57 ROTA RE-DESIGN TO IMPROVE TEAMWORK AND NIGHT STAFFING LEVELS, WHILST DELIVERING A FINANCIAL SAVING

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Issues A multidisciplinary team at a London Hospital is redesigning the medical rota to address numerous issues, including:

- Unsafe levels of night staffing – a single doctor covers all medical wards.
- Disjointed weekend working patterns – driven by short weekend shifts with staggered start times which: lower opportunities to communicate within the team, and cause inconsistent staffing levels.
- Increased cost – largely due to the increased expense of weekend cover* and a missing shift which is typically only offered to locums
- It is more expensive for junior doctors to work frequent short shifts at the weekend because they are paid an allowance that varies according to the frequency of weekends worked.

Intervention To address the above, our team created a new rota which:

- Reduces the frequency of weekend shifts (average weekend day shift lengths have been increased from 9.33 hours to 12.2 hours, meaning doctors will work fewer weekends without reducing the total number of weekend hours worked)
- Synchronises shift start and finish times at weekends
- Incorporates a locum shift into the rota to reduce cost
- Moves a doctor from the twilight shift onto nights

It was agreed the rota implementation date should coincide with the date of the junior doctors' changeover. However unfortunately due to issues implementing the rota this deadline was missed so the rota will be implemented at the next changeover.

Impact The weekend and locum shift changes are projected to save £40,130.78 per annum. This saving will be used to pay another doctor to work at night, whilst maintaining an overall financial saving of £9,589.74 per annum. Doubling shift cover and halving the number of patients each doctor looks after at night should result in improved patient safety and better service delivery. It is hoped the new rota will also lead to consistent weekend cover and improved teamwork. Junior doctors will be surveyed to ascertain the impact of these changes.

Leading across complex systems and organisations

58 HOW TO TURN A SOW'S EAR INTO A SILK PURSE: RAPID CULTURE CHANGE TO IMPROVE PERFORMANCE AND HEADLINES

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Our hospital's unscheduled care performance last winter was poor with long delays for assessment and admission, crowding

in our emergency department (ED) and an apparent inability to improve. PricewaterhouseCooper (PWC) were commissioned to work with us to change this.

We have moved from a system of 'bed management' meetings (sometimes several times a day) led by nurses to a system leadership model led by senior members of the hospital management team (HMT). Key to this is the daily safety huddle which is a multi-professional meeting inclusive of clinical and non-clinical staff. In addition we introduced two-hourly safety huddles in the ED led by the nurse in charge.

This has improved our ambulance handover time, reduced surgical cancellations, reduced critical care cancellations for elective and urgent surgery and reduced delayed transfers of care from critical care.

Cultural change included redefining the role of directors, improving cooperation between departments, and recognition of the interdependency of services and clinical areas.

The leaders were required to be visible, coach, demonstrate adaptability, use humour and to listen with fascination to colleagues' reservations.

Qualitative improvements include better integration with colleagues in community care, more confidence in the process (eg willingness to go ahead with surgery even when a bed isn't immediately available), better 'grip' in ED and the leadership development of operational managers and clinicians.

Designing a physician reimbursement contract

59 DESIGNING A PHYSICIAN REIMBURSEMENT CONTRACT

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Healthcare spending in most of the Organisation for Economic Co-operation and Development countries is expected to reach up to 14% of GDP by 2060. Physicians as the primary point of contact across the healthcare continuum and being largely in control of the clinical process are well-positioned to influence the cost and quality of healthcare, as well as to lead and shape healthcare improvements. Thus, it is essential to design the most appropriate reimbursement model that can support and drive the desired physician behaviours.

In this article, a hybrid compensation model is proposed which comprises of a base salary and individual bonus – where base salary is pegged at the average market rate according to the physician's qualifications, skills and experience, and the individual bonus is adjusted according to both the 'group-level' and 'individual-level' performance.

The proposed reimbursement model has the flexibility to be applied in different care settings after tailoring the performance metrics to suit the organisation's desired goals, e.g. using indicators from the NHS's Quality and Outcomes Framework for a primary care setting. However, administering the physician's incentive component in our proposed model would likely be relatively complex, given the need to account for the physician's 'group-level' affiliations, which could range