Building the will for a safer culture in the NHS - thinking differently about Patient Safety

Creating a system devoted to continual learning and improvement

Introducing NHS Improving Quality (NHS IQ)

- Set up from 1 April 2013 and hosted by NHS England
- Working to provide improvement and change expertise to support improved health outcomes
- Creating for the first time in the history of the NHS one improvement organisation that is in alignment with its needs and challenges
- Bringing together and building on the wealth of knowledge, expertise and experience of all that has gone before:
  - National Cancer Action Team, National End of Life Care Programme, NHS Diabetes and Kidney Care, NHS Improvement, NHS Institute for Innovation and Improvement.
Todays session:

- Set out the emerging plans for improving patient safety in England
- Look at some theory around large scale change
- Consider the issues and challenges in designing a national improvement programme, if change happens at the microsystem level

*Please ask questions or make your point at any time – let’s have a discussion not a lecture!*

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Who in the room is involved in Patient Safety?

Write down what your role is in improving patients’ safety
Key messages from the Francis Inquiry – 290 recommendations, 4,000 pages

- This was a **system failure** as well as failure of an individual organisation
- **No single recommendation** should be regarded as the solution to the many concerns identified
- A **fundamental change in culture** is required across the NHS
- We need to secure the **engagement** of every single person serving patients in the change that needs to happen
Old Way, New Way

<table>
<thead>
<tr>
<th>Quality</th>
<th>Better</th>
<th></th>
<th>Worse</th>
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</thead>
<tbody>
<tr>
<td><strong>Old Way</strong> (Quality Assurance)</td>
<td><img src="image1.png" alt="Diagram" /></td>
<td></td>
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</tr>
<tr>
<td>Requirement, Specification or Threshold</td>
<td><img src="image2.png" alt="" /></td>
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<td><img src="image3.png" alt="" /></td>
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<td><img src="image4.png" alt="" /></td>
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<tr>
<td>No action taken here</td>
<td>Reject defectives</td>
<td>Action taken on all occurrences</td>
<td></td>
</tr>
</tbody>
</table>

**New Way** (Quality Improvement)

Source: Robert Lloyd, Ph.D.

Institute for Healthcare Improvement (IHI)

Executive Patient Safety Course 5th-11th September 2013
Don Berwick Findings

“The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.”

“Our most important recommendations for the way forward envision the NHS as a learning organisation, fully committed to the following:”

- Placing the quality of patient care, especially patient safety, above all other aims:
- Engaging, empowering, and hearing patients and carers throughout the entire system and at all times:
- Fostering whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work:
- Embracing transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

Design Principles – “how”??

- 15th January – big “Design Day”- using accelerated design techniques
- Experts from UK and USA to help develop plans for the Patient Safety Collaborative
- We need to get this once in a generation opportunity right
The Patient Safety Collaborative for England

Key features:
- Learning from the past, adapting what works in improvement
- Systematic application across England with widespread engagement
- Positioned as transformational not transactional change
- Set within the context of NHS England’s Patient Safety Plan
- Locally led; across all healthcare organisations and all sectors – providers and commissioners
- Patient centred
- Engaged with clinical staff at all levels
- Focused on fewer priorities but at scale to demonstrate results in year one
- Using a range of improvement tools, techniques, social movement approaches and capability building

Patient safety collaboratives

- Academic Health Science Network footprint
- 2-5m population
- Centrally funded, locally engaged improvement teams
- Shared purpose
The programme has two major strands

Establish and support **15 networked and connected Patient Safety Collaboratives** across England - focused on delivering definitive and measurable improvements in specific patient safety issues over the next 5 years.

Build System wide capability for patient safety across England through a systematic education and training programme - in collaboration with key education and capability partners with safety becoming a core skill across healthcare.

Patient safety collaboratives – core priorities

<table>
<thead>
<tr>
<th>Core Collaborative improvement areas</th>
<th>Pressure Ulcers</th>
<th>Medication Errors</th>
<th>Measurement</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Outcomes Framework Improvement Area</td>
<td>VTE</td>
<td>HCAI</td>
<td>Maternity</td>
<td>Deterioration in children</td>
</tr>
<tr>
<td>Tackling other major sources of death and severe harm</td>
<td>Falls</td>
<td>Handover and Discharge</td>
<td>Nutrition and hydration</td>
<td>AKI</td>
</tr>
<tr>
<td>Improving safety for vulnerable patient groups</td>
<td>People with Mental Health needs</td>
<td>People with Learning Disabilities</td>
<td>Children</td>
<td>Offenders</td>
</tr>
</tbody>
</table>

Transition between paediatric and adult care

Plus any focus where the collaborative can make the case that it represents a major source of avoidable harm.

Patient Involvement
Whole pathway, and cross-sector
Evidence-based with consistent measurement for 5 years, centrally supported.
What we will achieve in year 1

Establish and connect 15 improvement collaboratives covering every geographical part of England.

Creation of a NHS Improvement Fellows programme; we propose 200 Fellows in year one, 1000 by end of year two, 5000 by end of year five.

Develop and embed a nationally consistent system for patient safety measurement and improvement across each collaborative. “Improving measurement as well as measuring improvement”

Ensure NHS staff from board to ward participate in identified development initiatives that support collaborative improvement activity and improve their knowledge and skills in the practical application of improvement science. We propose 700 people per year (around one per NHS organisation per year) are trained to PSO standard

Reducing harm from pressure ulcers and medication errors demonstrated by a statistically significant difference in the numbers of these harms.

Creating a patient safety movement:
four things we can learn from the great social movements

Julie Harries
(Helen Bevan’s Slides)
## Emerging themes in large scale change

<table>
<thead>
<tr>
<th>Foundation</th>
<th>Emerging direction</th>
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<tbody>
<tr>
<td>Organisation</td>
<td>Community</td>
</tr>
<tr>
<td>Power through hierarchy</td>
<td>Power through connection</td>
</tr>
<tr>
<td>Mission and vision</td>
<td>Shared purpose</td>
</tr>
<tr>
<td>Making sense through rational argument</td>
<td>Making sense through emotional connection</td>
</tr>
<tr>
<td>Leadership-driven (top down) innovation</td>
<td>Viral (grass-roots driven) creativity</td>
</tr>
<tr>
<td>Led by expert opinion</td>
<td>Allow all talent</td>
</tr>
<tr>
<td>Engaged patients</td>
<td>Passionate users</td>
</tr>
<tr>
<td>Clinical networks</td>
<td>Mass communities</td>
</tr>
<tr>
<td>Tried and tested, based on experience</td>
<td>“Net Generation” principles</td>
</tr>
<tr>
<td>Transactions</td>
<td>Relationships</td>
</tr>
</tbody>
</table>

## What are the implications for improvement leaders?

- From “doing” improvement to “connecting” for improvement at scale
- Rethinking:
  - who’s in the improvement community
  - How we lead change
  - Metrics of success
- New roles
  - Curators
  - Relationship leaders
  - Storytellers
  - Co-creators
- New mechanisms for connecting:
  - Social media
  - Web seminars
  - Tweet chats
- New methods for leading improvement
  - open innovation
  - hacks/hackathons
  - crowdsourcing
  - Ideas channels
Most large scale change fails to achieve its objectives

Source: McKinsey Performance Transformation Survey, 3000 respondents to global, multi-industry survey
Factor 1:
Focus on the physiology of change as much as the anatomy

<table>
<thead>
<tr>
<th>Anatomy of change</th>
<th>Physiology of change</th>
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<tbody>
<tr>
<td>Definition</td>
<td></td>
</tr>
<tr>
<td>Focus</td>
<td></td>
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<td><strong>Focus</strong></td>
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| **Leadership activities** | • measurement and evidence  
• improving clinical systems  
• reducing waste and variation in healthcare processes  
• redesigning pathways |

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</table>
| **Definition**   | The shape and processes of the system; detailed analysis; how the components fit together.  
The vitality and life-giving forces that enable the system and its people to develop, grow and change. |
| **Focus**        | Processes and structures to deliver health and healthcare  
Energy/fuel for change |
| **Leadership activities** | • measurement and evidence  
• improving clinical systems  
• reducing waste and variation in healthcare processes  
• redesigning pathways  
• creating a higher purpose and deeper meaning for the change process  
• building commitment to change  
• connecting with values  
• creating hope and optimism about the future  
• calling to action |
Intrinsic motivators

*connecting to shared purpose*

*engaging, mobilising and calling to action*

*motivational leadership*

*build energy and creativity*
Intrinsic motivators

• connecting to shared purpose
• engaging, mobilising and calling to action
• motivational leadership

build energy and creativity

Drivers of extrinsic motivation

create focus & momentum for delivery

Intrinsic motivators

• connecting to shared purpose
• engaging, mobilising and calling to action
• motivational leadership

build energy and creativity

Drivers of extrinsic motivation

• System drivers & incentives
• Payment by results
• Performance management
• Measurement for accountability

create focus & momentum for delivery
Internal motivators:
• connecting to shared purpose
• engaging, mobilising and calling to action
• motivational leadership build energy and creativity

Drivers of extrinsic motivation:
• System drivers & incentives
• Performance management
• Measurement for accountability

create & focus momentum for delivery

Transformation is not a matter of intent........
it is a matter of alignment
Peter Fuda

@helenbevan  @weatherbore
Factor 2: Build energy for change
burning platform
versus
burning ambition
@PeterFuda

Lessons for transformational change

1. In order to sustain transformational change, we as leaders need to move from a burning platform (fear based urgency) to a burning ambition (shared purpose for a better future)

2. We as leaders need to articulate personal reasons for change as well as organisational reasons

3. If the fire (the energy) goes out, all other factors are redundant
You get the best efforts from others not by lighting a fire beneath them but by building

Source: Bob Nelson

Task

Talk to the person next to you
- What is “my burning ambition” for Improving Patient Safety
- Try to make it personal: tell others why this ambition connects with your personal motivations
### Five energies for change

<table>
<thead>
<tr>
<th>Energy</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td><em>energy of personal engagement, relationships and connections between people.</em> It’s where people feel a sense of “us and us” rather than “us and them”</td>
</tr>
<tr>
<td>Spiritual</td>
<td><em>energy of commitment to a common vision for the future, driven by shared values and a higher purpose.</em> It gives people the confidence to move towards a different future that is more compelling than the status quo</td>
</tr>
<tr>
<td>Psychological</td>
<td><em>energy of courage, resilience and feeling safe to do things differently.</em> It involves feeling supported to make a change and trust in leadership and direction</td>
</tr>
<tr>
<td>Physical</td>
<td><em>energy of action, getting things done and making progress.</em> It is the flexible, responsive drive to make things happen</td>
</tr>
<tr>
<td>Intellectual</td>
<td><em>energy of analysis, planning and thinking.</em> It involves gaining insight as well as planning and supporting processes, evaluation, and arguing a case on the basis of logic/evidence</td>
</tr>
</tbody>
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**Factor 3:**

Frame to connect with hearts and minds

@helenbevan @weatherbore
Framing

Is the process by which leaders construct, articulate and put across their message in a powerful and compelling way in order to win people to their cause and call them to action

Snow D A and Benford R D (1992)

If we want people to take action, we have to connect with their emotions through values

Source: Marshall Ganz
Factor 4: build shared purpose

“A shared sense of corporate purpose, grounded in universal values, is the highest octane source of fuel for organisational action.”

We know that ... 

- Shared purpose is a common thread in successful change programmes* 

- Organisations and change initiatives with strong shared purpose consistently outperform those without it.**

*What makes change successful in the NHS? Gifford et al 2012 (Roffey Park Institute) 
**Management Agenda 2013 Boury et al (Roffey Park Institute)
From compliance to commitment

“We come from a culture of compliance and top down performance management, … It’s task-orientated to get things done. It needs to be much more about cooperation, about leading across boundaries … Being able to focus on shared purpose in those circumstances is absolutely crucial.” NHS interviewee

Avoiding “de facto” purpose

- What leaders pay attention to matters to staff, and consequently staff pay attention to that too
- Shared purpose can easily be displaced by a “de facto” purpose:
  - hitting a target
  - reducing costs
  - reducing length of stay
  - eliminating waste
  - completing activities within a timescale
  - complying with an inspection regime
- If purpose isn’t explicit and shared, then it is very easy for something else to become a de facto purpose in the minds of the workforce

Source: Delivering Public Services That Work: The Vanguard Method in the Public Sector
....the last era of management was about how much performance we could extract from people
.....the next is all about how much humanity we can inspire
Dov Seidman
A Comprehensive Framework for Patient Safety

Allan Pransky, MD
September 5, 2013

Disclosure: I am a Principal in a company called Pascall Metrics Inc. that develops and implements safety metrics. We will be discussing this topic in general and will reference many options about safety metrics, including those produced by Pascall. We will disclose the commercial interests we have, and present a balanced view of the topic.

Another Framework

- Reliable Process
- Improved Measurement
- Continuous Learning
- Transparency
- Communication
- Accountability
- Teamwork
- Leadership
- Psychological Safety
A safety framework – 9 components

- Leadership: facilitate and mentor teamwork, improvement and psychological safety
- Teams: agree upon specific behaviors
- Communication: transmission and reception of information is one and the same
- Accountability: supports psychological safety because employees believe they’ll be treated fairly
- Psychological Safety: speaking up is safe to do
- Continuous learning: generate reliable care by applying best evidence and minimizing variation
- Reliable care: continuous and owned by the frontline
- Improvement and measurement: generate quality, mitigates and eliminates defects
- Transparency

1. A framework
2. Measurement
3. Feedback
4. Improvement
5. Psychological Safety
6. Transparency
7. Accountability
8. Teamwork
9. Continuous Learning

**Reliability:**
- Processes are designed and built with the user, customization is encouraged and based on the patient's needs and clinical desire.

**Improvement and Measurement:**
- Aligns identify where you want to go and identify 'how much by when'
- Driver diagrams link your strategy to tactics, they explain your theory and what ACTIONS you need to take to achieve the Aim
- Systematic testing cycles (PDCA) are the small episodes of learning that help you refine your ACTIONS
- Measures reflect the magnitude of improvement and reflect the adequacy of the processes, the related outcomes and the balancing measures that allow us to know if there are any unintended consequences
- Data is measured over time using run charts or statistical process control charts

**Accountability:**
- You can’t be malicious
- Your scenario must be intact
- If you break a rule, we will apply Reason’s substitution test
- You can’t have a history of unsafe acts

**Leadership:**
- Guardians of learning
- Create an environment of Psychological Safety
- Nurture an environment of Respect

**Psychological Safety:**
- Comfortable asking questions
- Comfortable asking for and receiving feedback
- Comfortable being appropriately critical
- Comfortable being innovative

**Framework for Operational Excellence**
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“How” is still work in progress

- We need to create a “mass movement” for safety in England
- A great Improvement Programme is just one part.
- We intend to do “lots of lots” – creating networks, sharing good practice, frequent persistent communication and PR, maximising the role of champions / fellows, connecting the dots, social media, building capability, etc -etc. etc. etc. – plus some things we don’t yet know! Hacks, crowdsourcing, MOOCs (thanks Helen)

Patient Safety is everybody’s business

- What did you write down at the beginning of the session?
- Can you add to that now?
- What one thing will you do differently tomorrow?
- It’s not too late to make a pledge for NHS Change Day!

P.S. – wish us luck!
Questions / discussion

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