1 March 2018
Kings Fund/AQuA
Building a culture of improvement in practice

Andrew Foster
Chief Executive

The WWL Way
Our philosophy - the 2008-18 WWL Wheel

Patients
“Every patient receives the best possible care”

People
“Everyone has the opportunity to achieve their purpose”

Performance
“We aim to be in the top 10%”

Partnerships
“We work together for the best patient outcomes”

Compassionate
Forward Thinking
Respectful
Collaborative
Accountable

Safe
Effective
Patients & Community
Caring
Number of Airline Fatalities per Year vs. Number of Passengers per Year
Our system to spread quality improvement
6 years on - 365 Quality Champions

**Bronze: 299**


**Silver: 48**


**Gold: 18**


Your hospitals, your health, our priority
Addressing non-productive inpatient stay for stroke patients
Preparation of patient bed spaces
Timely & effective use of discharge lounge
Preventing perioperative hypothermia
Improving the patient pathway in audiology
Reducing medication omissions in patients who are nil by mouth
Improving the patient experience
Sustaining the safer surgery checklist
Avoiding readmissions in oncology
Harm from post-operative delirium
Cataract patients’ pathway
Preventing respiratory admissions
Back to basics – time to care
Privacy and dignity in theatre
Nurse-led discharge in surgery
Preventing falls
Rapid discharge at end of life
Increasing patient satisfaction with the use of Whiteboards
Improving hydration
Reducing length of stay in NICU
Reducing medication omissions
Reducing pressure ulcers
Pain management in A&E majors
Timely transportation of blood samples
MDT intervention and stroke patients’ dependence
Supporting carers of patients with dementia
Musculoskeletal checklist
Anaesthesia outside of OD
ACT
Handover
Improving discharge
Efficiency of bone bank service
Customer care focus in estates
Freepostology clinic for babies
Breast feeding of premature babies
12–16 year olds in A&E
Moving & handling induction
Intentional cooling of newborns
Quality champions knowledge management
Immobile patients with possible DVT
Dehydration in nursing homes
Ambulatory assessment discharge
Reducing falls in hospital
Training in dysphagia screening
Discharge of vulnerable adults
Communication on Rainbow Ward
Nutritional supplements in NICU
Speedy transfer to side rooms
Patient weights
Harm from urinary catheters
Improving appointment letters
Reducing deaths from sepsis
Shared Decision Making in maternity
Preventing readmissions (Urology)
Improving experience on Ward S
Infections in new born babies
Improving patient information in ENT
Improving experience in audiology
Improving hourly rounding
Improving accessibility of PALS
Improving the birth environment
Preventing aspiration pneumonia
Achieving NICE accreditation
Possibility box in theatres
Cancer pathway letters
Alcohol nurse clinic
Medicines safety after discharge
Tertiary referrals for upper limb surgery
ACS pathway
Improving blood glucose monitoring
Inpatient welcome booklet
NNU feeding checklist
ECG data quality
Inhaler technique
Reducing VAD complications
Reducing Hickman line complications
QC Toolkit/ reducing falls
Standardised e-reporting of perioperative adverse events
Training in ECG interpretation
Skin to skin contact at birth
Back care
Rounding tool in A&E
Platelet glue in chronic wound healing
Improving theatre environment
Clinic outcome forms
Practitioner led joint injections
Reducing contrast induced kidney injury
Discharge info for patients with dementia & carers
Staff wellbeing
Airway safety in ICU
Needle free palliative care
Improving anticoagulation
Tissue donation
Financial planning in theatres
Hearing loss awareness
Management of uDNAR
Pre-op assessment letter - cataract surgery
Statement writing
Home monitoring of patients with pacemakers
Smoking cessation
48 hour quality window in theatres
Skin integrity with eating disorders
Management of hypoglycaemia
Human factors in incident reporting
Missing records in max fax
Management of obstetric emergencies
Reducing implant loss after breast reconstruction
Day care anaesthesia
Improving social services referrals in MSK
Follow up care in head & neck cancer
Administration of meds in patients who are NBM
Promoting independence in patients following stroke
Resource file in ECC
Meds management training records
Hearing loss project
Careers contract (dementia care)
Improving safety & effectiveness in nurse rostering
Pharmacist participation in ward rounds
Improving software deployments
Improving IV fluid prescribing
Improving meds safety at transfers of care
Everyone has a voice
Safe discharge of ACS patients
The missing link
Reducing cancellations in pre-op
Advancing the AKI service
ANZIT during IV therapy
Improving therapy equipment training
Nursing revalidation
Collaborative care in heart failure & AKI
Perioperative NODC prescribing
Reducing cancellations in Cath Lab
Registry of assets
MEW compliance
Improving outcomes in neutropenic sepsis
Saving lives: health related anxiety; reducing readmissions
Anticoagulants & antiplatelets in endoscopy
Improving outcomes in pancreatic cancer
Optimising anaemia preop
Trauma recognition & treatment in ECC
Early ID of patients with alcohol related problems
Preoperative assessment
Improving adult safeguarding
The age well unit – improving the patient experience
Improving patient safety in PEC with PEWS
Can of worms!
Safe discharge of high risk conditions from ED
Expansion of the practitioner led hip injection service
Raising awareness of domestic violence in A&E
Improving the patient pathway for still birth and pregnancy loss
Team brief – can we do it better?
Preventing on the day cancellations of elective orthopaedic procedures for surgical reasons
ANP’s undertaking pit stop in A&E
Improving rapid resuscitation in ECC

6 years on - 198 Projects 2012-18

100% MUST score completion within 24 hours of admission
Improving discharge from NNU
COC – from good to outstanding
Improving patient experience of venous cannulation
Supporting the non adherent patient with medications
Reducing faits following orthopaedic surgery
On the ball
An end to grey wednesdays
Pain management training
Frailty tool for patients in ECC
Radiology ultrasound guided joint injection service
SEDU missing instruments
Reducing inappropriate referrals in A&E
Standardisation of anaesthetic rooms
Optimise quality of life for people with consequences of cancer treatment or disease
Early ID of patients with alcohol related problems
Standardising elective orthopaedic post op wound management
Improving appropriate placement for stroke patients
One stop early arthritis service to improve patient outcomes & experience
Increasing patient referrals to cancer rehabilitation exercise class
Interventional catheterisation in patients following spinal anaesthesia
QI in the xray department
Improving effectiveness of physiotherapy service on MAU & Lowton
Epidural flashcard
Importance of identifying hearing loss in early dementia
Loomi consultant access to HIS at TLC
Computer log-in self-service password reset
Improving management of serum calcium in neonates
12 o’clock catch up
Always events in theatres
Reducing ERCP cancellations in theatres
Improving airway safety
Improving VTE assessment & prophylaxis
Improving major haemorrhage management in orthopaedic surgery at Whighton Hospital
Improving the patient experience & staff working environment in ultrasound
Community midwifery: an improved learning experience
Improving pain assessment for sedated & ventilated patients in ICU
Control of waste within the catering department
Achieving 90% compliance in medical device training in NNU within 6 months
Improving the journey of a baby on NNU by completion of a baby passport
Induction admin handbook for junior doctors
Bringing enhanced supportive care to NW
Reducing the number of failed vaeectomy sterilisations
Implementing the ADHD quantitative behaviour test
Quality – the unifying motivator
### Quality Results

<table>
<thead>
<tr>
<th></th>
<th>2007-08</th>
<th>2016-17</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR (not rebased)</td>
<td>127</td>
<td>58</td>
<td>-46%</td>
</tr>
<tr>
<td>Deaths in Hospital</td>
<td>1,561</td>
<td>1,340</td>
<td>-14%</td>
</tr>
<tr>
<td>MRSA</td>
<td>19</td>
<td>3</td>
<td>-84%</td>
</tr>
<tr>
<td>C Diff</td>
<td>321</td>
<td>22</td>
<td>-95%</td>
</tr>
<tr>
<td>Pressure Ulcers (grade 2)</td>
<td>28</td>
<td>1</td>
<td>-96%</td>
</tr>
<tr>
<td>Serious and moderate falls</td>
<td>56</td>
<td>17</td>
<td>-70%</td>
</tr>
<tr>
<td>TOTAL HARMS</td>
<td>464</td>
<td>96</td>
<td>-79%</td>
</tr>
</tbody>
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And other results

• HSJ Acute Hospital of the Year 2014
• Sickness absence 4%
• CQC overall rating ‘Good’
• Best in GM for A&E target for 4 years
• Top 10% for Cancer, 18 weeks and F&F
• Cleanest hospital in NHS last 3 years
• Healthy financial surplus last year
Financial Overview

- Quality is directly linked to improving efficiency and reducing costs.
  - All new projects need to include an assessment of the financial impact.
  - Finance team has been working with Quality Champions to link financial benefits to the projects.
- Over 90 projects have been assessed for financial impact, but some of the most recent projects need to be costed.
# Financial Savings Overview

<table>
<thead>
<tr>
<th>Description</th>
<th>Savings up to 15/16</th>
<th>Savings 16/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Coding</td>
<td>£406k</td>
<td>£532k</td>
</tr>
<tr>
<td>Theatre Efficiency</td>
<td>£758k</td>
<td>£457k</td>
</tr>
<tr>
<td>Reduced LOS</td>
<td>£501k</td>
<td>£332k</td>
</tr>
<tr>
<td>Reduced Harm</td>
<td>£153k</td>
<td>£163k</td>
</tr>
<tr>
<td>Clinic Efficiency</td>
<td>£0</td>
<td>£10k</td>
</tr>
<tr>
<td>Penalty Reduction</td>
<td>£100k</td>
<td>£0k</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£1,919k</strong></td>
<td><strong>£1,494k</strong></td>
</tr>
</tbody>
</table>
Case Study – Reducing Antibiotic Usage in NNU

**Issue:** Babies were using antibiotics for too long due to a delay in receiving blood cultures from Salford;
- NICE guidance states antibiotics should be stopped at 36 hours

**Solution:** Improved transportation and reporting process for blood cultures

**Benefits:**
- Less exposure to un-necessary drugs
- Timely discharge – prevent bed blockage
- Reduced cost of medication

**Value of Scheme 16/17:**
- Reduced Drug usage £1,883
- Reduced Length of Stay £17,160

£20,033
Cost of Undertaking the Quality Projects in 16/17

£1,226k Savings Equates to 33 Band 5 Nurses

Quality Team Training Course and Celebration Days

Net Saving
Weaknesses in the WWL system

- 400 are Quality Champions; 4100 are not
- Quality Improvement is:
  - Separate from general management
  - Not performance managed
  - Crowded out by operational and workforce pressures
- Financial austerity and declining performance sit uncomfortably alongside Quality Improvement
SUMMARY

• Consistent priority for Quality since 2008
• Quality Champions since 2012
• Evidence of not just improved quality but healthier culture and improved performance
• Also evidence that Quality saves cost
• But weaknesses of both system integration and conflict with the financial environment
• Stories are more powerful than concepts
Happy staff = happy patients: A final story