandy Ashton (Leics County)
Edie Butterworth (Lincs)
Mark Driver (Northants)
Amanda Sullivan (Notts County)
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