KHP Cardiovascular Heart Failure Work Stream Event

12 December 2019

Team building –

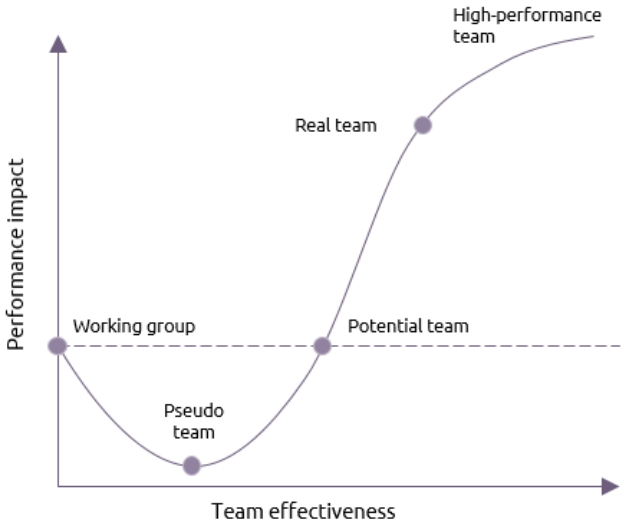
working across organisations and teams

Deborah Homa and Kiran Chauhan, The King’s Fund

Working in teams and systems

The King's Fund

Team working theory



Katzenbach, J. R. and Smith, D.K. (1993), *The Wisdom of Teams: Creating the High-performance Organisation,* Harvard Business School, Boston

Working groups

Team members come together to share information but have no common purpose or performance goals that require mutual accountability. Each team member only accountable for the work that the group has delegated to them

Pseudo teams

This team is at the bottom of the performance curve. Members may believe they are part of a team but not yet acting like one. This may be because they are not committed to a common purpose, shared performance goals and the mutual accountability this entails

Potential teams

Team members are moving towards a common goal and approach to achieving it. They are working towards a higher level of performance and must agree on mutual accountability

Real teams

A small group of people share a common purpose and approach. They have complementary skills and share accountability for results

High performing teams

The difference between a real team and a high performing team is the relationships between the team members. High performance results from the members being committed to one another's personal growth and development

What's a 'real' team?

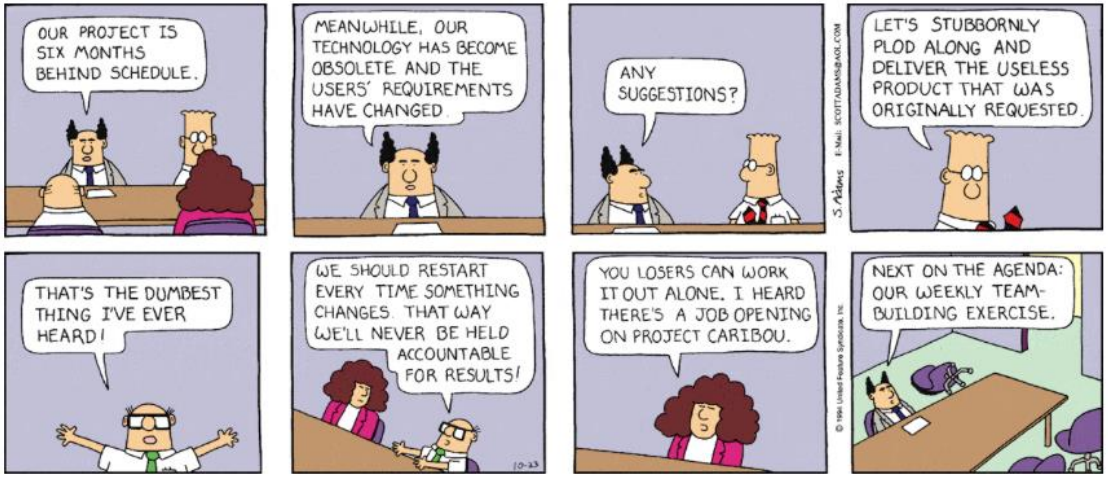
'Real' teams:

- Members work closely and interdependently
- Clear, shared objectives
- Regular and effective communication, (usually team meetings)
- Reflect on performance and how it could be improved

Lyubovnikova, J. & West, M.A. (2013). Why teamwork matters: Enabling health care team effectiveness for the delivery of high-quality patient care. In E. Salas et al. (eds.). Developing and enhancing teamwork in organizations: Evidence-based practice and guidelines. (pp.331-372). San Francisco: Jossey Bass.

Lyubovnikova, J., West, M.A., Dawson, J. and Carter, M. (2015). 24-Karat or fool's gold?: consequences of real team and co-acting group membership in healthcare organisations. In European Journal of Work and Organizational Psychology. 24, 6, 9 929 – 950.

What's a 'pseudo' team?



'Pseudo' teams

- Co-acting groups without clear goals
- No recognition of task interdependence
- Lack reflection on team performance

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What proportion of NHS staff work in a 'real team'?

92%

NHS staff report belonging to a team

40%

Experience 'real team' conditions

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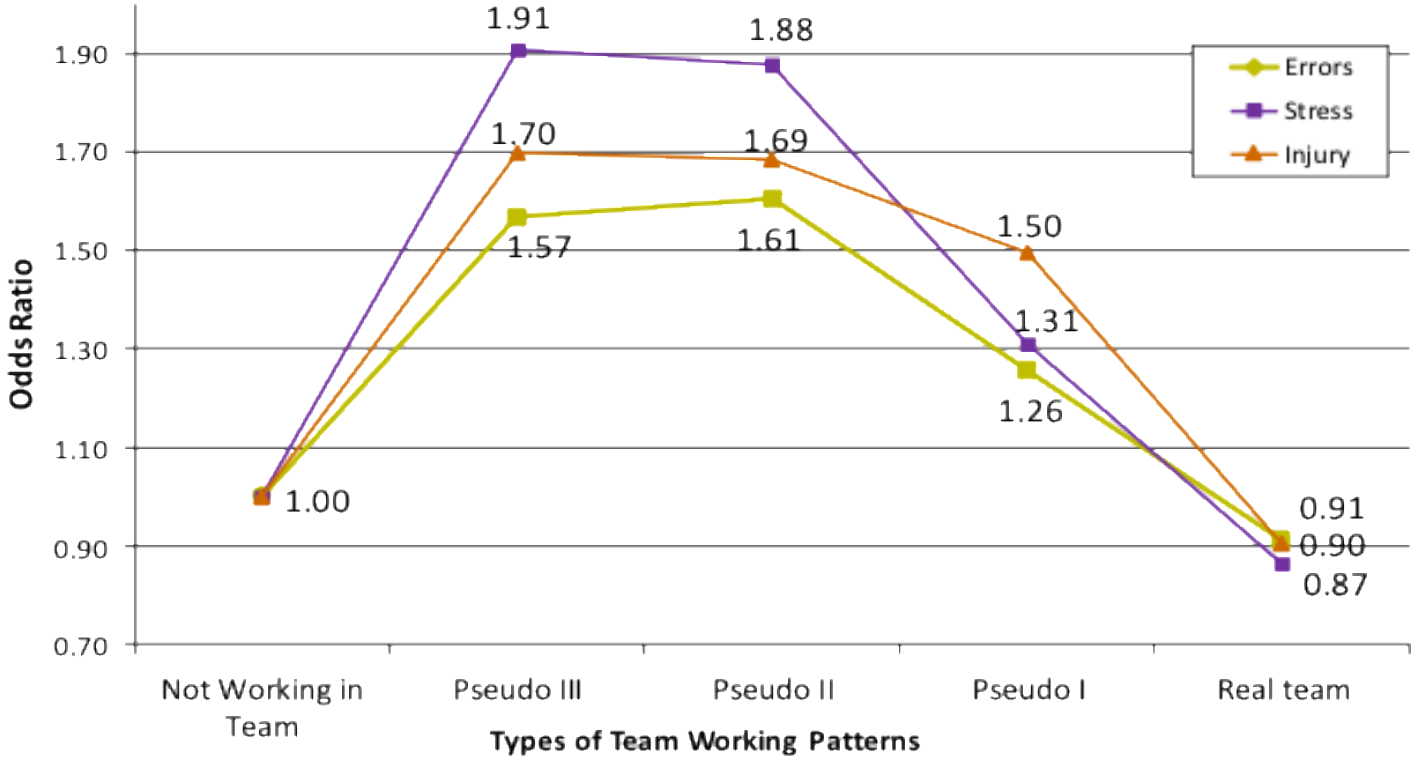
Does team working matter?

300 PCTs 50,000 respondents	% working in real teams	% working in pseudo teams
Organizational health and safety overall	**.41**	**-.43**
% staff suffering injury at work in previous year	-.30	.36
% staff witnessing potentially harmful errors/near misses in previous month	-.32	.30
% staff experiencing physical violence in previous year	-.36	.34
% staff experiencing bullying, harassment or abuse in previous year	-.29	.30

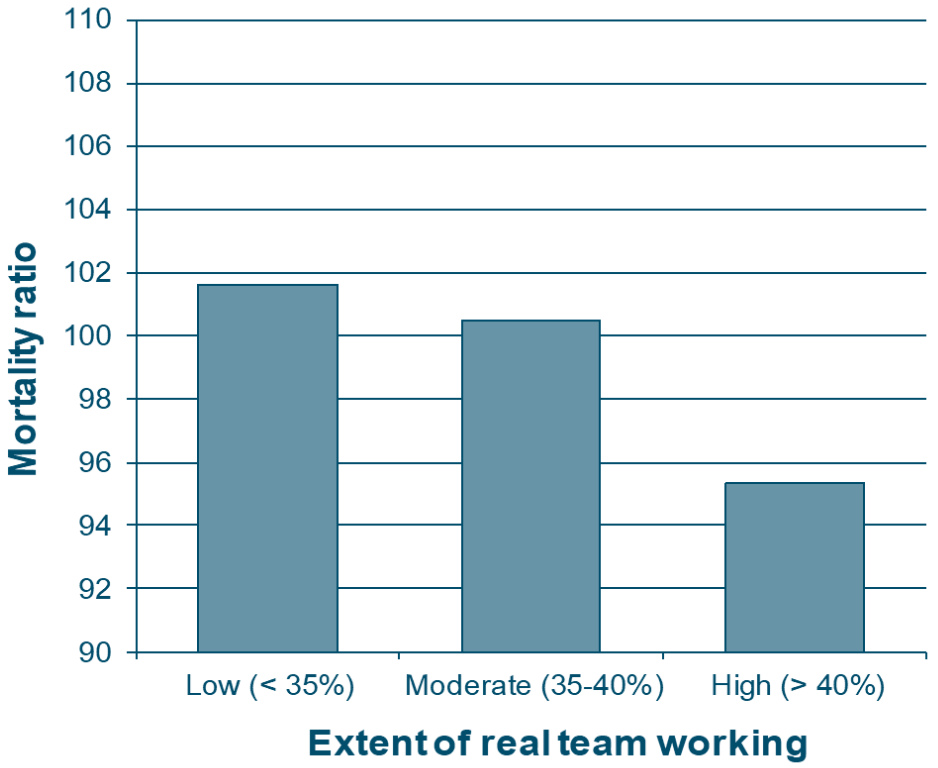
Error, stress and injury

(170 acute trusts; 120,000 respondents)



Patient mortality

- **5%** more staff working in real teams associated with 3.3% drop in mortality rate (p = .006)
- For an "average" acute hospital, this represents around **40** deaths per year
- 25% more real team working - **30,000** fewer deaths nationally



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Five dysfunctions of a team

Focus on collective outcomes

Confront difficult issues

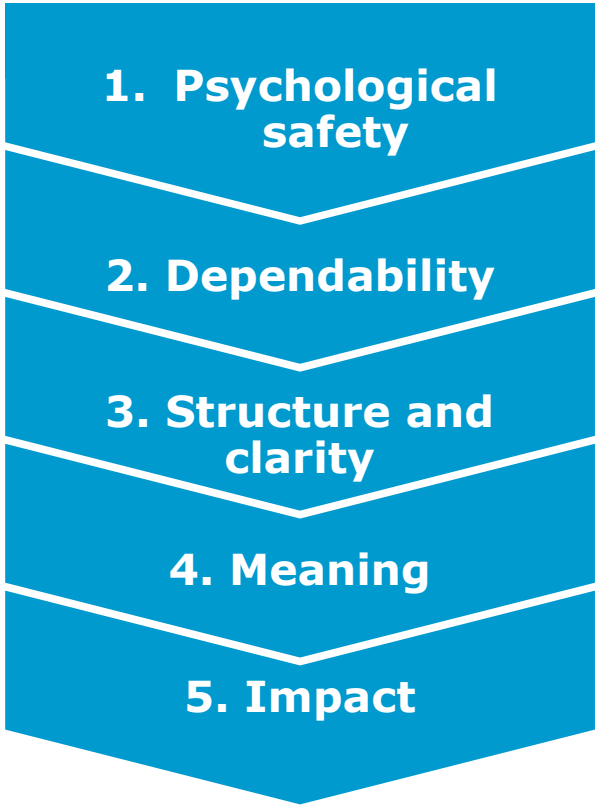
Force clarity and closure

Engage in unfiltered conflict around ideas

Go first!

Lencioni, 2001

Five keys to a successful team – Google



- Team members feel safe to take risks and be vulnerable with each other
- Team members get things done on time and meet Google's high bar for excellence
- Team members have clear roles, plans and goals
- Work is personally important to team members
- Team members think their work matters and creates change

Rozovsky, J. (2015). "The five keys to a successful team". https://rework.withgoogle.com/blog/five-keys-to-a-successful-google-team/

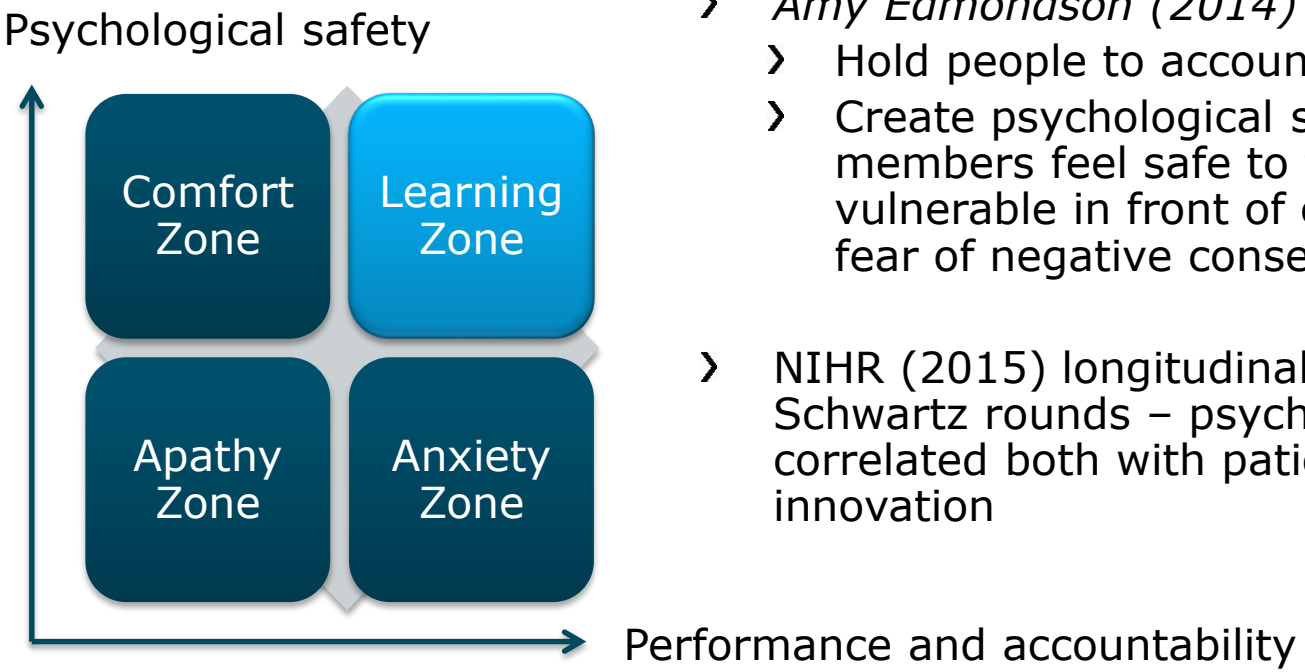
Psychological safety

"Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes"

Amy Edmondson, Novartis Professor, Leadership and Management, Harvard Business School (1999)

- Safety to take risks and be vulnerable in front of each other without fear of negative consequences
- Differences welcomed and valued Team
- High quality interpersonal relationships - support and trust

Building a psychologically safe workplace



- *Amy Edmondson (2014)*
  - Hold people to account AND
  - Create psychological safety - team members feel safe to take risks and be vulnerable in front of each other without fear of negative consequences
- NIHR (2015) longitudinal evaluation of Schwartz rounds – psychological safety correlated both with patient safety and innovation

Build a psychologically safe workplace

- **Create** and protect time out time for reflective conversations
- **Make explicit** that we need everybody's brains and voices in the game. Encourage diverse perspectives
- **Acknowledge** your own fallibility. Encourage peers and subordinates to speak up, e.g., "I may miss something — I need to hear from you"
- **Model** curiosity by asking a lot of questions. Be curious about other people's perceptions, experiences and ideas

Amy Edmondson (TED, 2014)

See also Laura Delizonna, *HBR,* "High Performing Teams Need Psycholoigical Safety. Here's How to Create It"

Summary - what leaders can do

- Make sure teams have characteristics of real teams (interdependence, shared objectives, autonomy, specified roles, boundedness etc.)
- Encourage inter-professional openness
- Encourage regular contact (to build trust)
- Provide appropriate team coaching
- Allow teams to take time out to engage in reflectivity

West and Lyubovnikova (2012)

- Establish direction and performance expectations
- Select team members based on skill and skill potential
- Set clear rules of behaviour
- Set challenging goals
- Meet regularly to review facts and information
- Spend lots of time together
- Exploit the power of positive feedback, recognition and reward

Katzenbach and Smith (1993)

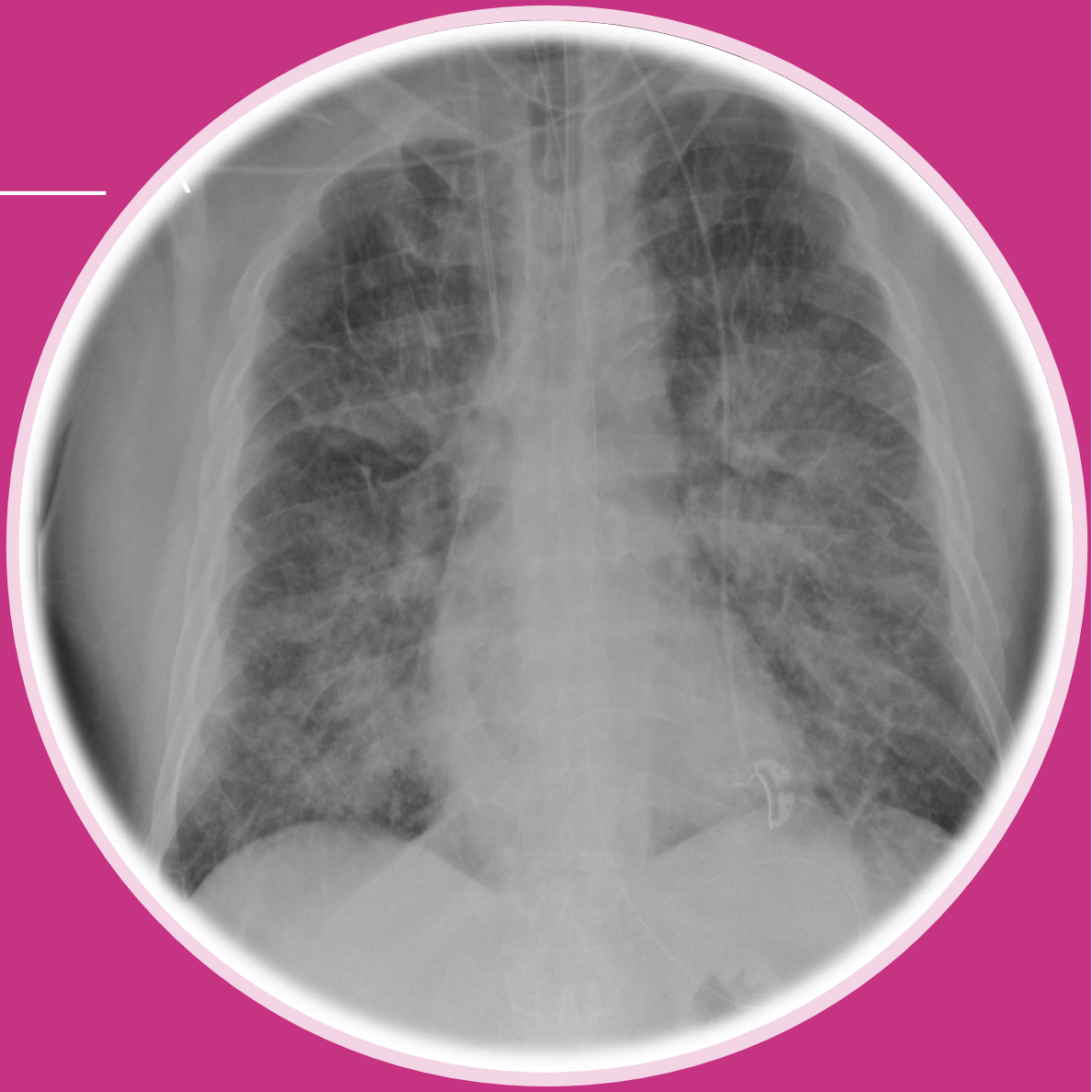
Working group updates

Dr Sue Piper and
Dr Jessica Webb

KHP HF Workstreams and examples of integration

- Acute Heart Failure
- Outpatient and New Referrals
- HFpEF
- Virtual Clinics
- Palliative Care
- Research

Acute Heart Failure



Streamlining Admissions in Acute Heart Failure

- Collaboration between A&E, acute medicine, @Home and HF Cardiology across KCH and GSTT
- An agreed & evidence-based pathway for the investigation & management of AHF
- Clear referral / discharge criteria and pathways
- Ensures timely & appropriate investigations
- Incorporates frailty, @Home and discharge criteria, to ensure patients are managed in the correct environment
- Guidelines for special groups, including pregnancy

Streamlining Admissions in Acute Heart Failure

- Same day NT-proBNP
- Teaching sessions planned for acute medicine and A&E staff
- Posters with headline treatment to be produced for acute admissions unit at GSTT and KCH
- Relationships developed and communication improved across emergency medicine and cardiology on both sites

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KHP Acute Heart Failure Pathway: Diagnosis

Diagnose and treat life-threatening cardiac emergencies

Acute coronary syndrome, hypertensive crisis, acute arrhythmia, tamponade, pulmonary embolus

Initial assessment of suspected AHF[1] should include ECG, CXR and NT-proBNP[2]

[1] Click here for symptoms/signs of AHF

[2] NT-proBNP should be an add-on test only; <300 pg/ml rules out AHF; click here for differential diagnosis

Is this the first presentation of AHF?

N

Y

Echo done in last 12 months & available to view?

N

Request echocardiogram (should be done <48 hrs)

Y

Triage to appropriate clinical area

For PRUH guidelines click here

Is there a life-threatening emergency?

Y → **Refer to cardiology SpR ± ICU**

N

Is the NT-proBNP >2000 pg/ml?

Y → **Refer to cardiology SpR**

Cardiology SpR will refer to HFU if appropriate. If not primarily HF, SpR will admit under general cardiology or refer to medics

N

Is the patient dry & well perfused

Y → **Ambulatory pathway for early ED discharge**

Details available here (inc. HFU/@home referral/new vs. decompensated)

N

Is HF the primary reason for admission?

LVEF <40% (measured using 2D echo)
Significant mitral or aortic valve disease
Significant LVH
Under cardiology follow-up

Y → **Refer to medical SpR & HFU referral for review on specialty ward**

N

Refer to appropriate specialty & online HFU referral for review on specialty ward

Including renal failure, respiratory cause of HF symptoms, new stroke, frailty ± multiple comorbidities*

- Refer to HFU via EPR
- Patients who are taken over by the HFU will be reviewed daily until they are transferred
- Click here for advice on special groups (pregnancy, ICC etc)

***Consider frailty pathway when...**

Details available here

All patients*

Detailed history and examination, FBC, U&E, LFT, glucose, HbA1c, lipid profile, HIV, ferritin & TSATs, ECG, TTE**

**Tests available as part of HFU order set*

****Please request TTE at point of first medical contact unless done in last 12 months & available for review**

Investigate underlying aetiology (new presentations) and/or causes of decompensation (known diagnoses)

Click here for possible causes and suggested investigations

King's College London

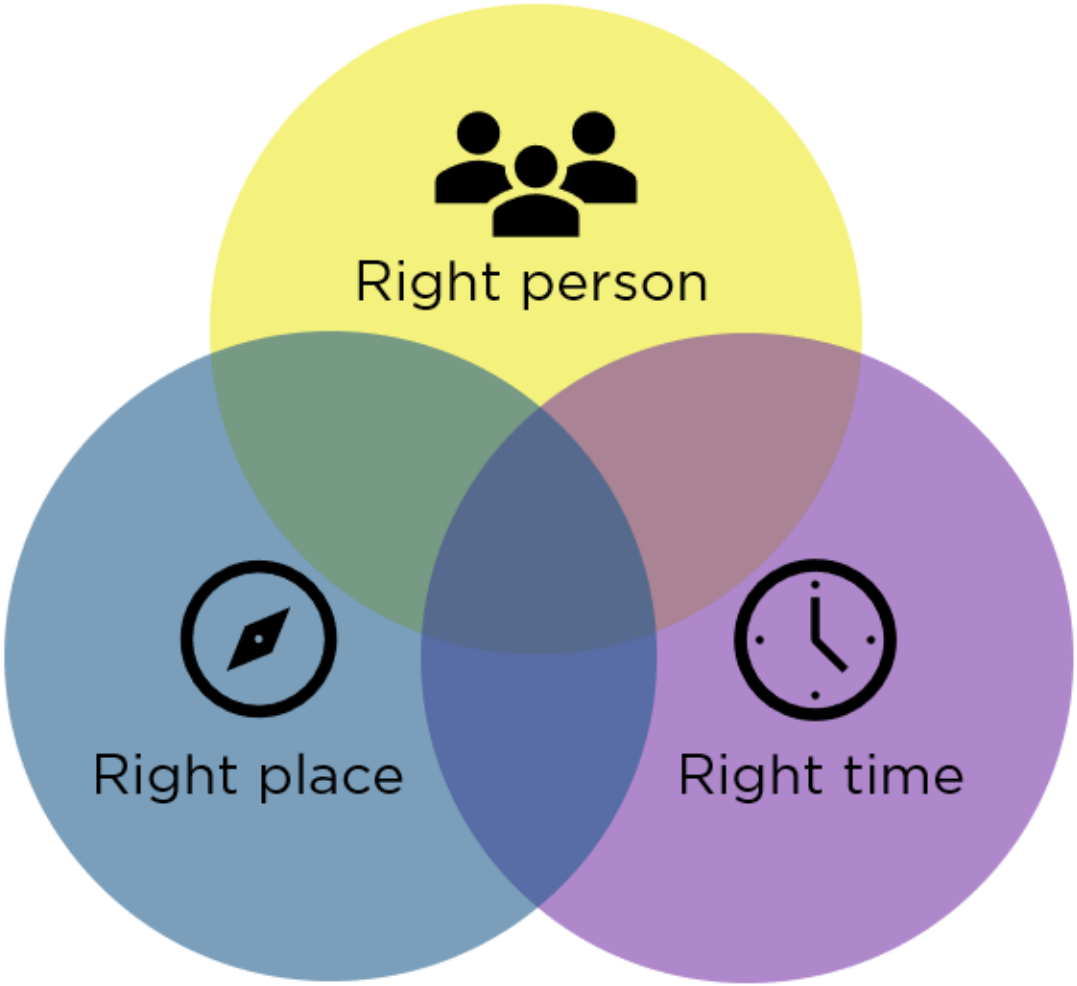
Guy's and St Thomas' NHS

King's College Hospital NHS

South London and Maudsley NHS

Outpatient and New Referrals

Improving Referrals - Consultant Triage



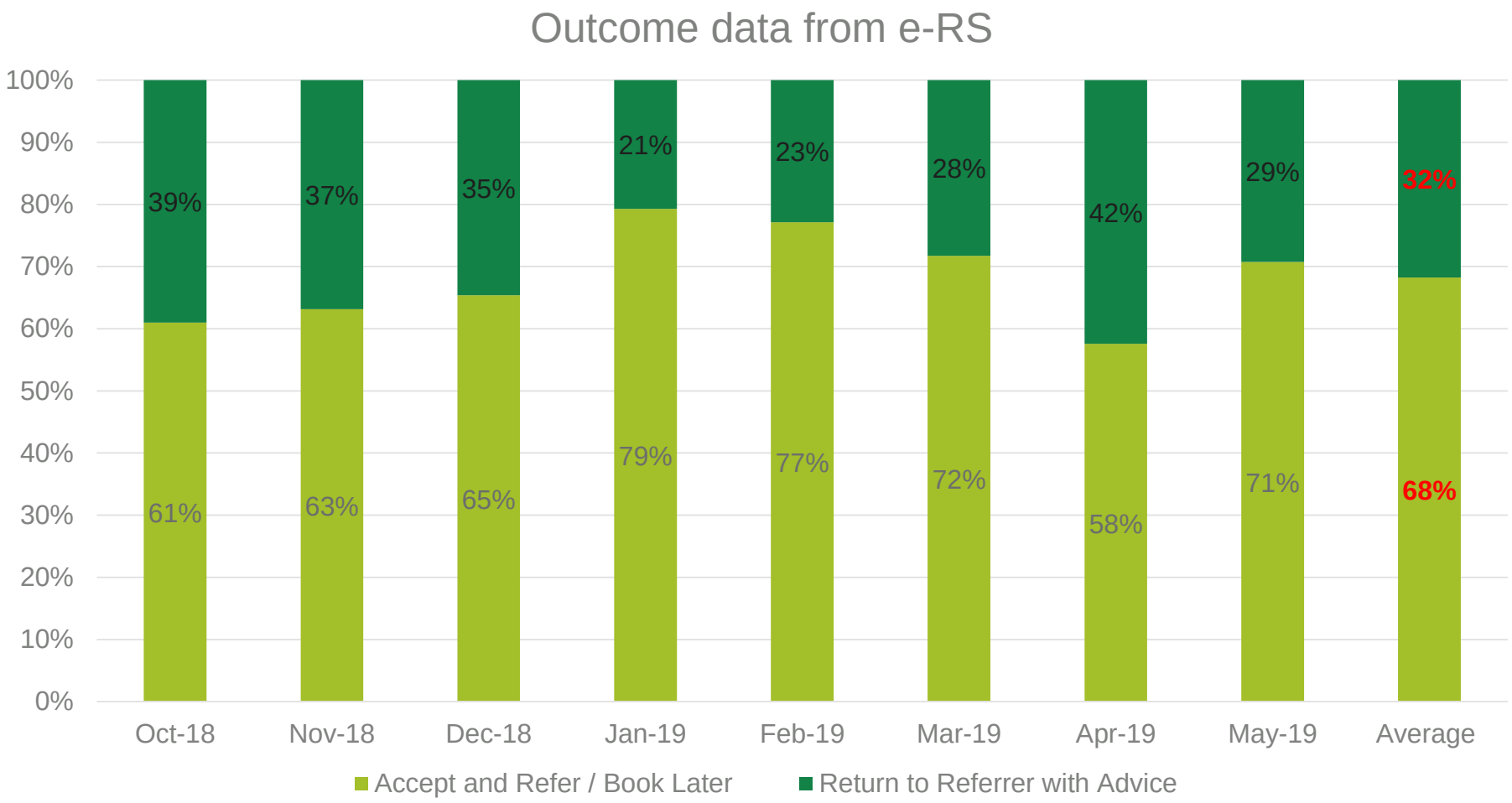
Heart Failure Triage for New Patients

- 100% triage of GP referrals across both sites
- Reduction in inappropriate referrals
- Average time from referral to triage reduced from 7 days to 1 day
- All new patients have an echo before their clinic appointment
- Urgent (2 week) referrals contacted by telephone at KCH
- 'One stop' clinics
- Review of triage/booking processes across KHP for all cardiac clinics.

Direct Referral to Geriatric HF Clinic

- Criteria agreed
- Dedicated Geriatrician HF clinics on both sites
- Triage direct to Geriatrician HF Clinic
- Direct booking into Clinics with echo on same day
- Advice for those patients in care homes

Heart Failure Triage at KCH



HFpEF

Transforming the HFpEF service

HFpEF diagnostic and management pathway completed and SOP developed, including best practice guidance managing comorbidities

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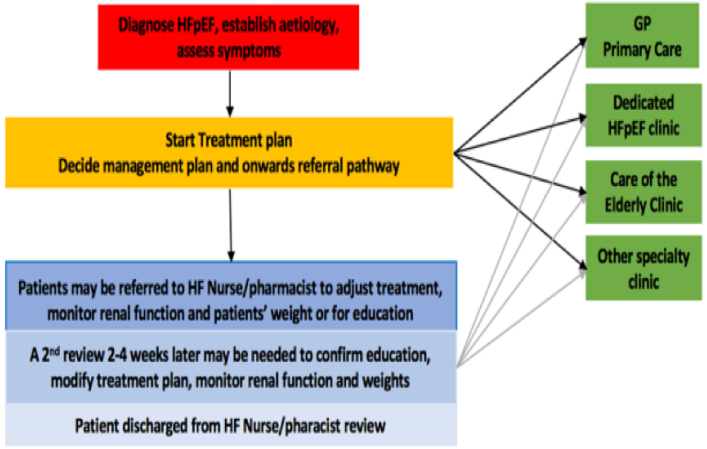
Who should be seeing patients diagnosed with HFpEF?

Patients with HFpEF need to be seen by a multidisciplinary team who can diagnose their condition, establish their symptoms and start treatment, assess if treatments are effective and decide on an onwards management plan. Some patients will be seen in a dedicated HFpEF clinic (for example, younger patients or with recurrent HF hospitalisations), more elderly patients in a Care of the Elderly clinic*, and some other patients in another speciality clinic with input from the HF team (for example those most symptomatic from other comorbidities). Patients who are stable will be referred back to primary care with a clear management plan, with details of what should happen if the patient were to deteriorate again, and contact details from their discharging team.

* COTE HF referral guidelines 2019

Patients with HFpEF may be referred to a specialist HF nurse or pharmacist to adjust treatment, monitor renal function and the patients' weight or for education, . A second review may be organised to consolidate knowledge and for review, before discharge.

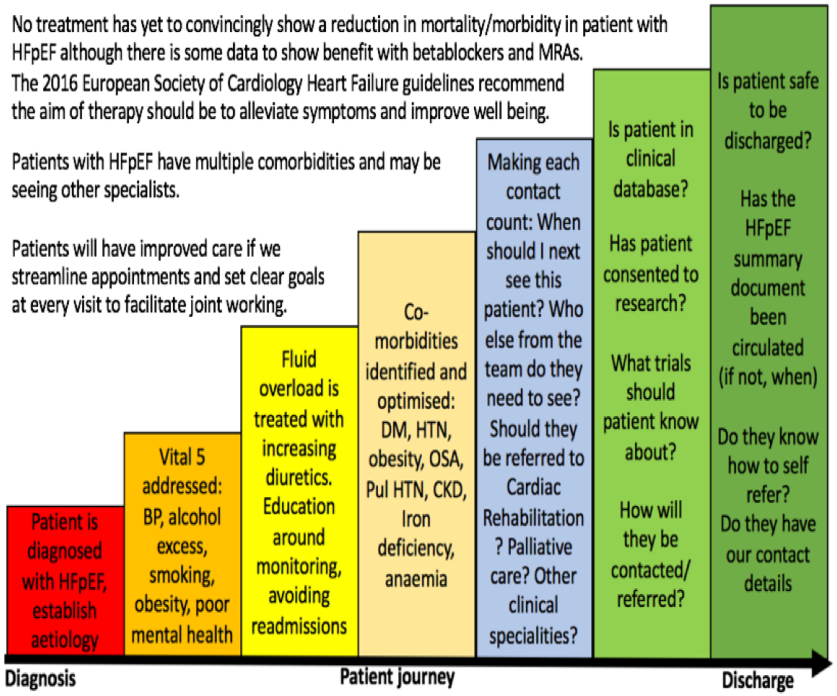


Management of patients with HFpEF

No treatment has yet to convincingly show a reduction in mortality/morbidity in patient with HFpEF although there is some data to show benefit with betablockers and MRAs. The 2016 European Society of Cardiology Heart Failure guidelines recommend the aim of therapy should be to alleviate symptoms and improve well being.

Patients with HFpEF have multiple comorbidities and may be seeing other specialists.

Patients will have improved care if we streamline appointments and set clear goals at every visit to facilitate joint working.



Virtual Clinics

Transforming communication between KHP and GPs: Virtual Clinics

- Multidisciplinary review of all patients on the GP practice HF register by KHP consultant, nurse, pharmacist and GP
- Forum to discuss patients already diagnosed, optimisation of treatment, "holistic" LTC management, onwards referral/signposting
- Promote the diagnostic pathway and facilitate accurate diagnosis for those with unconfirmed HF
- Closer working relationships with primary care : reduce admissions or unnecessary hospital appointments – locality team available for advice and queries
- Key points:
    - Not new, but has taken time to embed into routine practice
    - Standardisation of pathways across KHP was essential – one team, one message
    - Job planning
    - Ongoing analysis and review of the service is key to drive further changes and improvements

Palliative care

Strengthening Palliative Care in HF

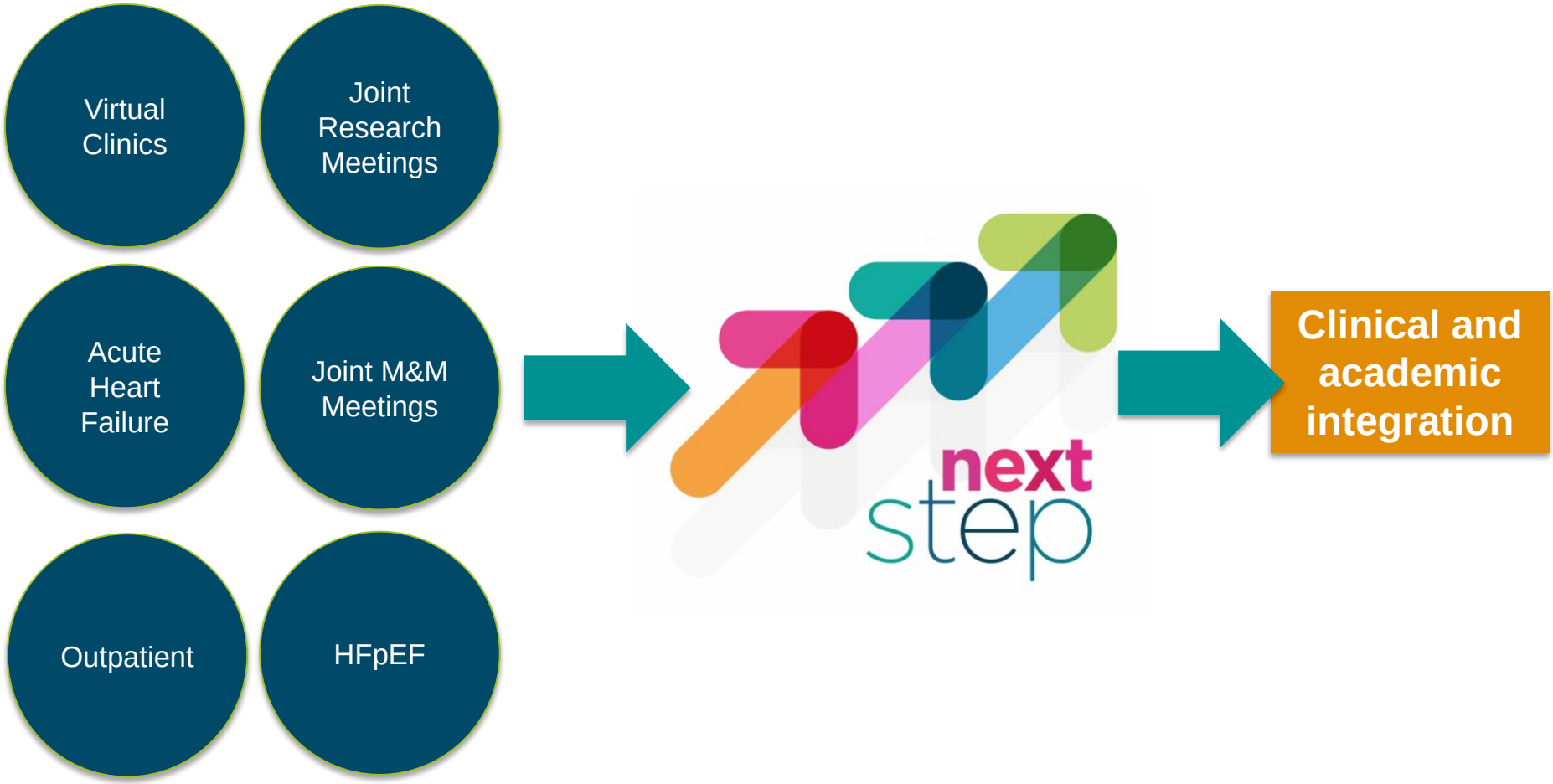
- ICD deactivation guidelines adopted at GSTT and KCH, shared between South London providers
- Presented at Grand Rounds, reciprocal teaching events, shared teaching events for SpRs, HFSN
- Work started on bereavement pathways for HF patients
- Reciprocal presence at MDTs between HF and palliative care

Future directions

New initiatives

- Cross site Mortality/Morbidity and MDT meetings
- Joint Clinical Research meetings, Joint Grant Applications

Further Integration of the KHP Heart Failure Teams



Possible Future Workstreams/pathways

- Advanced heart failure MDT with Papworth Hospital
- Cardio-renal pathways
- Palliative care

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