Pride in Pennine | Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS Trust

Pennine Acute Hospitals NHS Trust Quality Improvement Strategy (EDQ037) V2

Introduction

In August 2016, the Care Quality Commission rated Pennine Acute Hospital Trust overall as 'inadequate'. This is a significant challenge to us all but Pennine Acute has some of the most talented staff in the NHS and this Quality Strategy aims to provide a framework for which these dedicated staff can band together and improve broken systems and processes of care that are letting us and our patients down.

Our yearly Quality Account from 2009 onwards contains many promises of improvement. Whilst we have made some progress with these promises there remains a considerable amount of work that needs to be done to improve our systems. In March 2016 a new era dawned at Pennine Acute Hospitals Trust, with the opportunity to join a new collaboration with Salford Royal. This move opens new opportunities for collaboration and improvement and coupled with robustly executed service development, organizational cultural development and governance plans, the Pennine Acute staff will turn promises of improvement into results.

Since March 2016, Salford Royal has been managing Pennine Acute Hospital Trust. A new leadership structure has been developed with one Board of Directors across SRFT and PAHT (collectively called Group). Four distinct Care Organisations have been designated in this Group: Oldham, Bury/Rochdale, North Manchester, and Salford. Each care organisation has its own leadership team that report into the Group Board, called Committees in Common.

While this QI strategy addresses the distinct quality challenges of the three Care Organisations formerly known collectively as Pennine Acute, it is important to note that we will be working collectively as a Group on quality with each of the care organisations (Salford, North Manchester, Oldham, and Bury/Rochdale) working in concert to create best practice standard operating procedures.

This QI strategy is built on the knowledge that our staff are the best asset we have and we aim to provide the tools and space for learning, collaboration and improvement that will see our staff transform its services to 'good' or 'outstanding' in three years.

Group Mission Statement

The quality improvement strategy is a key ingredient to enable the delivery of the Group mission.

> Saving Lives, Improving Lives by delivering highly reliable services, at scale, which are trusted, connected and pioneering
>
> Our services will be:

- **Highly reliable**: high quality whatever the day of the week or hour of the day;
- **At scale**: creating benefits for populations through standardisation of the best practice;
- **Trusted**: providing safe and effective care on every occasion;
- **Connected**: seamlessly delivering what matters most to people and communities;
- **Pioneering**: continuously innovating and improving services.

Strategy Development

This strategy was developed using the output and recommendations of the numerous diagnostics within Pennine Acute that have been undertaken in recent months. These include: CQC inspection, Salford Royal diagnostic, incident reporting, mortality reviews, Dr. Foster diagnostics, ECIP reviews, and patient and staff survey results. In addition, the views of frontline staff and leadership on priorities have been incorporated.

Together these sources led us to use the following guiding principles, in support of our overall mission, when framing this three year strategy:

- Relentless pursuit of quality - but start small – don't overwhelm with initiatives
- Patient safety through strong governance systems and a safety culture
- Becoming experts at executing change at all levels
- Build up our best asset – our people – with development programmes
- Galvanise the organisation around a large successful project early and ramp up the quality portfolio based on this success (focused on deteriorating patients)
- Aims need to be challenging yet realistic
- Select improvement projects that have wide-ranging impact on many Trust departments and on multiple aims at once (harm, mortality, efficiency, etc.)

This 3 year strategy is designed to ***start*** us on a journey, not to be comprehensive in all aspects of quality and safety. We believe that this strategy does address all the building blocks necessary for Pennine to transform into a successful learning organisation for years to come.

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

Mortality (risk adjusted mortality)

AIM 1: No preventable deaths

As measured by:

- **Achieve 'as expected' for HSMR and SHMI**
- **50% reduction in unexpected cardiac arrests**
- **Improvement of first 48 hour care standards (SAM Guidelines)**

Hospital mortality is complex and nearly every intervention outlined in this strategy will contribute to an environment where patients are given the best chance of survival of the condition they have been admitted for. But in addition to the overall improvement of care processes in the Trust, we will aim specifically to improve recognition and treatment of the deteriorating patient. This will include increasing reliability to existing deterioration detection systems to reduce cardiac arrests and increase early treatment of patients with sepsis.

The first 48 hours of an emergency admission are crucial, and by redesigning our emergency pathways in the first 48 hours, we will ensure patients receive systematic review by the right clinicians during this critical timeframe. In addition, we aim to ensure that pathways are in place to address the unique needs of the frail elderly population, redesign the mortality review process to maximise learning, and work on reliability of ward rounds.

Harm

AIM 2: Continuously seek out and reduce patient harm

As measured by:

- Patient safety thermometer and locally created measures for: pressure ulcers, hospital associated venous thromboembolism, catheter associated urinary tract infections, falls
- Healthcare associated infections: MRSA, Clostridium Difficile
- Appropriate antibiotic prescription

Harm is suboptimal care which reaches the patient either because of something we shouldn't have done or something we didn't do that we should have done. Hospital acquired infections, pressure ulcers, catheter related UTI's and inpatient falls are examples of harm which are commonplace. Despite the extraordinary hard work of healthcare professionals patients are harmed in hospitals every day. Fortunately, catastrophic events are rare but we must acknowledge that unintentionally a significant number of our patients experience some harm.

Our first priority is being open about errors and adverse events with our patients and families. Shedding light on these problems will allow us to join together to build systems to avoid the unintended consequence of patient harm.

We will focus on testing and implementing harm reduction strategies that have been successful elsewhere, including a focus on appropriate antibiotic prescription.

Aim 3: Reliability: Achieve the highest level of reliability for clinical care

As measured by:

- Increase in number of green wards on the Nursing Assessment and Accreditation System
- Audit of adherence to best practice in maternity, cardiovascular disease, respiratory, musculoskeletal and frailty pathways

It is widely acknowledged that aspects of health care do not perform as well as they should. Studies have shown that there is inconsistency in the delivery of high quality care and that patients often only receive a fraction of the care that is recommended. Reliability science can help health care providers redesign systems to make sure more patients receive all the elements of care they need.

Over the next three years we will use the principles of reliability science to underpin our approach to reducing harm and avoidable mortality in the following pathways in particular: maternity, cardiovascular disease, respiratory, musculoskeletal and frailty. In addition, we will roll out the Nursing Assessment and Accreditation System to ensure reliability in all core nursing processes. Intentional Rounding will also be rolled out, a process to ensure we are checking in with every patient at least once an hour.

Aim 4: Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living

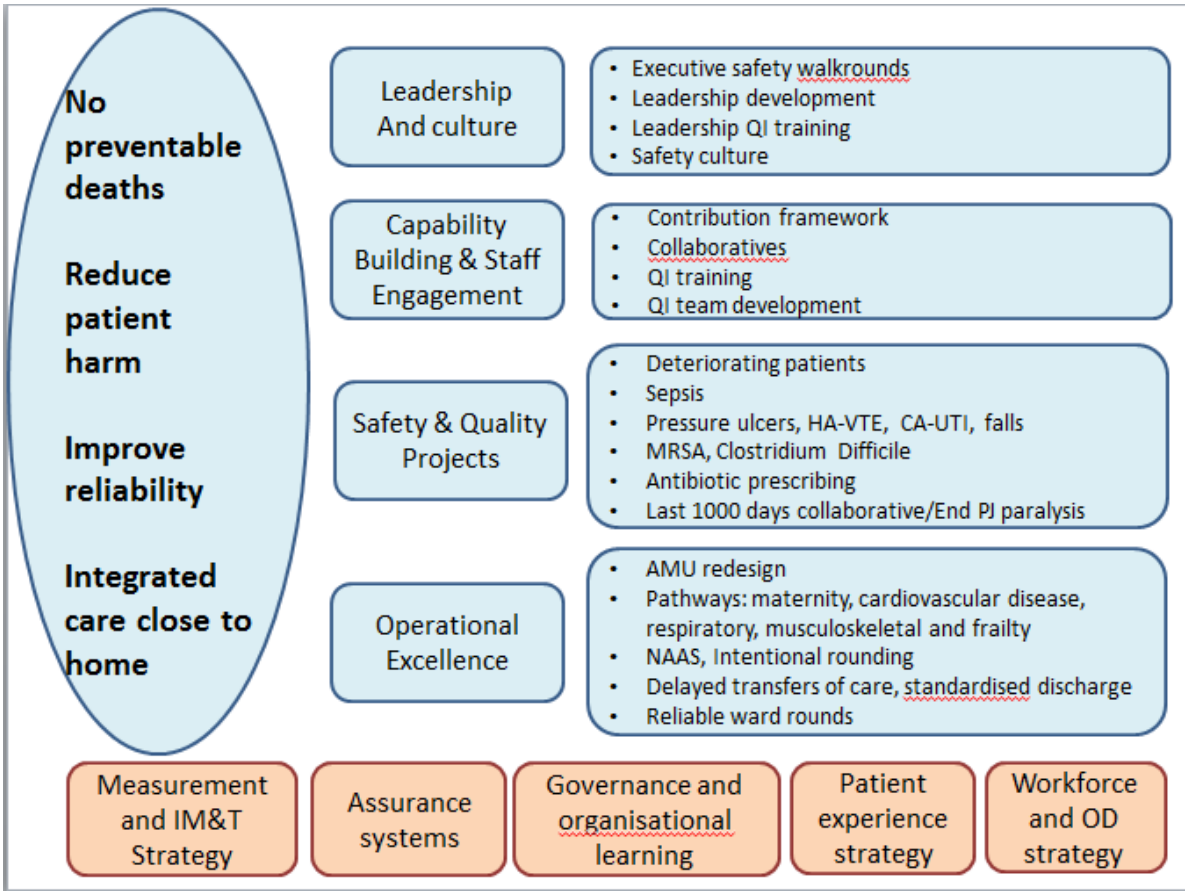
As measured by:

- Reduction in delayed transfers of care
- Safety Thermometer in community settings

Caring for patients, their families and carers, is just as important out of hospital as it is when they're staying with us as an in-patient. Community based teams such as district nurses, community allied health professions, and intermediate care teams provide high quality compassionate care closer to or in patient's homes. It's important that in and out of hospital care feel seamless for patients and is of a consistent high quality. For the next three years, we want to work with out of hospital staff to address their unique improvement ambitions including improving coordination of care and harm reduction. We will work on reducing harm to patients in the community setting as well as delayed transfers of care by standardising discharge processes and developing an Integrated Care Organisation for each locality.

Framework for Improvement

The improvements we are pursuing will not happen by themselves. There needs to be an understanding of the drivers and influencers of change, this section describes the primary drivers we will use to implement the strategy.



Leadership and Culture

Organisational culture is very difficult to define but is vital to address if the ambition is to be the best in the NHS. Organisational culture can be defined as the assumed understandings between the staff of an organisation. It means that they share views on the way staff should work together and treat each other and their patients. We have an ambition to be an organisation that has a safety culture. This means that we must embed the Hippocratic Oath "first do no harm" into our identity at all levels.

The main elements of a safety culture are:

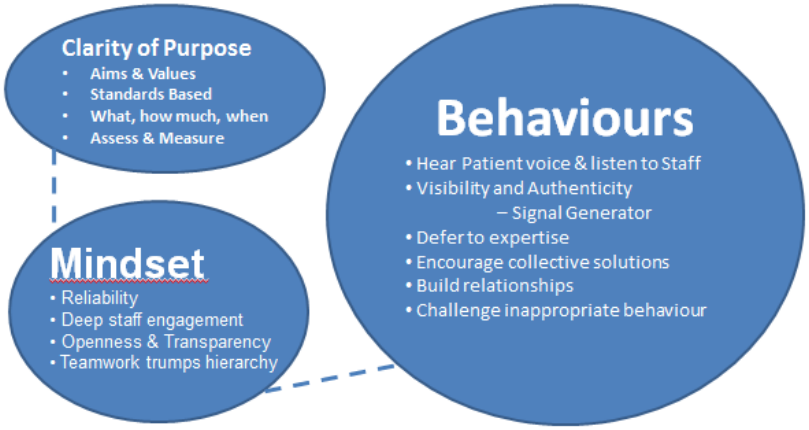
- Open and frequent communication
- High functioning multidisciplinary teams
- 'Just' culture (understanding of system vs. individual errors)
- Robust error reporting systems that 'close the loop'
- HR practices that support a culture of safety
- Leadership:
    - Visibility and Authenticity
    - Accountability for improvement and safety at all levels
    - Deep staff engagement
- Measurement for improvement

Over the next three years we will embark on a series of projects aimed at fostering a culture of safety. These initiatives include safety culture surveys and training, values based surveys and team-working interventions, Executive Safety WalkRounds, and the integration of quality improvement into every day workings of the Trust.

We will support leaders through human resources and organisational development processes, including developing a clear set of values and a framework for rewarding excellence and addressing mediocrity. Leadership will focus relentlessly on supporting this improvement at the frontline through the introduction of leadership walk rounds focused on listening, supporting and barrier busting.

In addition, we will invest time and resources in supporting and developing clinical leadership to work with their local teams to improve care every day. We will open up leadership development opportunities for clinical leaders to cultivate their skills in our leadership model.

Leadership Model



Capability Building and Methods

The methods for improvement that we have chosen are tools based on focusing and liberating the frontline's expertise and skills on a problem to come together to collaboratively solve problems. In order to unleash this potential in our frontline staff we will provide them with the skills and resources necessary to tackle harm and avoidable mortality in Pennine.

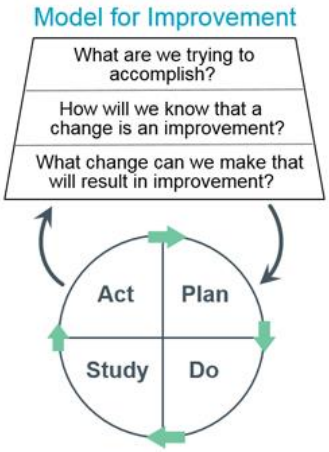
We'll build a small group of experts in change management who can support staff in deploying various methods and pass on improvement skills to frontline staff. While we will use a wide variety of improvement methods to ensure we are using the right tool to solve the problem, the most common methods will be:

Model for Improvement

The Model for Improvement is a simple, yet powerful, tool for accelerating improvement. This model is not meant to replace other change models being used, but rather to accelerate improvement by being used inside a wider change model. Our ambition is that all staff have knowledge of this fundamental unit of improvement, and can carry out small tests of change.

The Model for Improvement tests change on a small scale to find out what works. The model consists of three questions:

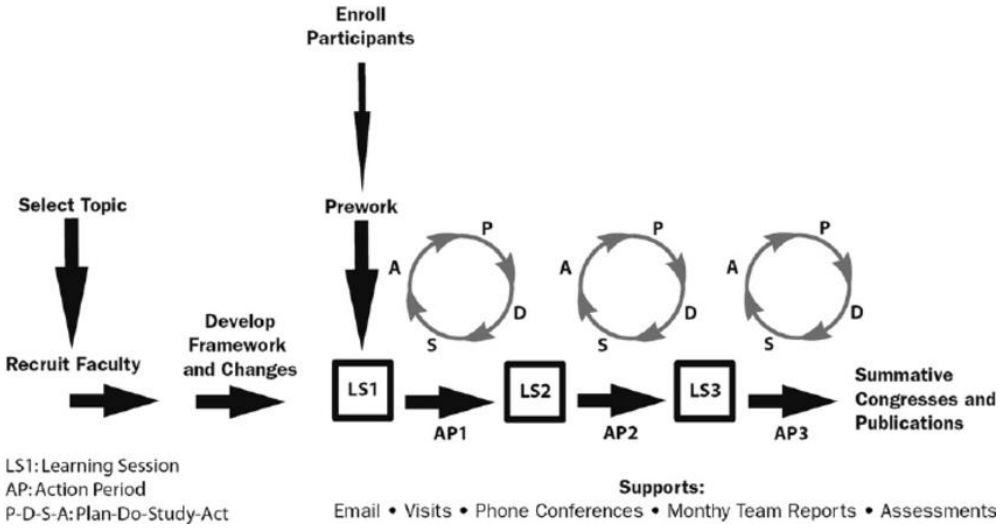
- What are we trying to accomplish? (teams will have clear **aims**)
- How will we know that a change is an improvement? (teams will have clear **measures**)
- What changes can we make that will result in improvement? (**ideas** to try out that come both from the literature and from the vast experience of frontline team members)



The next stage of the model for improvement is the PDSA cycle. PDSA stands for Plan, Do, Study, Act. This is when our frontline staff try out new ideas in their own clinical areas, and rapidly study the results and refine their ideas.

Breakthrough Series Collaborative Model

The breakthrough series collaborative (BTS) model, develop by the Institute for Healthcare Improvement, is a proven intervention in which wards and departments come together at learning sessions to learn from each other and from recognized experts around a focused set of objectives. The key to success is engagement, alignment, leadership and collaboration. Systems are redesigned from the bottom up using small tests of change. A BTS collaborative provides a framework to optimise the likelihood of success for improvement teams allowing time for teams to learn from each other and teach each other about successful interventions.



Microsystems Coaching

This method involves an improvement group of around five to ten people who meet weekly with their improvement coach. The group should be multidisciplinary and comprises staff of variable experience and seniority. This group uses effective meeting skills, including keeping strictly to a timed agenda, using meeting roles (Leader, Facilitator, Recorder and Timekeeper), and ground rules relating to conduct that are agreed by the group. The importance to the success of the work of both this structure, and the commitment to meeting weekly, should not be underestimated.

Another key aspect is the presence of an improvement coach at the weekly meetings. This person will be versed in quality improvement methodology and 'steers' the group when required. The coach works intensively with the group at first, with the aim that their involvement should tail off around the six month mark as the group becomes self-sustaining. The coach also liaises with senior leaders outside of the weekly improvement group meetings to set overall direction and maintain an appropriate course for the improvement work.

Lean Tools and Techniques

Lean is a systematic method for the elimination of waste and defects in a given process as well as emphasising the value to patients and customers. Some examples of Lean tools and techniques are process mapping, value stream mapping, fishbone diagrams and root cause analysis. This set of tools is particularly useful when redesigning a patient pathway.

Capability Building

While we will be building a small group of experts, the Quality Improvement Team, we'll also work on developing local expertise. Participating in collaboratives is a great way to build staff capability in improvement and can reach large numbers of staff across the organisation. In addition to collaboratives, we aim to provide a suite of capability building courses in a variety of quality improvement methods open to all staff and some focused courses for senior and middle managers.

The Pennine leadership team commits to the following pledges of building staff capability in improvement:

- Pledge 1: All staff will be recruited against our values and participate in the contribution framework
- Pledge 2: At least 1000 frontline staff will receive training in the model for improvement by collaborative participation
- Pledge 3: Multiple opportunities for developing QI skills will be opened up including participating in AQUA and Haelo courses, QI team course offerings, bespoke senior leadership development sessions, QI Fellowship across Group, Clinical Quality Academy
- Pledge 4: A dedicated team of skilled improvement advisors and project managers will be developed to support QI strategy projects and care organisations

Projects

A handful of focused projects with clear measurable goals and outcomes will deliver the strategy. In the first year the focus will be on the deteriorating patient (including identification and rapid response to patient's who develop sepsis), and on harm free care. The trust will marshal our resources around the Deteriorating Patients Collaborative to ensure its success which will help us build our confidence in running improvement collaboratives. Improvement projects, while receiving corporate support, will be largely led by the front line and supported by actively engaged middle and senior managers. For more detail on the year one project schedule, please see the project delivery section.

Operational Excellence

In order to achieve our aims, we'll need to ensure our operational systems are working efficiently, defect free, and are patient focused. The idea of operational excellence focuses on flow through our system, reducing delays, reducing cancellations, reducing waiting lists, and standardising our operating model. All of these principles will run through each project, but more specifically, we will be working on pathway mapping, creating standardised operating procedures for discharge, and redesigning our Acute Medical Units.

Measurement

There is a significant piece of work to be done across Pennine to underpin services with intelligence that can be used to manage patients and populations. We will implement an EPR system and a population health management system. If we get this right it will significantly impact on patient experience, flow, safety and reliability (compliance with evidence based guidance for individuals and populations).

However, outside of these high level developments of Pennine's intelligence systems, we'll need to develop ways to measure safety, mortality, and reliability to understand if the interventions we test are successful. We will develop measures for key programmes of work in the strategy building on and refining measures already in place for safety and mortality and the existing programme of audit. Each project will have a suite of measures that adheres to the principles of measurement for improvement.

In addition, we will seek to create ward to board dashboards and build capability in using measurement for improvement, particularly looking at change over time.

Supporting Strategies

Patient, Service User, and Family Experience Strategy: All of the various streams of the QI strategy are designed to improve experience of patients and service users. Reducing harm and mortality, be nature, would improve experience. We will also focus specifically on improving our patient and service user experience by acting on their feedback, given to us in many surveys and formats. The Patient, Service User and Family Strategy, developed across Group, will work closely with the QI Strategy. In particular, there will be a Group-wide collaborative focusing on reducing 'PJ Paralysis,' called The Last 1000 days. Projects are also underway to improve end of life care and will support both patient experience and QI strategies.

Governance and Organisational Learning: Our diagnostic shows that our current systems are reactive to external forces such as negative publicity or scrutiny. Our ability to learn, for example from the most serious untoward events, could be improved. First we must re-set the system and build trust so that our organisation can learn through scrutiny, testing and failing. Our current culture is fearful of failure but our future sustainability requires us to adopt new methods, which will see us fail fast and learn fast. Our Governance team will be working alongside the QI Strategy to develop robust systems for learning from incident reporting, complaints, inquests, and litigation. The team will aim to create a just culture of openness and transparency with staff and patients and families.

Assurance Systems: We require assurance at all levels of our system, from wards, through divisions and up to board. This will be a co-production exercise with local leaders but will build on the best practice of our sister organisation at Salford Royal. We will redesign our assurance structure to support accountability and leadership at a care organisation level as well as adopt the Nursing Assessment and Accreditation System. Board meetings will start with conversations about safety and quality from the patient's perspective and will use data from qualitative and quantitative sources to ask questions and gain assurance.

Organisational Development and Workforce: Improvement will be deeply embedded into the culture of our organisation through our values, organisational development and workforce plans. This isn't simply a plan on a page, it is 'alive' – you will see the values in the environment, the behaviours of staff and most importantly in the operating practices. Recruitment, annual appraisal and professional development programmes will centre on the need to continuously learn and improve. Perhaps most importantly frontline teams at the sharp end of delivery will have the freedom to act and will be supported by senior leaders and middle managers. Solutions will be actively sought from the frontline and leaders will understand that their role is to support and unblock, not command and control. Leadership will focus relentlessly on supporting this improvement at the frontline through the introduction of leadership walk rounds focused on listening, supporting and barrier busting. An aggressive recruitment plan will be enacted to address areas of staff shortage.

QI Team Development

There currently exists a small Quality Improvement team at Pennine Acute. We will be merging the Salford Royal and Pennine Acute QI teams so that quality improvement is led consistently across all four Group Care Organisations. Each Care Organisation will have their own QI team, managed centrally at Group level. In year one, there will be a programme of skill developed for the new joint QI team to ensure a high level of QI skills and experience is spread throughout each Group Care Organisation.

Project Delivery

Below is the project delivery schedule for year one, 2017-2018, projects. Each subsequent year, an annual delivery plan will be presented and approved at the Executive Quality and People Committee (EQPE) and take into account new or evolving Trust priorities. Each of these projects supports multiple aims. For example, all harm reduction programmes have an impact on length of stay and cost as patient harm frequently results in a longer hospital stay. These specific projects were chosen because of their ability to impact harm, mortality, efficiency, and patient experience all at once as well as involve the largest cross section of staff and departments in the Trust.

Some QI projects will be executed at care organisation level only, while others will be Group-wide or Pennine-wide, in which case a single organisation's QI team will take on the facilitation of the project across Group or Pennine. This model will enable both locally focused improvement priorities as well as learning across Group and implementing standard operating procedures. In all cases, the QI team will serve as the connector for learning and standardising across group in regards to quality improvement.

Each project will begin with a scoping period that will deliver a project initiation document (PID) to the EQPE. Each PID will include aims, measures, change ideas, QI methods, project team structure and target pilot areas. Progress of PID delivery will also be monitored by EQPE.

Schedule: Year 1

2017-2018	Project Aim	Project Method	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mortality review standardisation	Implement the national guidance on standardized mortality review	CO Led – Project Management approach	Policy delivered jointly with SRFT			Roll out and implementation								
Improving response to deteriorating patients	50% reduction in cardiac arrests 95% of wards implement NEWS	Pennine-wide Collaborative	Phase I Collaborative								Phase II Spread Collaborative			
Redesign MAU **(Including frailty in MAU)**	Redesign MAU to adhere to SAM guidance (Time to seen, etc.)	Lean/Microsystem CO level projects	NMGH initiated		ROH PID delivered NMGH continues			FR PID delivered ROH, NMGH continues			All 3 CO's working towards SAM guidance			
Reliable Ward Rounds	Adherence to RCP and surgical ward round standards (daily review, structured ward round, board round)	Medical Director led Microsystem – specialty by specialty	PID Delivered			Roll out moving specialty by specialty								
Sepsis	95% of A&E staff complete training Baseline data collected on antibiotic standard and aim set	CO level project Microsystem approach with A&E	PID Delivered			Microsystem commenced								
Pressure ulcers	30% reduction in Grade 2 Zero Grade 3&4 20% reduction in community acquired PU	Pennine-wide Collaborative	PID Delivered		Collaborative commenced									
HA-VTE	95% HAT risk assessment and Data collection on HA-VTE	CO level project Microsystem approach focusing on MAU	Scoping commenced				Revised HAT policy delivered		Microsystems commenced					
Falls	20% reduction in in-patient falls	CO nursing structure led project Rapid spread campaign	Change package development				Rapid spread campaign commenced							

Appropriate antibiotic prescription	All policies comply with national guidance Aim set once revised policies are established	Medical director led committee structure to revise policies	PID delivered, baseline data collected	Revised polices delivered	Improvement project PID delivered	Improvement project commenced
1000 days and PJ paralysis	Develop and roll out change package	Group-wide modified collaborative	PID Delivered	Collaborative commenced	Change package delivered	Spread and sustainability through NAAS
Intentional rounding	100% of wards using new intentional rounding	CO led Rapid spread	Engagement sessions	Rollout complete	Sustainability through NAAS	
Standardised Discharge Process	Create reliable discharge SOP for each CO	CO level project Microsystem approach	PID Delivered	Microsystems commenced		

Risks

Principal Risks	Likelihood	Impact	Key Control established	Control	Assurance	Risk Score
Staffing • Staff may have limited ability to participate in QI projects if the vacancy rate for nurses and doctors remains high • Vacancy rates may hinder full implementation of some project interventions (ex. full AMU redesign)	4	5	Workforce strategy that includes recruitment drive Where possible, microsystems approach that works with staff in own environment used	3	Monitored through Executive Quality and People Committee	12
QI Team Development • The current total QI Team staff do not have the capacity to deliver the projects outlined in the strategy • The current QI Team need some skill development in order to deliver the projects in the QI strategy	5	5	New QI team structure developed and approved Supplementing current team with additional posts Skill development programme for team members underway	2	Monitored through Executive Quality and People Committee	12
Competing/External priorities • There are many change programmes underway, there is a danger that they will compete for staff attention • It is possible for priorities set out by external bodies (CQC, etc.) change or override the priorities in the QI strategy over time	2	3	Many priorities from external bodies have already been aligned with the QI strategy. Core organisation leadership will ensure that priorities do not conflict	2	Monitored through Executive Quality and People Committee	7