Improvement Collaborative

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Trust Board paper A

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee		
Trust Board	Quarterly	Provide update on Improvement Collaboration activity effectiveness as part of Transformation Team

Executive Summary

Context

As part of the Board's wish to regularly hear updates on the progress of activities to improve the quality and efficiency of UHL processes, it was agreed that the Director of Quality Transformation and Efficiency Improvement would share examples of the work of the Improvement Collaborative with feedback from the CMGs involved.

Today, we will share details of an Improvement Collaborative activity that was conducted in Vascular Surgery. Susan Holt and Bianca Read will provide feedback of the activity from the CMG perspective. Guy Wood, Bob Diepeveen and Paul Brookes-Baker will provide feedback from QI team and share reflection and development points from the activity.

Questions

1) What benefits have we gained from conducting the Improvement Collaborative activity?
2) How can we further develop the Improvement Collaborative activity?

Conclusion

Benefits:

- We have cultivated improved communication between teams within Vascular which has helped to develop team work and find improvement ideas.
- Implemented ideas that have resulted in reduction in delayed starts to vascular surgery (starting to achieve a zero delay from baseline of 40 minutes)
- As a consequence, 6 extra patients have been operated on over 6 day monitor period. An extra 305 minutes of theatre time was utilised which equates to £6100 productivity gain for the same period.
- Improved awareness and understanding of QI techniques within the Vascular Team.
- The work of the Improvement Collaborative is part of our journey to become an improvement minded organisation with improvement focused teams leading local pieces of work to improve outcomes for patients as well as efficiency improvements.

Development:

- Not all initial targets achieved
- QI Skill level development within Vascular not tracked before and after activity
- Further development to improve process study phase and use of data
- Develop prioritisation method to identify areas for Improvement Collaboration activity in addition to supporting requests.

Input Sought

Trust Board members are invited to listen to this feedback and provide comments on current results and approach.

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures [Not applicable]
Safely and timely discharge [Yes]
Improved Cancer pathways [Yes]
Streamlined emergency care [Yes]
Better care pathways [Yes]
Ward accreditation [Not applicable]

2. Supporting priorities:

People strategy implementation [Not applicable]
Estate investment and reconfiguration [Not applicable]
e-Hospital [Not applicable]
More embedded research [Not applicable]
Better corporate services [Not applicable]
Quality strategy development [Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? None undertaken.
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required. None required.
- How did the outcome of the EIA influence your Patient and Public Involvement? N/A
- If an EIA was not carried out, what was the rationale for this decision? N/A

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None	X	

5. Scheduled date for the **next paper** on this topic: tbc

6. Executive Summaries should not exceed **5 sides** [My paper does not comply]

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Transformation Team : Trust Board Story

The Improvement Collaborative in Vascular Surgery

Thursday 4th November 2021

One team shared values

1. Pilot Activity: Vascular Initiate-Diagnose

Improvement Leader: Bob Diepeveen

Problem: Patients face last minute changes of theatre lists on the day, resulting in cancellations or delays to their surgery. Vascular and Theatre work-flow difficulties

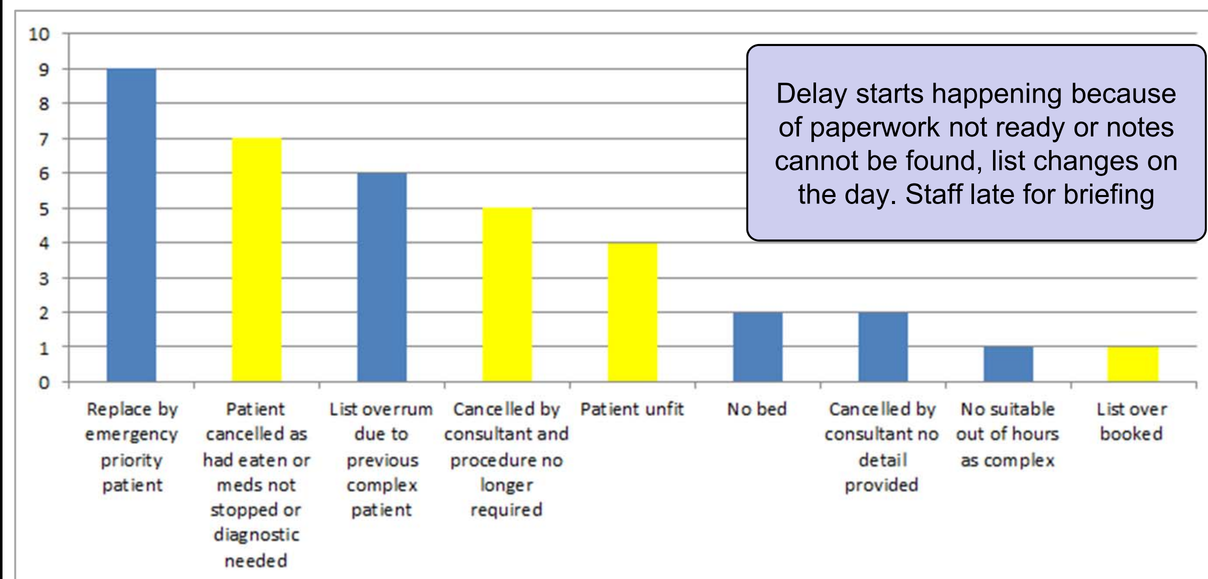
Objective: Reduce theatre cancellations on the day to 12% and reduce average late start to 15 minutes by the end of the Improvement Collaborative.

❷ Initiate Phase Findings:

- Patients face last minute changes of theatre lists on the day, resulting in cancellations or delay to their surgery.
- Challenged working relationship Vascular and Theatre staff resulting in poor communication and different views on the problem and solution
- Reduced theatre capacity pressures due to Covid
- Staff shortages on ward due to vacancies
- Workflow Vascular – theatre

❸ Diagnostic Phase Findings:

46% of OTDC are the focus of this activity (marked yellow)



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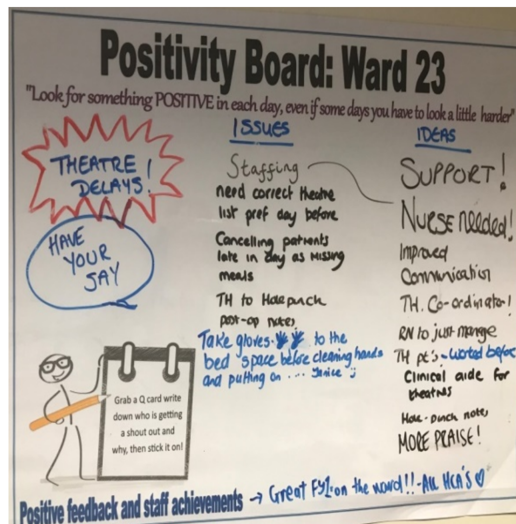
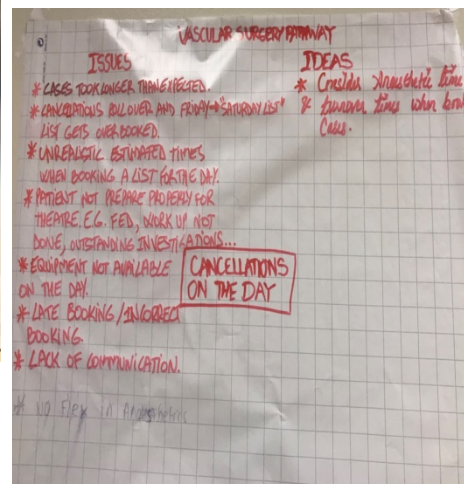
❹ Identify ideas & Test Phase





❺ Implement Phase

- Nurse-led pre-operative assessment of patients, improving which patients, what and where.
- Redesign Pre-anaesthetic assessment scoping for pilot to ensure timely and efficient reviews
- Using advanced models to determine theatre capacity requirement for timely access for emergency and urgent patients
- Testing Local Anaesthetic Varicose veins patient at start of list. Encouraging data thus far.

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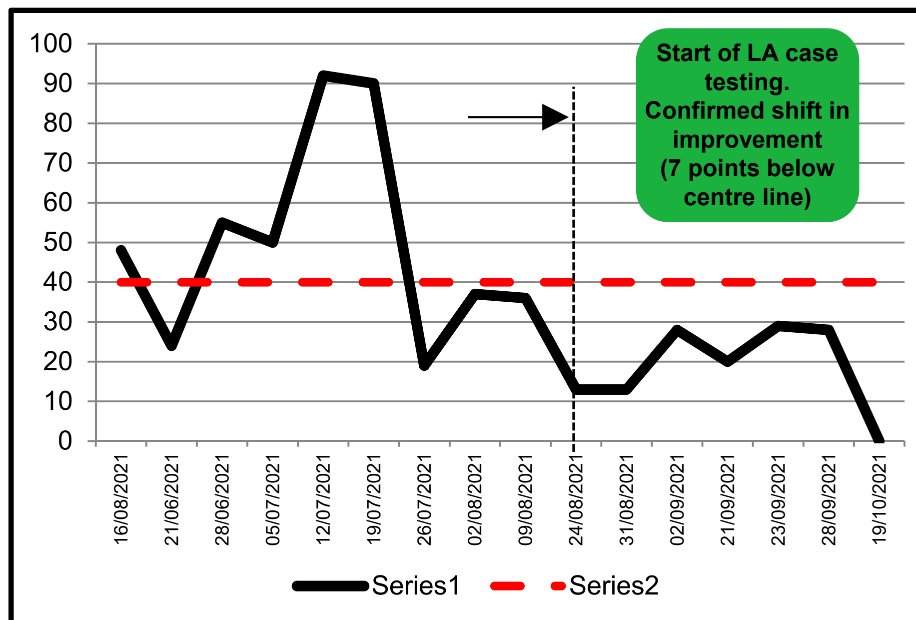
Results:



1. Achieved validated improvement in reduction of delayed starts. Latest data shows Zero minute delay for LA case.
2. 6 extra patients have been operated on over 6 days. An extra 305 minutes of theatre time was utilised which equates to £6100 productivity gain.
3. Improved working relationship between Vascular and theatre teams, reduced paperwork and standardised use of theatre booking system and process
4. OTD Cancellations remain at 12% level

One team shared values

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❻ Sustain Phase

<table>
<tr><th>Improvement</th><th>Sustainability Actions</th></tr>
<tr><td>Reduced Pre-op paperwork for LA Case</td><td>• Monitor process to ensure improvement maintained.
• Implement for in-house cases</td></tr>
<tr><td>Standardised use of theatre booking system and process</td><td rowspan="2">• Monitor to ensure new standard is maintained</td></tr>
<tr><td>Introduced notes trolley for patients going into theatre</td></tr>
<tr><td>Improved communication</td><td rowspan="2">• Maintain with existing and new staff now Guy / Bob have stepped back following conclusion of activity</td></tr>
<tr><td>Improved working relationship between Vascular and theatre teams</td></tr>
</table>

2. Pilot Activity Reflection

Positives

- Latest LA case data shows zero delay start achieved. Improving trend Vs target of <15 minutes (current = 18 mins ave)
- Good engagement and contribution from all working group team members
- QI skills developed in Specialist area
- QI Team development in approach & delivery skills

Areas for further development

- Did not achieve original objective of reduction of OTDC to 12% (no change).
- No before / after skills development tracking
- Deeper study of process required in order to truly understand causes of OTDC and develop suitable countermeasures
- Further development of Root cause analysis approach and QI problem solving skills required
- Improvement collaborative activities are currently conducted based on requests – need to develop a method to also prioritise IC activities based on size of improvement to UHL KPI.

3. Activity Improvements & next steps

Development Activities

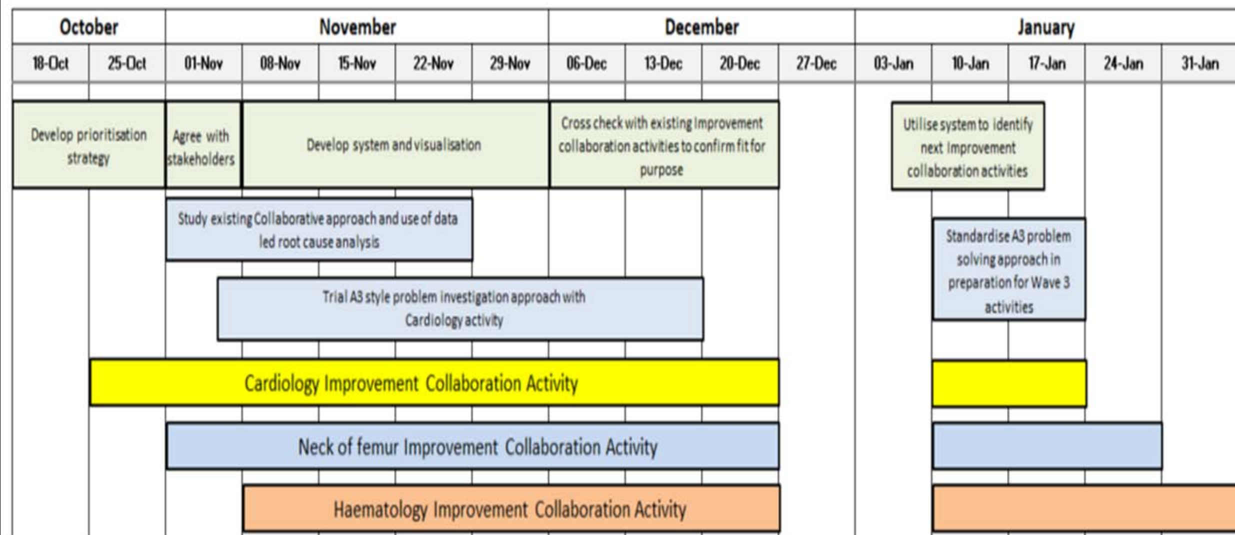
- Develop method to prioritise Improvement area selection based on impact scope.
- Develop performance visualisation for improvement areas based on prioritisation logic
- Develop A3 Investigation methodology as part of collaboration activity

Next Steps:

- 3 areas requesting improvement support.
- All 3 activities will be initiated during October.

Improvement Area	Improvement Focus	QA Team Lead	QA Team Support
Cardiology	Cath Lab productivity	P. Brookes-Baker	B. Diepeveen
Neck or Femur	Not achieving national average for Hip fracture prompt surgery	G. Wood	P. Brookes-Baker
Haematology	Improve capacity in day ward	B. Diepeveen	G. Wood

Activity Plan:



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Journey of Improvement

- Becoming an improvement minded organisation
- Using improvement methodology to drive clinical outcome, service, performance and efficiency improvements
- Improvement coaching and support '*in situ*'
- Measuring for improvement
- Understanding variability

One team shared values