Pennine Acute Hospitals NHS Trust: Improvement Journey

Pride in Pennine | Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS
NHS Trust

Pennine Improvement Plan

Improving Fragile Services	Improving Quality	Improving Risk and Governance	Improving Operations & Performance	Improving Workforce and safe staffing	Improving Leadership & Strategic Relations
Urgent care	Develop and Ignite our Quality Improvement (QI) Strategy	Implement new risk and governance arrangements across the Trust	Improving patient flow	Improve Safe Staffing	Implement Site Leadership Model
Maternity care	Improve safety	Review all safeguarding	Improving data quality	Deliver on Healthy, Happy, Here Staff programme	
Paediatric care	Improve effectiveness				
Critical care	Improve patient experience				

Pennine Improvement Board

- Established post risk summit convened by NHSE in July 2016.
- Improvement Board chaired by Jon Rouse, Chief Officer GM H&SCP, includes CCGs, NHSi, Pennine Acute representatives. LA reps, NHSE and CQC sporadic in attendance but receive papers
- The following Sub groups report in to the improvement board to provide additional assurance:
  - Clinical Quality Leads Group,
  - NE Sector Urgent Care delivery Board,
  - Maternity and Children's Group
- The Board provides oversight, ensuring effective governance for decisions to support improvement and monitors the implementation of delivery plans, including:

  Short term stabilisation actions to assure safe and reliable services for identified fragile services (first priority for action);

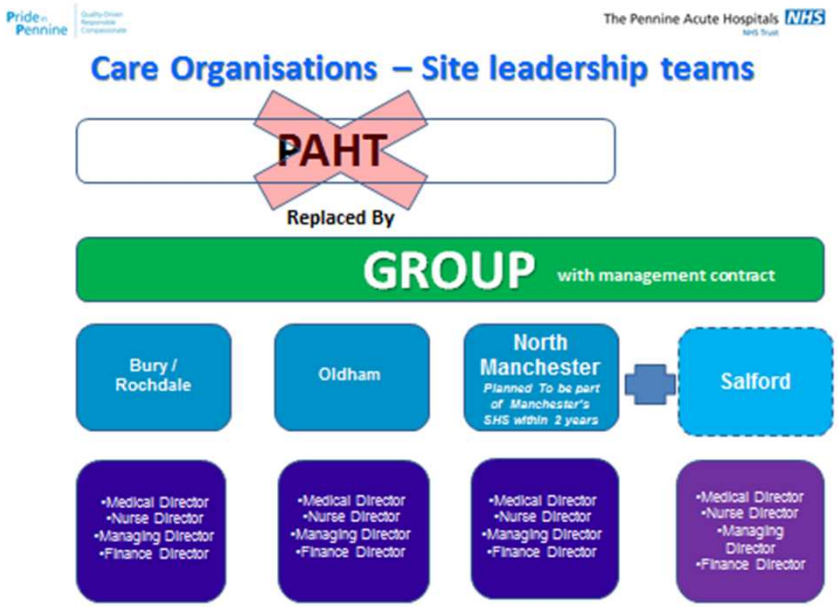
  Improvement and sustainability plan for services;

  Internal governance and operational system improvement

CQC re – inspection team expected between September – November

Leadership

- New Care Organisation Director team in post
- Transitioning to CO risk and assurance framework
- New Risk management system currently being deployed and risk training programme rolled out
- Executive Safety walkrounds and 'Work Withs' commenced across all sites
- Quality improvement programmes underway both across Group and health economy
- Staff engagement and clinical leadership programmes underway



Quality Improvement Strategy

Saving lives, Improving lives

NHS
North Manchester Care Organisation
Northern Care Alliance

Quality Improvement Strategy 2017 - 2020

What are we trying to accomplish?

Aim 1: No preventable deaths
Aim 2: Continuously seek out and reduce patient harm
Aim 3: Achieve the highest level of reliability for clinical care
Aim 4: Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living

Leadership and culture

We will foster a culture of safety by supporting all of our leaders to role-model our values of Patient and Customer Focus, Accountability, Continuous Improvement and Respect. Our leaders will be visible throughout the organisation and will develop the skills of leadership in all of our staff.

Capability Building and Staff Engagement

A small group of experts in change management will support frontline staff in using improvement methodology and developing improvement skills. We will encourage frontline staff to contribute their ideas for improvement and test these to see if the change in practice results in improvement. If it does, and we can replicate the change, then we will adopt and spread this change across the whole organisation.

Projects

We will choose a small number of focussed projects with clear measurable goals and outcomes that will deliver sustainable improvements to our patients.

Operational Excellence

One area of focus will be to improve how our patients 'flow' through our system so that we may reduce delays, cancellations and waiting times. Wherever possible we will standardise our approach into a standard operating model which can be used in each Care Organisation of the Northern Care Alliance.

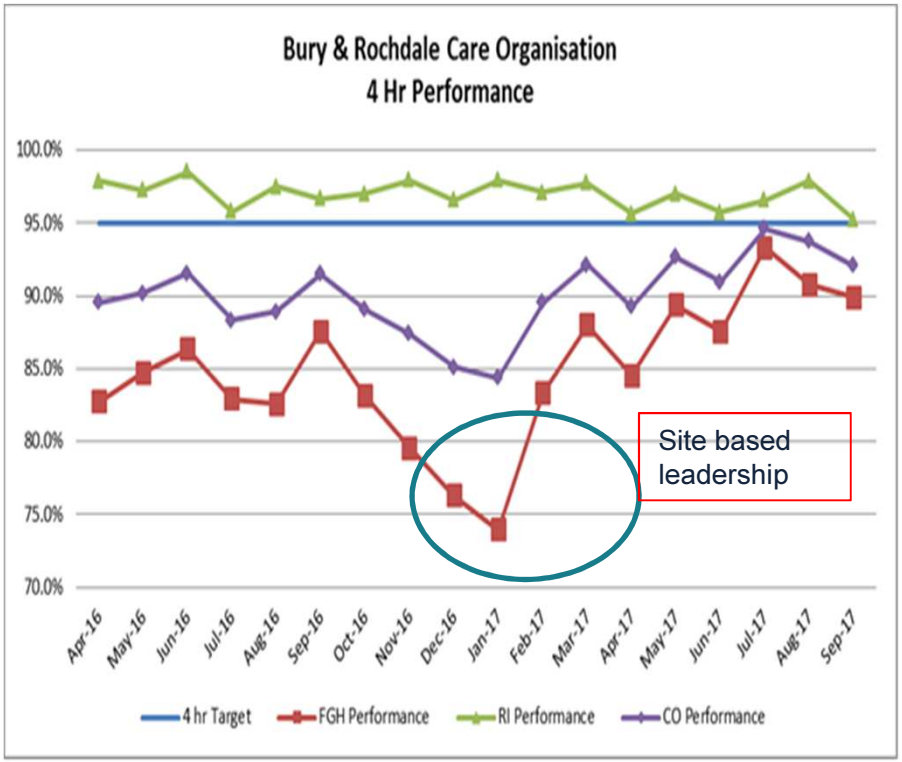
Quality improvement strategy launched mid 2017

Staffing investment has allowed greater involvement and engagement in projects

Expansion of QI team enables facilitation of collaborative events and greater focus on improvement

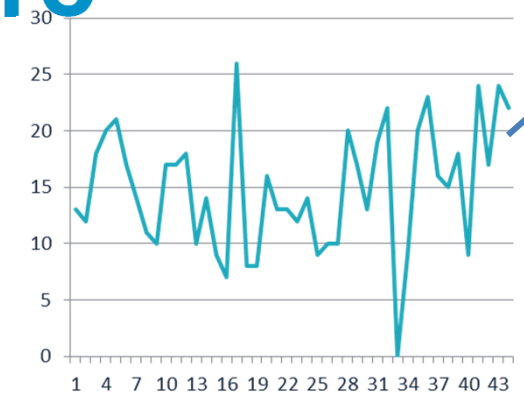
FGH/RI – ED/Medicine

- Nursing establishments increased by circa 20 wte (£682k) – full by end Sep 17 – FGH
- FGH Consultant Medical staff full, 4 remaining middle grades recruited -await start date
- UCC – RN vacancy reduced 30% to 8%
- AMU skill mix review – vacancies decreased from circa 45% to less than 5% (RN)
- AMU redesign plus further 10 beds Q3 17/18
- **Zero 12 hour ED waits since 02.17**
- **Sepsis training above 95%**
- Medicine Workforce - £1.3 m 17/18 – additional 14 RNs & 30 HCAs

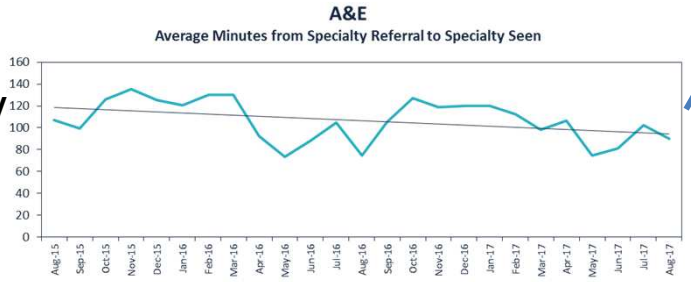


TROH Urgent Care

- Only ED with Green NAAS
- Investment in 25wte nurses and additional Band 6 posts in ED/AMU to strengthen leadership
- Expansion of Ambulatory Care
- Additional CT scanner
- Frailty model expanded to ED/AEC

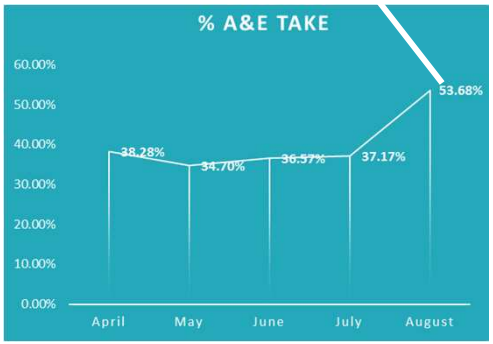


Primary care Streaming gaining traction



Speciality response to ED improving

Increasing use of AEC



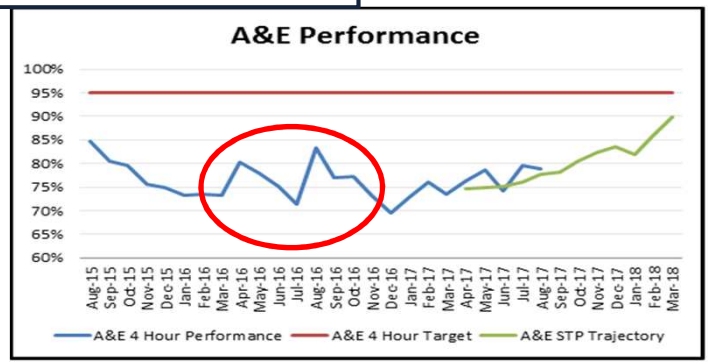
Pride in Pennine | Quality-Driven Responsible Compassionate

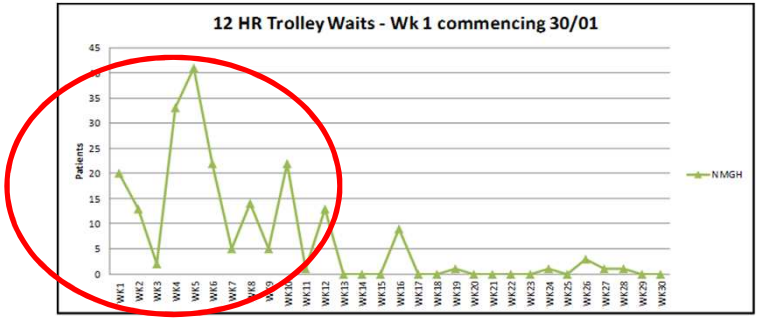
The Pennine Acute Hospitals NHS
NHS Trust

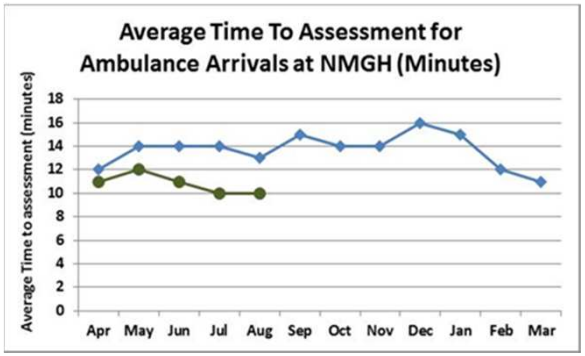
NMGH - ED

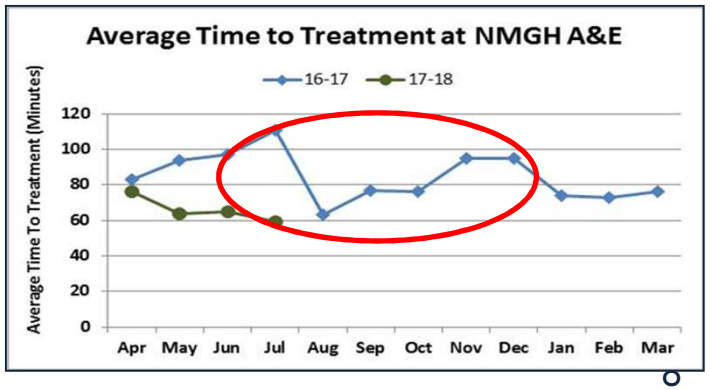
Unstable and unsafe system stabilised and improving

- Improvements on 4 hr performance trajectory - ahead of STP agreed trajectory by 1.22%
- Significant reduction/elimination of 12 trolley waits
- Escalation policy established and in place. Moving towards recognised OPEL
- ACU: National award for ambulatory care service from NHS England
- Ambulance arrivals to assess 14% improvement, 24% improvement in time to treatment
- Quality Improvement strategy: PDSA ongoing: See and treat in ED/ 2 hourly Quality rounds



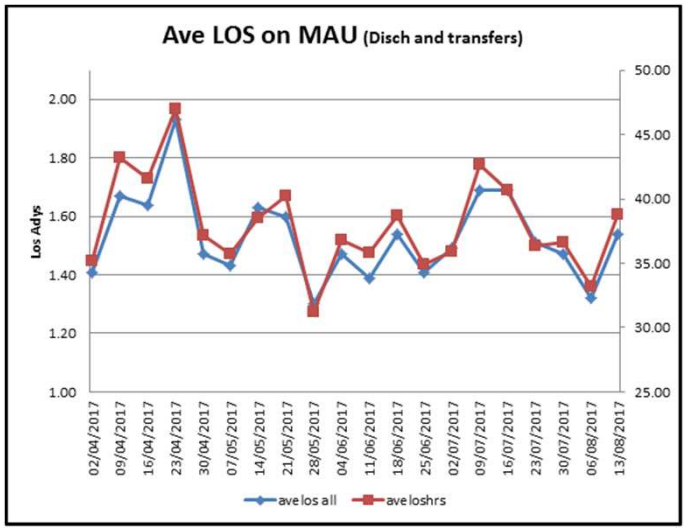


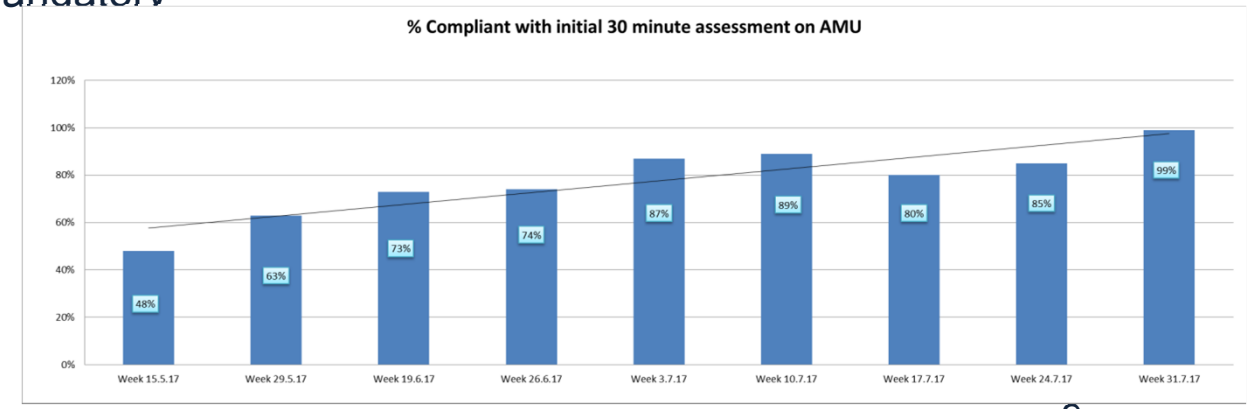




Fragile Service - AMU

- AMU redesign
  - Additional 8 beds opened July 2017
  - Full expansion to 50 beds October 2017
  - Pathway redesign based on SAM guidance with focus on frailty and full MDT working
  - Improvements in LOS
  - 94% compliance with mandatory training

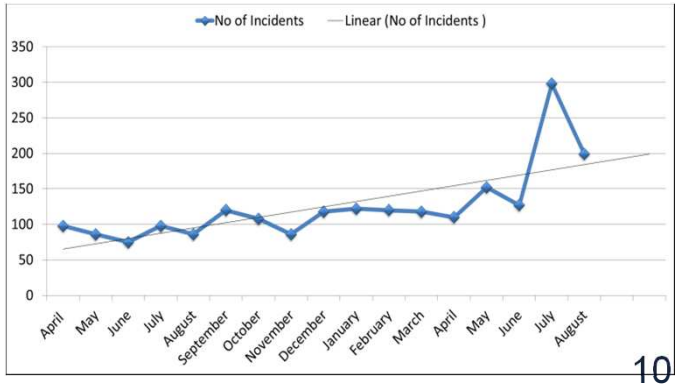




Maternity services

- £1.2m investment in midwives to achieve Birth rate +
- 9 consultants recruited with clinical directors in post at both NMGH and ROH
- Bi- weekly practice review meetings in place
- Increased incident reporting
- Improved Governance processes
  - improved culture of incident reporting
  - managing incidents in real time
  - weekly complaints an incidents meeting to identify learning
- 93% Mandatory training compliance
- 84% Essential training compliance

	ROH		
	Births (Mums)	Funded wte	Worked wte
April'17	425	1:27.2	1:26.7
May'17	412	1:26.4	1:25.5
June'17	404	1:25.9	1:26.5
July'17	430	1:27.6	1:28.7
Aug'17	454	1:27.9	1:30.6

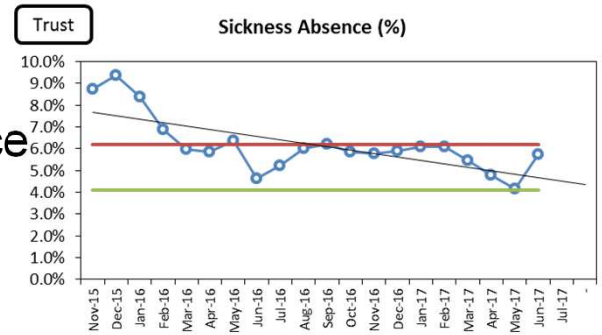


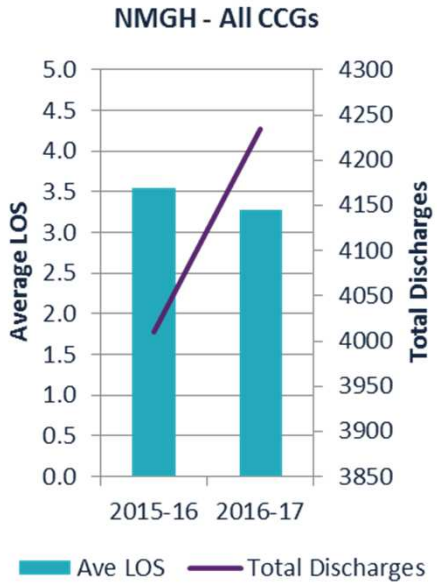
Maternity services

- CTG central monitoring now live and working well with a clear reduction in CTG related incidence upon audit
- CTG training at 94%
- 50% reduction general anaesthetic at non-elective caesarian section
- Significant reduction in blood loss during post-partum haemorrhage
- Reduction seen in trauma post C Section and general anaesthetic emergency section down from 30% to 15%
- Early warning score assessment for mothers significantly improved and a reduction in critical care admissions
- Trust part of wave 1 for the NHSI maternity and neonatal safety collaborative

Paediatrics

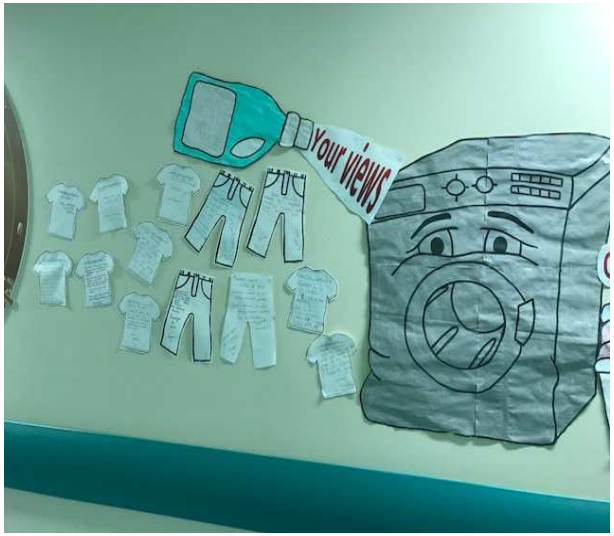
- Strengthened clinical leadership teams – consultants, ward leaders, matrons
- 26 new nurse starters
- Attention to risk and governance systems with weekly review meetings, joint boards rounds, annual education programmes, risk register reviews.
- Reliably staffing HDU beds and sustained reduction in transfers out of area
- Training to support identification and support of the unwell child
- Paed O&A expansion to create additional capacity and reduce LOS

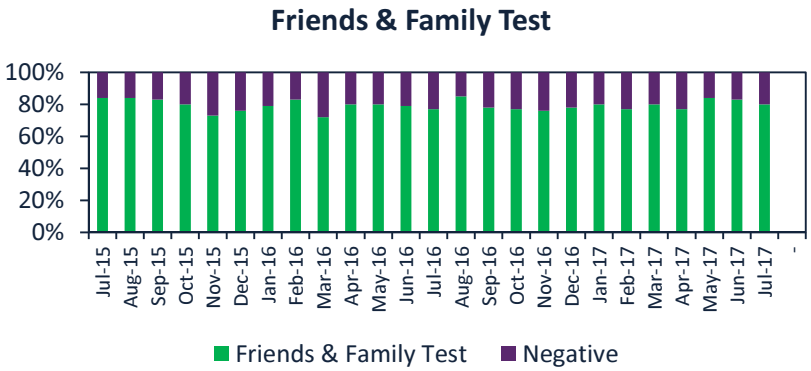




	April 2016		September 2017	
	ROH	NM	ROH	NM
APLS/PILS	51%	50%	97%	95%
HDU Module	1	1	3	4
Assessment Module	1		3	
Simulation Training	N/A		8	26

C&YP Experience





Feedback Cloud

Where word occurrs at least 10 times

Healthcare Communications

Envoy Messenger™ Every patient counts

Positive

advice amazing attentive away brilliant busy care child childrens daughter dealt doctor doctors ease efficient everything excellent extremely fantastic fast feel friendly good great helpful likely little long looked lovely nice nurse nurses old professional quick quickly seen service son staff straight thank thorough time triage wait waiting well yes

Negative

child daughter doctor hour hours long old seen son staff time triage wait waited waiting yes

Critical Care

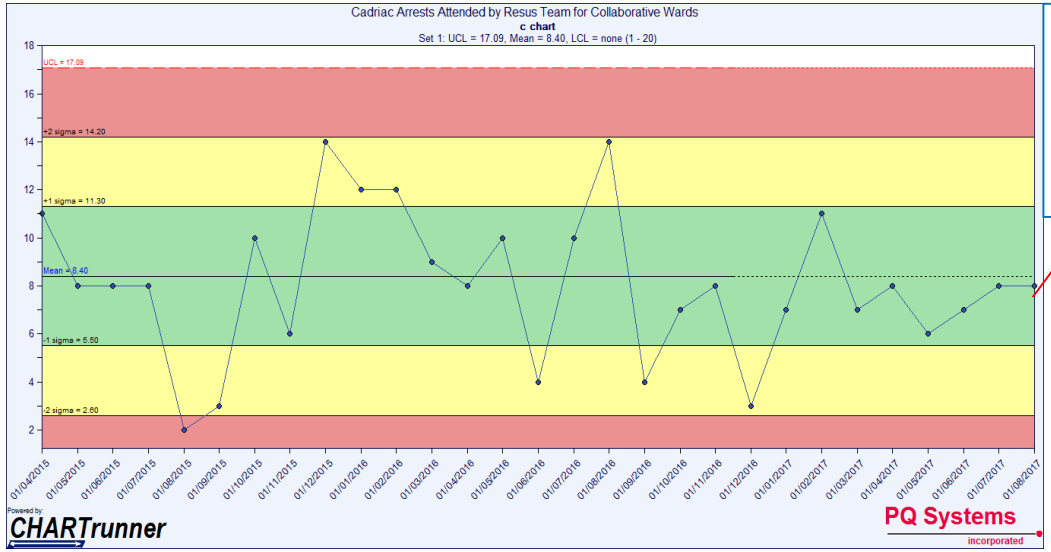
- ROH HDU rota – increased from 5 hours a day of a consultant Intensivist and a speciality doctor, progressing to 10 hours a day 7 days a week.
- Speciality Doctors - 3 wte overseas recruits with a further 2 to join the service by the end of the year.
- Advanced Critical Care Practitioner (ACCP) training commenced in February 2017 – two underway and two further trainees from February 2018.
- An ICM trainee has started with the Trust based at ROH
- Supernumerary shift leader recruitment is on-going, with steady improvement
- Recorded handover from ROH HDU to parent teams with a structured ward round document with safety checklist
- Daily joint multidisciplinary handover of the unit at the ROH in the morning
- Ventilator Acquired and Associated Pneumonia (VAP) screening done daily process for recording rates under development
- Procedural checklists introduced – CVC, tracheostomy, bronchoscopy, intubation
- Monthly joint M&M/MDT between ROH/FGH meetings and bi weekly M&M/MDT at the ROH

Pride in Pennine | Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS
NHS Trust

Deteriorating Patient Collaborative

AIM: To reduce the cardiac arrest rate (per 1000 admissions) by 50% on collaborative wards by 31st November 2017



For collaborative wards, the chart is within statistical control. If you compare baseline with intervention period then there has been a 14% decrease.

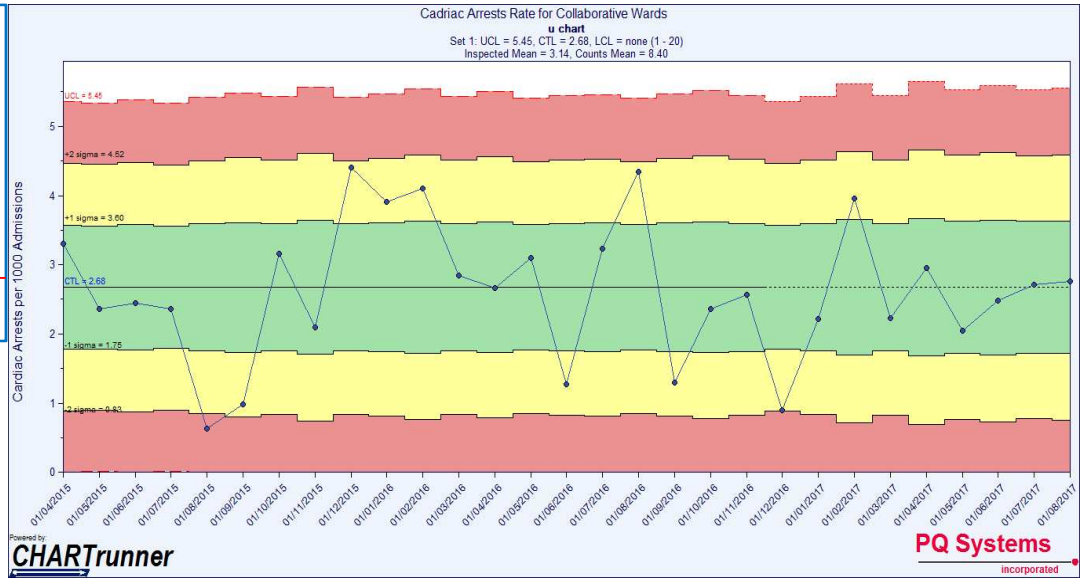
Trust-wide roll out of NEWS observation chart

Roll-out of Patientrack e-obs system commenced

Highlighting sick patients at the start of each shift

Weekend plan/escalation stamp

For collaborative wards, the chart is within statistical control. If you compare baseline with intervention period then there has been a 9% decrease.



Cardiac arrest role allocation

Using manual observations for more accurate identification of deterioration

Code red-escalating clinical intuition and empowering staff

AIM: To ensure 90% of all Red Flag Sepsis patients to receive antibiotics within 1 hour of arrival (in A&E) or within 1 hour of sepsis screening (inpatients) by 31st March 2018

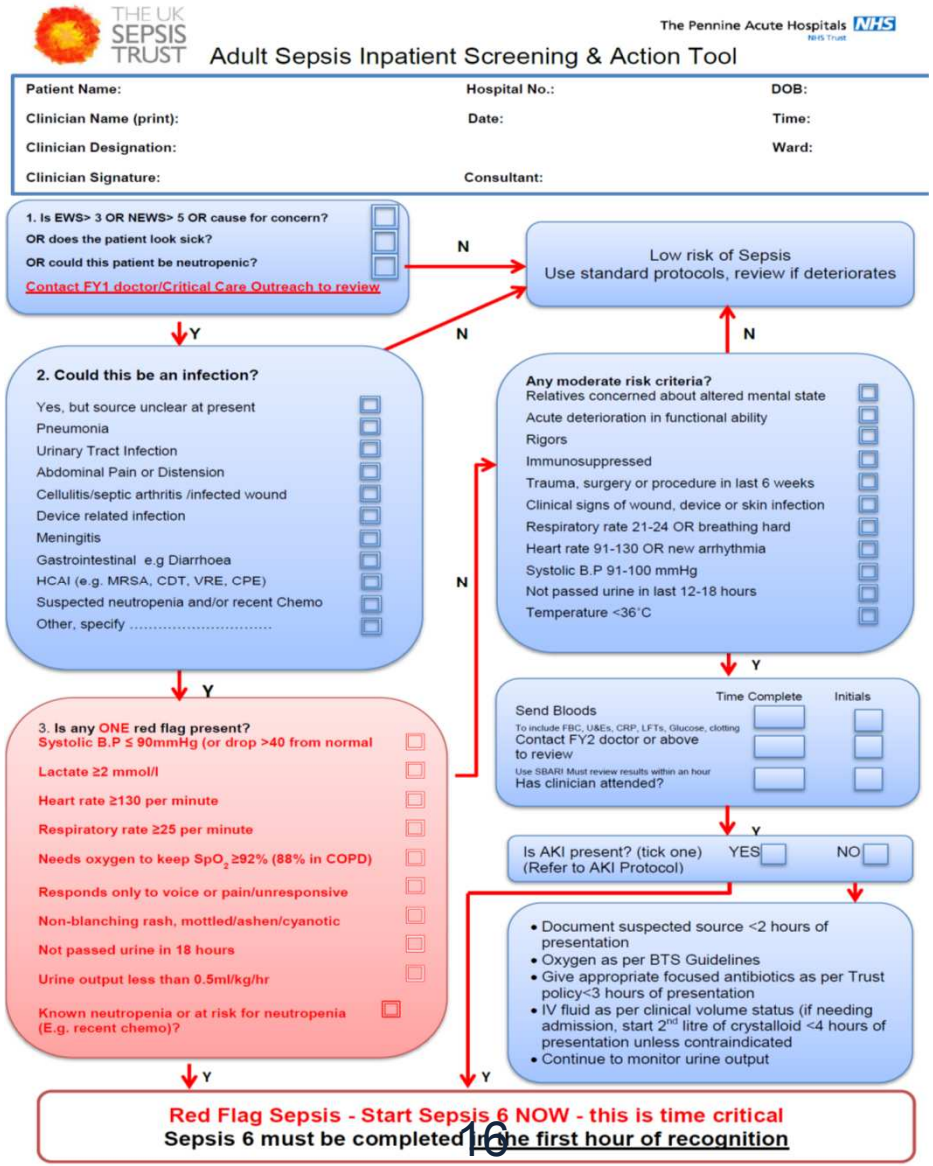
CQC MD 12: Ensure that staff are always escalating patients who trigger the sepsis pathway for immediate medical review

- In-Patient Sepsis Screening and Action Tool launched 10th April with NEWS Observation Chart across all sites
- 'Screen for Sepsis' visual prompt included in NEWS Observation Chart to ensure staff complete the Sepsis Screening Tool if any Sepsis triggers are identified
- If staff identify 'Red Flag Sepsis' using the Sepsis Screening and Action Tool, then the 'Sepsis Six' pathway is available to follow immediately

CQC MD 41: Ensure that staff complete training in 'Sepsis six' so staff are aware of the process to follow when a patient is put on a 'Sepsis six' treatment pathway

- Adult Sepsis E-Learning Module now included within Essential Job Related Training for all nursing, midwifery and medical staff working with adults

Clinical microsystems established for each Care Organisation to focus improvement work locally within all A&E departments with the aim of improvement the early identification and timely management of sepsis.

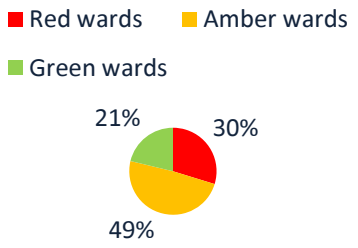


NAAS

70% of all wards assessed at Green or Amber. 21% at Green

Across all 4 sites

50 areas in total to be assessed
47 undertaken
3 outstanding



Investment in 3 corporate quality Matrons (introduced June 2017

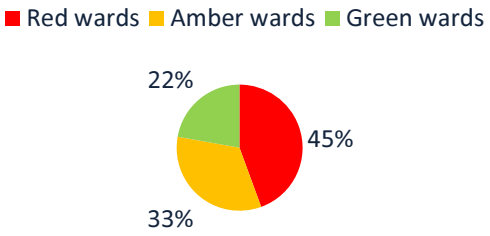
Still significant work to be done but steady improvements in outcomes

Far greater visibility of ward quality and performance

November 2017 roll out of paediatric NAAS

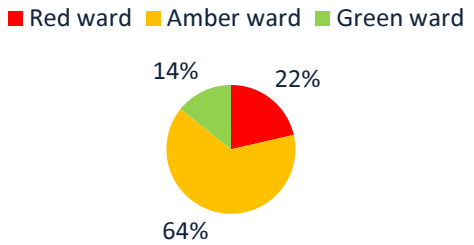
NMGH

18 areas in total to be assessed
18 undertaken
0 outstanding



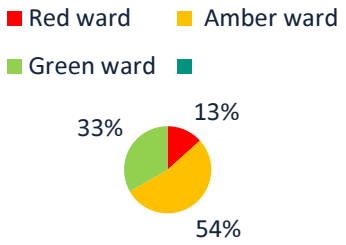
TROH

16 areas in total to be assessed
14 undertaken
2 outstanding



FGH / RI

16 areas in total to be assessed
15 undertaken
1 outstanding

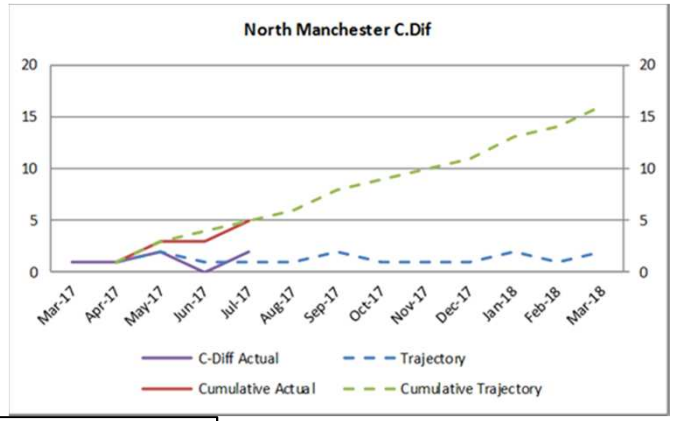


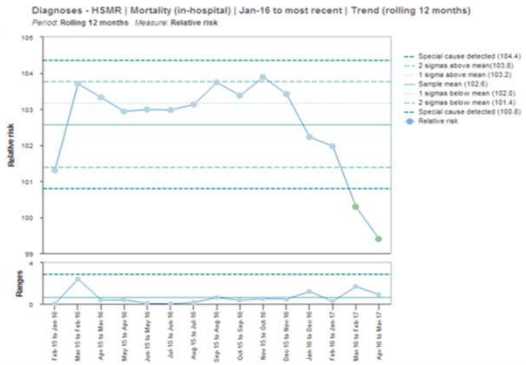
Harm Free Care

15% reduction in falls, 11% reduction in harms

VTE assessments compliance – seen increases from 15% to 47% in improvement wards

Pressure Ulcer Collaboratives – NMGH – no Grade 3 since February 2017





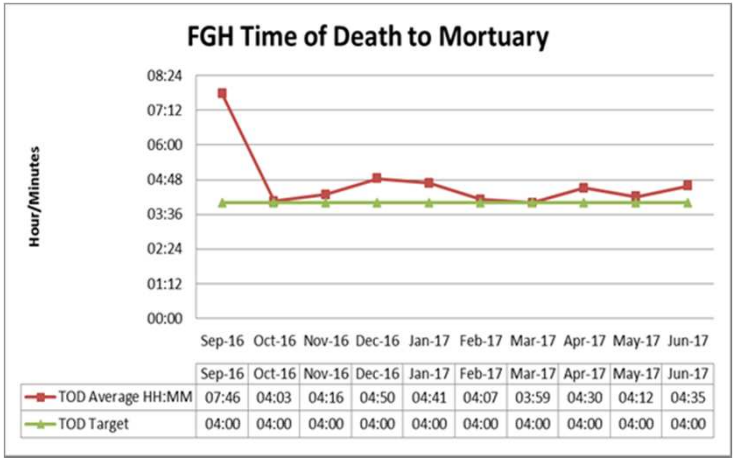
Morbidity and Mortality

August 2016 – Significant concerns identified

August 2017 – Systematic processes introduced to rapidly address preventable harm

End Of Life & Bereavement

- EOL Resource boxes on all wards and departments
- Dedicated Bereavement Offices with Bereavement Clerks, separate to General Office
- SWAN bereavement suites on all sites & in A&E
- celebration packs, comfort packs and z-beds for relatives staying overnight with loved ones.
- Tissue Donation process improved
- 3 Dedicated Bereavement Nurses, EOL Support Volunteers and investment in training and education days

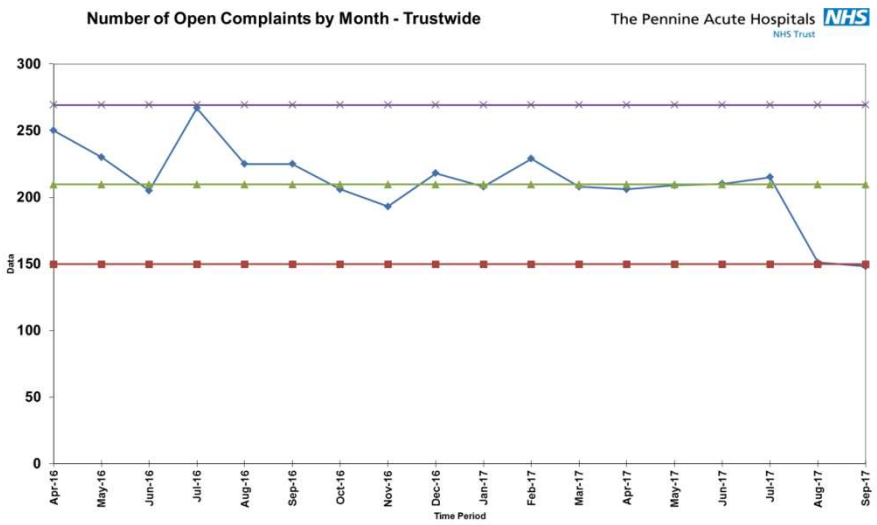


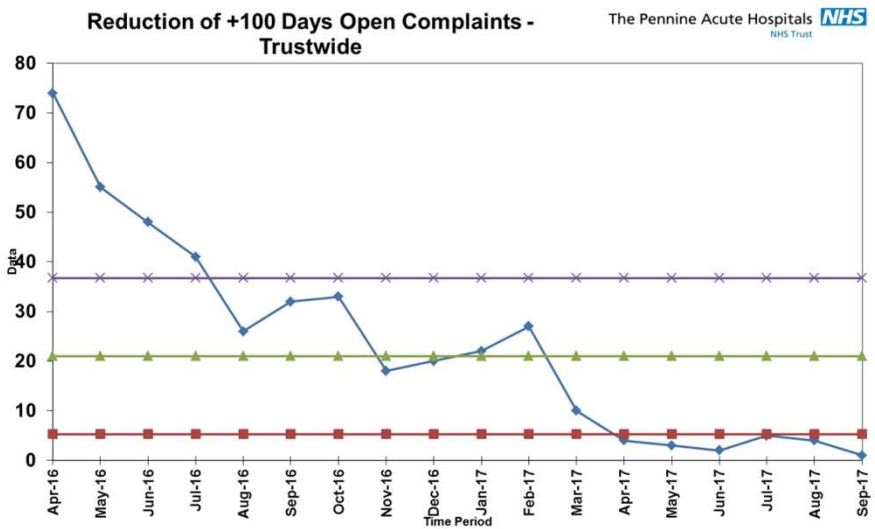
	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
TOD Average HH:MM	07:46	04:03	04:16	04:50	04:41	04:07	03:59	04:30	04:12	04:35
TOD Target	04:00	04:00	04:00	04:00	04:00	04:00	04:00	04:00	04:00	04:00

Complaints

Complaints reduction and earlier response rate less dissatisfied complainants with introduction of new head of complaints and investment in 4 Complaints handlers posts and administration support

Eradication of +100 days open complaints



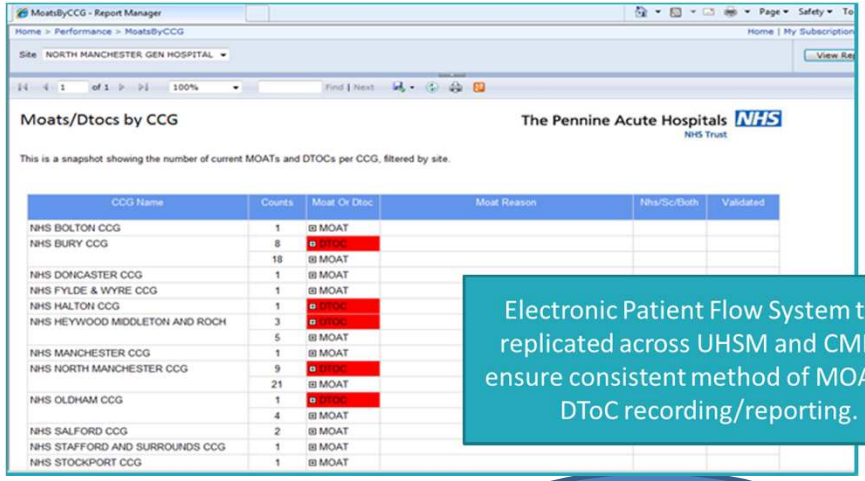


Incidents, Claims and Coroners

- Care Organisation incident reporting increased by 10%
- Serious Untoward Incident investigation backlog reduced from 102 to 4
- Reduction in SUI related deaths
- Duty of Candour for Serious Untoward Incidents – increased from 20% to 100% (Director or Deputy led process)
- Coronial information request data backlog Aug 2016 n=1000 – Aug 2017
- Prevention of Future deaths notices reduced
- Legal representation at inquests reduced from 44% to 5%

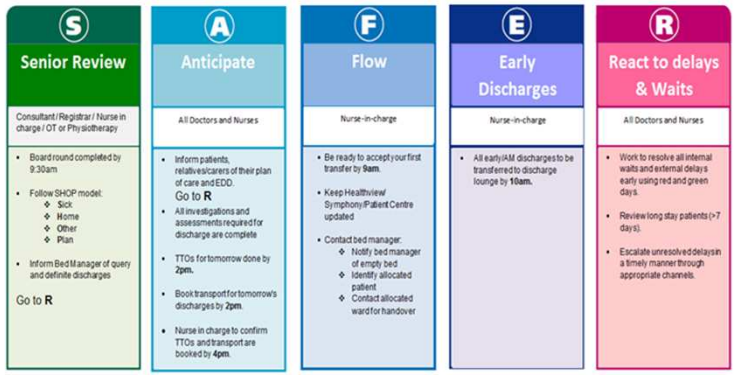
Delays and Outliers

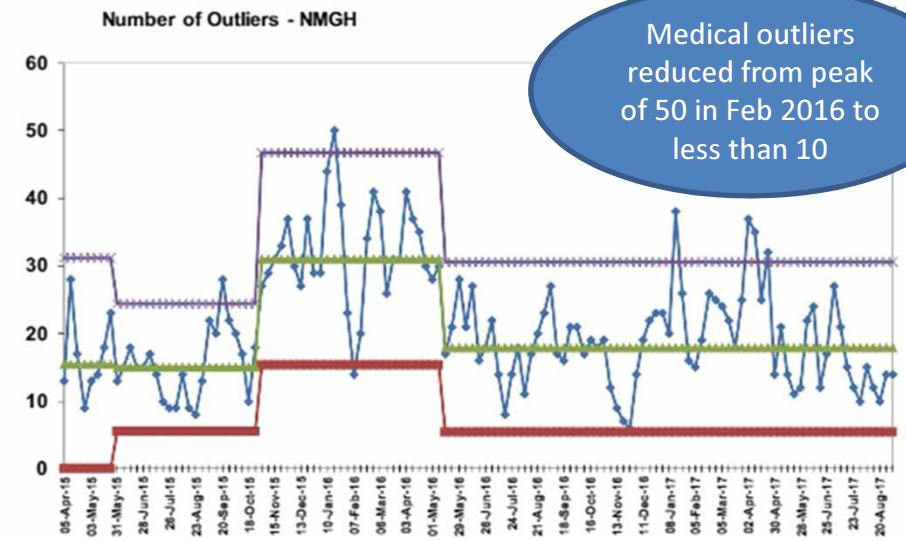
90 improvement cycles and clinical microsystem coaching



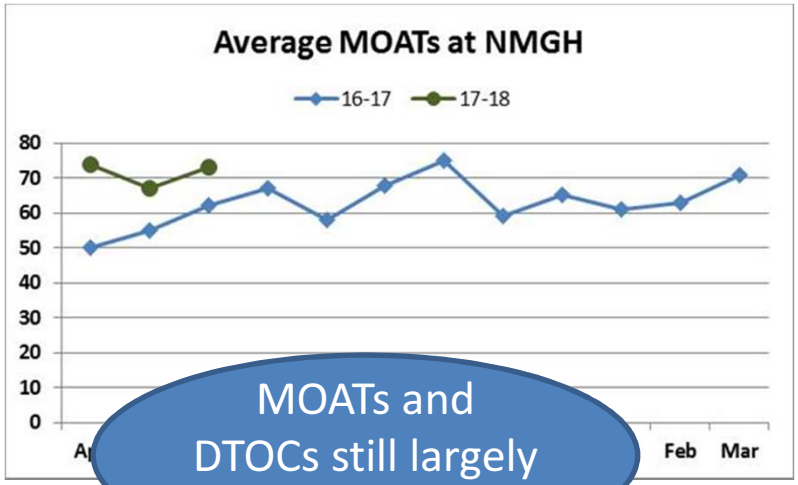
Electronic Patient Flow System to be replicated across UHSM and CMFT to ensure consistent method of MOAT and DToC recording/reporting.

Five SAFER actions for patient flow





Medical outliers reduced from peak of 50 in Feb 2016 to less than 10



MOATs and DTOCs still largely unchanged

New Workforce Strategy - Aims

Workforce Stats

Staff Group	January 2016	August 2017	Difference	Recruitment pipeline
AHPs	514.86 wte	556.35 wte	+ 41.49 wte	67
Nursing & Midwifery	2618.55 wte	2744.45 wte	+ 125.9 wte	337
Clinical support staff	1406.86 wte	1549.87 wte	+ 143.01 wte	148
Medical & Dental	735.47 wte	731.60 wte	- 3.87 wte	46

More work to be done on Medical recruitment

104 RNs and 37 Midwives started Sept

A workforce of sufficient numbers

Key changes

- Significant investment in recruitment activities
- Leveraging of SRFT brand
- Part way through implementing radical transformation of recruitment activity from administration to assertive management
- Starting journey to develop and embed new employee value proposition
- Implementing NHSP across all functions (medical implemented in Nov 17)
- Revision to workforce planning – first phase medical rotas
- HRD business partner model

Highly motivated people – May 2017 results

Results

- Overall most measures have improved significantly over the last twelve months.
- The overall engagement score for the Trust has increased to 3.91 from 3.77.
- 63.92% of staff would recommend the Trust for care or treatment compared to 52.88% in March 2016
- 56.36% would recommend it as a place to work compared to 45.51% in March 2016.
- Measure of Staff confidence in the future of the organisation increased (3.08 from 2.58)
- Staff feeling able to achieve their work objectives increased to 3.63
- Sickness absence reduced by one percentage point in year 2016/17
- Staff turnover rate stabilised

Highly motivated people

Key Changes

- CO Director leadership
  - Shop floor presence
  - 1000 voices
  - Comms
- Increased appraisal coverage
- Roll out of Pioneer (Go Engage) programme
- Revision of grievance & disciplinary practice
- Revision of sickness management practice
- Revision of L&D and OD practice and leadership
- Launch of MES programme
- HRD Business Partner Model (inc changes to contracting out model)

Highly Competent People

Key Changes

- Launch of clinical leaders programme
- Prioritisation and review of clinical development programmes
- Working up new LNA aligned with Trust priorities and staff aspirations
- L&D & OD functions with new operating models
- Revision of Contribution Framework

Looking Ahead

- Reliable process to maintain fundamental clinical & operational standards;
- Scale up and spread of QI change packages and launch of QPID methods
- Establish robust and reliable learning Framework
- Enhanced observation – appropriate use of staff and interventions
- Workforce; alternative roles and reducing reliance on agency staff
- A&E and UCC – maintaining progress and maximising winter resilience
- Reducing harm caused by pressure ulcers , falls and C-Diff
- Continue to be key stakeholder in development of LCOs
- Engagement, Engagement, Engagement