LEADERSHIP FOR IMPROVEMENT

7th Dec 2017

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Medical Director
Health Foundation / IHI Quality Improvement Fellow

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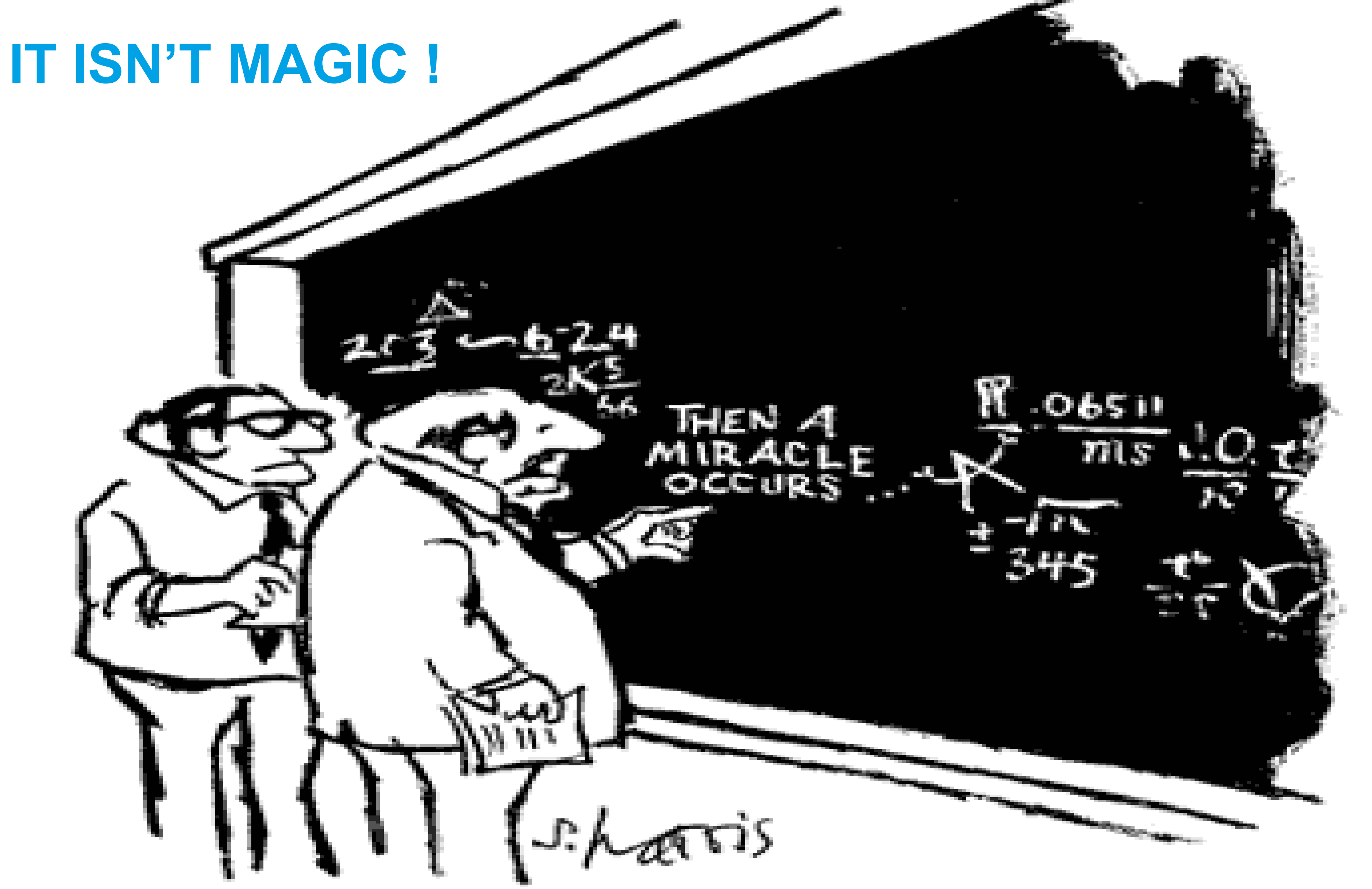
@brobson3

IT ISN'T MAGIC !

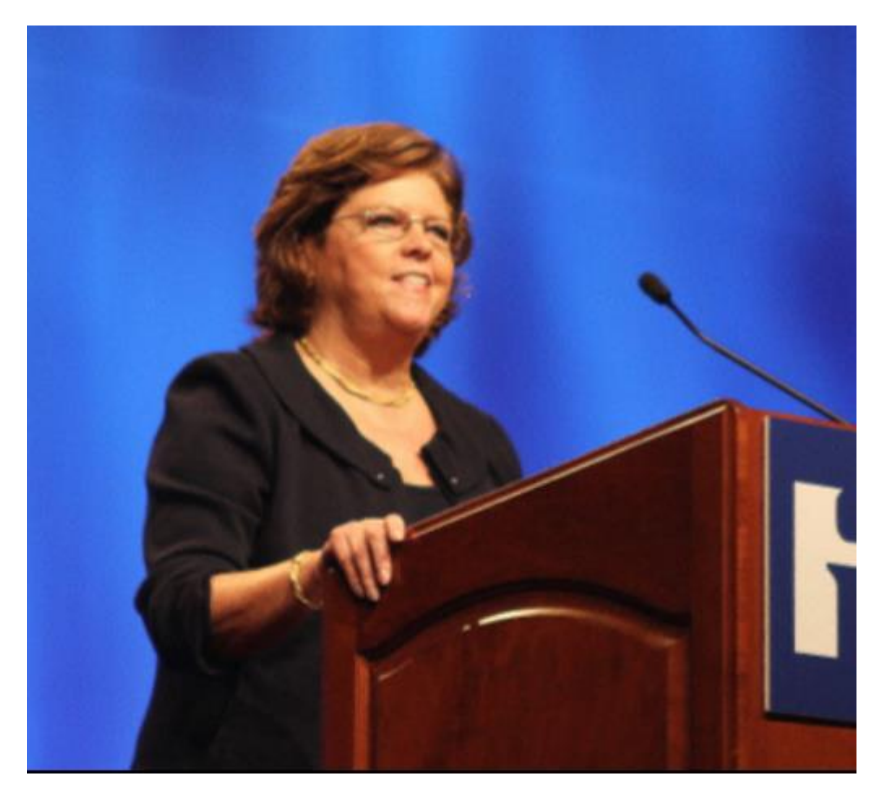


"I think you should be more explicit here in step two."

THERE WILL BE
NO MIRACLES
HERE

WE HAVE THE SAME PROBLEMS

*" Working together means that you should **never worry alone.**"*



Maureen Bisognano

#mhimprove

Mearns Medical Centre

welcome

Patient permission granted

< PREVIOUS NEXT >

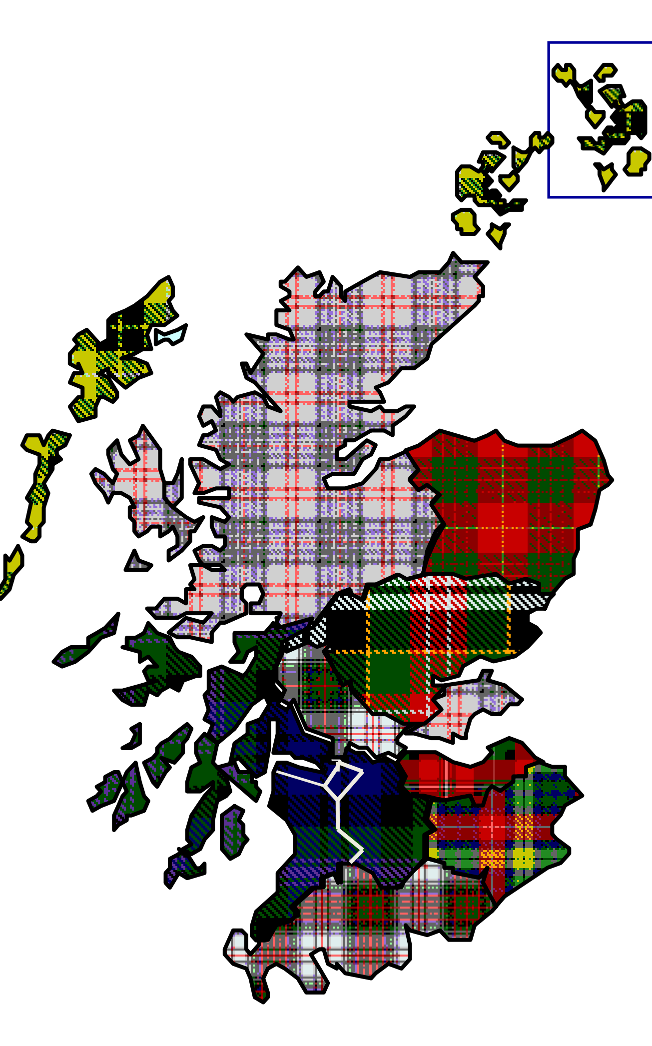
WHAT WE DO

Integrated cycle of Improvement

Scottish Medicines Consortium

Death Certification Review Service

regulation of independent healthcare



- **5.37 million population**
- **£13 billion H&SC budget**
- **14 territorial boards**
- **Special boards**
  - NHS Education for Scotland
  - NHS National Services Scotland
  - Scottish Ambulance Service
  - Golden Jubilee Foundation
  - NHS Health Scotland
  - State Hospital
  - NHS 24
- **Moving to integrated health & social care**
- **Public Body** – Healthcare Improvement Scotland

THERE IS NO MORE MONEY

RESOURCE MANAGEMENT

restraint

precision

creativity

panic

#mhimprove

So what is the plan this morning ?

Engage Across Boundaries

Create Vision and Build Will

Driven by Persons & Community

Develop Capability

Deliver Results

Shape Culture

Engage Across Boundaries

Swensen S, Pugh M, McMullan C, Kabcenell A. High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013. (Available at ihi.org)

http://www.ihi.org/resources/pages/ihiwhitepapers/highimpactleadership

“A clear theory is crucial....

however, theories are like toothbrushes ... everyone has one but doesn't want someone else's!"

	What is happening where you are?	What can you do to strengthen this?
1. Create Vision & Build Will		
2. Develop Capability		
3.Deliver Results		

4.Engage Across Boundaries		
5.Shape Culture		
6. Driven by Persons & Community		

	What is happening where you are?	What can you do to strengthen this?
1. Create Vision & Build Will		
2. Develop Capability		
3.Deliver Results		

Talk and scribble

4.Engage Across Boundaries		
5.Shape Culture		
6. Driven by Persons & Community		

Some general bits first …

NOT JUST IN ENGLAND …

- Complex landscape
- ‘blunt end’ and ‘sharp end’
- aspiration for quality
- bright spots

But ….

- Lack of goal setting
- Externally focussed compliance
- “forgotten patients”
- “Structural and cultural threats to quality”
- “Poor IT systems… support …management”

Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study

Mary Dixon-Woods,[1] Richard Baker,[1] Kathryn Charles,[2] Jeremy Dawson,[3] Gabi Jerzembek,[4] Graham Martin,[1] Imelda McCarthy,[4] Lorna McKee,[5] Joel Minion,[1] Piotr Ozieranski,[6] Janet Willars,[1] Patricia Wilkie,[7] Michael West[8]

[1]Department of Health Sciences, University of Leicester, Leicester, UK
[2]Imperial College Centre for Patient Safety and Service Quality (CPSSQ), London, UK
[3]Institute of Work Psychology and School of Health and Related Research, University of Sheffield, Sheffield, UK
[4]Aston Business School, Aston University, Birmingham, UK
[5]Health Services Research Unit, University of Aberdeen, Aberdeen, UK
[6]Department of Social and Policy Sciences, University of Bath, Bath, UK
[7]National Association for Patient Participation, Surrey, UK
[8]Lancaster University Management School, Lancaster, UK

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Received 3 March 2013
Revised 16 July 2013
Accepted 17 July 2013

To cite: Dixon-Woods M, Baker R, Charles K, et al. BMJ Qual Saf Published Online First: [please include Day Month Year] doi:10.1136/bmjqs-2013-001947

ABSTRACT

Background Problems of quality and safety persist in health systems worldwide. We conducted a large research programme to examine culture and behaviour in the English National Health Service (NHS).

Methods Mixed-methods study involving collection and triangulation of data from multiple sources, including interviews, surveys, ethnographic case studies, board minutes and publicly available datasets. We narratively synthesised data across the studies to produce a holistic picture and in this paper present a high-level summary.

Results We found an almost universal desire to provide the best quality of care. We identified many ‘bright spots’ of excellent caring and practice and high-quality innovation across the NHS, but also considerable inconsistency. Consistent achievement of high-quality care was challenged by unclear goals, overlapping priorities that distracted attention, and compliance-oriented bureaucratised management. The institutional and regulatory environment was populated by multiple external bodies serving different but overlapping functions. Some organisations found it difficult to obtain valid insights into the quality of the care they provided. Poor organisational and information systems sometimes left staff struggling to deliver care effectively and disempowered them from initiating improvement. Good staff support and management were also highly variable, though they were fundamental to culture and were directly related to patient experience, safety and quality of care.

Conclusions Our results highlight the importance of clear, challenging goals for high-quality care. Organisations need to put the patient at the centre of all they do, get smart intelligence, focus on improving organisational systems, and nurture caring cultures by ensuring that staff feel valued, respected, engaged and supported.

INTRODUCTION

A commitment to delivering high-quality, safe healthcare has been a policy goal of governments worldwide for more than a decade, but progress in delivering on these aspirations has been modest:[1] patients everywhere continue to suffer avoidable harm and substandard care.[2 3] England's National Health Service (NHS) has not been immune to these problems. Despite some encouraging evidence of improvement in quality and safety,[4 5] large and inexplicable variations in quality of care are evident across multiple domains and sectors of healthcare, from primary through to community and secondary care.[6 7] England has also seen a number of high-profile scandals involving egregious failings in the quality and safety of individual providers. These include the case of Mid Staffordshire NHS Foundation Trust,[8] the subject of a recently published public inquiry by Sir Robert Francis into how catastrophic failings in the quality and safety of care went undetected and uncorrected.[9]

Francis identified the causes of organisational degradation at Mid Staffordshire as systemic; he saw the underlying faults as institutional and cultural in character. He found significant weaknesses in NHS systems for oversight, accountability and

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Dixon-Woods M, et al. BMJ Qual Saf 2013;0:1–10. doi:10.1136/bmjqs-2013-001947

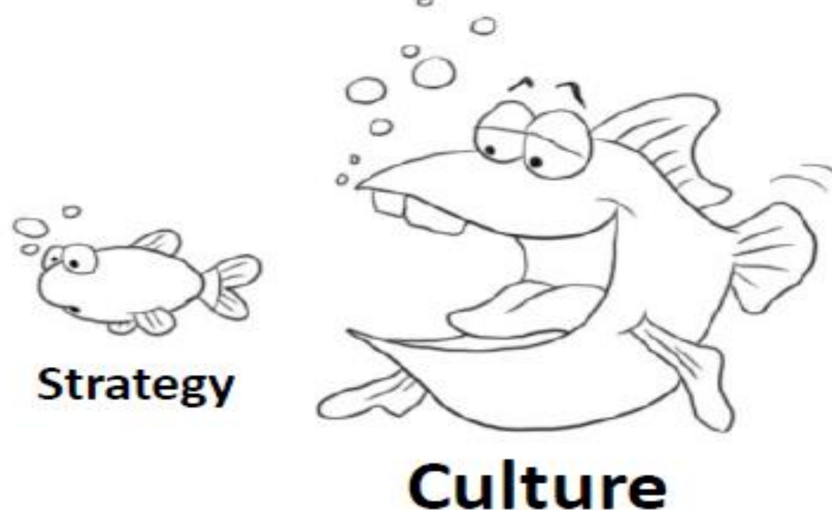
THE MDW ANSWERS ………

Box 1 Strategies for creating positive cultures

Senior leaders should:

- Continually reinforce an inspiring vision of the work of their organisations
- Promote staff health and wellbeing
- Listen to staff and encourage them to be involved in decision making, problem solving and innovation at all levels
- Provide staff with helpful feedback on how they are doing and celebrate good performance
- Take effective, supportive action to address system problems and other challenges when improvement is needed
- Develop and model excellent teamwork
- Make sure that staff feel safe, supported, respected and valued at work.[35]

SUPPORTING STRUCTURES ?



ALL TOOLS FOR IMPROVEMENT

Quality Planning

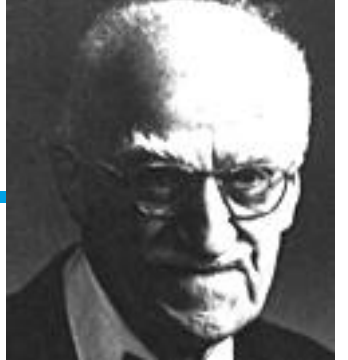
Provides a system that is capable of meeting quality standards

Quality Control

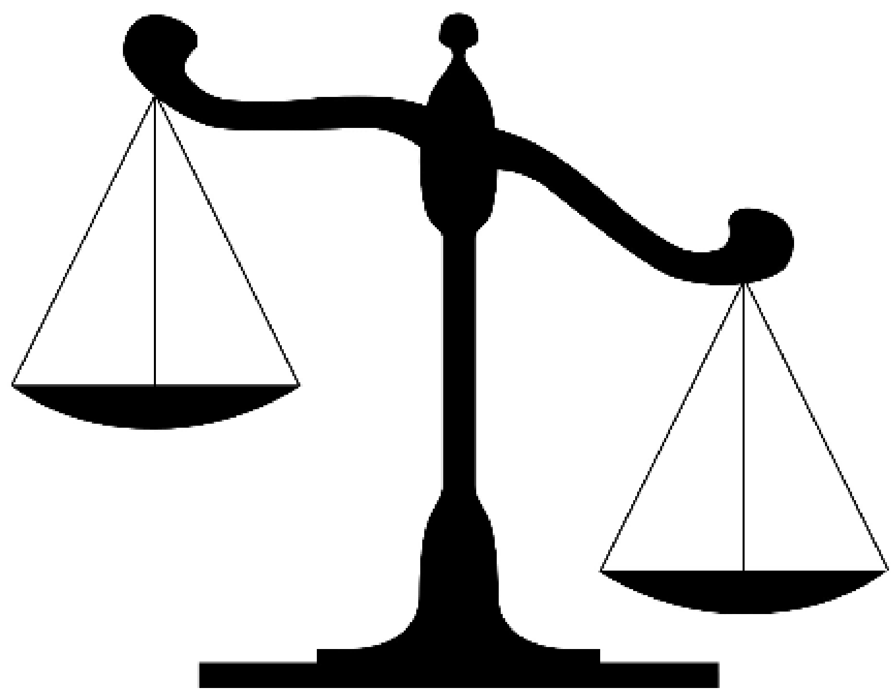
Used to determine when corrective action is required

Quality Improvement

Seeks better ways of doing things



INTERNAL OR EXTERNAL QUALITY CONTROLS?



http://www.ihi.org/resources/Pages/Presentations/TheMoralTestBerwickForum2011Keynote.aspx

Thoughts, comments on the general bits?

'This is not the end.

It is not even the beginning of the end, but it is, perhaps, the end of the beginning.'

Sir Winston Churchill

NUFFIELD TRUST

1. Continuity and consistency
2. Intrinsic ethical and professional motivations and personal connections
3. Widespread use of small scale testing and revision
4. National scrutiny and improvement support in same organisation
5. Building QI capacity

Dayan M & Edwards N. 2017. *Learning from Scotland's NHS: Research Report*. https://www.nuffieldtrust.org.uk/files/2017-07/learning-from-scotland-s-nhs-final.pdf

QUALITY IMPROVEMENT IS MESSY

MAN, I AINT SO SURE ABOUT THIS ... THAT LOOKS PRETTY MUDDY TO ME

Engage Across Boundaries

Create Vision and Build Will

Driven by Persons & Community

Develop Capability

Deliver Results

Shape Culture

Engage Across Boundaries

Swensen S, Pugh M, McMullan C, Kabcenell A. High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013. (Available at ihi.org)

http://www.ihi.org/resources/pages/ihiwhitepapers/highimpactleadership

1. Create Vision & Build Will

Engage Across Boundaries

Create Vision and Build Will

Persons & Community

Shape Culture

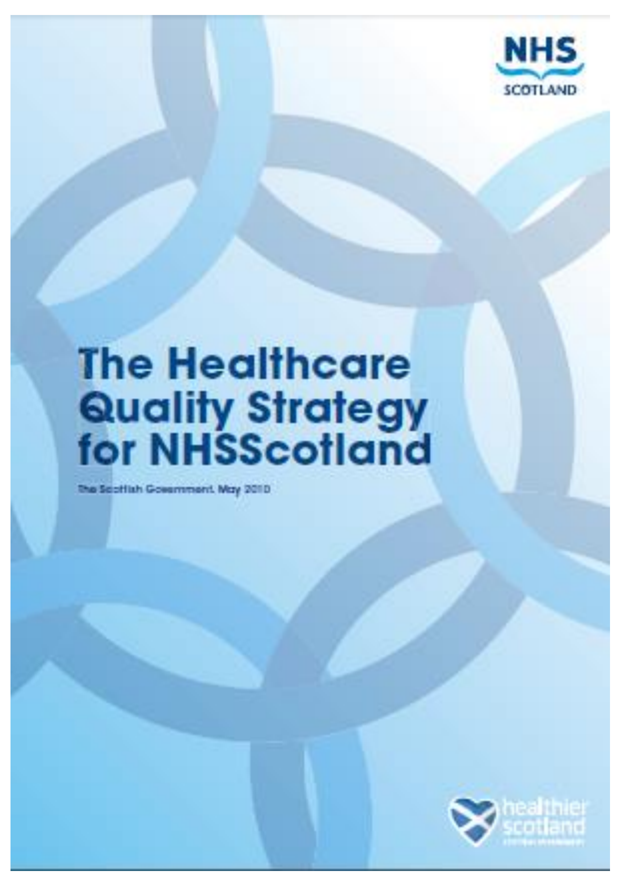
Engage Across Boundaries

*We have had 5 decades of clinical audit and 10 years of clinical governance. The future will focus on **patient safety and reducing harm**.*

Prof Sir Graham Teasdale

EVERY PERSON
EVERY TIME
SCOTTISH
PATIENT
SAFETY
PROGRAMME

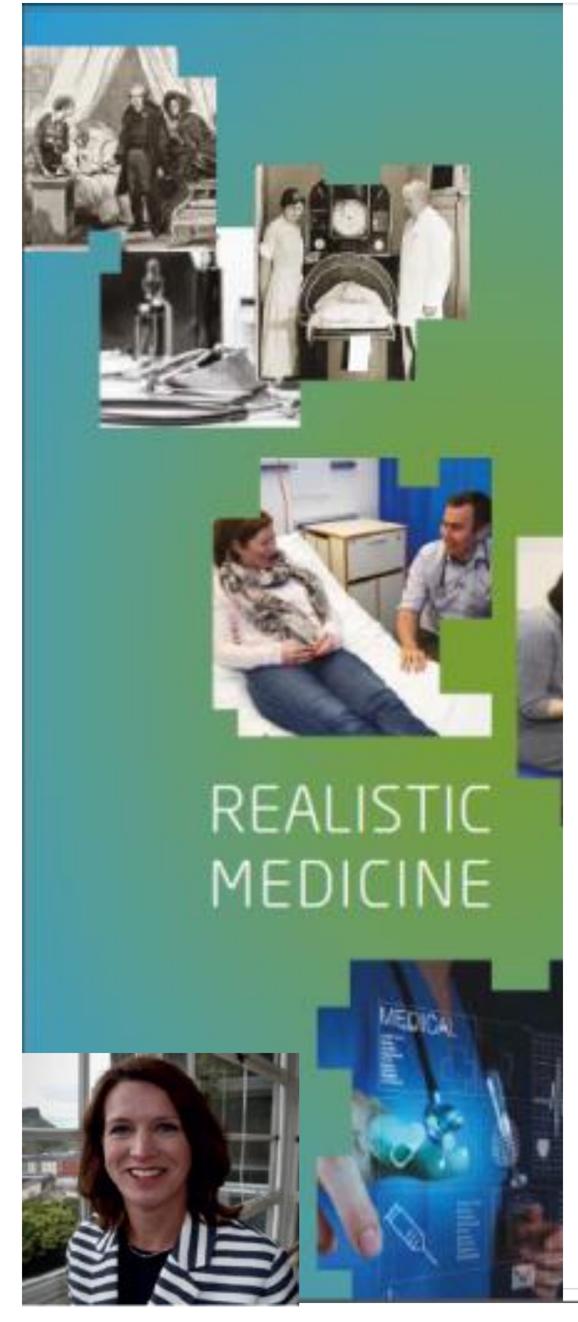
NATIONAL COMMITMENT TO QUALITY



3 Quality Ambitions

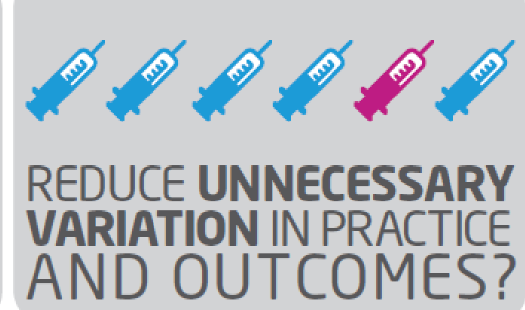
- Safe care
- Effective care
- Person-centred care

http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf Scottish Government, May 2010



REALISTIC MEDICINE

CAN WE:



http://www.gov.scot/Publications/2016/01/3745/downloads

Convening the co-producers

Celebrating success

Talk and scribble

	What is happening where you are?	What can you do to strengthen this?
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2. Develop Capability

Engage Across Boundaries

Create Vision and Build Will

Persons & Community

Shape Culture

Engage Across Boundaries

In times of change, learners inherit the Earth. . .

---

while the learned find themselves beautifully equipped to deal with a world that no longer exists.

Eric Hoffer

“...everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it.”

What is “quality improvement” and how can it transform healthcare?
Batalden,P; Davidoff.F Qual Saf Health Care. 2007 February; 16(1): 2–3

Subject Matter Knowledge: Specialist knowledge and skills required to be a good clinician

Improvement

Subject Matter Knowledge

Profound Knowledge

Profound Knowledge: The interaction of the theories of **systems**, **variation**, **epistemology** and **psychology**.

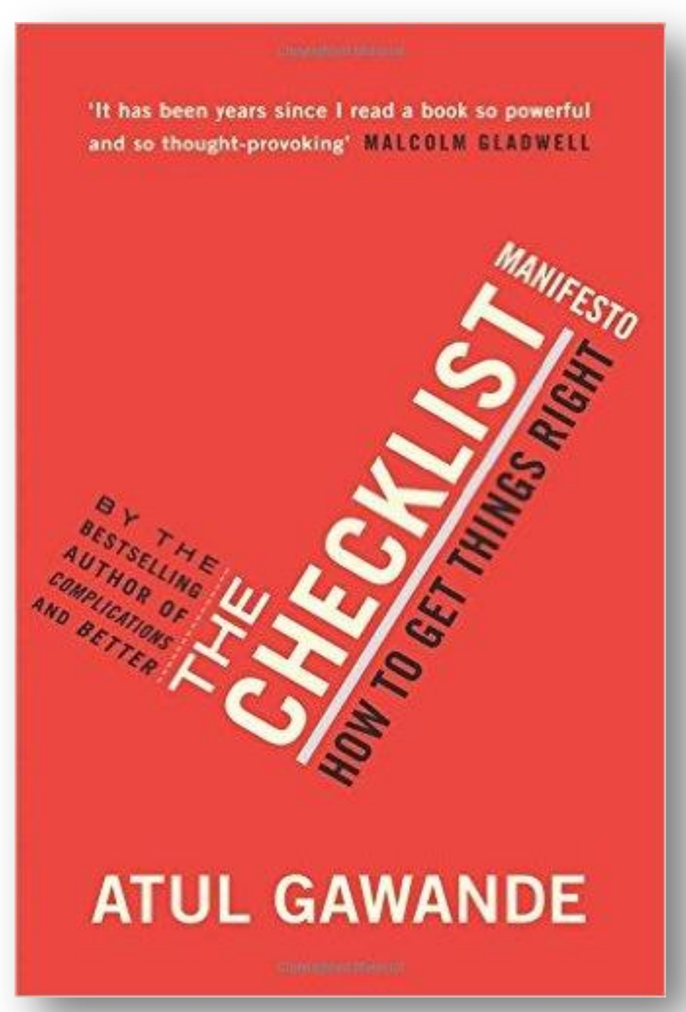
EARLY SUPPORT

NEW TOOLS ...

Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?
Act
Plan
Study
Do

Practice Safety Climate Compared

BEHIND THE TOOLS...



"... using a checklist requires [doctors] to embrace different values from ones we've had, like **humility, discipline, team.**"

https://www.amazon.co.uk/d/Books/Checklist-Manifesto-How-Things-Right-Atul-Gawande/1846683149

Advanced Knowledge ← Introductory Knowledge → Advanced Knowledge

Improvement Science	Leadership for Improvement

Scottish Improvement Leader (ScIL)

Quality Improvement Fellowship

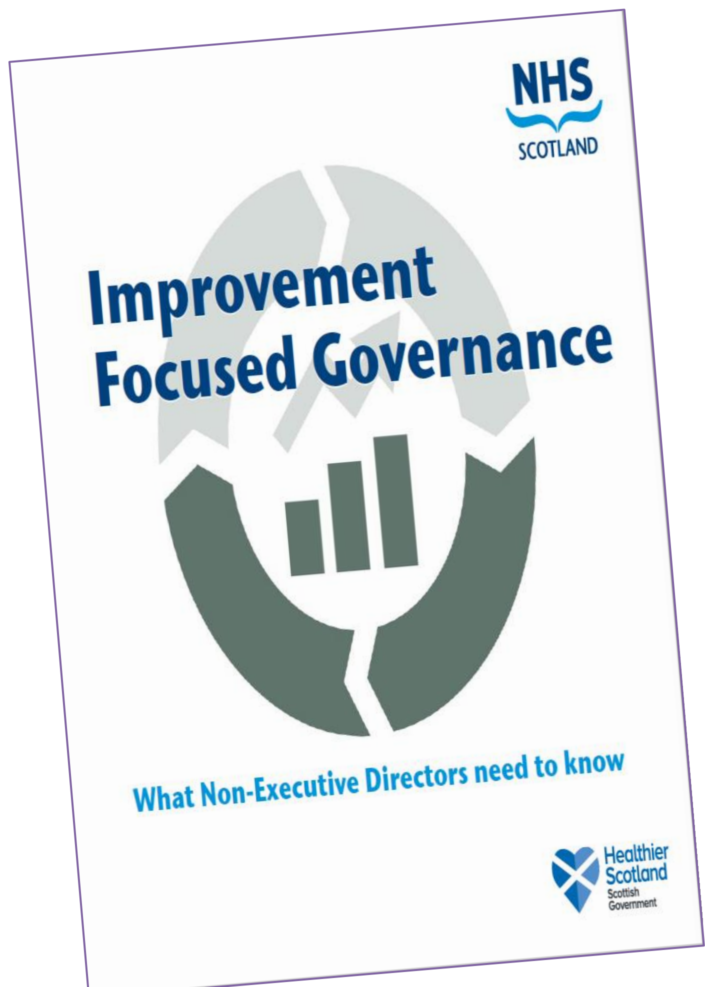
Impr Science in Action

Boards on Board

Improvement Collaboratives

laura.allison@nes.scot.nhs.uk

IMPROVEMENT LEARNING AT ALL LEVELS



http://www.gov.scot/Publications/2017/02/1090/downloads

http://www.gov.scot/Publications/2016/01/3484/downloads

QUALITY & SAFETY FELLOWS (COHORTS 1-10)

222
Quality & Safety Fellows

141
Medics

70
NMAHPs

10
Pharmacists

1
Dentist

143	34	14	13	15	1	1	1
Scotland	N Ireland	Ireland	Denmark	Norway	England	Wales	Canada

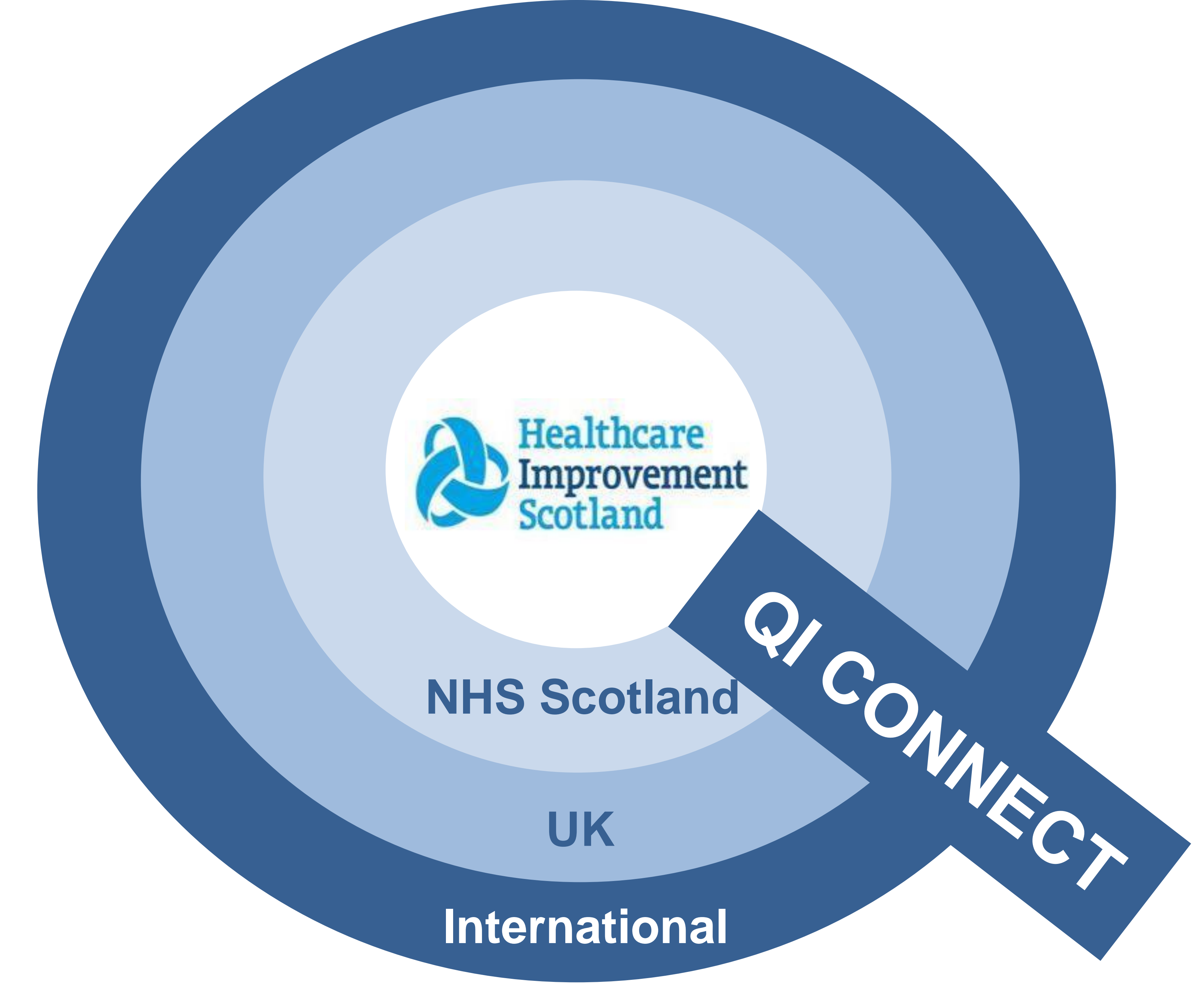
“I have realised that there is a greater world out there. I want to be a credible clinician improving care: **this is my professional future**”

SPSP Fellow, 2014

“I know the world is changing…

…. I want to change with it and improve care."

Scottish Q&S Fellow, 2017


Healthcare
Improvement
Scotland
NHS Scotland
UK
International
QI CONNECT

QI CONNECT 2017: INNOVATION & INTEGRATION

Chris Ham
The Kings Fund
26 January

Jaideep Prabhu
Cambridge Judge Business School
21 February

Emmanuel Gobillot
Global Author & Speaker
4 April

Stephen Swensen
Mayo Clinic
2 May

Don Norman
The Design Lab University of California
25 May

Anna Roth
Contra Costa Regional Medical Center
27 July

Bill Lucas
University of Winchester
28 September

Tom Marshburn
NASA
26 October

Sally Magnuson
Playlist for Life
21 November

QI CONNECT 2018: INNOVATION & INTEGRATION

Dr JD Polk
Chief Health &
Medical Officer
NASA
25 January

Dr Nirav Shah
Former Senior
Vice President &
Chief Officer for
Clinical Operations
Kaiser Permanente
22 February

Professor Al Mulley
Managing Director,
Global Health
Care Delivery Science
Professor of Medicine,
Geisel School of Medicine
The Dartmouth Institute
29 March

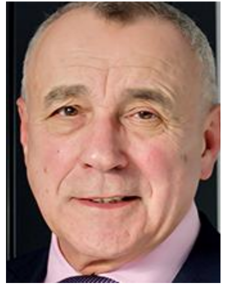
Atul Gawande
Surgeon, Writer &
Public Health Researcher
26 April

Toby Cosgrove
Former President &
Chief Executive
The Cleveland Clinic
31 May

Fiona Godlee
Editor in Chief
BMJ
Date TBC

Danielle Martin
Physician,
health care administrator
& an associate professor
University of Toronto
Date TBC

Brene Brown
Scholar, author, and
research professor
University of Houston
Graduate College of Social
Work
Date TBC



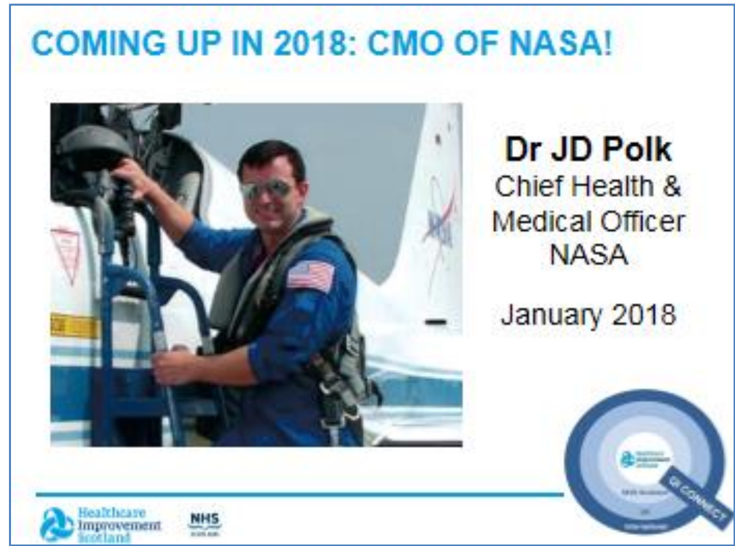
Roy Lilley
Health policy analyst,
writer, broadcaster and
commentator
Date TBC

ePatient Dave
Cancer survivor and
expert in the meaningful
use of
health IT
29 November

LEARNING WITH NASA !

Dr Tom Marshburn
Emergency Medicine Physician &
NASA Astronaut

26 October 2017

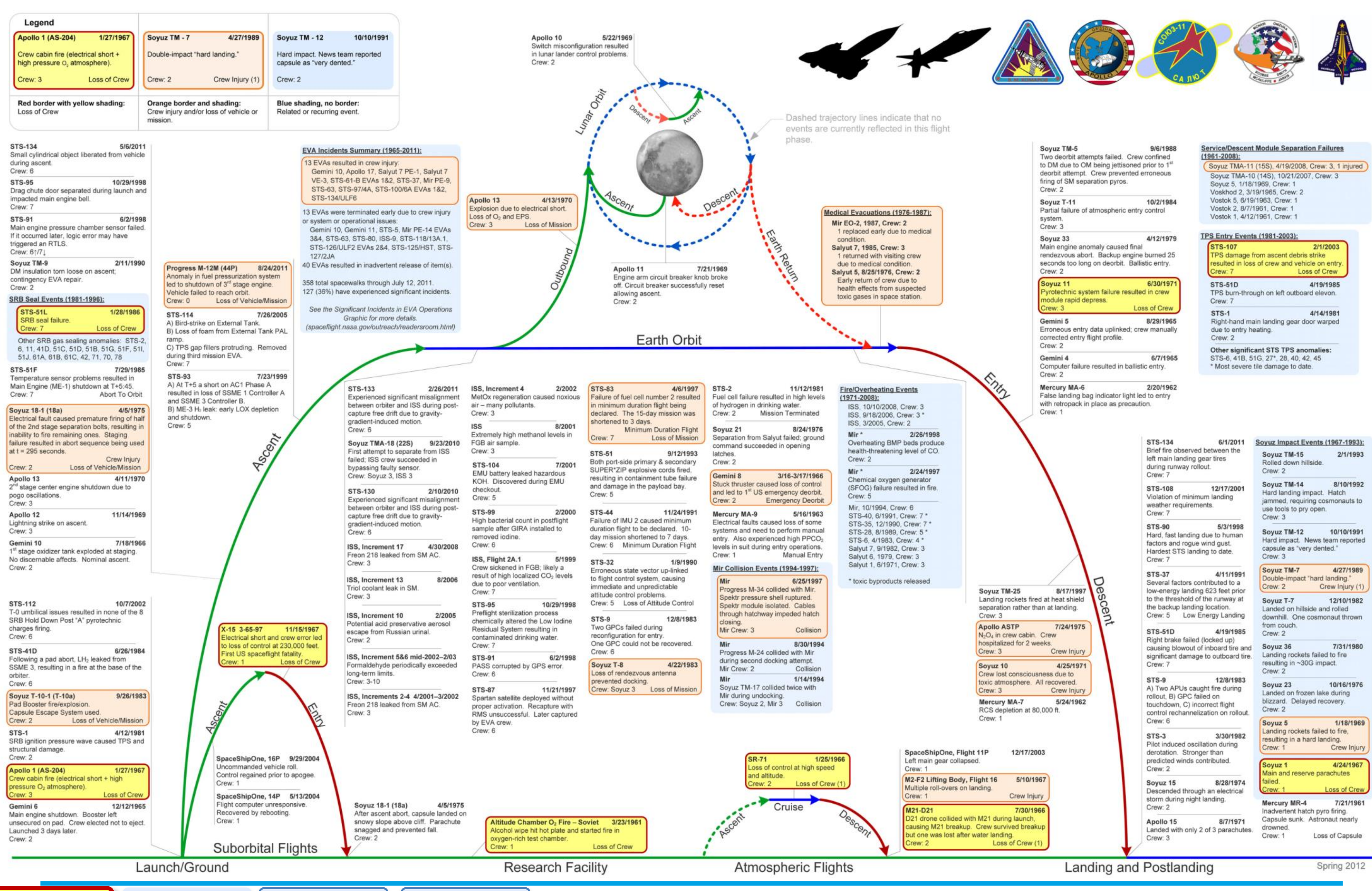


http://www.healthcareimprovementscotland.org/our_work/clinical_engagement/qi_connect.aspx

< PREVIOUS NEXT >

LEARNING ?

https://spaceflight.nasa.gov/outreach/Significant_Incidents.pdf



Loss of Crew
Related or Recurring Events
Human Error
Systems
Acronyms
Injury or Loss of Vehicle or Mission
Vehicles
Country
Story
Contact Us

*"It is intended to **spark an interest** in past events, **inspire** people to delve into the **lessons learned** and **encourage** continued vigilance."*

BUT.... ARE WE USING THEM?

It doesn't matter how many resources you have...

If you don't know how to use them, it will never be enough.

	What is happening where you are?	What can you do to strengthen this?
1. Create Vision & Build Will		
2. Develop Capability		
3.Deliver Results		

Talk and scribble

4.Engage Across Boundaries		
5.Shape Culture		
6. Driven by Persons & Community		

3.Deliver Results

Engage Across Boundaries

Create Vision and Build Will

Community

Develop Capability

Deliver Results

Shape Culture

Engage Across Boundaries

Our change theory

A clear and stretch goal

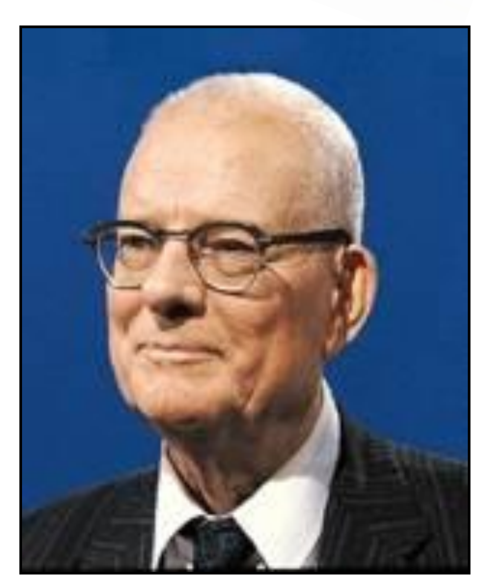
A method

Predictive, iterative testing

RELENTLESS MEASUREMENT

"In God we trust…
All others bring data."

W. Edwards Deming



DATA ON EVERY WARD .... IN PUBLIC !

BIG DOTS …

HSMR for deaths within 30-days of admission (with regression line);
Scotland, Jan-Mar 2011 to Apr-Jun 2017p

Standardised Mortality Ratio (SMR)
Regression

Standardised Mortality Ratio

1.4
1.2
1.0
0.8
0.6
0.4
0.2
0.0

Baseline Period

9.1 % reduction

Desired Direction of Travel

Mar 11 Jun 11 Sep 11 Dec 11 Mar 12 Jun 12 Sep 12 Dec 12 Mar 13 Jun 13 Sep 13 Dec 13 Mar 14 Jun 14 Sep 14 Dec 14 Mar 15 Jun 15 Sep 15 Dec 15 Mar 16 Jun 16 Sep 16 Dec 16 Mar 17 Jun 17

Quarter Ending

NHS FV ICU VAP incidence/% VAP Preventon bundle compliance
Sept 05 - Dec 12

VAP Rate / 1000 Ventilation days

40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0

% VAP Prevention bundle compliance

100
90
80
70
60
50
40
30
20
10
0

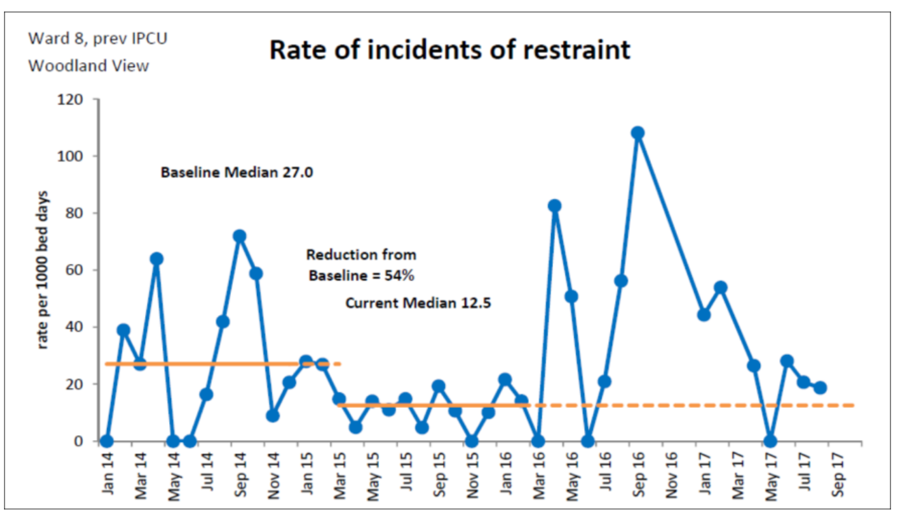
Sep-05 Dec-05 Mar-06 Jun-06 Sep-06 Dec-06 Mar-07 Jun-07 Sep-07 Dec-07 Mar-08 Jun-08 Sep-08 Dec-08 Mar-09 Jun-09 Sep-09 Dec-09 Mar-10 Jun-10 Sep-10 Dec-10 Mar-11 Jun-11 Sep-11 Dec-11 Mar-12 Jun-12 Sep-12 Dec-12

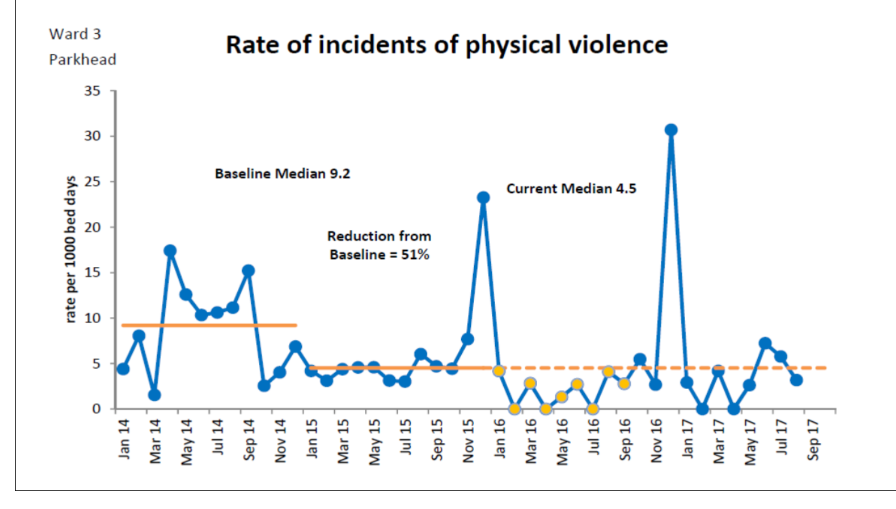
NHS Greater Glasgow & Clyde PICU VAP Rate per 1000 Ventilation Days Jan 2013 – Sep 2015

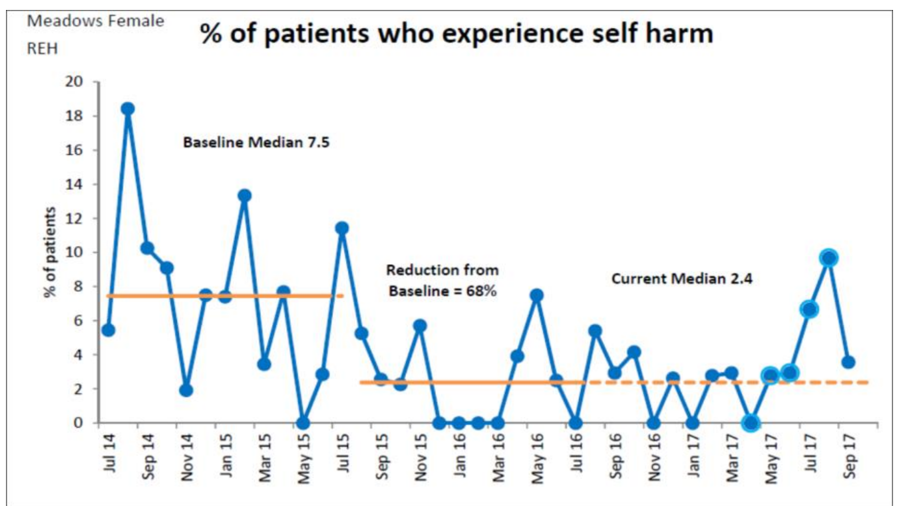
NHS Forth Valley Pressure Ulcer Count November 2010 – May 2015

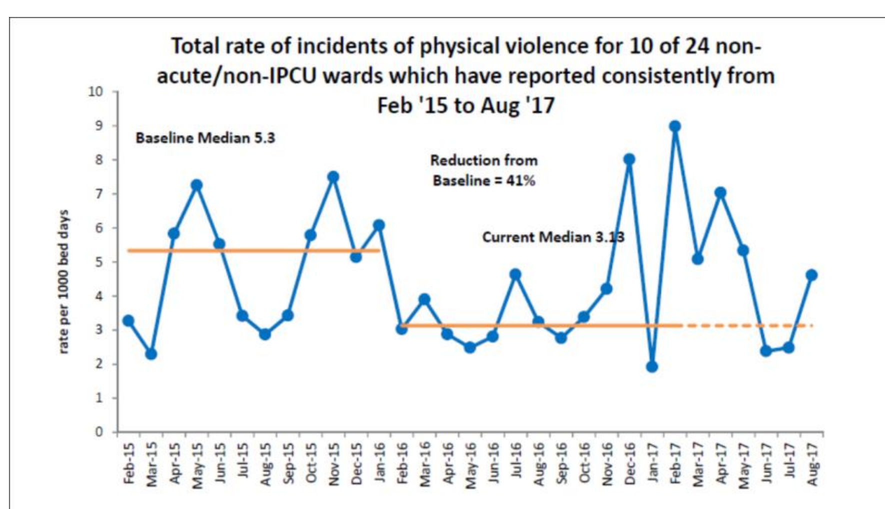
Total Falls Rate for 7 Scottish Boards January 2014 – June 2015

IN MENTAL HEALTH TOO…









IN NATIONAL DATA TOO …

% 30 day mortality of ICD-10 A40/ A41

Collaborative Launch

Mean 1: 24.8%

Mean 2: 19.5%

24.8% to 19.5% is a 21% reduction post collaborative launch

% mortality: 0%, 5%, 10%, 15%, 20%, 25%, 30%, 35%

Month: Jan 11, Mar 11, May 11, Jul 11, Sep 11, Nov 11, Jan 12, Mar 12, May 12, Jul 12, Sep 12, Nov 12, Jan 13, Mar 13, May 13, Jul 13, Sep 13, Nov 13, Jan 14, Mar 14, May 14, Jul 14, Sep 14, Nov 14, Jan 15, Mar 15, May 15, Jul 15, Sep 15, Nov 15

BEHIND THE DATA

Courtesy of Malcolm Daniel

SEPSIS ~~6~~ 60

Evaluation of the Scottish Patient Safety Programme sepsis VTE collaborative: Short Report

Carolyn Tarrant, Barbara O'Donnell, Graham Martin, Julian Bion

University of Leicester

CHARLES' 'BUBBLES' BROADENED OUR THINKING

Has patient care been safe in the past?

Are we responding and improving?

Are our clinical systems and processes reliable?

Past harm

Integration and learning

Reliability

Safety measurement and monitoring

Anticipation and preparedness

Sensitivity to operations

Will care be safe in the future?

Is care safe today?

http://www.health.org.uk/publication/measurement-and-monitoring-safety

From assurance to inquiry

Moving from being wise after the event to being wise before the event

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Tea break ?

4.Engage Across Boundaries

Engage Across Boundaries

Create Vision and Build Will

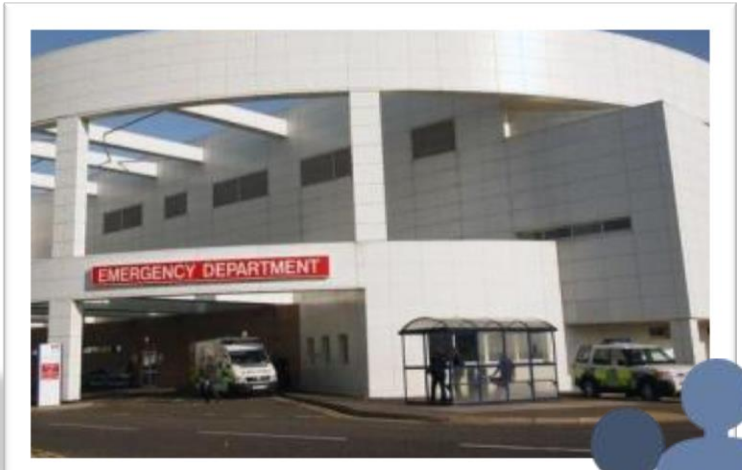
Persons & Community

Shape Culture

Engage Across Boundaries

EVERY PERSON
24
7
EVERY TIME
SCOTTISH
PATIENT
SAFETY
PROGRAMME
Acute
Adult
Maternity
and Children
Mental
Health
Primary
Care

Strategic Direction of Change



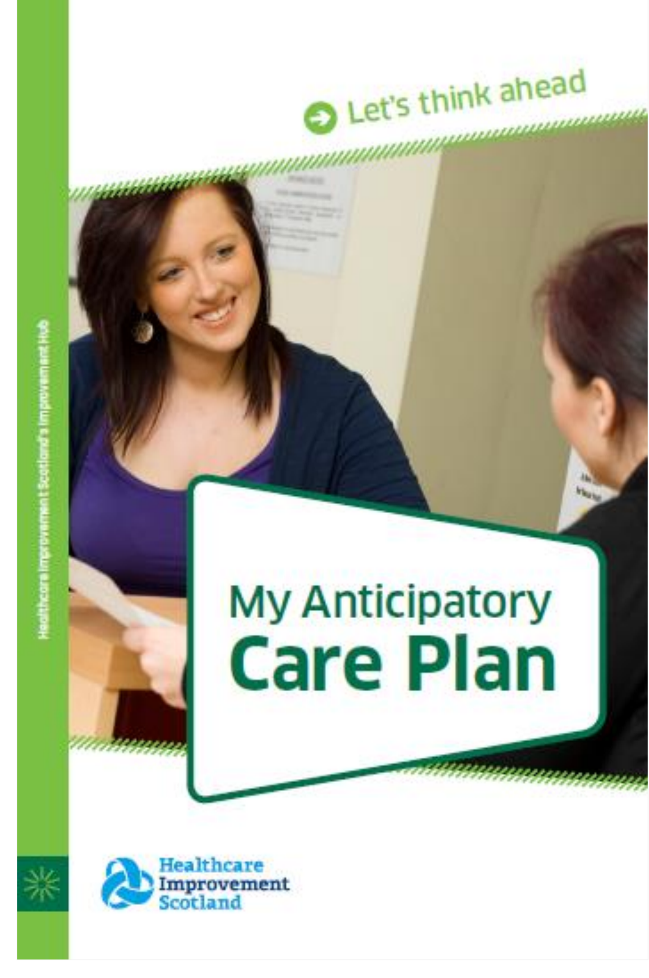
Improving
Population Health

Health and social care

Our improvement programmes have a new home – the ihub.

http://ihub.scot

Developing a national ACP



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5.Shape Culture

Engage Across Boundaries

Create Vision and Build Will

Driven by

Capability

Results

Shape Culture

Engage Across Boundaries

SMART ISN’T ENOUGH

ELAINE'S STORY

TEAM BRIEFINGS ...

NHS Lothian

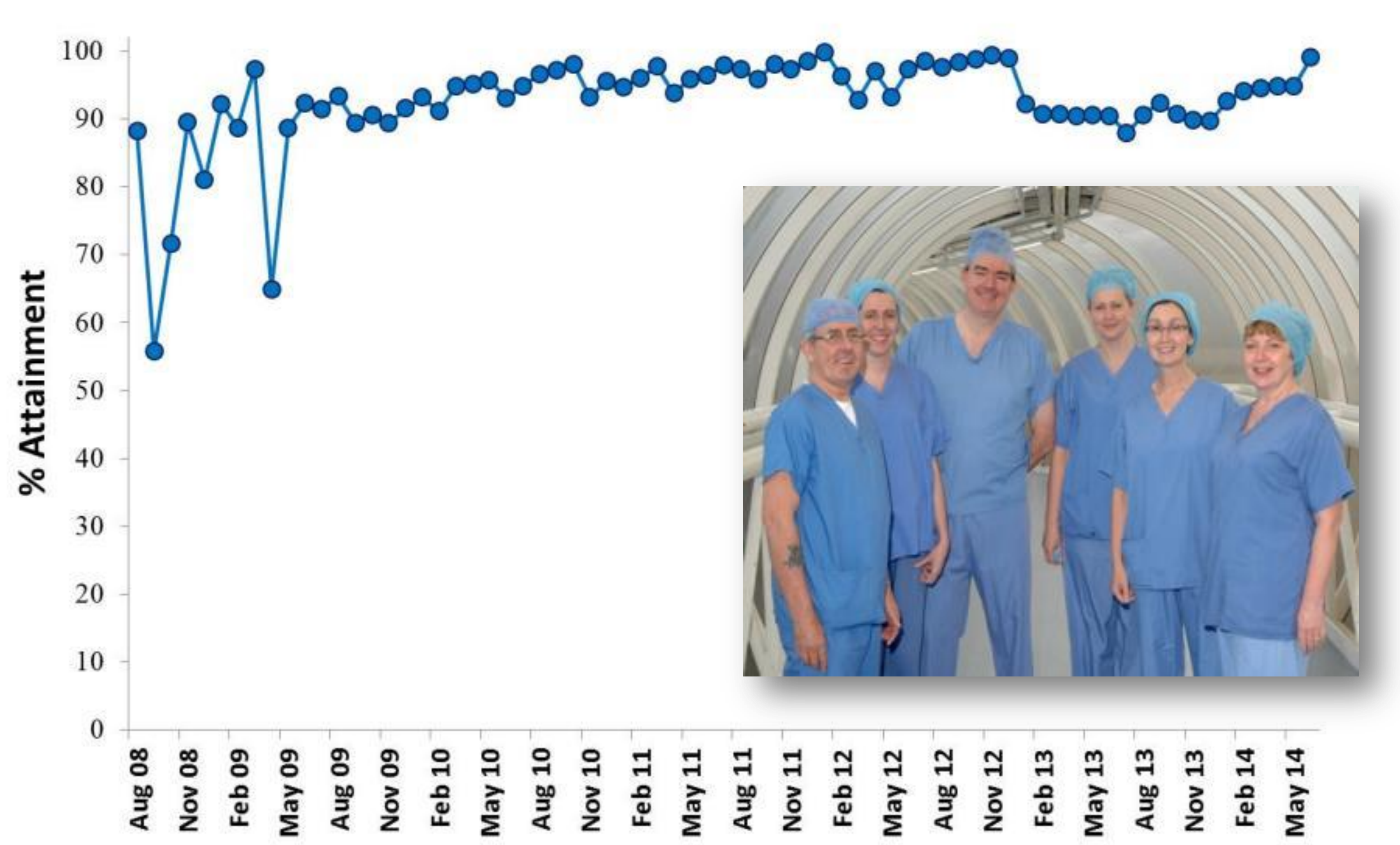
CHANGING THE CULTURE...

“I now consider the safety brief to be every bit as important to the safety of our patients as what I do as a surgeon during the operation...”

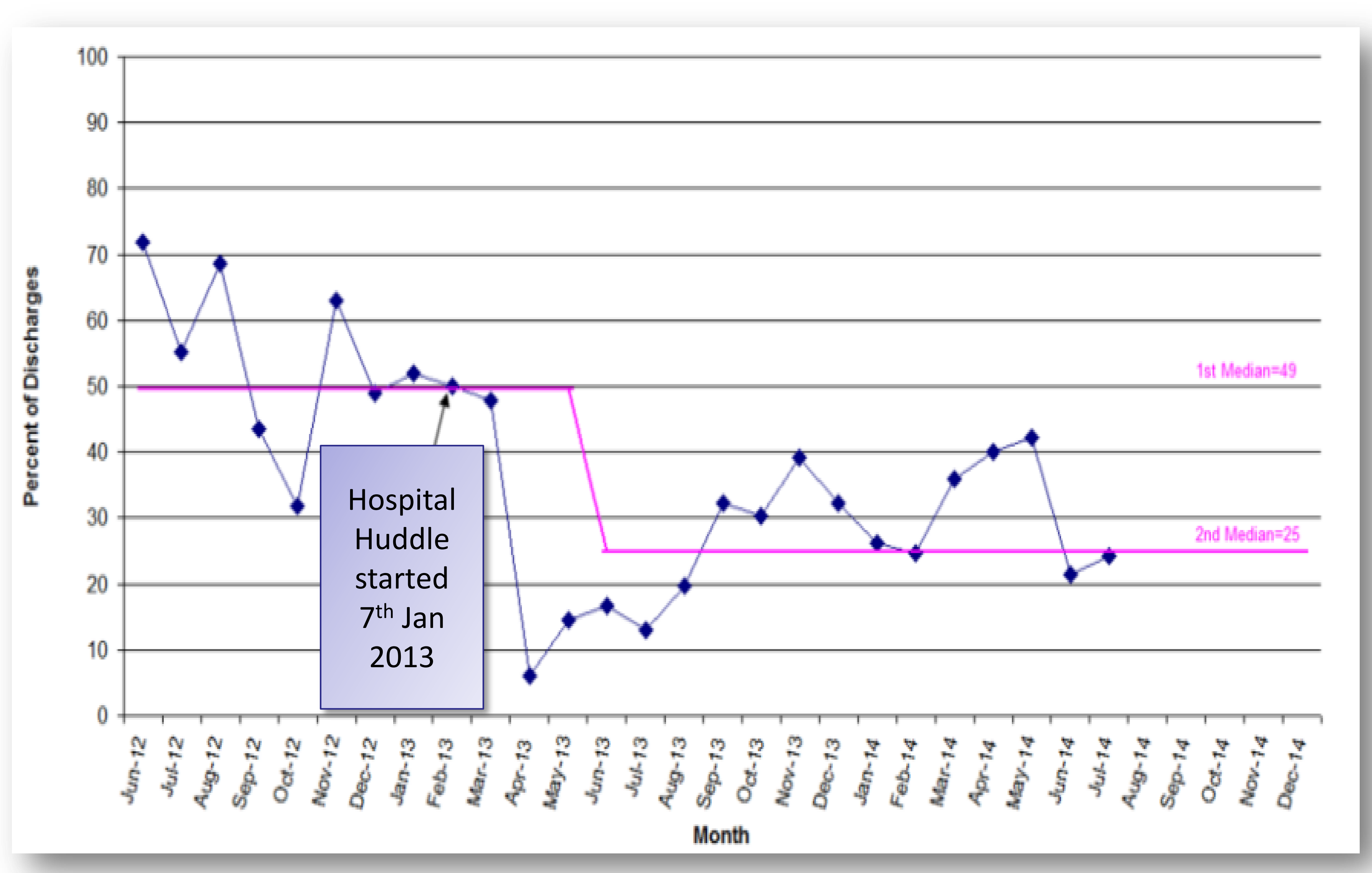
“ ....I don’t know why theatre teams are allowed not to do a morning brief .... I wouldn’t operate without it !”

Surgeon

NHSScotland Surgical Safety Briefings



Royal Hospital for Sick Children, Yorkhill PICU Total Delayed Discharges (+ 4 hrs)



Since 2008.......
....over 1,700 leadership walkrounds have been conducted in Scotland.

Physical

Social

Sexual

Patients are and feel safe,
Staff feel and are safe

Psychological

#mhimprove

	What is happening where you are?	What can you do to strengthen this?
1. Create Vision & Build Will		
2. Develop Capability		
3.Deliver Results		

Talk and scribble

4.Engage Across Boundaries		
5.Shape Culture		
6. Driven by Persons & Community		

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Engage Across Boundaries

Create Vision and Build Will

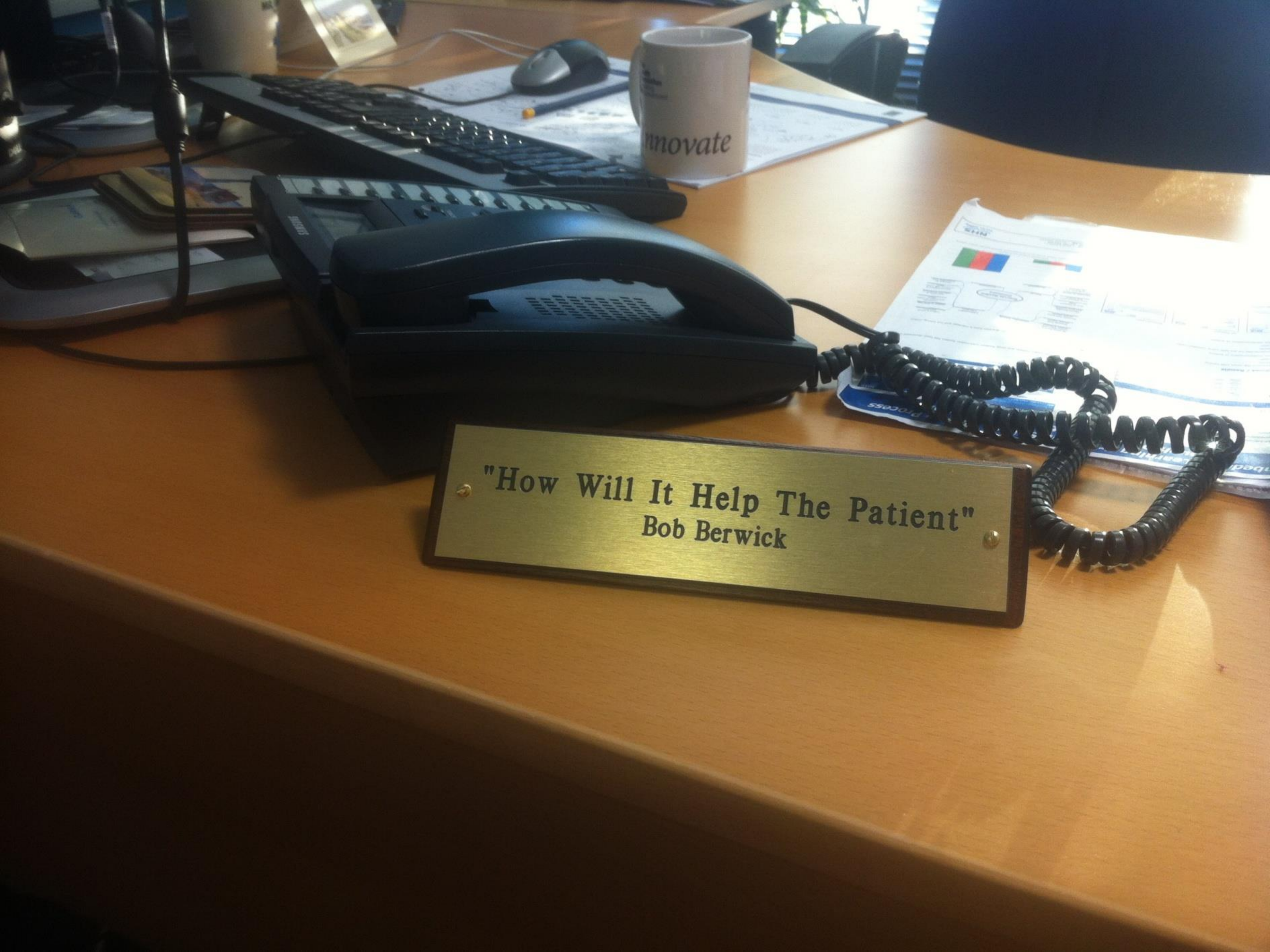
Driven by Persons & Community

Capability

Results

Shape Culture

Engage Across Boundaries


"How Will It Help The Patient"
Bob Berwick
nnovate

Paul Gray
Director General and CEO NHS Scotland

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Talk and scribble

Engage Across Boundaries

Create Vision and Build Will

Driven by Persons & Community

Develop Capability

Deliver Results

Shape Culture

Engage Across Boundaries

Swensen S, Pugh M, McMullan C, Kabcenell A. High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013. (Available at ihi.org)

http://www.ihi.org/resources/pages/ihiwhitepapers/highimpactleadership

Talk and scribble

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Thank You

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