NEW NES PSMSG WEBSITE
The website of the NES Patient Safety Multidisciplinary Steering Group is now live on the NES website at
http://www.nes.scot.nhs.uk/patient_safety/

This website links to an electronic knowledge management portal on patient safety available to NHSS Scotland staff through the e library where educational resources are being added for stakeholders (see below), integrating also with other linked knowledge services developments, including for clinical governance.
http://www.clinicaldecisions.scot.nhs.uk/home.aspx

NES FACILITATED ‘EDUCATIONAL SUMMIT’, JUNE 2009
In view of the evolving Scottish Government ‘Quality Strategy’, NES hosted a meeting of key stakeholders, chaired by Malcolm Wright (including QIS new Chief Executive, and Scottish Government (including Derek Feeley, Patient Safety Advisors and Improvement Support Team (IST) to consider the development of a supporting educational framework. The recommendations from that meeting included:
  o NES should be the lead organisation in NHSScotland to coordinate, on a partnership basis, an integrated educational framework, to support Scottish Government patient safety commitments including the spread into primary care.
  o That a comprehensive educational framework covering all partners be developed to support patient safety/quality improvement and focussed on capacity building with Health Boards in order to achieve self-sufficiency in the next three years as the foundation for developing a culture of ‘improvement’ across NHS Scotland.
  o Essential staff groups who should be prioritised for targeted educational resources include: undergraduate and pre-registration students (a Cabinet Secretary commitment at the 2008 NHS Scotland event), clinical staff involved in SPSP delivery, middle managers and Health Board executive leads.
  o The educational framework will be based on a range of patient safety educational resources including quality improvement methodologies.
OUTCOMES OF NES PSMSG ACTIONS, NES RESPONSE TO SCOTTISH PATIENT SAFETY PROGRAMME, 2008-09

The outcomes from the work of the NES PSMSG are in the PSMSG Strategic Options paper to NES Board, September 2009 and include the following key areas:

(Also see: http://www.nes.scot.nhs.uk/patient_safety/)

- Patient Safety Leadership Development course pilots, early 2009
- E-Education developments including a pilot ‘patient safety’ portal
- Raising the NES profile in relation to existing workstreams contributing to patient safety
- NES Support for the SPSP Fellowship programme
- Evaluation of patient safety education focussed on identified measurable outcomes
- Strengthening key partnerships in NHSScotland (and at national and international levels) to enhance patient safety

NES PSMSG STRATEGIC OPTIONS APPROVED BY NES BOARD, CONTRIBUTING TO THE PATIENT SAFETY PARTNERSHIP EDUCATIONAL FRAMEWORK

NES PSMSG strategic options are included either as an enabler of other strategic options and/or anticipated to especially build capacity and capability of patient safety knowledge, skills and behaviours. For selected options, where the work proposed is new, the contribution to building capacity and capability will be identified following feasibility work and evaluation/impact assessment. The following list is a summary of our strategic options, contributing to the evolving partnership patient safety educational framework

1. Strengthening our partnership working, supporting safer care (enabler)
2. Developing the patient role in “patient safety educational solutions” (enabler)
3. Training the Trainers, Patient Safety Course Delivery, supporting the SPSP/SPSA, short-medium term (building C&C)
4. Embedding “patient safety” knowledge and skills development in all types of NES education infrastructure (building C&C)
6. Raising the NES profile and developing our contributions to patient safety (enabler)
7. Impact Assessment and development of existing NES education infrastructure (enabler, building C&C)
8. Developing a Patient Safety Portal and Managed Knowledge Network (enabler, building C&C)

9. Developing Learning Objectives for Patient Safety & NES Priority Curriculum and NES “Faculty” – A Whole System Approach (enabler, building C&C)

10. Priority development and research, providing learning outputs, supporting the service to improve patient safety (enabler, building C&C)

11. Fellowship Model (including other senior clinical leadership development activities) (enabler, building C&C)

12. NHSS Executives/ Board Patient Safety Leadership Development (enabler)

SELECTED UPDATES: NES PSMSG STRATEGIC OPTIONS/ PARTNERSHIP WORK

Partnership Pilot Patient Safety Leadership course, contributing to sustainability of the Scottish Patient Safety Programme (SPSP)

The Partnership Planning Group met in July, where it discussed how the training should move forward. It was agreed that the course would be shortened and pilot Boards would be invited to host the course in their area. A project plan and senior leader support would be essential to attendance to ensure that the education leads to maximum benefit for patient safety. At this stage it is planned that 2 courses will be run early 2010. The NES training team (TDSU) will develop:

- Pilot courses for 2-3 cohorts of “training the trainers” in host boards, for staff with a remit to build capacity and capability.
- Partnership team to develop course contents, coordinated through TDSU. Planning ongoing with QIS and Scottish Government.
- Course contents and tools to be provided to trained staff at local level for developing others.
- TDSU development/ coordination of a menu of partnership bespoke/ existing courses/ workshops, supporting the service including from IST, National Services Division (NSD), NES, QIS.

NES contacts: John McKinlay, Jane Ross

SPSP Fellowship

NES continues to contribute to the SPSP fellowship steering group. An evaluation report from the first round of SPSP Fellows is now available on the NES website The aims of NES evaluation are to evaluate the effectiveness of the SPSP Fellowship as the return on expectation of the fellows and stakeholders; and to inform future fellowship design and delivery, to go on web at: http://www.nes.scot.nhs.uk/patient_safety/

- Early evaluation of delegate participation and sponsors at national and local levels is highly positive. Cohort 1 Fellows valued the opportunity to meet and learn from the experts, with individualised mentoring and feedback.
The longer-term impact of this fellowship has yet to be determined and will be part of the overall evaluation of the SPSP. The NES evaluation report includes a series of recommendations for the second pilot cohort, and subsequent programmes:

- For example, the SPSF attempts to teach fellows the philosophy and principles of quality improvement. Stakeholders may want to consider changing the name of the fellowship to better reflect its full focus about quality improvement.
- Although all the fellows achieved their project aims and objectives they did not attempt any formal evaluation. It should be a requirement of future fellows that they incorporate an evaluation strategy and impact assessment from conception-stage into their projects to better quantify the organisational benefit. This may require encouragement, additional teaching and practical support.

The Fellowship Project Programme Group is reviewing key messages from the NES evaluation, November 2009.

*NES contacts: Carl de Wet, Philip Cachia, Fiona Gailey*

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**Knowledge Support for Patient Safety and Linked Areas**

The project commenced at the end of June 2009 when Suzanne Graham, the Knowledge Support for Patient Safety Project Manager, joined the Knowledge Services Team at NES, with links also to the NES PSMSG. The Knowledge Support for Patient Safety Project aims to develop an integrated knowledge support for patient safety to support the Scottish Patient Safety Programme. It will link the services listed below into a coherent knowledge infrastructure to underpin delivery of safer, more effective patient care.

**Services:**
- Clinical Decisions portal (www.clinicaldecisions.scot.nhs.uk)
- Online Clinical Enquiry Service: currently being developed by NES KSG and NHS QIS.
- Clinical Governance Portal and Managed Knowledge Network: currently being developed by NES KSG and NHS QIS.
- New Patient Safety portal: currently being developed by NES KSG.
- 18 Weeks Referral to Treatment portal: recently completed.

The Knowledge Support for Patient Safety Project will also work with various stakeholders including, NHS QIS, NHS National Services Scotland, Scottish Government, NHS Patient Safety Leads, NHS Board Clinical Governance Leads and Patient Safety Fellows to ensure the service meets the needs of stakeholders. For example:

- A Steering group has been formed with representatives including from NHS QIS Clinical Governance and Patient Safety, NHS Board Patient Safety Leads, NHS Board Clinical Governance Leads, and the Scottish Government.
- Enhancements are being made to the clinical decisions portal based on an evaluation of the service.
- Resources to be available from the patient safety portal have been discussed. It is envisaged that these will be made available via a searchable database.

*NES contacts: Suzanne Graham and Ann Wales*
E-training developments & Developing an Integrated Multi-Professional Model for the Postgraduate Education and Training of Healthcare Professionals

From NES scoping, networking and research work, we are aware that engaging clinicians in patient safety and quality improvement - and sustaining involvement - is an ongoing challenge. Our mapping work shows that training provision in quality improvement methods across the healthcare professions is variable and traditionally has low priority status on most educational curricula.

NES PSMSG proposes a multipurpose development that builds on existing work and involves a Generic Model for Education and Training in Quality Improvement Methods: for the Training and Assessment of Healthcare Professionals (and other relevant NHS staff).

This e-training where supported by feasibility work will be developed to include assessment by NES trainers/ mentors and supervisors through a phased approach across professions. This e-training/ learning will contribute also to other patient safety education infrastructure.

A high level scoping report of patient safety e-learning available to NHSS staff is nearing completion, and will be included on the NES PSMSG website.

NES contacts: Paul Bowie and Carl de Wet and HAI team colleagues

The use of rapid cycle change strategies in improving the quality and safety of patient care: A systematic literature review.

Rapid cycle change strategies (of which the Plan-Do-Study-Act Cycle (PDSA) is the most prominent example) are small tests of change, which can be used by healthcare teams as part of a continuous approach to improving the quality and safety of patient care. From NES ongoing scoping work, there appears to be limited evidence of its impact as a quality improvement tool on patient care and in terms of sustainability and spread of the approach. From a learning perspective, the key barriers and facilitators to the success or otherwise of PDSA cycles have yet to be identified and defined. This is important if lessons are to be learned across the health service and inform the on-going education and training of health care professionals and other NHSS staff.

A NES GP Research Fellow has undertaken preliminary work with colleagues to develop an appropriate search strategy for conducting a systematic literature review of this topic area. The systematic literature review is underway, and a written report for NES and other stakeholders outlining the barriers and facilitators associated with the application of PDSA cycles in healthcare settings, will inform the work of the Scottish Patient Safety Programme, and will be incorporated in other educational infrastructure.

NES contacts: Paul Bowie, Esther Curnock