Transformation and Quality Improvement

Making it Happen!
Mark Newton
Head of Service Urgent Care/Consultant Paramedic
Associate Director of Transformation
So Why Transform?

- Performance not achieved since 13/14
- Last Year worst since targets introduced – trend continued
- Turnaround increased from 27 mins to approximately 35 mins
- Red Tails over 30 mins increase
- Staffing challenges

111-999 Activity

Delivering the right care, at the right time, in the right place
<table>
<thead>
<tr>
<th></th>
<th>RED1 response</th>
<th>RED 1 prolonged attendance 'Tail'</th>
<th>RED2 response</th>
<th>RED 2 prolonged attendance 'Tail'</th>
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Delivering the right care, at the right time, in the right place

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Too many long waits!!
Organisational Context - We felt we were ready!

- Clinical leadership - embedded and expanding

- Early QI work produced real results – Turnaround - Sepsis (reduced wait for definitive care – evidence from data on outcomes)

- Highly educated and evolving workforce

- Caring staff – every report reflects this

- Commissioning – **Block contract**, STPs, Transformation, Devolution

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- National support – ARP/PDA, NHSI
Three fundamental Lenses...

- Improve Quality
- Improve Performance
- Cost Sustainability

- Test and Refine System/Process Change
- PDSA
- Scale Up
- No needless waiting
- Reduce Red waits
- Reduce complaints
- Reduce Incidents
- Improve outcomes
- Opportunities for collaborative
- Deliver cost benefits by increasing H&T and S&T
So, how will we make it work?

- Clinical decisions will be taken as far forward in the patient pathway as possible
- All process change will aim to eliminate needless waiting
- This is known as ‘left shift’
- Decisions made towards the ‘left’ will ensure that response is proportionate to the clinical presentation of the patient
- The impact on the wider system will therefore be proportionate.
WARNING NOTE

Transformation & Quality Improvement needed dedicated staff, the right staff and time put aside for development work - -our diaries are full, this is a big thing!

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Why do we need QI methodology?

- Very different way of approaching problems
- Scientific methodology
- Needs training and ongoing support
- Data, Data, Data – but the right data
- Coping with ‘failure’ – crucial to finding right solutions
- Involved all of workforce to find solutions - crucial
Did we have a culture of Quality Improvement?

- Was everyone bought in?

- Multi-Directorate Delphi

- Showed patient outcome and quality was unanimous priority

- Quality considered before performance and cost

- Was our data provision telling us the right thing?

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- Were we using data well?
The Importance of Leadership

Change requires new mind-sets, not just new skills.

To change the culture, we must change ourselves.

Organisational Transformation requires leaders to drive change...

Our leaders must be able to:

- Envision
- Energise

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Example: ROSE (review of serious events)

The Rose Meeting was introduced to provide real time surveillance of harm. It is attempting to do two things, introduce a proactive response to keep patients safe and introduce a leadership culture of constant monitoring and reflection.

Emerging Themes

1. The welfare of the staff involved in the incident, who has spoken to them and how they have been de-briefed following the incident.
2. The interaction with the next of kin and patient (if appropriate) with respect to the timeliness of the interaction, the type of interaction (face to face or telephone)
3. The interplay between ‘being open’ and duty of candour
4. The requirement to ensure that an end to end review of the patient’s care is carried out to understand the full extent of the delays in the system
5. The frequency of the review or recommendation of a follow up discussion
6. The allocation of a suitable clinical investigator.

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The Measurement and Monitoring of Safety

- ROSE aligned to the recommendations of Vincent and colleagues

- Has patient care been safe in the past?
- Are our clinical systems and processes reliable?
- Is care safe today?
- Will care be safe in the future?
- Are we responding and improving?

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Thank you