Safety Forum
Promoting shared learning and leadership

The HSC Safety Forum

(Northern Ireland)

On the trail of quality and safety in health and social care

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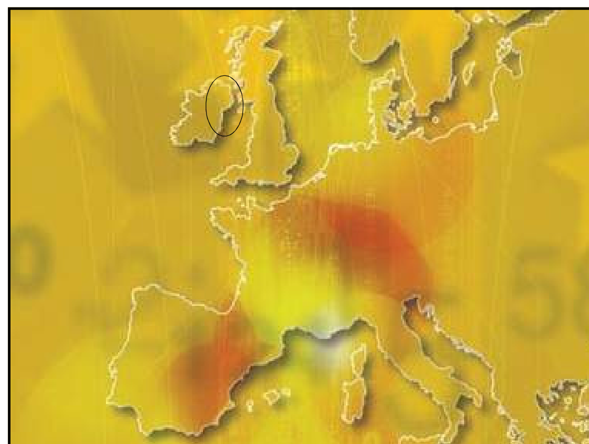
ISQUA 2009



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NI

- **1.8 million people; 5 HSC Trusts**
- **551,098 (55,000 – 6; 165,000 – 18)**
- **Not a 'Campaign'…but Cumulative and progressive content areas:**
  - Leadership (80%), Critical Care (VAP, CVC-BSI), Medical Care (deteriorating patients), Medicines (interface primary and secondary care), Surgical care (SSI, WHO Checklist), VTE, Perinatal Care
  - *Transforming Care at the Bedside prototype*
  - *Clinical Microsystems prototype*
- **All Hospitals, Mental Health Inpatient Units; future to engage Primary Care and Ambulance services**
- **Concerted multi-agency efforts: many aims, all aligned towards improved and sustained safety & quality**

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On the trail

2009 onwards…Single interventions AND system interventions; Patient & Client involvement, Primary and social care, Ambulance Service

STEEEP as a frame

Quality & Safety
Time

- **VTE Prevention, Surgical Checklist, Medication Safety at the Interface between Primary and Secondary Care**: adopted by all Trusts (Collaboratives Start)
- Northern Irelands **Quality Strategy** process starts
- **Clinical Microsystems** Prototype

- One person from each Trust (funded by Forum) completes the IHIs Patient Safety Officer Executive Development Programme
- Safety Improvements Targets set by DHSSPSNI in five areas as part of *Priorities for Action 08-09*
- Collaboratives (2008-2010) start in each target area: **VAP, CVC-BSI, Mental Health, Crash Calls, SSIs (ortho, c-section)**
- All Trusts report monthly on process and outcome measures
- 80% of Trusts using **Leadership Walkrounds**
- **Transforming Care at the Bedside** prototype
- Northern Irelands first **Perinatal Collaborative** starts
- HSC Safety Forum and **The Health Foundation** sign agreement (building capability)

all

- HSC Safety Forum is formed (DHSSPSNI sponsor) and organises Northern Irelands first ever **Safety Improvement Breakthrough Collaborative**
- Trusts select **3 interventions to save lives and reduce harm** as part of DHSSPS *Priorities for Action 07-08*

6

- Northern and Belfast HSC Trusts are selected for **THFs SPI Wave 2**; Whiteabbey Hosp. joins IHI's **5M Lives Campaign**

2

- Enrollment of Mater Hospital on IHIs **100k Campaign**
- Down Lisburn Trust selected for the Health Foundations **Safer Patients Initiative Wave 1**

2004 2006 2007 2008 2009

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The journey…

- 2004 – 2005: Ones who dared (2 out of 18)
- 2006: Others who dared (3 out of 5): 'hot' on agenda…
- 2007: Everyone, together and collaboratively…
  - Stage 1: Voluntary (Forum created)…

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Alignment & Steering

Continuous Safety & Quality Improvement

DHSSPSNI (£)
Policy

Regional HSC Board
Commissioning, Performance Management

RQIA
Regulation

HSC Public Health Agency (2)
Public Health & Wellbeing

HSC Trusts (5)
Service Provision

The Health Foundation

NIAS
Ambulance

Patient and Client Council

Business Services Organisation
Central Services, IT

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The journey…

- *2004 – 2005: Ones who dared (2 out of 18)*
- *2006: Others who dared (3 out of 5): top on agenda…*
- *2007: Everyone, together and collaboratively…*
  - *Stage 1: Voluntary (Forum created)…*
  - Stage 2: Part of policy (mild, no measurement system)
  - Stage 3: Part of policy (performance-managed 'targets', measurement system / Extranet) – MANAGING TENSIONS
    - Balanced approach: no blanket targets but QIPs plus reporting to Trust Boards
    - Avoidance of 'hitting the target but missing the point'
- Single interventions AND systems
  - Prototyping TCAB and Clinical Microsystems

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The Forum today…

Support organisations to Continuously Improve Safety, Quality and Reliability of Care throughout the HSC

- Alignment and Partnerships *(shared agenda)*
- Breakthrough Improvement Collaboratives *(shared working and learning)*
- Building Capability *(safety improvement knowledge)*
- Supporting the Implementation of Frameworks for Continuous Improvement *(sustainability)*

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At the heart of all we do…

Will
Ideas
Execution

Best available evidence…

Structure + Process + (Context + Mechanism) = Outcomes

System: interdependencies

Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?
Act Plan
Study Do

Learning

Understand Variation:
•Run charts, SPC Charts

Psychology:
•Engagement
•Ownership
•Sense of direction

IHI, Deming, API

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Focus Areas 2008-2011

Breakthrough Improvement Collaboratives *(shared working and learning)*

Government Targets	Non-targets
Surgery - SSI	*WHO Surgical Checklist*
Medicine - Crash Calls, VTE	
	Meds Safety at Interface 1-2 Care
Mental Health	
	Maternity (Perinatal Care)
Critical Care (VAP, CVC-BSI)	

- Quality Improvement Plan
- 2-4 x year
- Breakthrough Collaboratives & Charter
- Monthly reporting
- Patient Safety Officer: catalyst

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Leading to…

- Energy generation and management
- Mobilisation
- The power of shared learning & collaboration (in and out)
- Data and the improvement conversations
- The opportunity gap
- Changing norms
- Safer care?

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Some early results…

Front line staff making a difference and leading concerted multi-agency improvement efforts…

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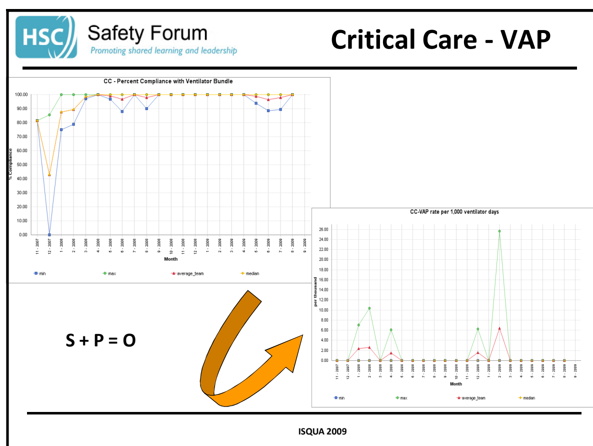

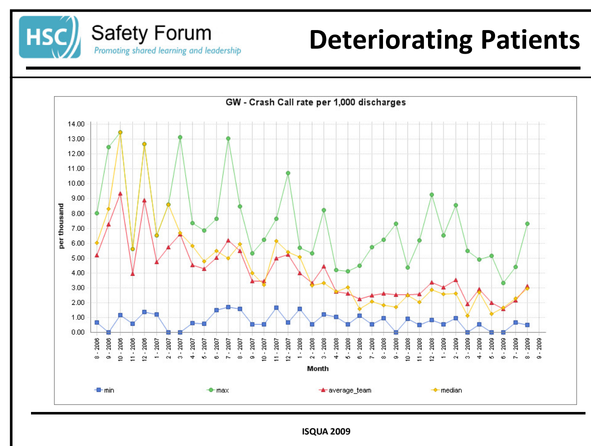

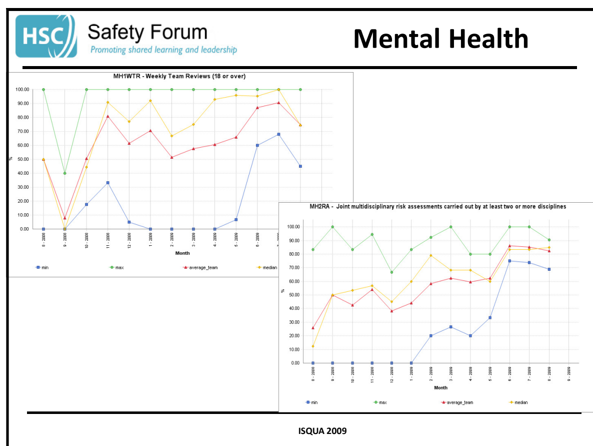

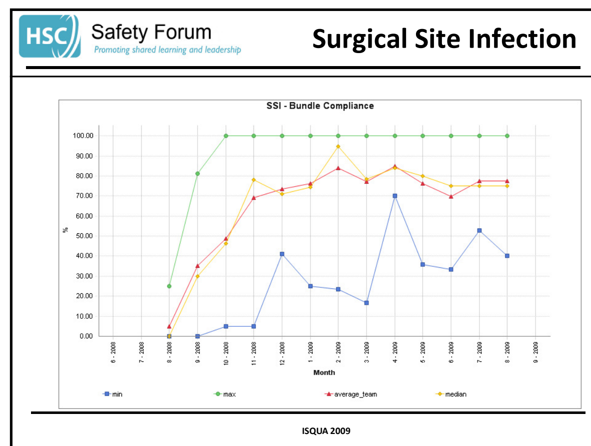

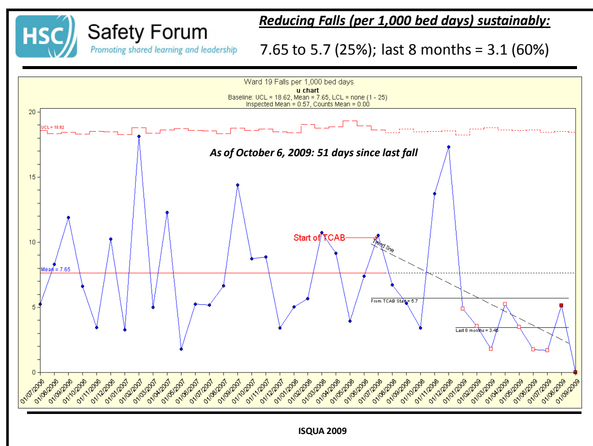

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Frameworks for CQI

- Prototypes
  - Transforming Care at the Bedside:
    - Safety and Reliability
    - Value-added care
    - Team vitality
    - Patient-centred care
  - Clinical Microsystems:
    - Assessment (5Ps), Diagnosis, Treatment
    - Continuous Improvement

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Transformation Equation

$$Q_{HS} = Q_{M1} + Q_{M2} + Q_{M3} + Q_{MN}$$

Note: Quality (Q) of the whole healthcare system (HS) is equal to the quality of care for individual patients within each microsystem (M_1 to M_N) that cares for the patient plus the handoffs that occur between microsystems (+, +, +) that are involved in the care of each individual patient.

Marjorie Godfrey, 2009

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It is the nature of systems that smaller systems are embedded in bigger systems

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Challenges: *still on the trail…*

- Involving patients and clients meaningfully
- Getting the communications piece right (media, intra and inter Trust)
- Re-structuring in the NHS (!!!)
- Different speeds: **political pressure** (accountability & immediate results) **v results** (rhythm of testing / implementation / spread methods, data for improvement, sustainability)
- Moving from 'volunteers' (early majority/early adopters, initial units testing and implementing) to the system: **implementing and spreading**
- Creating second-order change: 'the way we do business around here'
- 'Credit Crunch': making the business case…
- IT: how can we integrate solutions…
- Swine Flu….

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"I dwell in Possibility…" – Emily Dickinson

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has"
Margaret Mead

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THANK YOU

For more information visit

www.hscsafetyforum.com

Or email me

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