Sherwood Forest Hospitals
NHS Foundation Trust

Holistic Improvement Approach at SFH Using Theatres as a Test Site

Purpose

This paper aims to support further thinking on a suitable holistic approach to improvement in SFH. It builds further on 'Thoughts on Standardised Change/Improvement', tabled at the Senior Leadership Team earlier this year (Appendix I). It also addresses recent feedback from CQC on the need for a standardised and consistent approach to Service Improvement at SFH. A proposed approach, co-developed[1] by Heads of Services, is presented and a mandate to proceed in a pilot area is sought.

Case of Need

The Trust faces a challenging change agenda driven internally and externally through programmes (table 1). These programmes touch most parts of the organisation. Each change programme is supported by different teams within SFH but all require the input of the same group of staff to enact and embed change, causing an unrelenting pressure on operational and clinical colleagues. We therefore need to find the right way to support our Divisions to make the most impactful changes without being overloaded.

Internal	External
Advancing Quality Programme Financial Improvement Programme Patient Safety Culture Maximising our Potential	CCG QIPP STP

Current Work Happening in Theatres; an example

Supporting team	Change activity
Service Improvement and Safety Team	PASCAL Culture survey in Theatres starting in July 2018; previous results have demonstrated that this results in significant staff feedback on the culture within an area, and identifies both obstacles to and opportunities for improvement
PMO	FIP target of £2m for Theatres workstream. Currently £760k identified to be delivered through 9 schemes. A further 11potential opportunities have

[1] *Head of Service Improvement, Head of PMO, Head of TED, Surgery Triumvirate, Head of Governance, Deputy Chief Nurse*

	been identified but are not currently being progressed due to either 1)capacity, 2) appetite 3) complexity
PMO	QIPPs with a value IRO £3m including changing procedural setting in line with BADs, and the highly ambitious Elective Care Transformation
HR	Maximising our potential
Triumvirate	Overall operational and financial efficiency. Staff survey improvement plan

The Proposed Holistic Improvement Approach

1. Structure and Governance

The premise of the whole approach is based on inclusivity and transparency, with staff working collectively to share knowledge and information, and to achieve common agreed goals.

- **Sponsor**: Proposed Executive Sponsor would be Dr Andy Haynes or Richard Mitchell, CEO.
- **Project Users**: Identified Project Users who can support the design of any improvements and sense check outcomes and any proposals (interested staff and service users)
- **Project Board**: Wide representation, including Operations, PMO, Service Improvement, OD and Governance.
- **Project team**: Agreed from within these functions to support individual workstreams.
- **Administration & Assurance**: PMO will be responsible for the day to day management of the project in terms of documentation and outputs, and there will be an over-arching governance structure to provide assurance to the wider organisation.

2. An Improvement Framework

Having recently reviewed current global service improvement methodologies, which included an evidence scan around the success and sustainability of different methodologies; the conclusion of the review was that it did not point to a single best methodology for sustained improvement in healthcare organisations.

2.1 Proposed 'Sherwood 6 Step' Improvement Framework

We propose a simple, effective, and proven approach that we can move quickly with. It is based on the Institute of Healthcare Improvement's 'Model of Improvement'[2] which focusses on defining quality, and measuring and testing outcomes to ensure that the change achieves its improvement aim.

This would provide a locally shaped, best practice framework that will define the Service Improvement approach, so that staff are clear that 'this is the way that we do things around here'.

It will also underpin QI training at SFHFT, as it is intuitive to staff (the framework received very positive feedback from staff as part of the development process, where it was shared at event at KMH, MCH and Newark Hospital) and follows a prescriptive approach that echoes the progression of a project, from start to finish. Figure 1 provides a summary of the 6 steps.

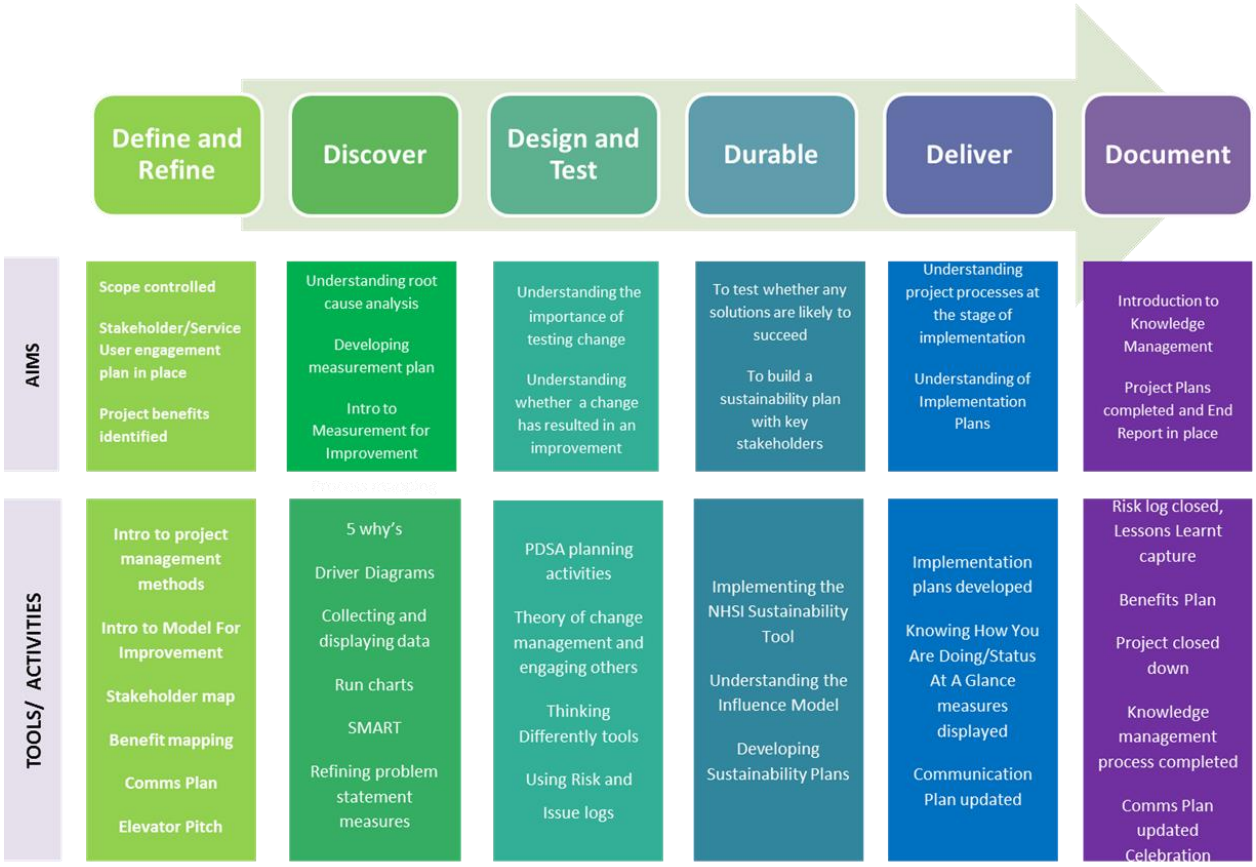


Fig 1: Improvement journey steps suggested under the Sherwood 6 Step Framework

[2] . *Most health and social care providers use the Model for Improvement as the basis of their approach, and this blends a Service Improvement and Project Management approach, as recommended by best practice evidence*

3. The Productive Hospital Model

In order to ensure a truly holistic approach, whilst the 'Sherwood 6 Step' provides a useful framework for delivering the project, there needs to be collective and inclusive agreement on 'what good looks like' at every aspect of the service.

The 'Productive' model started with 'The Productive Ward' and was tested and rolled out to some clinical areas several years ago – Productive Outpatients, Productive Primary Care etc. It is based on Lean principles, but its main features is its focus on ***local ownership*** of how areas work effectively, using specific tools to increase transparency of performance.

This innovative approach would entail staff being given the opportunity to identify, share, develop and implement measures of what is important to them across the service, and to gain a better understanding on how they interact. This could potentially include them defining further quality measures, or defining 'ideal standards' across service pathways (for example, admin or communication processes that impact on the effectiveness of the service); this is why it is truly inclusive, as it can pull across many different streams and functions. This would both learn from and build on quality improvement work undertaken by theatres over recent years.

The Divisional Management Leads are critical stakeholders in this process, and this approach will fail without their full support and visible input.

No health care provider has tried and tested the 'Productive Hospital' approach, which means that there is an opportunity for SFH to lead on, and own this agenda. NHSI are meeting with the Chief Nurse and Associate Director of Service Improvement in May which may result in SFHFT acting as a national partner to test and roll out the Productive approach, and this is, potentially, an exciting development that will put SFHFT on the national stage for QI.

In Appendix 3, there is an example of how the Productive approach works in practice, and how staff have defined key concepts into tangible, measurable outcomes, in order to support service efficiencies.

4. Building Capability to Support the Model

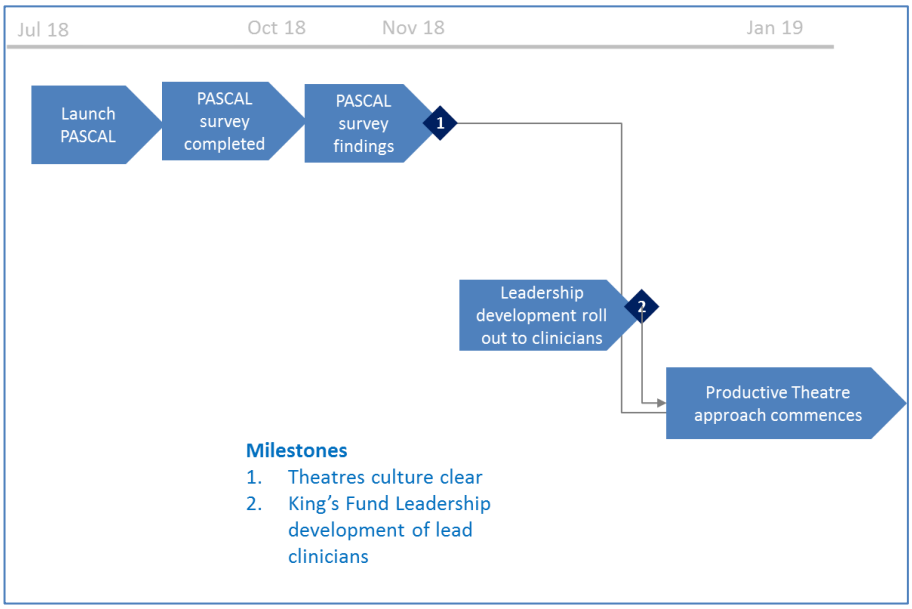
Two recent NHSI publications 'Building Capacity and Capability for improvement: Embedding QI skills in NHS providers' and 'Developing People-Improving Care' give recommended national best practice in regards to developing QI capability across the workforce.

The papers above, in turn, borrow from the Institute of Healthcare Improvement's 'dosing' approach to developing QI skills, which involve administering 'just enough' training at different skill sets within the organisation so that everyone has some knowledge and skills on quality, but at targeted levels of expertise.

In order to build capability and to give staff the tools to deliver improvement, there will be targeted and 'dosed' training on QI and Leadership, at all levels of staff, built into this process.

Considerations

Some essential elements of our approach are already scheduled; dependencies with other programmes create constraints to our timeline.



The Division are critical stakeholders to this process, as this work could entail 'deconstructing services' and putting them back together in a more effective way; this will need visible ownership and support.

There may be organisational KPI's and outputs through current work that might potentially be impacted by the proposed approach.

Recommendations

That the Executive Board provides the mandate for the key stakeholders to test this approach in Theatres from November 2018 onwards.

Appendix 1 – Paper to Senior Leadership Team

At Sherwood we already have well-structured and understood improvement programmes which support:

1. Staff motivation and engagement
2. Quality, safety and patient experience
3. Access
4. Finance and FIP
5. QIPP

Like in most (all) NHS Trusts, our improvement programmes are not as tightly aligned as they could be. Three examples are i) on the day cancellations in theatres, ii) did not attends in outpatients and iii) timely inpatient discharge. All three would benefit from input from the above five improvement programmes but to discuss them in each improvement programme would lead to repetition and possibly confusion. As mentioned, at the moment the "home" for on the day cancellations in theatres is the cost improvement programme but where are the elements of staff motivation, patient safety and access recognised within this?

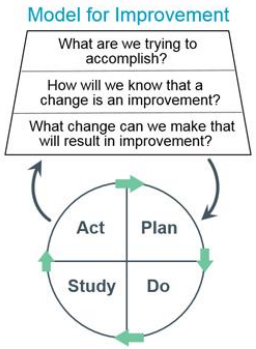
I first raised the idea of tying our improvement work together in late summer/ early autumn 2017 but it is very difficult to launch this successfully. It takes a lot of time and effort. GSTT FT, University Hospitals Bristol FT, Western Sussex FT all took a year from first talking about this to launching it and I think on reflection I underestimated the time it involves. I have trailed the idea of a "Sherwood way" for this but this has not been launched yet and I am not wedded to the name of this. I do think we should make this idea a central area where we collectively focus in 2018.

We recognised we have improved immeasurably as a Trust over the last couple of years but further improvement is essential. It is clear life in the NHS will continue to be challenging and providing a more aligned way of managing change with staff engagement and safety at the centre of everything we do can only make life easier for our staff and patients https://www.kingsfund.org.uk/blog/2018/03/staff-engagement-comes-first .

We agreed last week we should trial this in one location and we felt theatres is a logical place to start. Theatres are complex environments where many different staff groups interact to provide care to patients. For theatres, we already have information about:

- Staff engagement plus lots of qualitative feedback from staff
- Quality, safety and patient experience
- Throughput, start times, finish times, cancellations etc
- The income and expenditure associated with theatres – Productive, cost efficient theatres must be central to our financial improvement plan
- QIPP schemes which should reduce elective load or convert inpatient work into day case.

We also know we want to improve our theatre and intensive care estate and increase our market share on patients who are suitable for elective acute care.



APPENDIX 2 – The Sherwood 6 Step Approach

	Define and Refine	Discover	Design and Test	Durable	Deliver	Document
AIMS	**Project aim and scope defined and agreed** **Stakeholder/Service User engagement plan in place** **Project benefits identified**	Understanding root cause analysis Developing measurement plan Intro to Measurement for Improvement	Understanding the importance of testing change Understanding whether a change has resulted in an improvement	To test whether any solutions are likely to succeed To build a sustainability plan with key stakeholders	Understanding project processes at the stage of implementation Understanding of Implementation Plans	Introduction to Knowledge Management Project Plans completed and End Report in place
TOOLS/ ACTIVITIES	**Intro to project management processes and governance** **Intro to Model For Improvement** **Stakeholder mapping** **Benefit mapping** **Communication Plan** **Elevator Pitch**	Process mapping 5 why's Driver Diagrams Collecting and displaying data Run charts SMART Refining problem statement measures	PDSA planning activities Theory of change management and engaging others Thinking Differently tools Using Risk and Issue logs	Implementing the NHSI Sustainability Tool Understanding the Influence Model Developing Sustainability Plans	Implementation plans developed Knowing How You Are Doing/Status At A Glance measures displayed Communication Plan updated	Updated Risk, Issue and Lessons Learned Log Benefits Plan updated Project governance process closed down Knowledge management process completed Communications Plan updated Celebration

APPENDIX 3 – Productive Hospital Components

Well Organised Department

Overarching Aim

To maximise value by minimising waste – enabling the service to act in the most efficient and effective way for patients, and customers

Objectives – What we will achieve

	People	Items/Rooms
Structure*	• Clear staffing structure • Clear, well communicated and visible roles and responsibilities • Staff situated where and when they are required • Staff equipped with the required skills and knowledge	• Items/rooms are located in the most efficient way to minimise movement of patients and staff. • Specific places for specific activities • The right amount of equipment, always available, when and where required •Just in Time stock
Process*	• Staff rostered to work in the way/place time required to support patient and information flow • Clear routes of communication and escalation • Staff time is maximised in activities which directly adds value to patients and/or customers	• Visible, efficient scheduling of room usage • Equipment and rooms used in the most efficient way at the time/place required by patients.

*** Structure = Set-up/layout/orientation**

*** Process = the way people work/things are used**

Initiatives – What do we need to do to achieve this?

	People	Items/Rooms
Structure*	• Review, update and display accurate key service information • Create visual identification of people/roles • Define and publish clear criteria for staffing requirements – based on needs of patient flow • Clearly displayed up-to-date rotas and contact details •How do people 'feel'? • Demonstration of 'Values and Behaviours'	• Waste walks. • Spaghetti charts • 5s • Visual Management (inc signposting of rooms and layout of items) • Patient/staff surveys • Effective sign-posting
Process*	• Clear processes/rules for construction of staff allocation • Clearly defined roles responsibilities and levels of decision making • Standardised ways of working	• Defined scheduling process for room usage • Clear processes for inventory management • Agreed standards for layout and usage of equipment and rooms