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

from the physician's role in a specific clinical program to his/her association with the parent clinical department. Thus, it would be crucial to ensure that the necessary supporting resources and infrastructure are in place, e.g. robust information systems that can measure, collect, analyse and report data in an accurate and timely manner, which would coincide with health organisations' increasing focus on the use of information systems in delivering effective value-based healthcare.

Communication with patients

60 TAKEPHONERSHIP

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Issue Our inability to answer the phone and resolve patient problems in a timely manner. This manifested as:

- Poor patient experience
- Answerphone messages not actioned
- Incorrect diverting of calls
- Unnecessary emails between teams
- Lack of education around the role of admin teams.

Bristol Dental Hospital Executive commissioned work to resolve this which had clinical leadership, Consultant Scott Deacon and managerial leadership, Deputy Divisional Director David Wynne-Jones.

Strategy for improvement A task and finish group was setup including clinicians and admin stakeholders. Additional drop in sessions were setup to engage staff and embed a culture of ownership. The initiative was called 'TakePhonership' and the Trust communications team supported creating the brand.

The initiative went live with data to highlight problem areas. Drop in sessions were well attended and straightforward actions were implemented. Including:

- Check telephone number accuracy on website and letters
- A 'Power Hour' – focussed on the busiest call times
- Purchasing headsets
- Educating departments on team roles
- Embed culture of responsibility
- Looking at various call routing mechanisms
- Engaging with centralised call centre
- Issuing anonymised updates

The agreed measurements of improvement were:

- Volume of calls
- % of overall calls answered
- % of overall calls answered when available
- Level of telephone related complaints

These are reviewed and fed back to teams via email, meetings, and ongoing engagement drop in sessions and leadership walk rounds.

Measurement We now receive under 3000 calls a week; almost halving the call volume. At the height of complaints only 66% of calls were being answered when we were available. This has risen to over 75% and is likely to exceed 80%. Complaints have fallen significantly by 300%.

Impact Bristol Dental Hospital has taken 'phonership' and changed the culture is. This initiative has been adopted across the Trust.

Leading across complex systems and organisation

61 IMPROVING IV FLUID PRESCRIPTION IN NEWCASTLE, UK – A TRAINEE DOCTOR LED QUALITY IMPROVEMENT PROJECT

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Aims The aim was to improve the prescription of intravenous (IV) fluids in the emergency department, medical wards and surgical wards using principles of leadership and service improvement.

Methods The proposed change to practice was to introduce a new IV fluid prescription sheet that contained decision-aids that closely matched the most recent NICE guidelines on IV prescription in adults. The change was assessed in three ways. Firstly, the NICE clinical audit tool for IV fluid prescription in adults was performed before and during the pilot period by junior doctors working in the acute medical unit (AMU). Secondly, electronic records for sodium and potassium blood results were measured for the first 7 days of admission both before and during the intervention. Chi-square test was used to test for significance. Thirdly, a feedback sheet was put up in the nursing and non-medical staff room for comments on the intervention. Principles of trainee doctor leadership such as early senior medical staff buy-in, multi-disciplinary involvement and qualitative feedback were used.

Results There was a statistically significant reduction in rates of hypokalaemia, defined as a potassium result below the reference range, for the first 7 days following admission to hospital via the AMU. There was a mixed response to the NICE Clinical Audit tool, with improvements in some areas and reductions in others. Qualitative feedback helped discover issues with the sheet not previously identified.

Conclusions It is possible to lead a service improvement project as a foundation trainee. The principles of medical leadership and service improvement genuinely help to make small ideas into reality. This project shows that small simple changes to frequently performed tasks in a hospital have the potential to impact patient safety. The trial fluid prescription sheet is being used to inform the implementation and design of electronic IV fluid prescribing within the trust.

Developing effective leaders

62 THE ACADEMIC FOUNDATION PROGRAMME IN HEALTHCARE LEADERSHIP AND MANAGEMENT – RECOMMENDATIONS BASED ON TRAINEE EXPERIENCE

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The Academic Foundation Programme (AFP) provides themed posts in leadership and management; since 2015 two posts a year have been provided by Torbay and South Devon NHS Foundation Trust (TSDFT). Early leadership development in trainees is recognised as important^{1 2} but a lack of leadership opportunities for junior doctors remains.² The program at