Barts Health NHS Trust
Team Transformation

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Sign Up to Safety
Identifying the problem – targeting solutions

- Annual Data 14-15 for falls, HAPU’s & CA calls
- Annual Trend for falls and HAPU’s
- Ward Accreditation Scores
- Scored 1,2,3 for each harm
- Wards with no previous input from TT or QIC
- Wards with previous support
- Impact of each harm on the ward in terms of numbers
- Background of staff satisfaction & Duncan Lewis report
- OD hot spots – teams with challenges

Differentiated needs
Team learning hub & QI support
Targeted support
Rapid spread activity
Smaller breakthrough series for single harms
Outcome measures of effective teamwork
(Measures of effective teamwork (adapted from Mickan [1]))

<table>
<thead>
<tr>
<th>Organisational benefits</th>
<th>Team benefits</th>
<th>Individual benefits</th>
<th>Team members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced hospitalisation time &amp; costs</td>
<td>Improved co-ordination of care</td>
<td>Enhanced satisfaction</td>
<td>Enhanced job satisfaction Reduced unanticipated admissions</td>
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<tr>
<td>Efficient use of health-care services</td>
<td>Acceptance of treatment</td>
<td>Better accessibility for patients</td>
<td>Greater role clarity</td>
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<tr>
<td>Enhanced communication &amp; professional diversity</td>
<td>Improved health outcomes &amp; quality of care</td>
<td>Reduced medical errors</td>
<td>Enhanced well-being</td>
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To reduce hospital acquired harms by 35%* by July 2016 with an overall reduction of 50% by July 2017

*falls 25%

**Barts Health Sign Up to Safety Driver Diagram**

**Objective**

1. **PROGRAMME DELIVERY**
   - Delivery and assurance of learning and development

2. **COMPETENCIES**
   - Ensuring we have a nursing workforce competent to deliver harm free care

3. **GOVERNANCE**
   - Ensuring we can manage and report on the SU2S programme

4. **COMMUNICATIONS**
   - Ensure we have a clear and easily understood message for SU2S

5. **ENGAGEMENT**
   - Ensure we have a well engaged workforce

6. **METRICS**
   - Ensure we are measuring for success

**Primary Drivers**

1.1 Learning hubs delivery
1.2 QI skills delivery and training
1.3 SU2S resources
1.4 SU2S conferences
1.5 Harms training
1.6 Well Run Ward tool
1.7 Targeted Support Team
1.8 Rapid Spread work

**Secondary Drivers**

2.1 Core competencies for each harm
2.2 Identifying lack of competencies
2.3 Complete needs reviews
2.4 Individual SU2S ward plans
2.5 Produce SU2S ward plans
2.6 Appoint sufficient QI nurses
2.7 QI link nurses on each SU2S ward
2.8 Input into nursing documentation development

3.1 SU2S role in site corporate governance
3.2 Standard working model for all sites Safety Huddle
3.3 Ensure access to up to date Policies
3.4 Team representation at site harm reduction groups
3.5 Site SU2S Group established
3.6 Develop reporting structure through governance Structure
3.7 Regular Monday TT/SU2S meetings

4.1 Intranet site
4.2 Create recognisable brand for SU2S
4.3 Agree and disseminate SU2S message of the week
4.4 Communications strategy and plan
4.5 SU2S twitter account
4.6 SU2S safety seminars

5.1 SU2S Pledge from staff
5.2 SU2S launch events on each site
5.3 SU2S reward and recognition scheme
5.4 Team safety Culture

6.1 Documentation audit bundle
6.2 Create reports on progress
6.3 Dashboard
6.4 Incident reporting
6.5 Ward accreditation
6.6 Complete Observations of Care
6.7 Observations of Care themes
6.8 Harm reduction metrics
Clinical standards
- Standardisation
- Well Run Ward
- Quality & safety evidence base
- Increase QI capability
- Integrate the patient voice

Measures of improvement
- Agree, assess & audit
- Develop understanding
- Use the Ward dashboard
- Observation of Care
- Safe & Compassionate
- Team Health

Delivery & skills
- Local faculty expand & support
- Build on Leading Care programme
- Link to Trust improvement plans & work streams
- Link transformation expertise

Team diagnostics & development plan

Programme of events & wider development

Promoting engagement

Learning hubs
- team & individual coach
- Quality improvement skills
- support & sustain
- team days & events
- evaluation & impact

Team Transformation method overview
Success & challenge

HAPU's from 01/04/14 Trust

Source Datix
Key Messages

- There has been a reduction of over 50% in hospital acquired pressure ulcers in the 6 month period post the learning hub.
- There has been a period of 130 days pressure free between August and December 2015.
Sign Up to Safety
X Ward Improvement and Development

Team development and Improvement

Direct Ward based Training
- Team working and Comms
- Falls prevention
- Pressure Ulcer Mgt
- Nutrition & Hydration
- Safeguarding MCA/Dols
- Liaison with Patients
- Specialist Care
- Medicines Mgt

Weekly feedback and reflection QIN & ward Manager

Coaching 1
Coaching 2
Coaching 3
Coaching 4

Specific Issues Identified
- Reducing Harm from Falls and PU’s
- Medicines Management and Safety
- Dashboard and Governance
- Rota Management
- Well Run Ward
- Observations of care

X Ward

Team Health Audit Safety Culture

Ward Manager Direct Support and Development

QIN Clinical Support & targeted support
• Sustaining impact is an early & high planning & design priority
• Impact of stability of the team is high in determining approach
• Differentiated model for transforming challenged teams is required
• the power of targeted support in practice
• Multi-professional engagement
• Impact of long term leadership development faculty & QI skills
• Getting to the micro level of care
• Improving the macro level
• Create award & reward