Engaging clinicians in quality improvement

support  collaborate  challenge  improve  inspire
Dr Diana Hamilton-Fairley  
Medical Director, Medway NHS Foundation Trust

Dr Meghana Pandit  
Medical Director, University Hospitals Coventry and Warwickshire NHS Trust
Clinical Leadership – does it matter?

Dr Diana Hamilton-Fairley
Medical Director
Our Journey So Far

2013
- Placed into Special Measures
- Mortality outlier: HSMR of 122 Keogh review
- New Chair and CEO

2014
- UHB GSTT buddy agreement

2015
- CQC Inadequate rating
- New Chair and CEO

2016
- CQC Fieldwork CQC inspection

2017
- Exit from Special Measures

Trust remains in special measures
- New CEO June 2015.
- New clinical structure launched, October 2015

CQC note improvements
- Launch of Trust recovery programme

Exit from special measures
- Trust continues its Improvement journey
<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
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<tr>
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<tr>
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**Inspection ratings**

- **August 2015**
- **Inadequate**
  
  - **46 Must Do actions**
  - **25 Should Do actions**
# Inspection ratings

**March 2017**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
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<td>Outstanding</td>
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- **Requires improvement**
  - 13 Must Do actions
  - 20 Should Do actions
2015 and before

- Lack of Leadership
- Lack of direction
- Very poor quality care leading to high mortality
- Weak Clinical Governance
- Silo working
- Lack of clinical engagement
- Competent and capable medical staff
- High vacancy rates in all disciplines
How do you change an organisation?

- Vision
- Strategy
- Goals & Objectives
- Tactical Plans
- Performance
- Operations
- Projects
Priorities

Clinical
- Patient Safety
- Patient Experience

Leadership
- Strategy
- Skills and Attitude

Engagement
- Vision and Values
- Ownership
What did we do?

**Clinical**
- New patient pathways
- Fundamentals of care
- Education and training

**Leadership**
- Vision and values
- Appointed new triumvirates
- Leadership skills

**Engagement**
- Regular interactive clinical and managerial meetings
- Staff stories
- Theme of the week
Getting doctors on board

• What do they care about?

• What don’t they care about?
The leaders’ approach

- Praise not blame
- Speak to the heart and the head
- Promote ownership of problem by them
- Provide data
- All ideas are encouraged
- Negatives are discouraged
Recovery Programme

**SAFE**
- Clinical Governance
- Deteriorating Patient
  - NEWS
  - ART

**EFFECTIVE**
- Mandatory training
  - MCA and DOLS
  - Safeguarding
  - End of Life
- Nursing Fundamentals
- Transforming Care
- Perfect Ward
- Super 7

**CARING**
- Improving RTT
- Improving Cancer pathways
- Complaints and SI reporting significantly improved in quality and timeliness
- Transforming Care
- Perfect Ward
- Super 7
- Mortality reviews
- Mortality action plan
- Mandatory training
- MCA and DOLS
- Safeguarding
- End of Life

**RESPONSIVE**
- Well established and cohesive Executive Team (2 from GSTT)
- Shared vision and clarity of purpose.
- Transformation of medical leadership,
- Functioning Directorate teams and Directorates

**WELL LED**
- Medical Model
- Patient Safety Strategy

**73% ↑ 90%**

NHS Medway
NHS Foundation Trust
We have bold ambitions and a focused programme of work for 2017/18 and have started to deliver improvement at pace.

<table>
<thead>
<tr>
<th>Integrated health care</th>
<th>Innovation</th>
<th>People</th>
<th>Financial stability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Patient flow</strong>, including: A&amp;E, DTOCs</td>
<td>4. Care redesign and networks, including clinical and non-clinical functions and pathways, and Getting it right first time</td>
<td><strong>8. Building a sustainable workforce</strong>, including recruitment, talent management, retention and 7-day working</td>
<td><strong>11. Financial recovery</strong></td>
</tr>
<tr>
<td>2. STP &amp; working with our communities and out of hospital, especially planned care</td>
<td><strong>5. Digital</strong></td>
<td><strong>9. Culture and engagement</strong>, including communicating and celebrating what we do well and engaging staff at all levels</td>
<td><strong>12. Commercial efficiency</strong>, including pharmacy, procurement and tendering</td>
</tr>
</tbody>
</table>
Be the Best

B Bold
E Every Person Counts
S Sharing & Open
T Together

Making our vision reality
Clinical engagement in UHCWi
July 2017

Meghana Pandit
CMO and Deputy CEO
UHCWi

Partnership with VMI since November 2015
Chief Officers – Trust Guiding Team
Director of Transformation
Kaizen Promotion Office
Clinical Leads
Education

• Masterclass - 192 staff
  – Principles of UHCWi and what is ‘Patient First’
  – The tools that we teach are waste, 5S, mistake proofing and defect free healthcare. We end the session on our culture

• Lean for Leaders - 34 staff have completed training and another 54 have commenced training
UHCW Value Streams

First areas of work identified by Trust Guiding Team
Ophthalmology, Patient Safety Incidents, Theatres, Discharge

Value Streams selected based on
Putting Patients first
Together Towards World Class Programme
Aim to be safest hospital in the UK

Ophthalmology Value Stream 1
3 RPIWs:
- Referral management
- Patient flow in clinic
- Eye Casualty

Patient safety Incidents Value Stream 2
3 RPIWs:
- Grading
- Serious incidents
- Investigation – low harm/no harm incidents

Theatres Value Stream 3
2 RPIWs
- Assessment on the day of Surgery
- Delays on the day of Surgery

Simple Discharge Value Stream 4
Just started….
RPIW and Report Out

• Rapid Process Improvement Workshop (RPIW)
  – a five-day workshop focused on a particular process in which people who do the work are empowered to eliminate waste and reduce the burden of work on staff
  – It is a structured process with a 5 week planning cycle and an implementation phase after the workshop, re-measuring the improvement at 30, 60 and 90 days
  – Ends with a ‘Report Out’
Ophthalmology Value Stream

- Patients should leave with an appointment
- Improvement to Clinic set up
  - standard tray with necessary items
- Eye Casualty
  - testing streaming (right place, right person) & improved communication (internet, posters to avoid unnecessary visits), review of staff profile to meet demand
Theatres Value Stream

Theatres

Improvement of privacy & dignity for patients via SODA

Changes to documentation for patients who are admitted on the day of surgery via SODA

Improvement in processes pre-op and preparing theatre on the day for patients having urology surgery
Patient Safety Value Stream

Patient safety
Incident reporting improvements (time to report, making harm visible to investigator)

Improved investigation process
• right person investigates
• contributing factors identified
• In the test areas these are shared at the huddle. These safety huddles have been rolled out across the Trust during May & June

• Immediate senior clinicians respond for serious harm incidents

NHS
University Hospitals
Coventry and Warwickshire
NHS Trust
Patient Safety Response Team: an immediate senior clinician response to serious harm incidents.
A new quicker and easier incident reporting form and a Patient Safety Huddle in each area... have rolled out Trust wide in June 2017
PSR – Patient Safety Response, A senior Consultant, senior nurse and member of patient safety team meet daily at 8am and respond to any serious harm incidents.
Patient Safety Incidents
Rating and Response

Level of Harm

- NO HARM: Incident that has no potential to cause harm or does not result in any harm.
- LOW: Incident that, if not addressed, may cause harm or injury but does not result in any harm.
- MODERATE: Incident that, if not addressed, may result in immediate harm to one or more patients.
- SEVERE: Incident that appears to have resulted in permanent harm to one or more patients.
- DEATH: Incident that has resulted in the death of one or more persons.

Local Incident Review
How do I follow up No Harm and Low Harm incidents?
Investigator to review, add findings, and actions (if required) to Data and close within 16 days. Themes to be reviewed at Patient Safety Huddle and QPS and where necessary risk added to risk registers.

Higher Level Response
How do I follow up higher level incidents?
All Patient Safety Incident rated moderate or above require Duty of Candour and Patient Safety Response (see below). Some categories of Serious Incident and Never Event do not result in patient harm, but these are treated as moderate or above. See Patient Safety Incident Procedure for more details.

Duty of Candour

What is the Duty of Candour?
A requirement in the Healthcare Safety Investigation and Learning Standards. A requirement in the Care Quality Commission Regulations and crucial in Joint Standards on Data of Care.

What are the steps?
1. Stage 1: Understanding the patient and family.
2. Stage 2: Understanding the situation.
4. Stage 4: Understanding the impact on the patient and family.
5. Stage 5: Understanding the learning.

Who are the PSR?
The Patient Safety Team is a multidisciplinary team, including the Patient Safety Nurse, Medical, and Administrative staff. The team is responsible for ensuring the quality and effectiveness of the Patient Safety Team.

What happens next?
Stage 1: Reviewing the incident.
Stage 2: Preventing the incident.
Stage 3: Learning from the incident.
Stage 4: Improving the service.
Stage 5: Reporting the incident.

Patient Safety Response

Using the UHCW Improvement System (UHCW) putting patients first

NHS University Hospitals
Coventry and Warwickshire
NHS Trust
Improving safety through incident reporting

Find out about the many improvements University Hospitals Coventry and Warwickshire NHS Trust (UHCW) have made to increase the reporting of incidents.

UNDER-REPORTING OF INCIDENTS

1.5 million patient incidents are reported across the NHS every year

14,000+ incidents are reported across UHCW every year

10% These figures are believed to account for only 10% of the true number of incidents, and the Trust knew there was huge potential to increase their own results.

KEY FACTORS AFFECTING REPORTING

Staff don’t have the time

Staff don’t see the benefits

Staff don’t own the process

INCREASING REPORTING IN CRITICAL CARE

4 week-long sessions designed to drill down to the root cause of the problems and identify solutions.

Improvements made:

Streamlined incident reporting form: the form has proved highly successful and is now being implemented right across the Trust.

Enhanced process of investigating minor incidents: those who have suffered the trust can identify the key contributing factors, drive forward appropriate changes in practice, and feedback lessons learned to the staff.

New daily huddles: at the huddle staff discuss all incidents that have occurred in the previous 24 hours.

SUCCESS AT UHCW

↑ 103% increase in reporting

↓ 77% reduction in lead-time for investigation minor incident

Increased reporting has led to a number of practical improvements: Avoidable pressure sores in Critical Care
• https://m.youtube.com/watch?v=l-uWQYoXHIw
5S – Theatre Drug Cupboards
Dr Ingram
• Sort

Virtual Red Tagging
<table>
<thead>
<tr>
<th>Shelf</th>
<th>Drug</th>
<th>No of Boxes</th>
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<tbody>
<tr>
<td>Top</td>
<td>Ephedrine 30mg</td>
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<tr>
<td></td>
<td>Metaraminol 10mg</td>
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</tr>
<tr>
<td></td>
<td>Glycopyrrholate 600mcg</td>
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<tr>
<td></td>
<td>Calcium Chloride 10mmols</td>
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</tr>
<tr>
<td></td>
<td>Calcium Gluconate 10mls</td>
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<tr>
<td></td>
<td>Magnesium 5g / 10mls</td>
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<tr>
<td></td>
<td>Flumazenil 0.5mg / 5ml</td>
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</tr>
<tr>
<td></td>
<td>Antileptines 0.5 / 2.5</td>
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</tr>
<tr>
<td></td>
<td>Atropine 600mcg</td>
<td>2</td>
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<tr>
<td></td>
<td>Glycopyrrholate 600mcg</td>
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<td>Chlorphenamine 10mg / ml</td>
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Please only stock above drugs in this cupboard, in this order

All drugs must remain in original packaging / boxes

- **Simplify**
Defects
Waste

- Returned to main theatre drug storage cupboards
- Looked at costings with pharmacy
Sweep and standardise

- All main theatres standardised
• Self Discipline

• Challenge - Time
• Consultant Rounding once month
• Asking Why?
• Listening
SET UP REDUCTION- Paediatric Recovery
Carolyn Bradshaw

• A work in progress following an airway issue in a child:
• Time to access emergency drugs before: 241 seconds
• Time to access emergency drugs after: 50 seconds
• Plan to have box of emergency drugs in recovery plus a fridge with emergency drugs in it (muscle relaxant)
5 S Paediatric Gratnell Trolley

- Before
- After
Patient Safety Huddle

**Purpose:** To review all patient safety incidents for your area that have occurred in the last 24 hours and identify any immediate lessons learnt

*Questions to ask:*
1. What happened yesterday?
2. What went well?
3. What did not go well?
4. What are we going to do differently today?

*And for the weekly grand huddle:*
- What are the themes and trends?
- Are there any risks for the register?

You can find all the information you need on your Datix Dashboard. For more information contact the Patient Safety Team on extension: 25176
Conclusion

• High levels of engagement are a must to achieve transformational change
• Education plays a big part
• Evidence of improvement challenges the cynics
• Delivery and diffusion at pace can be challenging
• Discipline and consistent messaging is the key