Perspective on Organisational Culture Change – two examples of how to successfully spread and sustain improvement.

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Sheffield MCA

- Hosted by Sheffield Teaching Hospitals
- Train QI ‘team’ coaches (143 so far from several organisations)
- Central team within the trust
- Organised into sub teams
  - Project Management
  - Building Capability
  - Elective
  - Non-Elective
Different views of the same thing..

Everyone sees part of a more complex reality........
Sheffield Teaching Hospitals very own Elephant!
1,035,094
Out-patients treated

112,855
Inpatients treated in 2015/16

1,188,903
Contacts with Community patients

152,539
Accident and Emergency Attendances

16,000
Staff employed

70+
Different professions
Each of us has seen and been part of exceptional care and caring. But Improvement is hard to sustain...and hard to link together

The challenge of sustaining improvement is well documented. How can we do more, to enable teams to improve **more services** for **more patients**?
Two different approaches

Collaborative approach - wards

Programme approach - theatres
Aims of the Ward Collaborative

• To spread the approach and learning from the improvement approach adopted in the Respiratory wards

• To build quality improvement capability with the staff on those wards so that quality improvements can be maintained and improvement becomes continuous during this period.

• To support and develop new MCA coaches working in the ward environment by buddying them with experienced service improvement coaches.

• To create an opportunity for wards to learn from each other, share improvements and good ideas to accelerate the rate of improvement for patients

• To support wards to improve care for the patients they serve by March 2016.
Timeline and Structure

April 2015

Learning Session 1
17 April 2015

Learning Session 2
16 July 2015

May 2015

MCA Coach Training Programme

Learning Session 3
26 Nov 2015

Action Meeting 1
20 May 2015
13:30 – 16:00

June 2015

Action Meeting 2
15 Sept 2015
13:30 – 16:00

July 2015

Action Meeting 3
19 Jan 2016
13:30 – 16:00

September 2015

Pre-Phase

SPs Assessment Phase

Coached weekly MDT improvement meetings progressing up the improvement ramp using effective meeting skills

November 2015

Final Session
Poster & sharing event

TBG

January 2016

March 2016

Service Improvement
A clearer perspective....

Shared Understanding of Opportunities and Challenges

**Timely Assessment**
- Pull the right patient from assessment units
- Specialty consultants in teams – consultant of many days, ward based consultant.

**All patients have a clear plan**
- Consultant approved care plan within 14 hrs of admission.
- Daily review of care plan to agree plan for the day and daily goals.
- Regular MDT review of plans for patients with extended length of stay – home first mindset. D2A

**Improved ward flow and MDT working**
- Daily Board rounds
- One stop MDT morning ward rounds
- Ward round checklists
- 'E-Whiteboard and handover

**Patient Experience**
- Patient and carer involvement in ward round, discharge planning.
- Clear verbal and written communication of the plan of care.
- Patient involvement in improvement.

**Mesosystem**

**Microsystem**

Individual ward teams engaged in regular improvement meetings
Before the ward collaborative....

Pre Ward Collaborative MCA teams at 12 months

Green - Active
Red - Inactive
Good foundations for sustainability?

- Co-coaching model helps support ‘novice’ coaches and aids ‘resilience’.
- Teams regularly sharing ideas and challenges supports spread and sustain.

“I hope it will become part of our culture that we pick up. There are lots of other things that we need to apply the same principles to.”

“We have been doing some new things in the department and that is possible only because there is a sense of direction that has been created by the Trust and by our own local leadership”

“The sharing events - it was very useful to know that most other groups were struggling with participation and that it could be overcome.”

“Interesting hearing from other wards – hearing stories, difficulties and challenges.”
<table>
<thead>
<tr>
<th>Team &amp; Wards</th>
<th>Themes</th>
<th>PDSAs</th>
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</table>
| GSM (B5,6 & 7, RH5 & 6 NGH) | Communication, Noise                           | Board Round redesign  
|                           |                                                 | E-discharge  
|                           |                                                 | Case note standardisation  
|                           |                                                 | Ward Environment |
|                           | Entertainment, Patient Nutrition                | Junior doctor induction pack..  
|                           |                                                 | Patient entertainment – availability of a newspaper/sweet trolley and working TV’s Drug Rounds |
| Spinal (Osborn 2)         | Organisation, Ward Processes, Food              | MDT ward round standardisation  
|                           |                                                 | Patient information & Food storage  
|                           |                                                 | Drug round redesign |
| Spinal (Osborn 3)         | Team Work                                      | Ward documentation  
|                           |                                                 | Improving flow of ward round  
|                           |                                                 | MDT communication tests  
|                           |                                                 | Standardisation to reduce time wasted  
|                           |                                                 | TTO’s  
|                           |                                                 | Discharge Processes |
| Infectious Diseases       | Ward attenders                                  | Overall process redesign. New labelling for tests, diary system, blood result redesign, patient tracking TTO’s |
| (E1 & E2 RHH)             |                                                 |                                                                      |
| Orthopaedics (F1 RHH)     | TED Stockings Process Pain Management Patients  | Tested stocking aid reducing delay in discharge. Test re  
|                           | belongings                                      | X ray process to improve pain management and immediately start physiotherapy. Joint School |
Geriatric and Stroke Medicine

The team used a fishbone diagram to identify the reasons for e-discharge delays.

E-discharge is used to essentially inform the GP about the patients medication and history.

A new discharge checklist was introduced and reminders were also put up on the wards.

E-discharge compliance improved from 37 hours to 11.
An intervention was introduced in November: Consultants were asked to release junior doctors from the board and ward round to write TTOs early for any patient identified for D/C that day. This was only when staffing numbers allowed. 4 juniors is considered minimum staffing levels (1 junior per team) when a junior can not be released from the ward round to do TTOs. This table shows the number of junior doctors available on the ward round and afterwards to do jobs. This is a significant barrier to sustainability of this improvement.

<table>
<thead>
<tr>
<th>Month</th>
<th>Low staff</th>
<th>High staff</th>
<th>Average</th>
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<tbody>
<tr>
<td>August</td>
<td>5</td>
<td>8</td>
<td>6.5</td>
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<td>September</td>
<td>4</td>
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<tr>
<td>November</td>
<td>6</td>
<td>8</td>
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</table>
Spinal Injuries

Weekly ward rounds were chosen as an area for specific improvement to address key challenges:

- Meetings not starting on time
- Not all MDT members recording feedback
- Difficulties around disseminating information gathered/discussed in the ward round meeting
- Not having a clear set of actions from the discussion
- Not fully understanding/appreciating other professional roles

- **100% of patients who have clear set of actions agreed during the MDT.**
- **30% increase in number of patients that are discussed, seen, and have agreed actions within 12 minutes per patient.**
- **Significant decrease in time spent to disseminate outcomes of MDT to nurses caring for these patients on the ward**

The future......
Two different approaches

- Collaborative approach - wards
  - MCA
  - WARD
  - Collaborative

- Programme approach - theatres
  - Seamless Surgery
Microsystem Improvement work in theatres

Identify Available Technology

Process mapping of scheduling and planning processes

Staff and Patient views

Best practice internally and externally
• Consultant Anaesthetists & Surgeons
• Senior theatre managers
• Theatre flow experts
• Service Improvement experts
the vision...

“To create a best practice, truly patient centred experience of elective surgery where the referral to recovery process is right first time”
Once listed for surgery dates for future appointments (e.g. for pre-op or for surgery) agreed with the patient present or over the phone.

All appropriate patients will use electronic pre-operative assessment (ePAQ-PO).

Escalation plans are in place to address issues with upcoming lists (e.g. lack of equipment, staff or patients).

Scheduling meetings take place every week with staff from theatres, the Directorate with clinical input to plan theatre capacity ahead and review the lists for the following two weeks.

Weekly root cause analysis is undertaken of the previous weeks on day cancellations.

Electronic diaries to manage lists and to enable effective communication between teams.

Alturos is used to plan lists in conjunction with the operating surgeon.

Lists are uploaded to ORMIS two weeks before they take place.

All patients are called four days prior to their planned admission, to ensure they are fit, ready and able to attend.

List orders are finalised and fixed 48 hours before admission.

Operating teams are consistent with a regular core and appropriately skilled team.

Operating teams agree and standardise the organisation of the theatre, equipment needed and specific staff roles.

Theatre teams are supported to ensure lists start on time, turnaround times are minimised and the list finishes on time.
The Launch – July 2016

- Half day theatre shut down
- Over 300 staff attended launch/workshop
- Senior Executive Presence and Support
- Mix of presentations, videos from patients and staff and opportunity to work in MDT teams to discuss action plan
Post Launch

- Continued quality improvement training with focus on elective pathway
- Interactive game, helps staff see full pathway and experience from patient perspective

- Set up weekly/fortnightly meetings to continue working on action plans
- Seamless Surgery Board
Outcomes so far

Increase in cases per list from 2.11 to 2.13 meaning an additional 6 patients per week operated on within existing resources

Staff have feedback that “Having time for all theatre users to meet and discuss problems was fantastic. This is the first time in 27 years we've had a chance to do it”

50% reduction in on day cancellations in Orthopaedic Surgery from 6% to 3%, meaning an additional 3 cases per week

Electronic pre-operative assessment has enabled a one stop service for 220 patients per month, whilst freeing up 220 hours of face to face slots, delivered by senior nursing staff

300 more patients to be operated on with additional gross income (within existing fixed and staff costs) of around £540,000 and potential annual income of over £2m.

For electronic pre-operative assessment patients told us - “Very easy and speeds things up, “Minimal waiting times – would recommend to other hospitals”

Redistribution of 3000 excess stock items in ENT theatres, with a value of over £26,000 – with the work being spread to other theatres

Redesign of Spinal Surgery and Neurosurgery theatre lists to ensure appropriate staffing to reduce gaps, increase flow and throughput has enabled a 33% increase in patients on the list
Reducing cancelled lists

<table>
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Key:
- U.C.L.: 57.6
- Mean: 20.8
- L.C.L.: n/a

Seamless Surgery Launch
...treating more patients
...improving our income

Elective monthly income - variance against target
Next Steps...Seamless Surgery Phase Two

Improved Visibility of Key Metrics

Development of SOPs for key parts of Elective pathway

Sharing and Celebration Event
More Information....

@seamlesssurgery

www.sheffieldmca.org.uk/seamless-surgery
“While the literature often portrays an organization’s quest for change like a brisk march along a well-marked path, those in the middle of change are more likely to describe their journey as a laborious crawl towards an elusive, flickering goal, with many wrong turns and missed opportunities along the way. Only rarely does an organization know exactly where it’s going, or how it should get there.”

What we are learning...

Microsystem improvement engages people and help build motivation and improvement capability to tackle strategic challenges.

Building on this for wider system level improvement:

• No one size fits – different contexts need different approaches.
• Stick to the improvement principles whichever approach.
• Build a shared purpose.
• Clinical and managerial champions creating the conditions.
• Opportunities for teams to learn together and share.
• Simple organisational drivers/principles
• Visible metrics that matter.
Common Challenges

Communication to wider team

“And you’d like to get different people to come and get an experience but you really want continuity because otherwise you spend half an hour telling people what you’ve been doing the week before. So it needs to be similar people each time”

Resilience under pressure

But it’s still getting them, oh I need this, I need to care for this patient, I need to do that, and it’s difficult to argue when you’ve not got many staff..........So we are going to keep doing it, we will get better eventually, we’re going to keep meeting every week and were going to keep doing it. That’s what we’ll do”

Leadership support

“We have been doing some new things in the department and that is possible only because there is a sense of direction that has been created by the Trust and by our own local leadership; if we apply the same principle it should work.”
Common Challenges

Timescales

“It’s a bit like steering a super tanker isn’t it. You can’t just spin the steering wheel and turn it round You’ve got to do gradual changes to make the whole thing improve. But people struggle to see what on a daily basis”

Opportunity and Capability

In fact one of the most vociferous and active members of our team is a support worker, very, very, very good. She was the one who led the survey and formulated the ballot boxes,

Measurement

I found it all really useful, stuff that I have never thought of in such a way that you analyze your work, obviously because there is no point in doing a change and not actually looking at whether it’s made a difference or not
Back to Sheffield Teaching Hospitals very own Elephant!
Join us for....

June 5th and 6th
Sheffield Hallam University, Sheffield

We are delighted to invite you to join us at our third MCA Expo event to be held in Sheffield this June. Expo ‘17 features presentations and reflections on the range of service improvement work happening in Sheffield and beyond.

Whatever your knowledge or background of quality improvement in healthcare, you are invited to learn, share ideas and be inspired.

See more: http://www.sheffielmdmca.org.uk/mca-expo-17