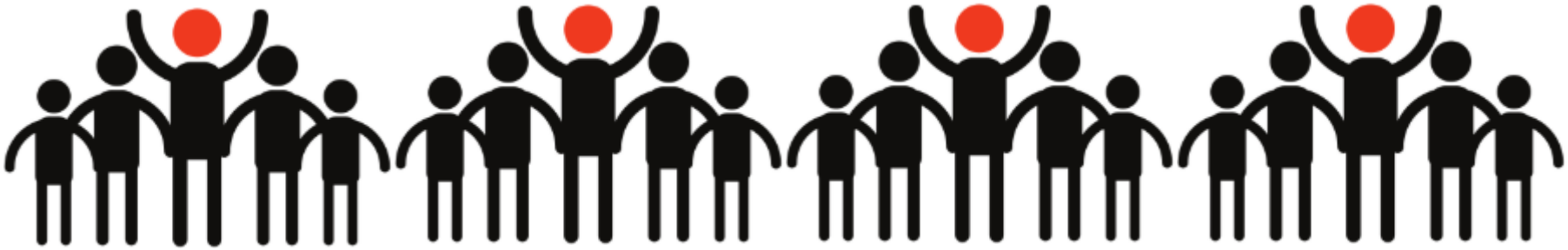
Fundamentals of Quality Improvement

9.00-12.30

Helen Bevan and Goran Henriks

Download the slides : bit.do/fundamentalsQI



@goranhenriks @helenbevan #Quality2019

Objectives of this session

- Understand WHY quality improvement is important to everyone who works in health and care
- Appreciate WHAT the different dimensions of quality and the aims of health and care improvement are
- Know HOW to go about improvement in your own setting

What is quality improvement?

The combined and unceasing efforts of EVERYONE–healthcare professionals, patients and their families, researchers,payers, planners and educators–to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development…..

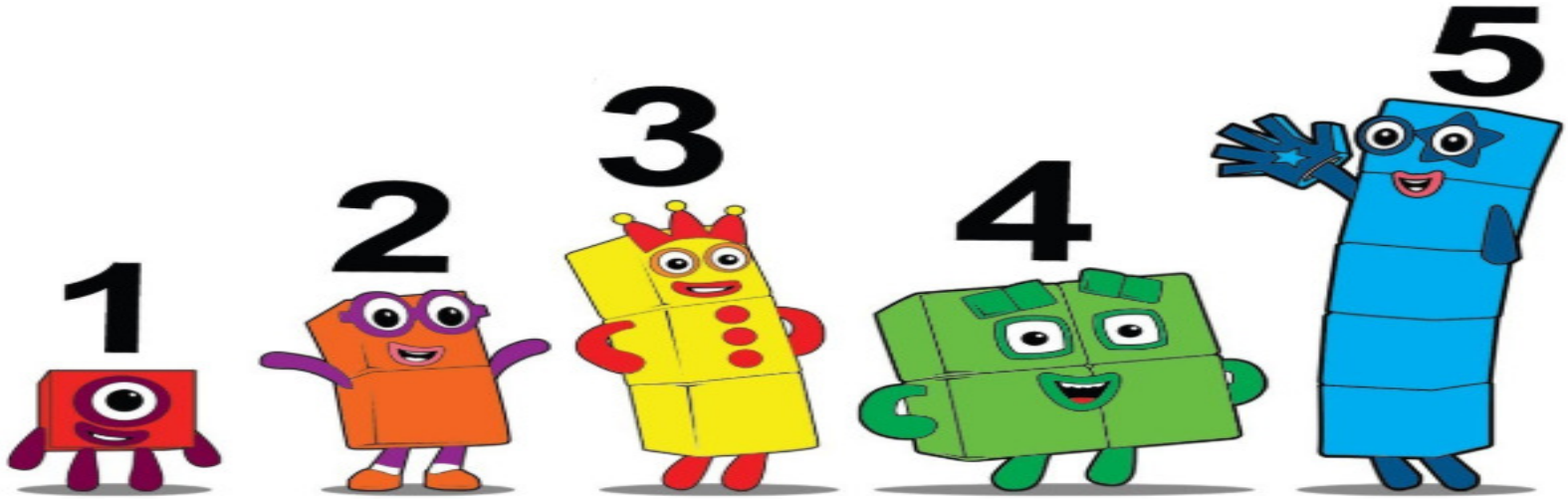
This definition arises from our conviction that healthcare will not realise its full potential unless changemaking becomes an intrinsic part of everyone's job, every day, in all parts ofthe system.

Paul Batalden and Frank Davidoff

What is "quality improvement" and how can it transform healthcare?

A human spectrogram

What is your level of skill and confidence in quality improvement ?



Very low

High

The Academy of Medical Royal Colleges framework:

- Understanding the system
- Human elements of change
- Measurement of change
- Implementing change
- Sustainability and spread of change
- Leadership and team-working

We are adding:

- Co-production with patients and families
- Safety

My quality improvement (QI) journey: pick three cards

1. "Where are you from?"

One card that captures how you thought and acted when you first thought about QI

2. "Where are you now?

One card for how you are using QI now

3. "Where are you going?"

One card about how you would like to use QI in future

My quality improvement (QI) journey: pick three cards

1. "Where are you from?"

One card that captures how you thought and acted when you first th

2. "Where are you now?

One card for how you are using QI now

3. "Where are you going?'

One card about how you would like to use QI in future

On your table, each person should describe their QI journey to date, using the three cards

A history of quality improvement

Professional knowledge
- Subject knowledge
- Personal skill
- Values, ethics

Improvement knowledge
- Appreciation of a System
- Understanding variation
- Psychology
- Theory of Knowledge

Improvement of diagnostic and treatment

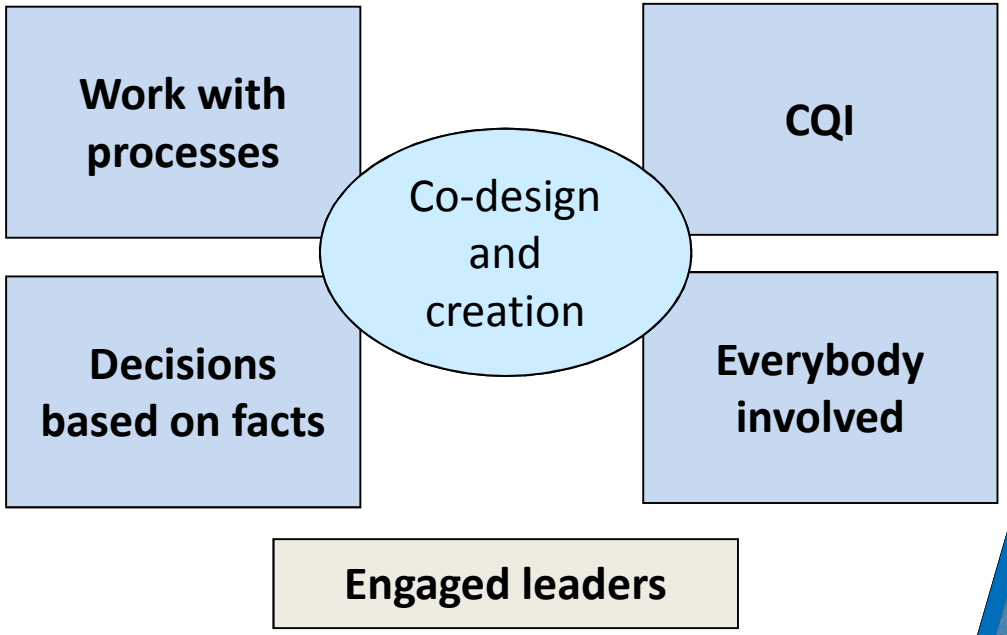
+

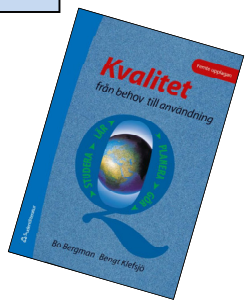
Improvement of processes and system in healthcare

Higher value for the patients

Reference: Stoltz, Batalden

Cornerstones in Quality Improvement





Bergman & Klefsjö. Kvalitet från behov till användning. Studentlitteratur, 2012.

What are the differences between a product and a service?

Our reality

I want to feel welcome and that they see me as a Bertil not my disease. ……Look even to my wife Stina. Does she need and get support?

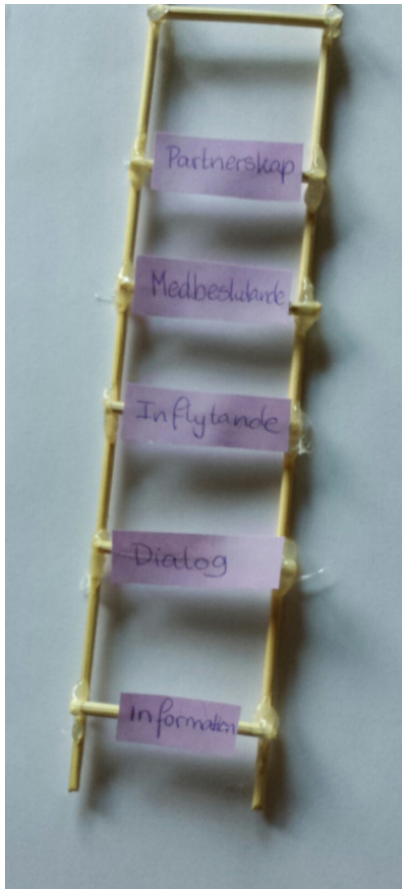
We want to know what we can expect , even if it is getting worse, have a plan B what can I do and in what way , where can I turn to with my questions?

Our reality

I want to be a part of the improvement work so that it really will be for the best for Esther and not for the organisation.

It is not enough to have good intentions and methods.
All will come back to the experience of the customer.
The customer defines quality and by the way it is fun to be a part of improvement work

Ladder of participation



Partnership

Shared decision making

Influence

Dialogue

Information

Vackerberg 2014(inspired by Arnstein 1969 & Castell 2013)

Quality of Service

Reliability

Communication skills

Responsiveness

Credibility

Availability

Security

The desire to correct errors

Quality can help to transform our mindsets

- Expert eyes see what is missing
- Loving eyes see what exists and what you have

Today´s ambition of tomorrow - explore and exploit

- **Co** learning
- **Co** llaborating
- **Co** creating
- **Co** nnectivity
- Co Me Passion IT (festival)

What really matters?

- https://www.youtube.com/watch?v=YG2xB0poGo0

"Behind her smiles and spritely personality, health is a worry for Mdm Teo."

Understanding the system

Understanding the system

10 BARRIERS TO STRATEGY EXECUTION AND TRANSFORMATIONAL CHANGE

Efficient and effective strategy execution is difficult. Too often barriers get in the way.

Here are 10 common barriers you can avoid:

1. Unclear and imprecise strategic thinking coming from the top team.
2. Lack of consistent support for strategic initiatives from the top.
3. Not having a clear project implementation model.
4. Poor separation between planning/design and implementation/doing.
5. Too many strategic initiatives.
6. Failure to kill off projects and reallocate resources.
7. Lack of clarity over the role of strategy execution within the organizational structure.
8. Inappropriate rewards i.e. rewarding short-term success rather than overall performance.
9. Failure to manage change effectively.
10. Overpromising stakeholders through 'pie in the sky' strategy documents.

Do you recognise any similarities to your situation at home?

https://t.co/WBYIfOfUVK?amp=1

https://twitter.com/helenbevan/status/1172759046128058369

@goranhenriks @helenbevan #Quality2019

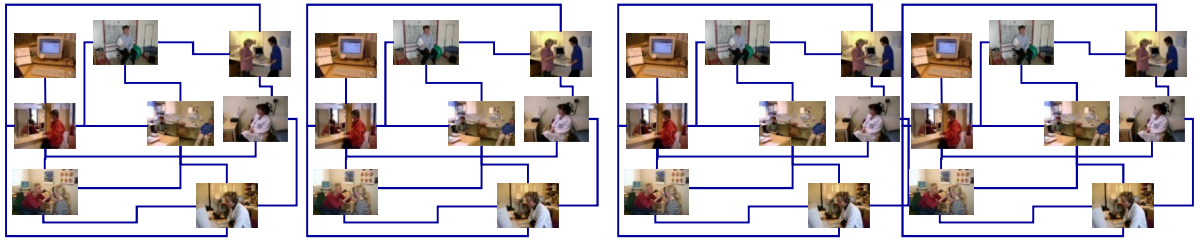
It begins with 5Ps – and the microsystem

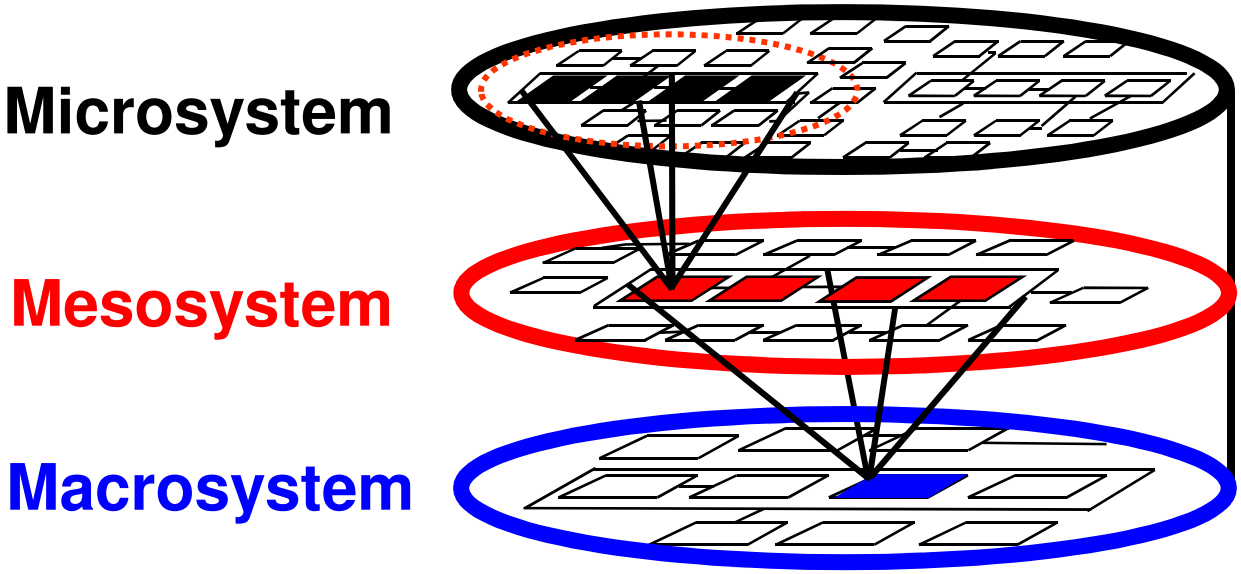
P	P	P	P	P
Purpose **What are our aims, strategic goals ?** Why are we here? What value will we deliver?	**Patients/ Customers** **Who are they?** How well do we know them? How do we involve them?	**People** **The staff – who are they?** How do we use their skills? How do we involve them in improvement work? How do they increase their understanding about what they shall accomplish?	**Processes/ Flow** **How do we learn more about our processes?** How do we use our outcomes? How do we become better at cooperating?	**Patterns / Results** **What results do we follow?** How do we evaluate variations in the clinical work? Patterns in our business over time?

+Passion

Reference: Godfrey, Nelson

System levels





Reference: Norman, Bojestig, Henriks

Before and now

Dominant element

Disease
Care
Doctor and Nurse
Specialization
Hospitals
Episodic treatment
Standardisation
Patients comes to CG
The patient must have patience
Produce

Drivers

The development of knowledge
Demographics
Epidemiology
Technology
Robotisation
Costs
Patients awareness
Social Networks
Complex systems

The new

Health
Support
Prevention
Team
Integrated treatment
Network
Follow-up care
Individual
Interaction at a distance
Proactive patients
Quality and safety

We all strive for a learning organisation….

- A learning organisation is a social system unlike a mechanical or biological system….. the people in a social system—doctors, nurses, technicians, and administrators—may all bring different values and purposes to the organisation.
- Without leadership there will be no common purpose or values

Reference: Maccoby, Norman

Quality as business strategy: Promoting the idea of a learning organisation

”For a good life in an attractive region”

Vi leder, samordnar och utvecklar genom:

Invånarinflytande	Beslut och ledning	Omvärldsbevakning	Systematiskt förbättringsarbete	Resultatuppföljning
Val Medborgarpaneler	Budget och verksamhetsplanering Balanced Scorecard med handlingsplaner Mötesplatser och medarbetarsamtal Samverkan med fackliga organisationer	Öppna jämförelser Folkhälsoläge Regler och program Kongresser, seminarier, litteratur	Ledarutveckling Microsystem Patientsäkerhet Professionell kunskapsutveckling Forskning	Bokslut Rapporter Resultattavlor Kvalitetsregister Revision

Så arbetar vi för att möta invånarens behov:

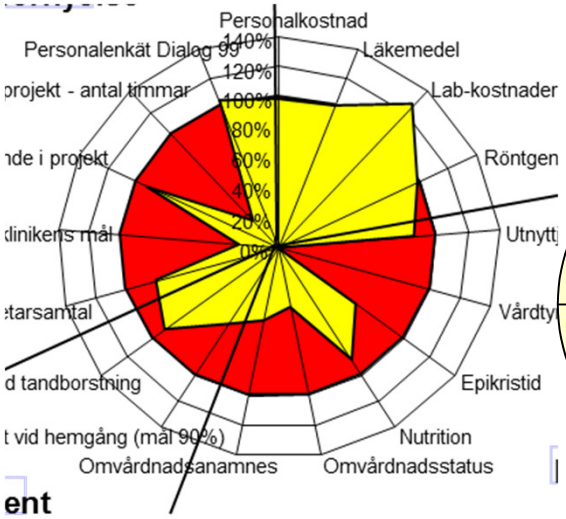
Vision för Region Jönköpings län: För ett bra liv i en attraktiv region

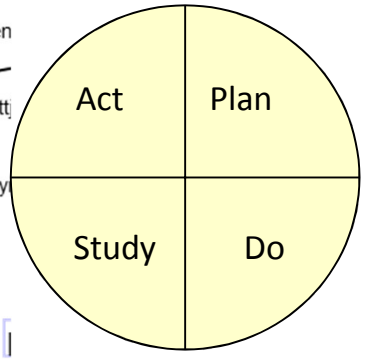
Skapa kontakt	Analysera, åtgärd och följ upp behoven inom hälso- och sjukvård och tandvård	Förbättra folkhälsan	Utbilda	Stimulera regional tillväxt
Bemötande Telefoni Mina vårdkontakter	Prevention Diagnostik Behandling Omvårdnad Rehabilitering	Främja kulturintresse Scenkonst Utställning och utsmyckning Mötesplatser	Folkbildning för demokrati och ökad sysselsättning Verksamhetsförlagd utbildning	Infrastruktur Kompetensutveckling Företagsutveckling i samverkan med näringsliv och föreningar /organisationer Turism Internationell samverkan
Ge stöd till egenvård E-hälsa Lärcaféer			**Underlätta resande med kollektivtrafik**	

Samverkan i systemet och med kommuner, myndigheter, regionen och civilsamhället.

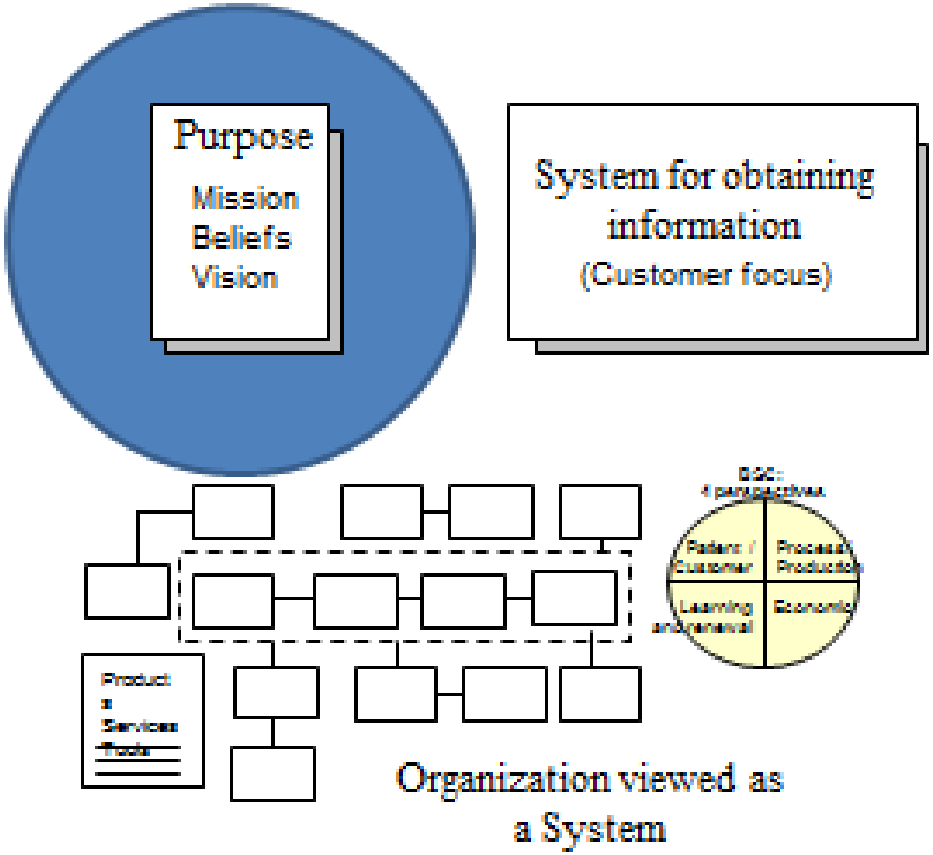
Så arbetar vi för att utveckla och stödja verksamheten:

Resursfördelning	Personalutveckling	Ge service	Kommunikation	Utvecklingsarbete
Vårdpeng Anslag Ersättningssystem Avgifter Frisktandvård	Löner Rekrytering Arbetsmiljö Jämställdhet Mångfald Kompetensutveckling	IT och telefoni Varu- och tjänsteförsörjning Hjälpmedelsservice Transporter Vaktmästeri Medicinsk teknik Kost Administration Lokalförsörjning Städ	Intern/extern webbutveckling Strategiskt/integrerad kommunikation Aktiv kommunikationsplanering Utveckling av kommunikationskanaler	Metodutveckling Utbildning
				Miljöarbete





The organisation viewed as a system

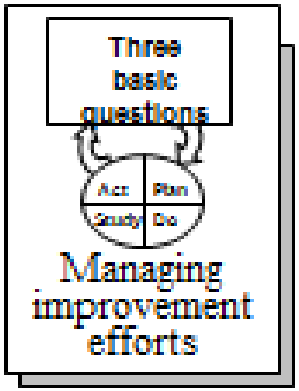


Planning

Strategic objectives

Improvement efforts

Resources



Norman, API

Is your organisation a cathedral or a bazaar?

http://www.unterstein.net/su/docs/CathBaz.pdf

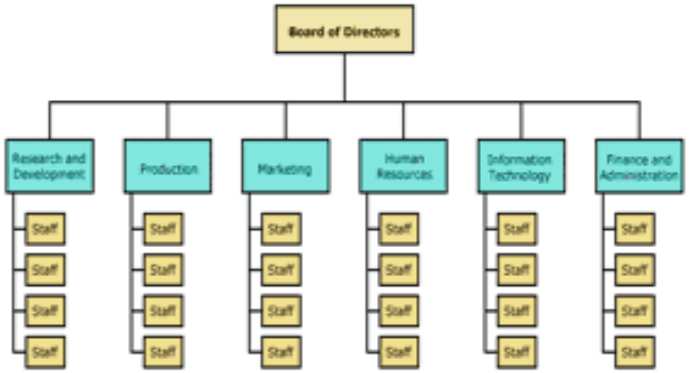
What is needed?

Changing Management Structures by moving from scalable Efficiency to scalable Adaptability in order to succeed

The Digital Transformation of Knowledge Work

The traditional Org-Chart

Scalable Efficiency



doing things right

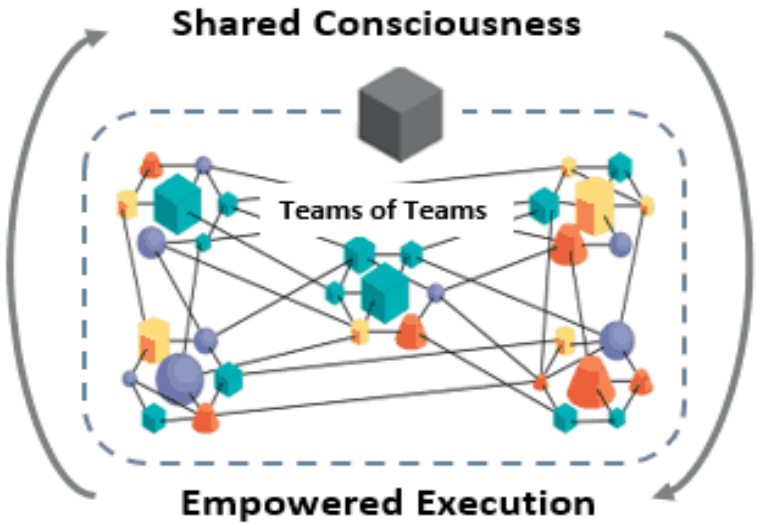
Efficiency

Digital Transformation

Team of Teams

Scalable Adaptability

BI-CHC Example



doing the right thing

Adaptability

@goranhenriks @helenbevan #Quality2019

The human elements of change

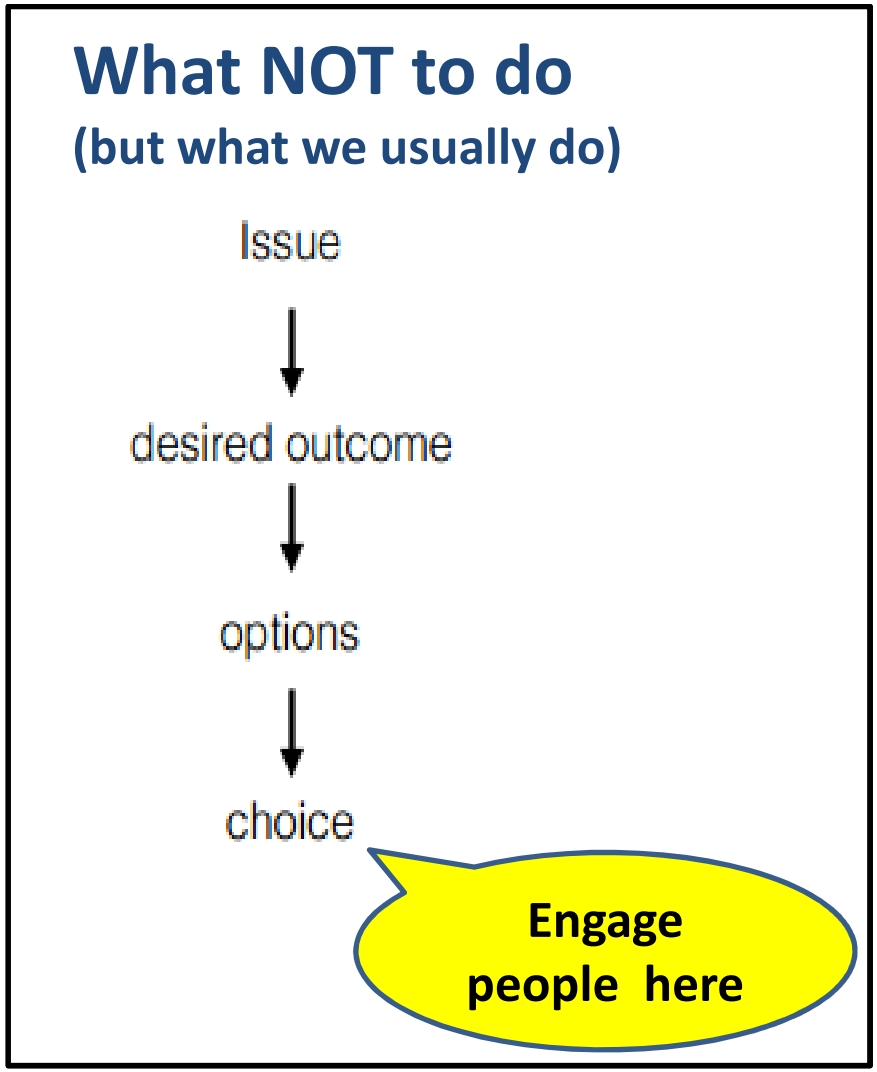
@goranhenriks @helenbevan #Quality2019

The human elements of change

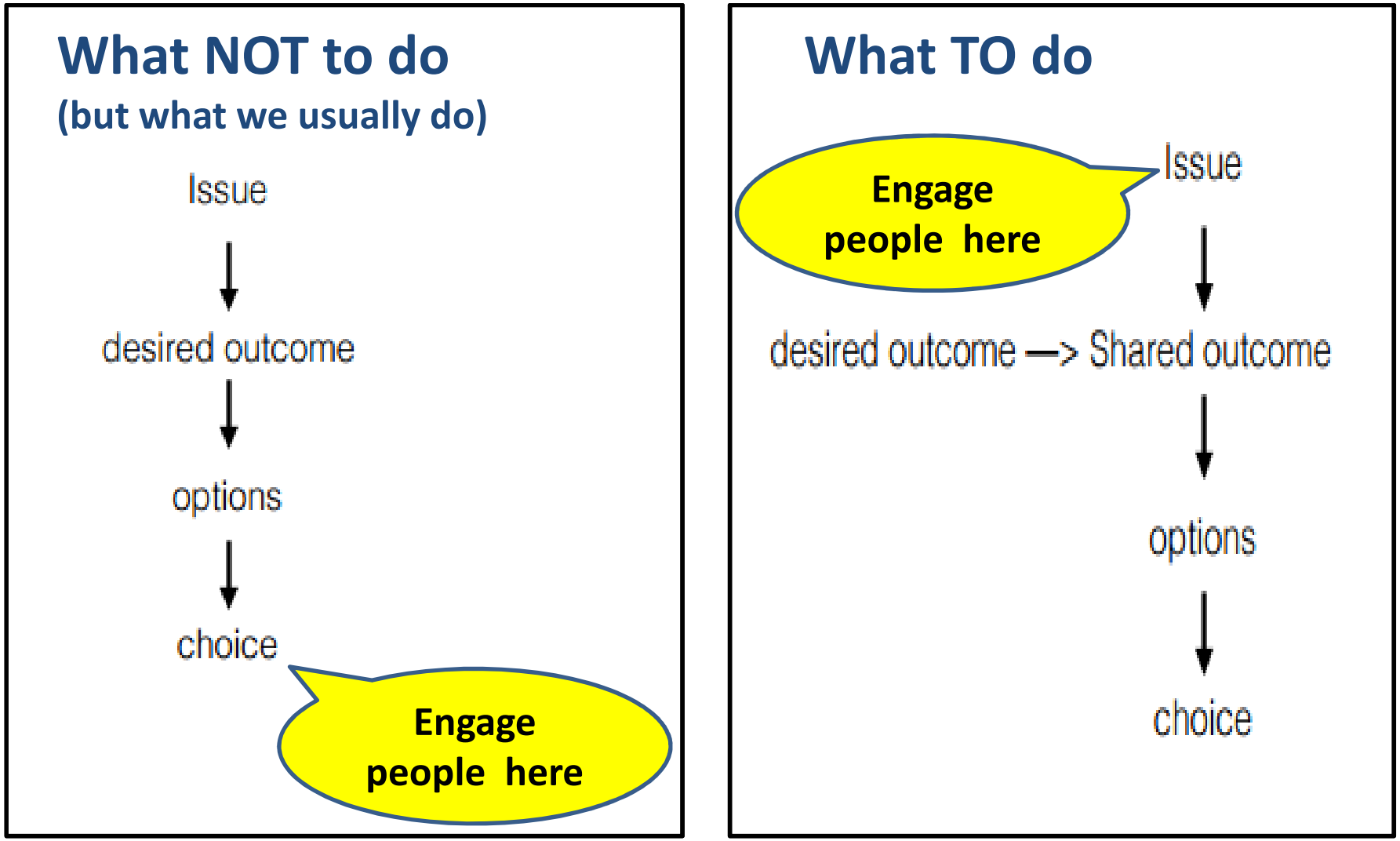
Think about a specific time when you were trying to make change happen and you needed to get other people on board.

Share your stories on the table and pull out three factors that all your stories have in common

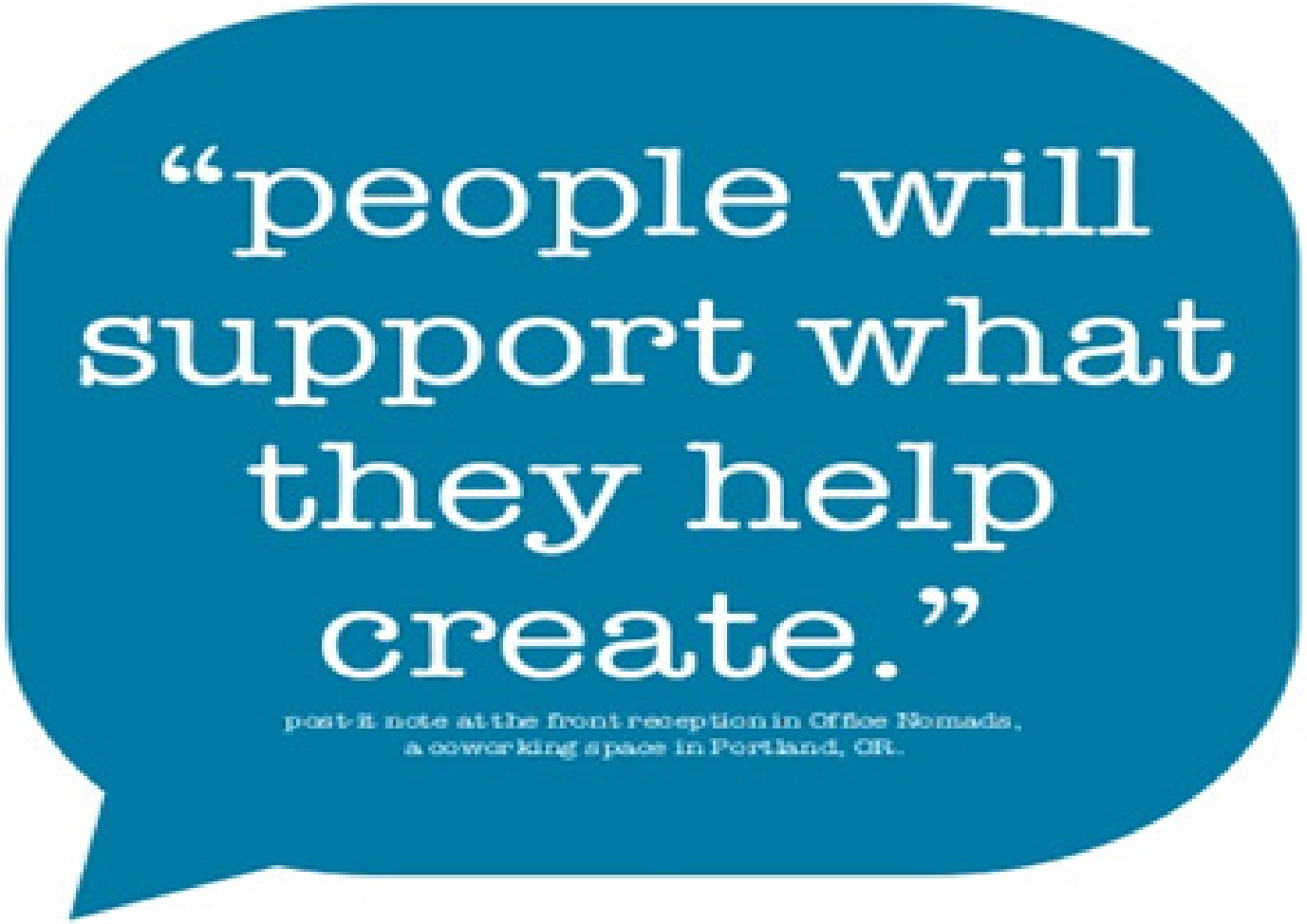
Mark Jaben on the science behind resistance to change



Mark Jaben on the science behind resistance to change



We don't need buyers (who "buy-in" to change)
We need investors



@goranhenriks @helenbevan #Quality2019

Measurement of change

Exercise

Moving from a concept to a measure

A friend asked you to consult on a personal improvement project

Project aim: lose some weight

1. Identify the key concepts related to losing weight
2. Then specify measures that appropriately represent these concepts
3. Organize your concepts and measures according to
   - Outcomes
   - Processes
   - Balancing considerations

Project aim: lose some weight

Type of Measure	Concept	Measure
Outcome	1.	1.
	2.	2.
Process	1.	1.
	2.	2.
Balancing	1.	1.
	2.	2.

Five Core Components:
The Model for Improvement

Core Component

1) Goals
Aim Statement

2) Content Theory
Driver Diagram or Change Package

3) Execution Theory
Logic Model

4) Data Measurement & Learning
Measurement Plan

5) Dissemination
Dissemination Plan

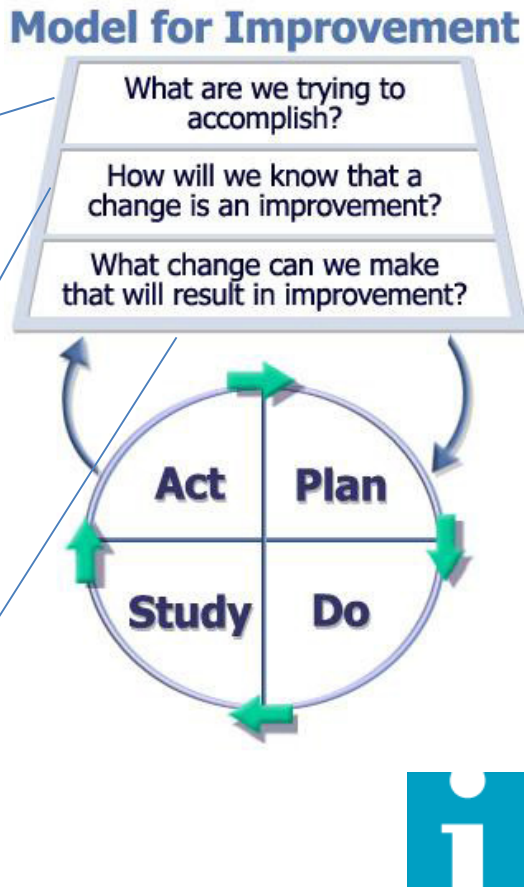


Table 2. Characteristics of Measurement for Improvement, Accountability, and Research

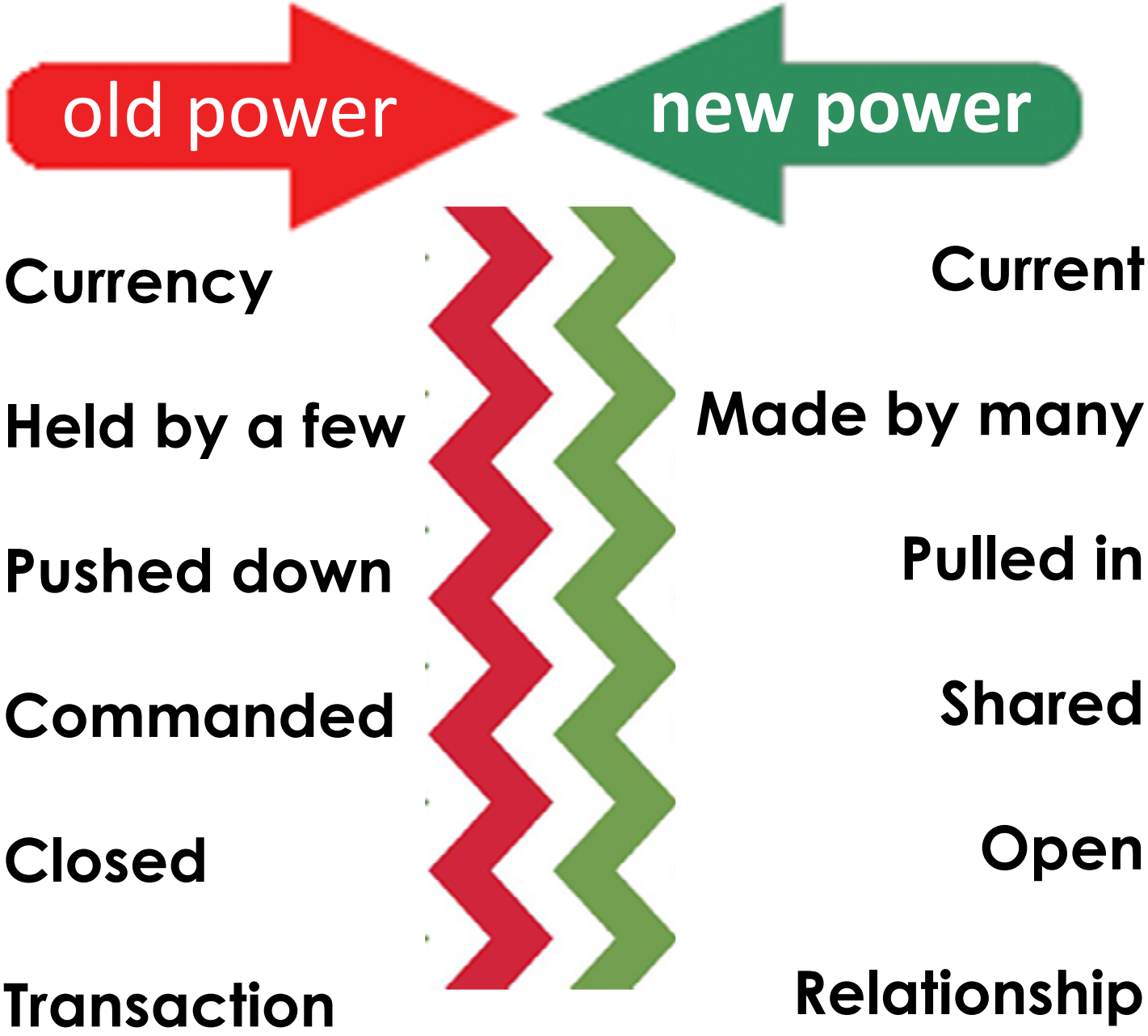
	Improvement	Accountability	Research
Who?			
Audience (Customers)	Medical group Quality improvement team Providers and staff Administrators	Purchasers Payers Patients/members Medical groups	Science community General public Users (clinicians)
Why?			
Purpose	Understanding of a. process b. customers Motivation and focus Baseline Evaluation of changes	Comparison Basis for choice Reassurance Spur for change	New knowledge, without regard for its applicability
What?			
Scope	Specific to an individual medical site and process	Specific to an individual medical group and process	Universal (though often limited generalizability)
Measures	Few Easy to collect Approximate	Very few Complex collection Precise and valid	Many Complex collection Very precise and valid
Time period	Short, current	Long, past	Long, past
Confounders	Consider but rarely measure	Describe and try to measure	Measure or control
How?			
Measurers	Internal and at least involved in the selection of measures	External	External and usually prefer to control both process and collection
Sample size	Small	Large	Large
Collection process	Simple and requires minimal time, cost, and expertise Usually repeated	Complex and requires moderate effort and cost	Extremely complex and expensive May be planned for several repeats
Need for confidentiality	Very high (Organization and people)	None for objects of comparison—the goal is exposure	High, especially for the individual subjects

The Three Faces of Performance Measurement:

Improvement, Accountability, and Research

Leif I. Solberg, MD
Gordon Mosser, MD
Sharon McDonald, RN, PhD

implementing change:
Being a change agent

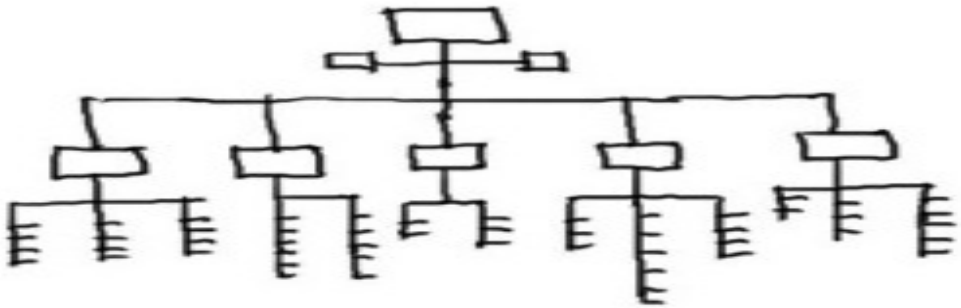


Jeremy Heimens, Henry Timms New Power: How it's changing the 21st Century and why you need to know (2018)

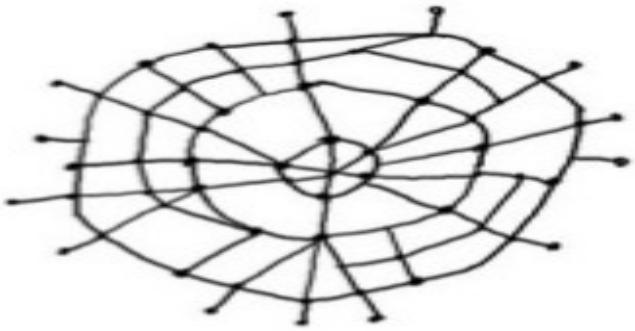
The Network Secrets of Great Change Agents

Julie Battilana &Tiziana Casciaro

As a change agent, my **centrality in the informal network** is more important than my **position in the formal hierarchy**



Designed for
DIVISIONS



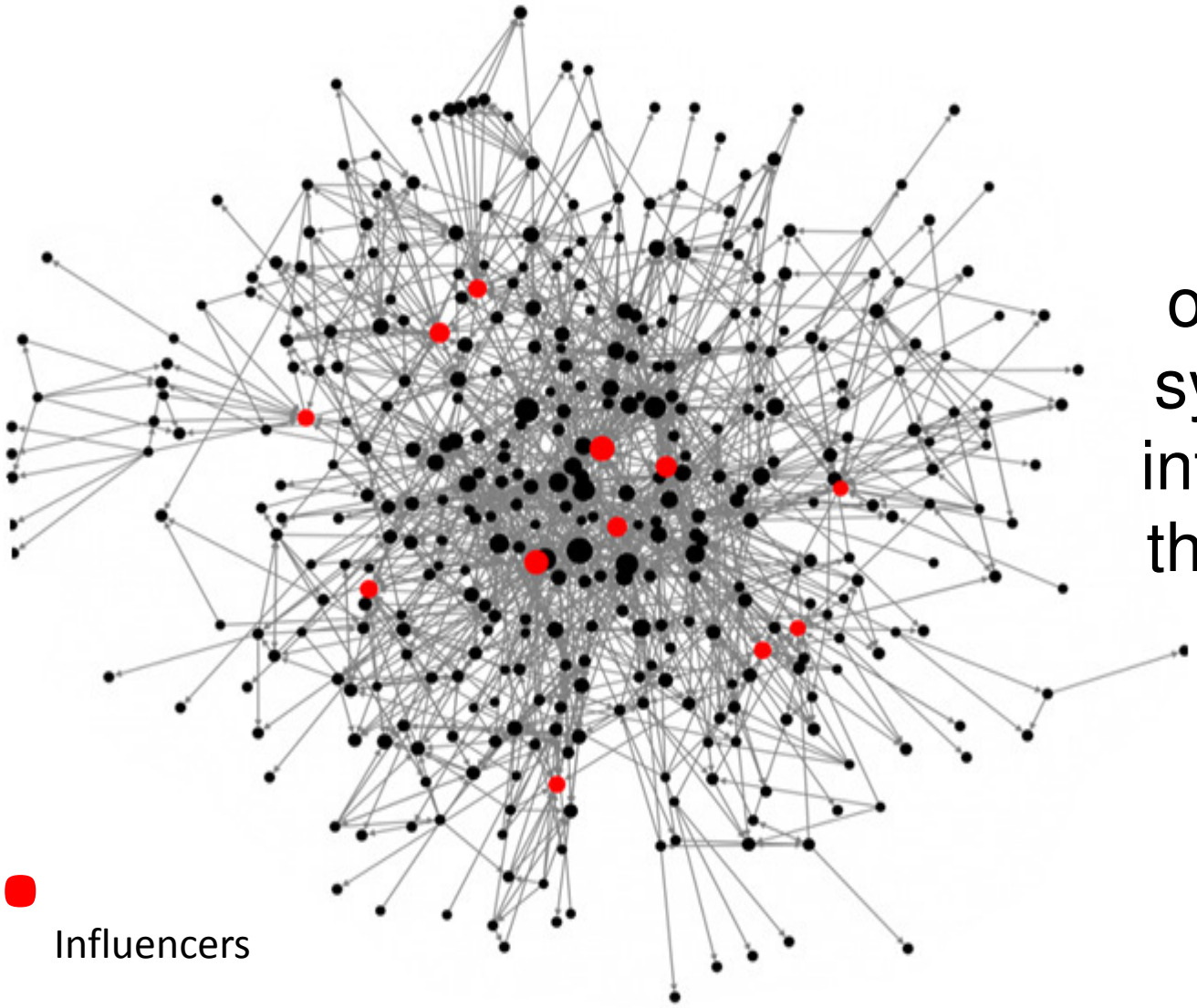
Designed for
CONNECTIONS

People who are highly connected have twice as much power to influence change as people with hierarchical power

Leandro Herrero

http://t.co/Du6zCbrDBC

Find the 3% “super-connectors”!



Just 3% of people in the organisation or system typically influence 85% of the other people

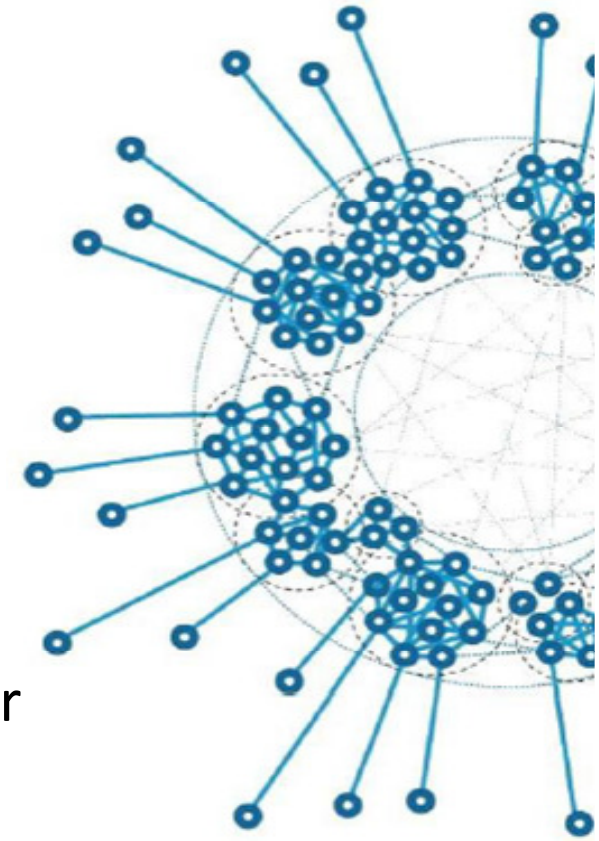
Source: Organisational Network Analysis by Innovisor

Why superconnectors?

A major cause of change failure is poor dialogue with the informal organisation

The 3% informal influencers:

- Have the relationships, networks, content and context
- drive the perceptions of other people
- are the go-to people for advice
- make sense of things and reduce ambiguity for others
- Are trusted by peers more than formal leaders are trusted
- Are largely unknown to formal leaders

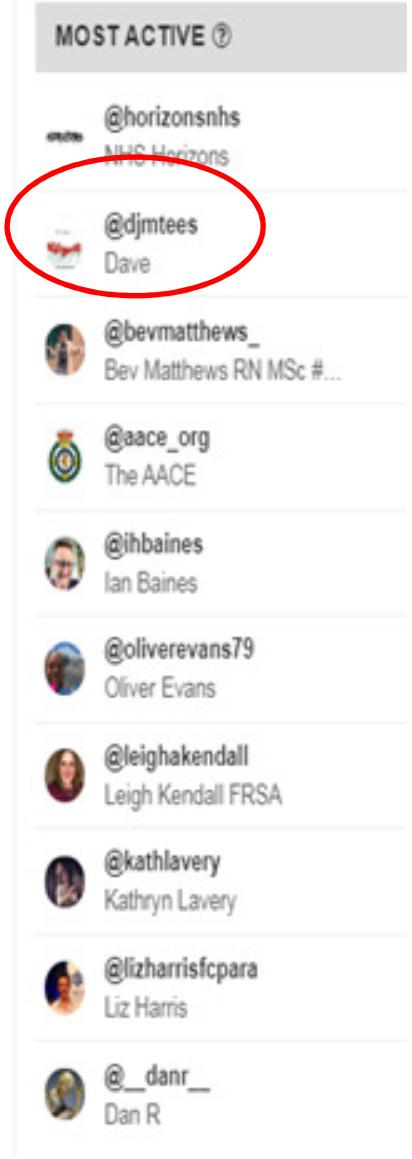


Source of graphic: The Strategy Group

Source: Innovisor

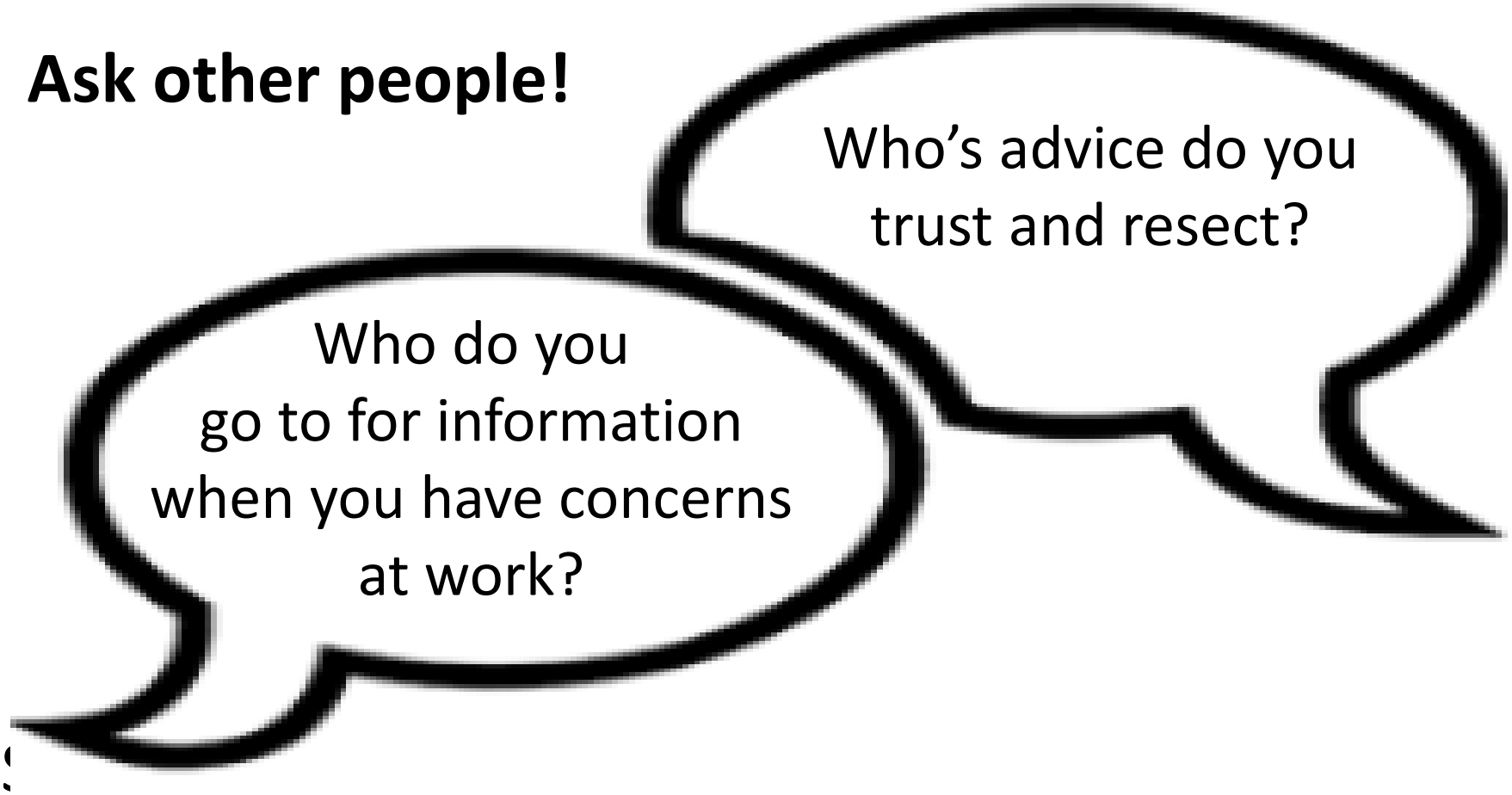
Find the 3%: meet David Morgan,
North East Ambulance Service

- “Dave knows everyone in the ambulance service, not just in the North East ”
- “He’s really influential on Twitter and loads of ambulance staff use Twitter for work topics”
- “Dave wants to help you sort out issues”
- “He is respected by senior people and by frontline”



How do you find your superconnectors?

Ask other people!



Innovisor Evidence-based change

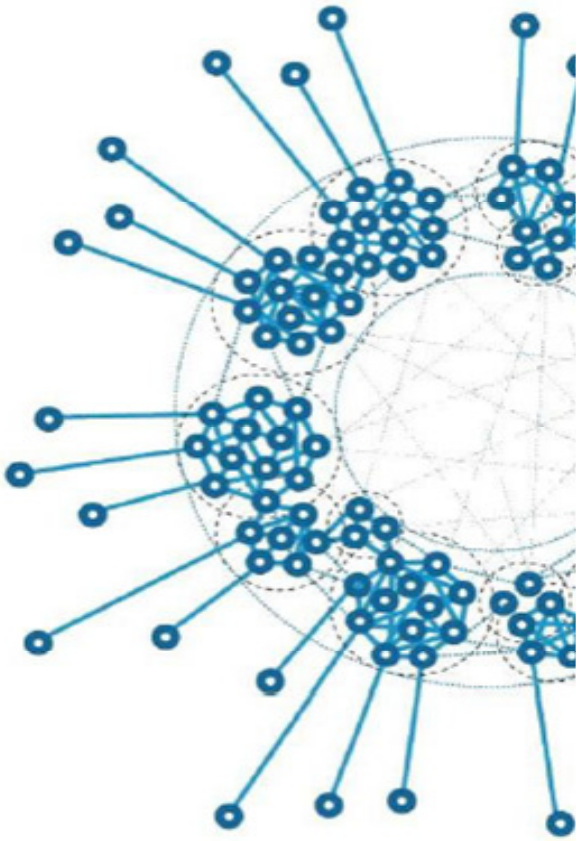
McKinsey Tapping the power of hidden influencers

Mike Klein Internal influencers: actionable and no longer optional

What does this mean for me?

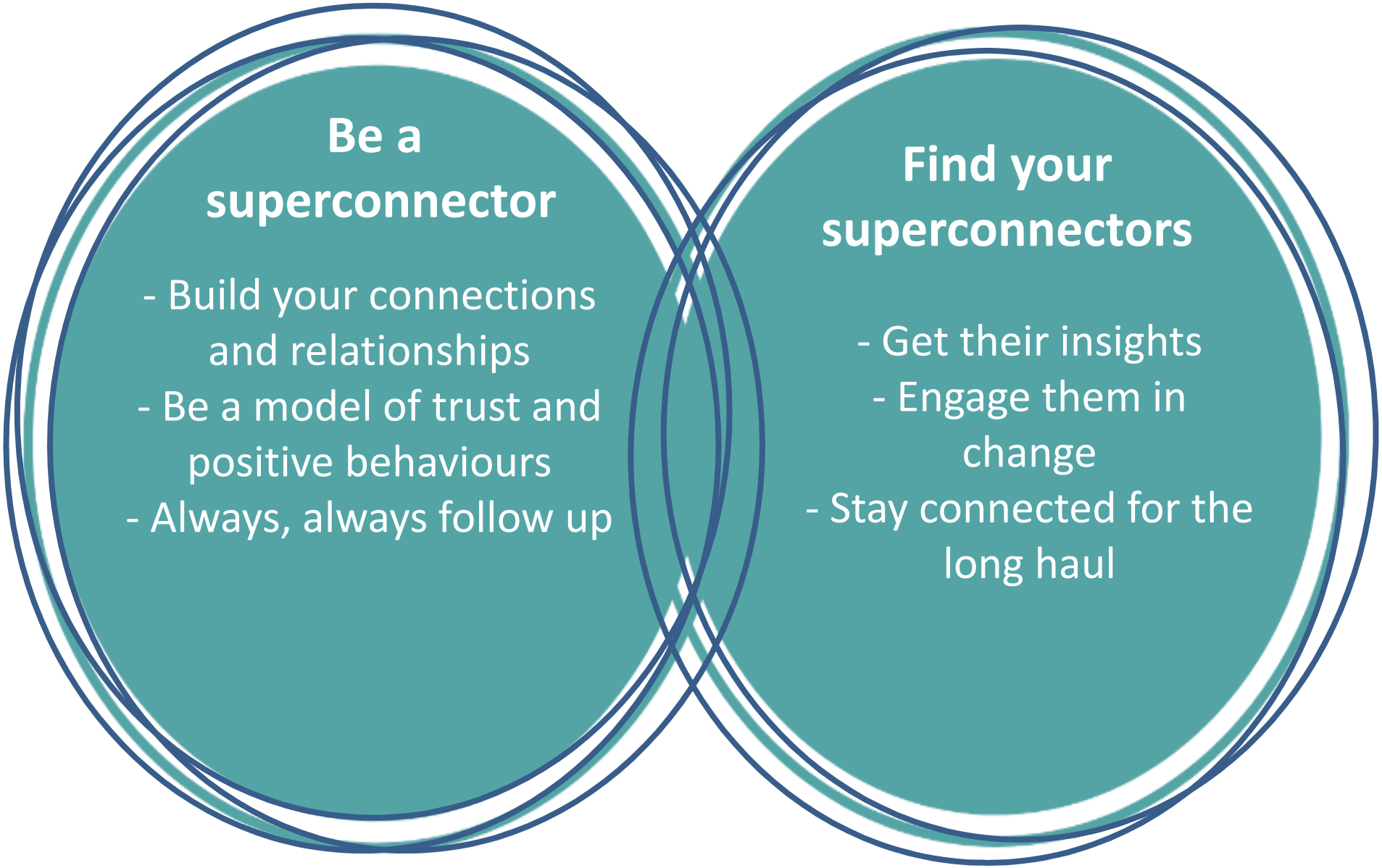
Be a superconnector

- Build your connections and relationships
- Be a model of trust and positive behaviours
- Always, always follow up



Source of graphic: The Strategy Group

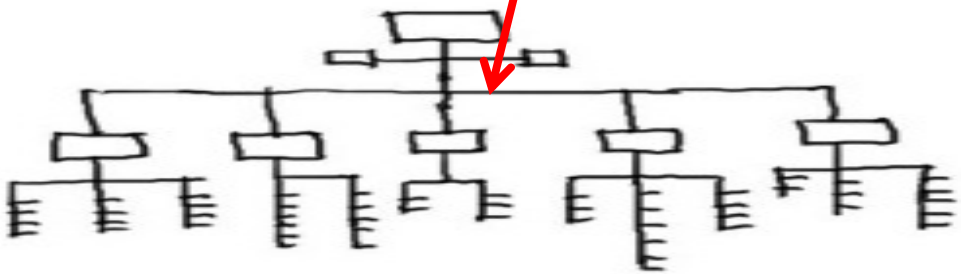
What does this mean for me?



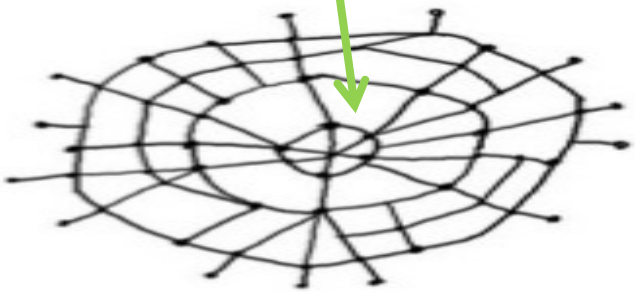
As senior leaders, we may be less influential than we think

If we want to get the same level of influence through top down change as the 3% get, we need **four times** more people

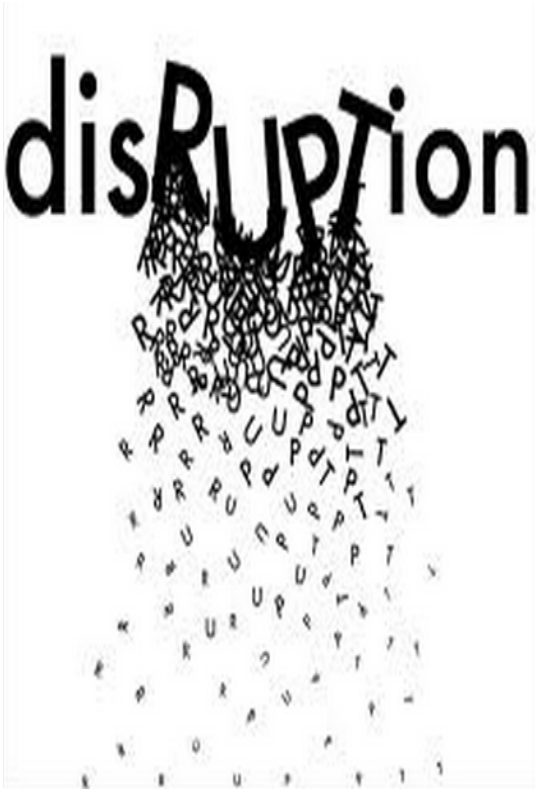
Source : Jeppe Hansgaard



Designed for
DIVISIONS



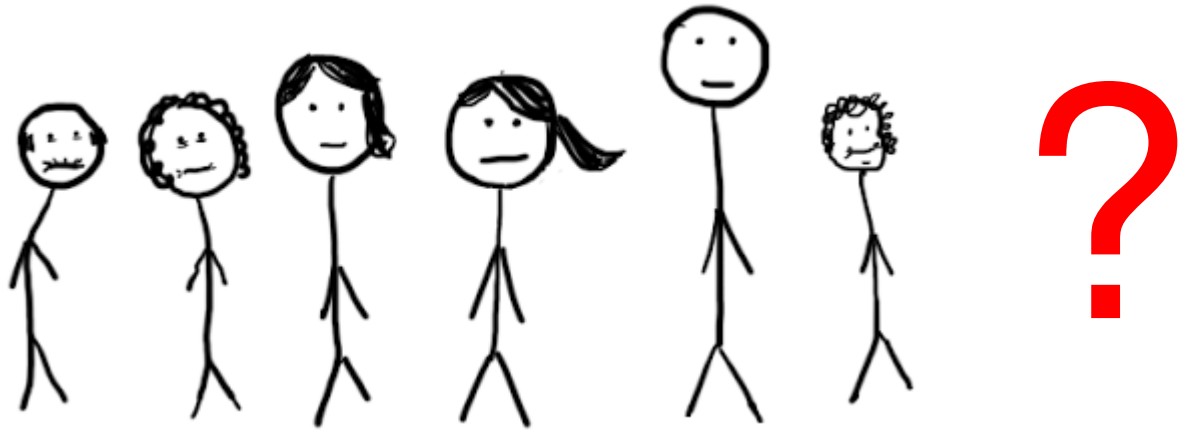
Designed for
CONNECTIONS



"Tomorrow's management systems will need to value diversity, dissent and divergence as highly as conformance, consensus and cohesion."

Gary Hamel

What happens to rebels/heretics/radicals/mavericks in organisations?



Source of image: thinglink.com

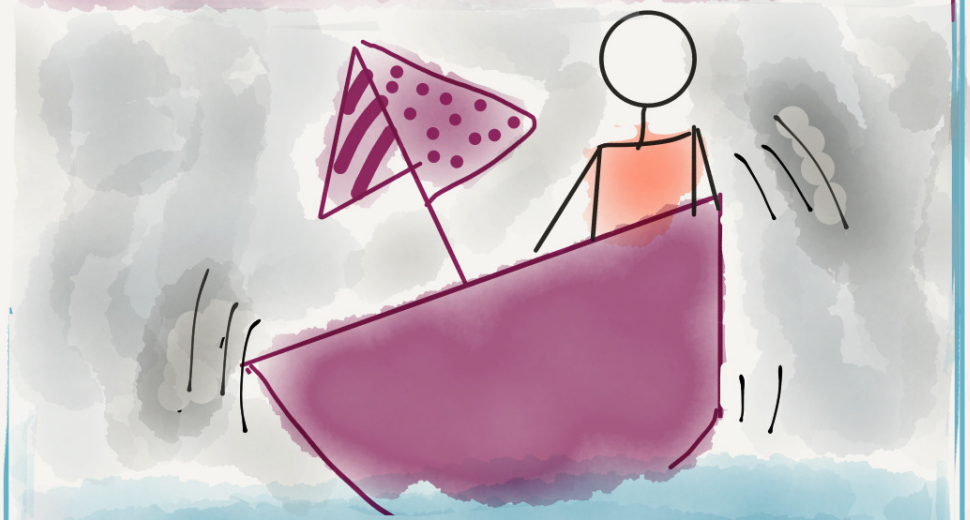
We need to be boatrockers!

- Rock the boat but manage to stay in it
- Walk the fine line between difference and fit, inside and outside
- Conform AND rebel
- Capable of working with others to create success NOT perceived by others as a destructive troublemaker

Source: Debra Meyerson

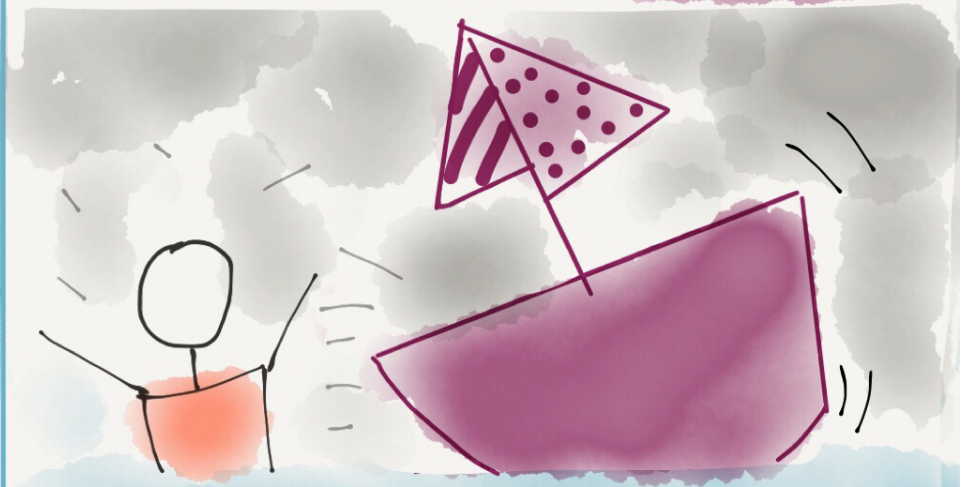
Rocking the Boat

Boat Rockers...



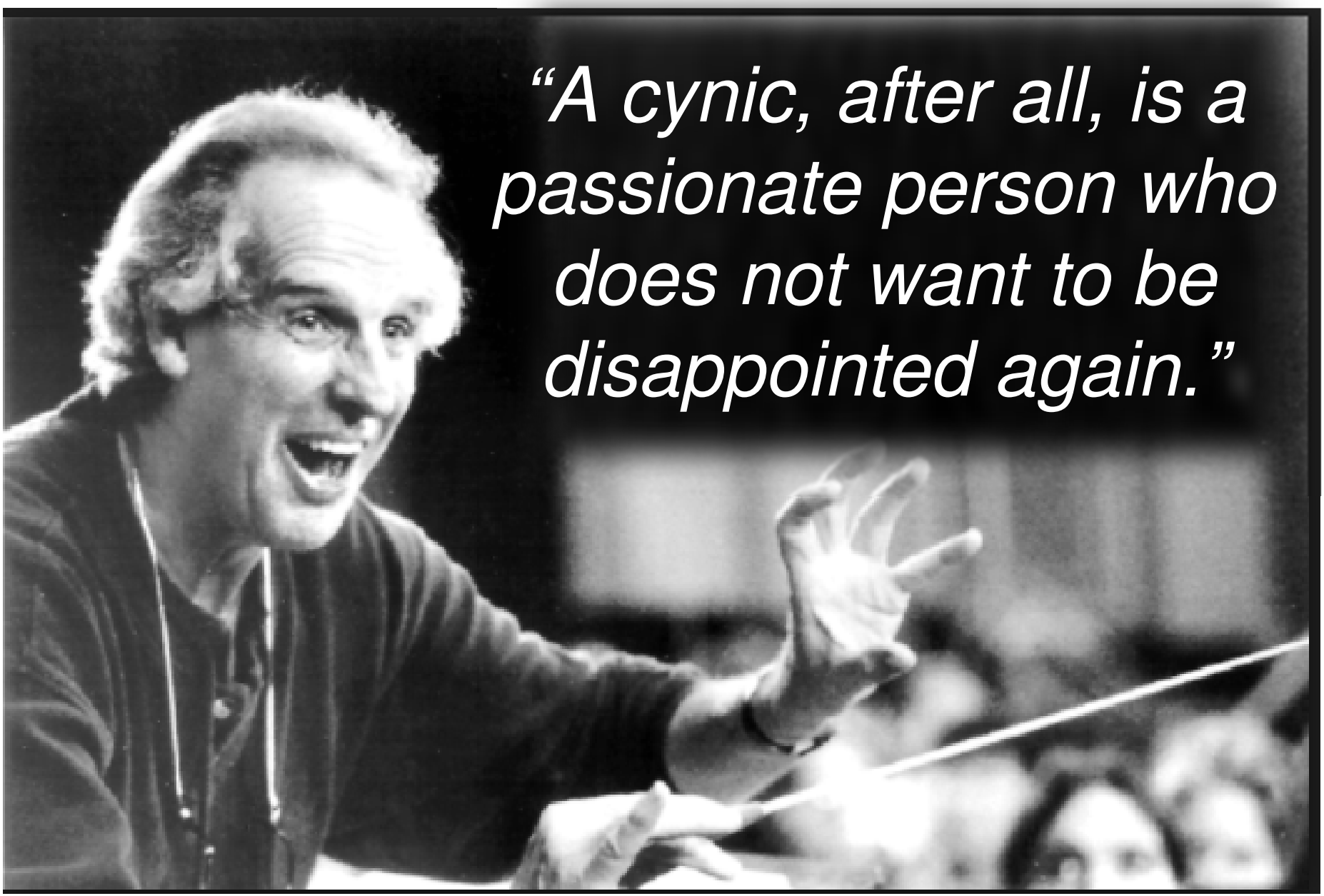
- Mission-focussed
- Passionate
- Keep perspective
- Optimistic
- Energy-generating
- Attracting others
- See possibilities
- Together.

Falling Out...



- Complaining
- Me-focussed
- Angry
- Pessimistic
- Energy-sapping
- Alienate others
- See problems
- Alone.

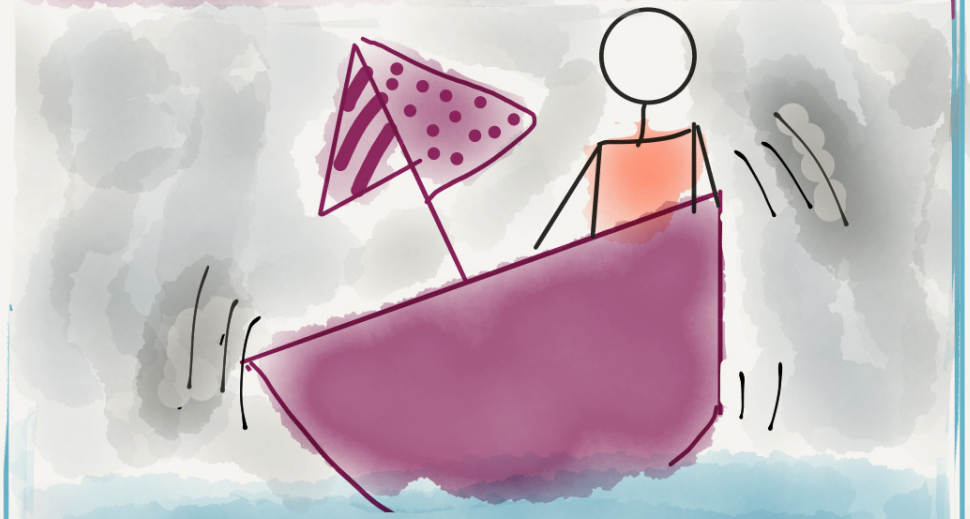
@HorizonsNHS @Sch4Change #S4CA



Source of graphic: Benjamin Zander’s TED talk

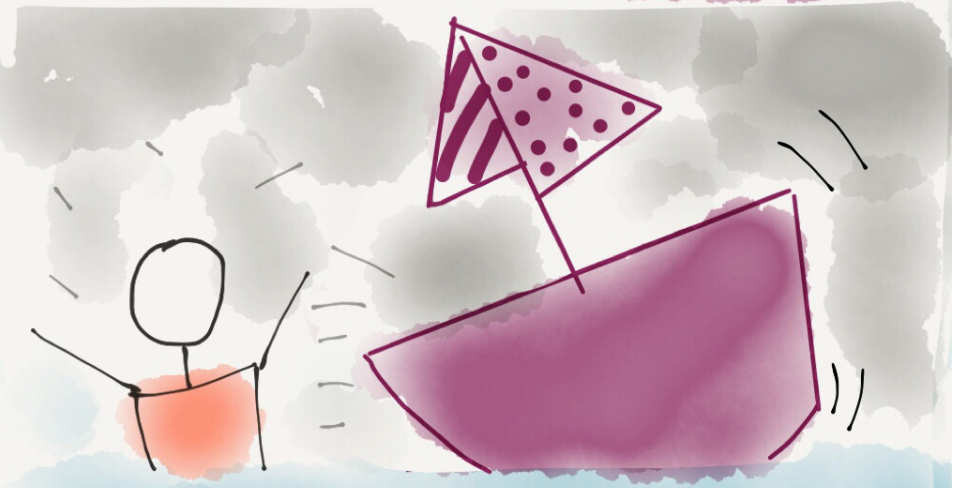
Rocking the Boat

Boat Rockers...



- Mission-focussed
- Passionate
- Keep perspective
- Optimistic
- Energy-generating
- Attracting others
- See possibilities
- Together.

Falling Out...



- Complaining
- Me-focussed
- Angry
- Pessimistic
- Energy-sapping
- Alienate others
- See problems
- Alone.

@HorizonsNHS @Sch4Change #S4CA

More reading

Lois Kelly and Carmen Medina The rebel at work handbook

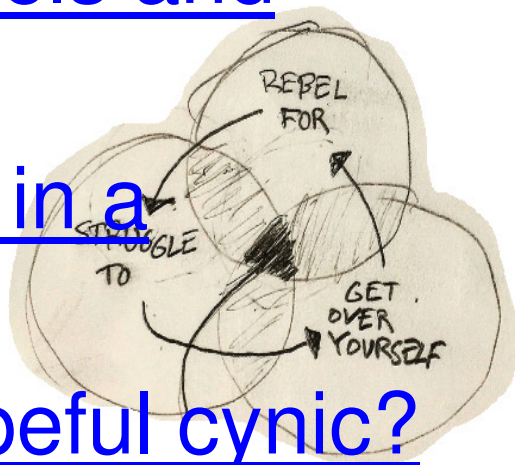
Harvey Schachter How to be a rebel, not a troublemaker at work

Debra Meyerson Tempered radicals: how people use difference to inspire change at work

Jane Watson A spotter's guide to rebels and cynics

Umair Haque How to be more loving in a cynical world

Clark Quinn Skeptical optimist or hopeful cynic? science mindset



Source of graphic : Umair Haque

Sustainability and spread

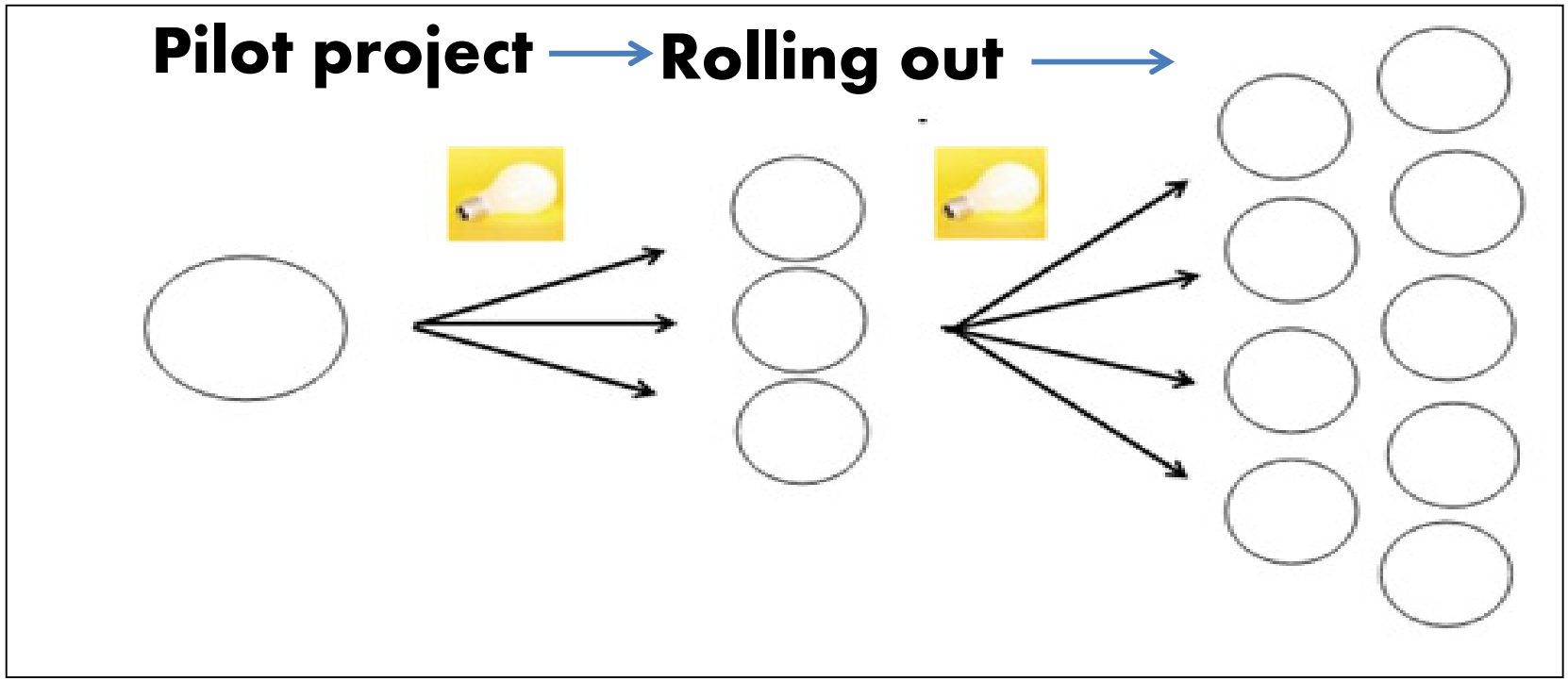
Spreading and sustaining change

Spread: “when new practice is disseminated consistently and reliably across a whole system and involves the implementation of proven interventions in each applicable care setting’.

Sustainability: “when new ways of working and improved outcomes become the norm”

Shelly Jeffcott

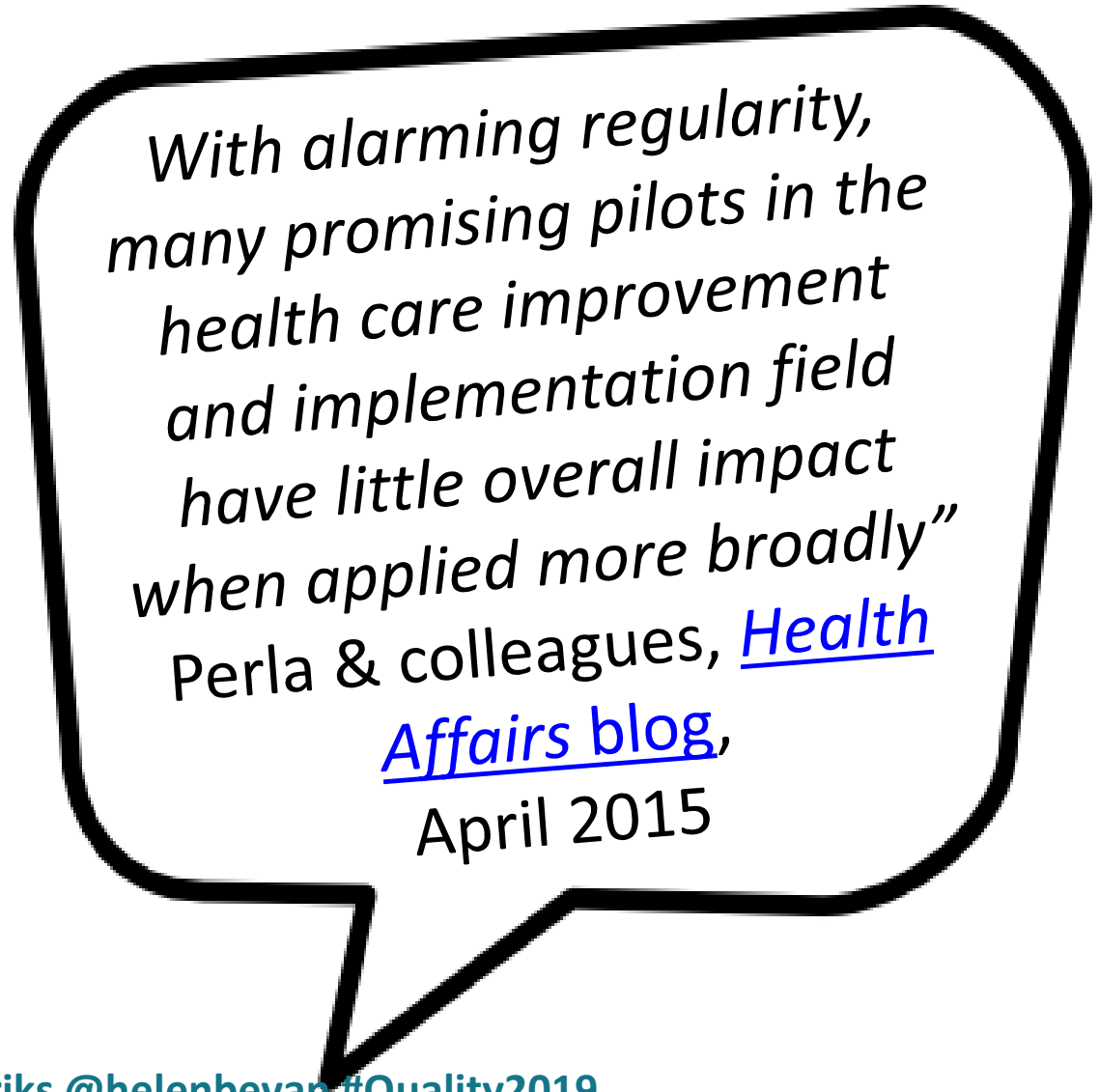
Across the globe, people are questioning the conventional “spread” model



“If we opened our eyes we would see the wonderful irony. Trying to manage human change through pilot and roll-out has actually grown something. A proliferation of project managers”.

John Atkinson

Because the reality is often different

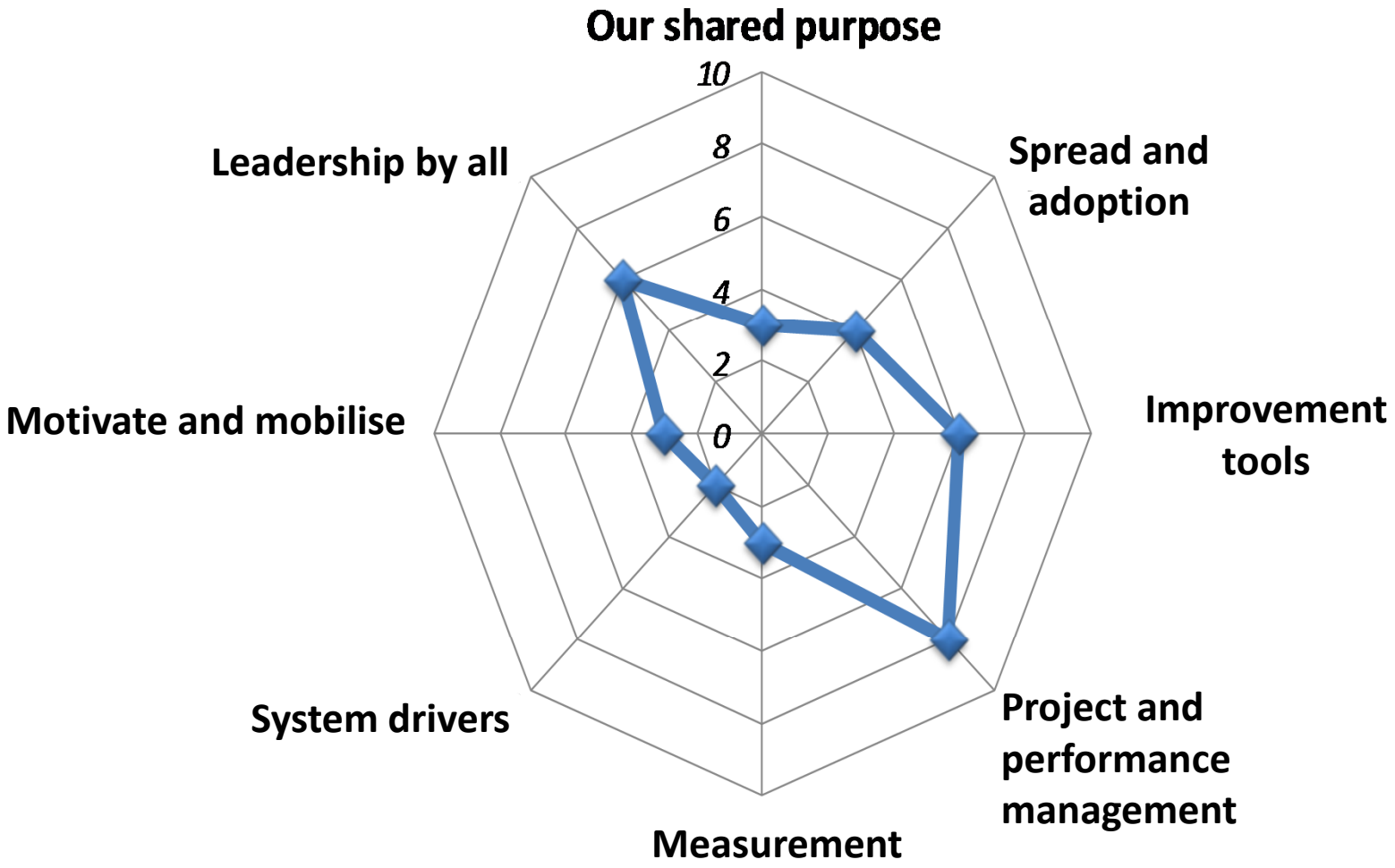


The factors for sustainability and for spread are the same

We have to think about them at the beginning of change

The Change Model: factors for spread and sustainability from the start

What's our prognosis for this asthma pathway project?



The Change Model:

Think about a project you are working on at present: Give yourself a score out of five for each factor

Leadership and team working

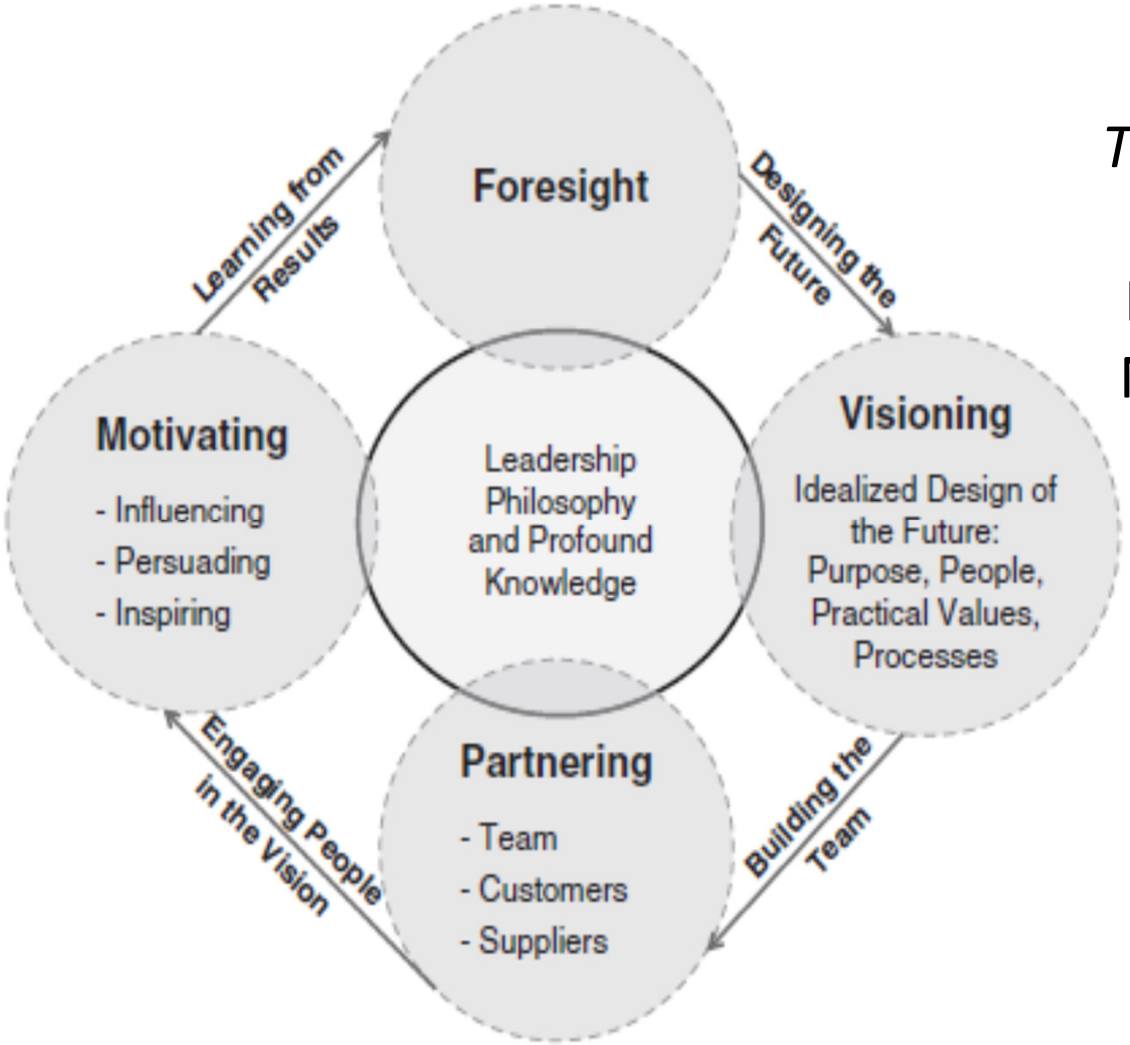
@goranhenriks @helenbevan #Quality2019

https://www.youtube.com/watch?v=ZTbZGAeJ374
78 133 has seen the Hand washing video

Develop the robust microsystem
Togetherness, passion, inspiration, patient centeredness

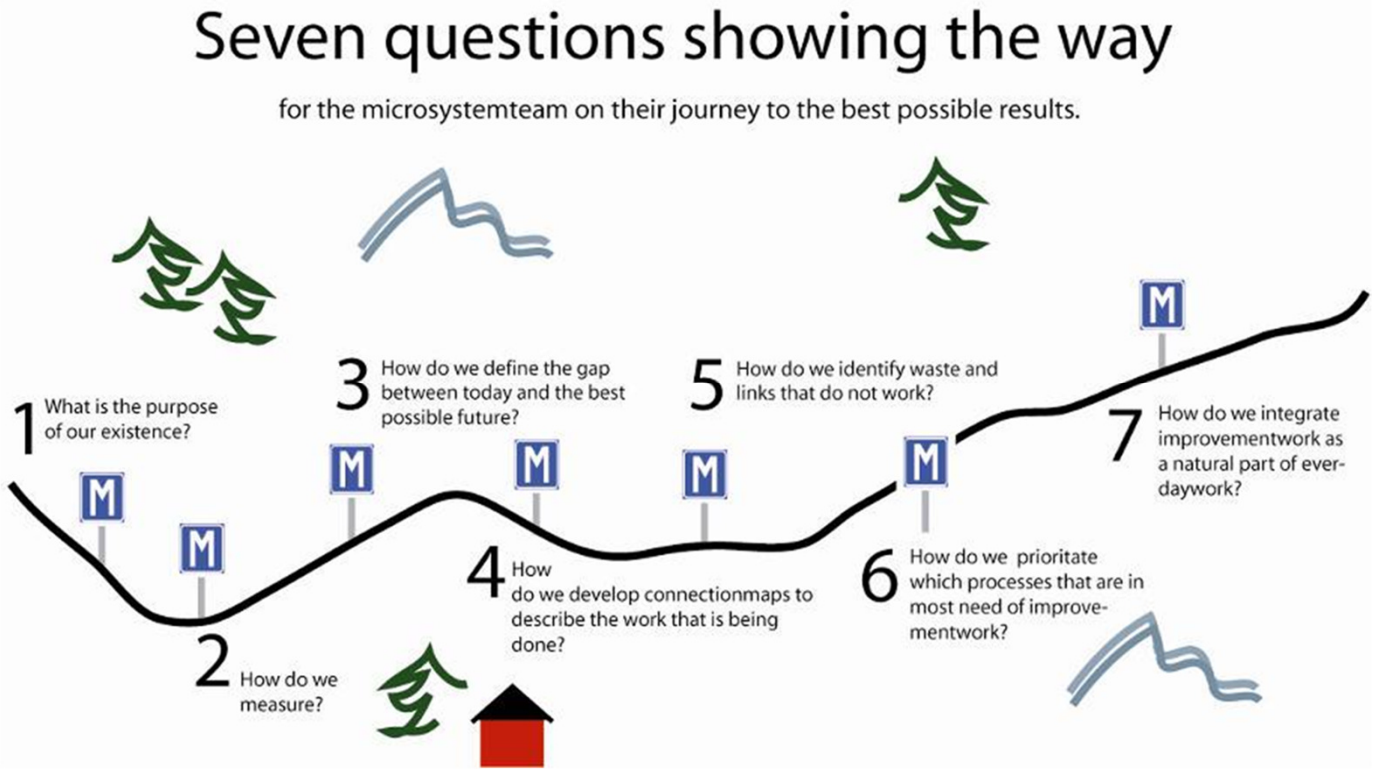
About hand disinfectant, gloves and robustness

Strategic intelligence, leadership philosophy and profound knowledge



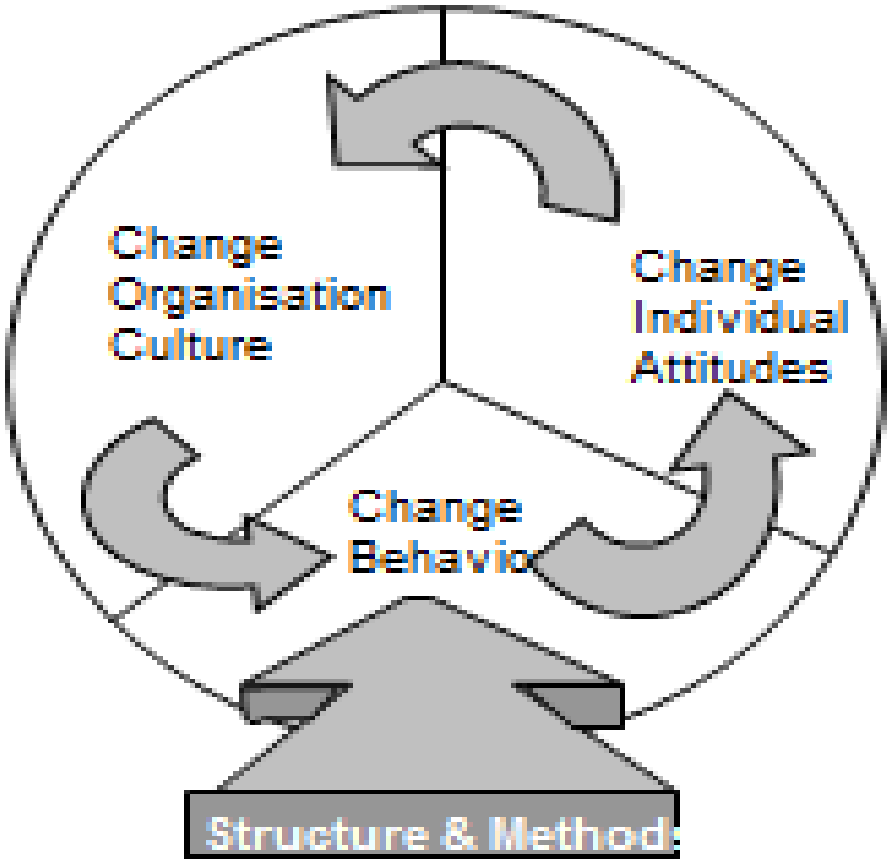
Transforming Health Care leadership
Maccoby, Norman, Norman, Margolies

Microsystem team work



Reference: Bardon, Bojestig, Nilsson, Henriks

To make the transformation happen



Norman, API

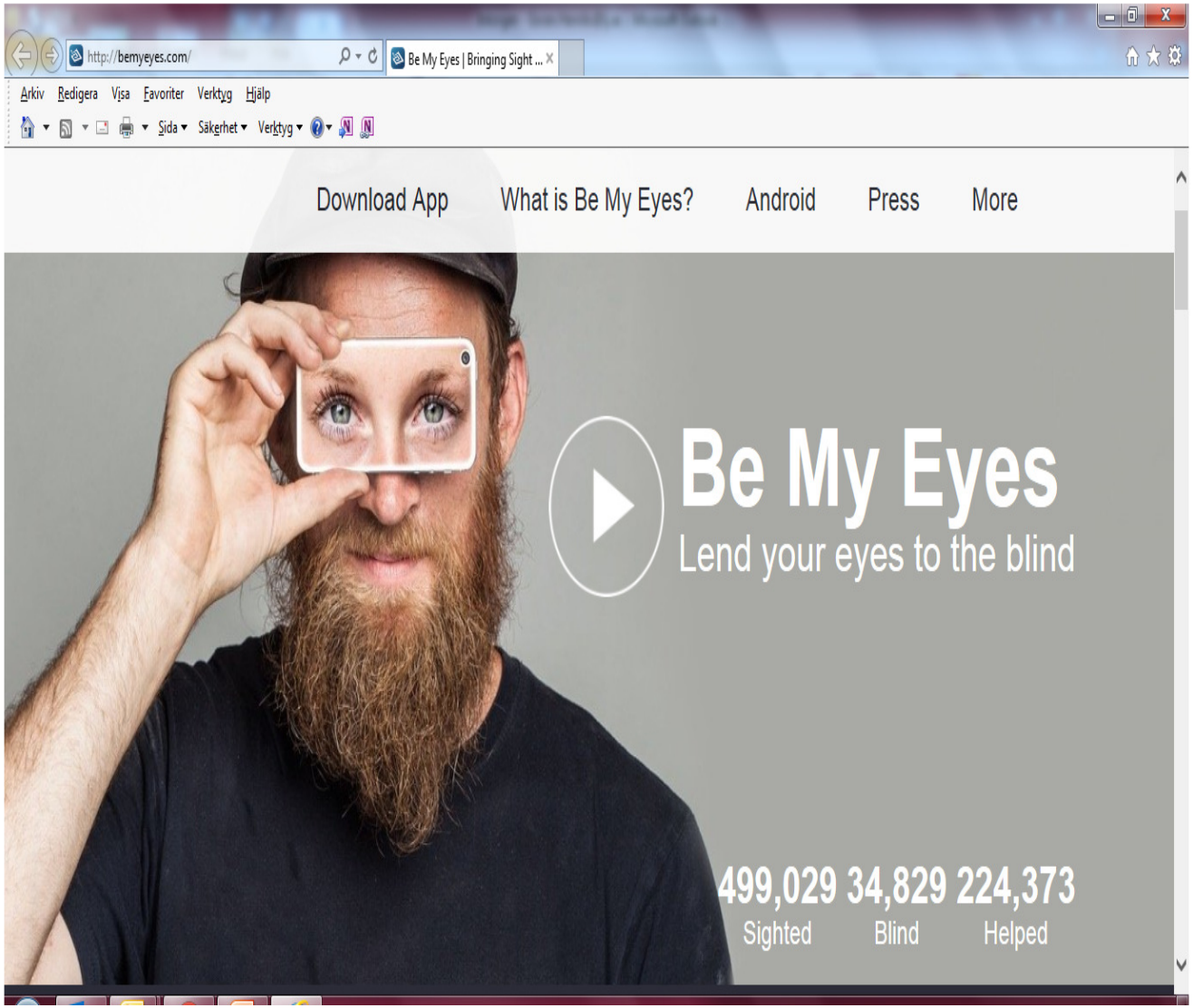
A comprehensive leadership philosophy include 4 elements, based on the answers to these questions:

1. What is the purpose of my organisation?
2. What ethical and **moral reasoning** determines the key decisions we make?
3. What **practical values** do we need to practice to achieve the purpose?
4. How do we define goals and results so they are consistent with our purpose and values?

Transforming Health Care leadership
Maccoby, Norman, Norman, Margolies

Co-production with patients and families

@goranhenriks @helenbevan #Quality2019



Be My Eyes is an app that connects blind and visually impaired with sighted helpers from around the world via live video connection.

@SaraRiggare
http://bemyeyes.com/

Ejje https://vimeo.com/55094566

Quality 3.0

Göran Henriks & Paul Batalden

@goranhenriks @helenbevan #Quality2019

How might we improve the value of the contribution that healthcare service makes to health?

@goranhenriks @helenbevan #Quality2019

Quality 1.0

- Professional societies
- Accreditation
- "Be at least this good…" (floor)
- Standards
- Discipline-focus
- Audits/inspections
- Indicators
- Guidelines…

Not: 1.0 vs 2.0 vs 3.0
Rather: 1.0 + 2.0 + 3.0

Quality 2.0

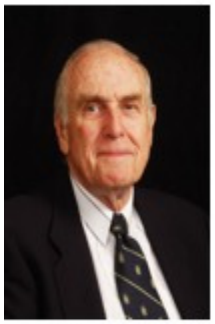
- System/process
- Variation & "statistical thinking"
- Intrinsic motivation
- Learning from testing change
- "Customer" mindedness
- "Improvement & Implementation"
- "Be as good as possible" (ceiling)
- Outcomes focus, measurement
- Quality "in"…

Quality 3.0

- Ownership of "health" service & product
- Relationship + action
- Service coproduction
- Lived reality of TIFKAP, TIFKAPro
- "As is" system journey
- Science-informed practice
- Heterogeneity
- Integrative thinking
- Prototyping
- Value-creating system architectures
- Quality "of"…

Paul Batalden
August, 2019

Key principles



Victor Fuchs 1924-

Making a service is different than making a product…

1968

Carl Gersuny 1928-2013

1973

"Co-production"

The coproduction of a public service involves two parties in some way.

Elinor Ostrom 1933-2012 Nobel Laureate 2009

Robert Lusch 1948-2017

2018

Stephen Vargo 1945-

Service-dominant logic

"Product-dominant" logic confuses the way we think about services

Stephen Osborn

Zoe Radnor

@goranhenriks @helenbevan #Quality2019

Relationship

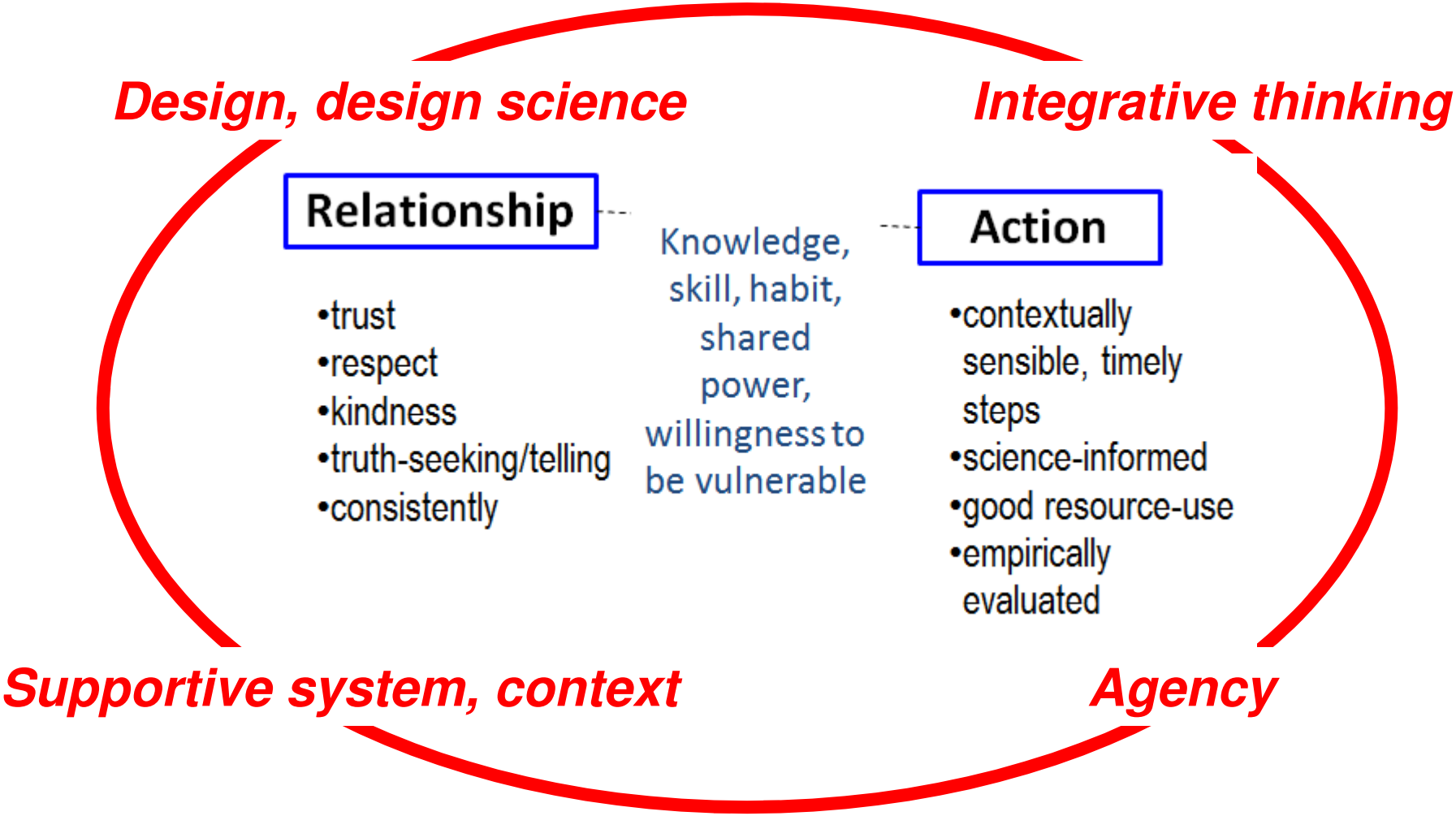
- trust
- respect
- kindness
- truth-seeking/telling
- consistently

Knowledge, skill, habit, shared power, willingness to be vulnerable

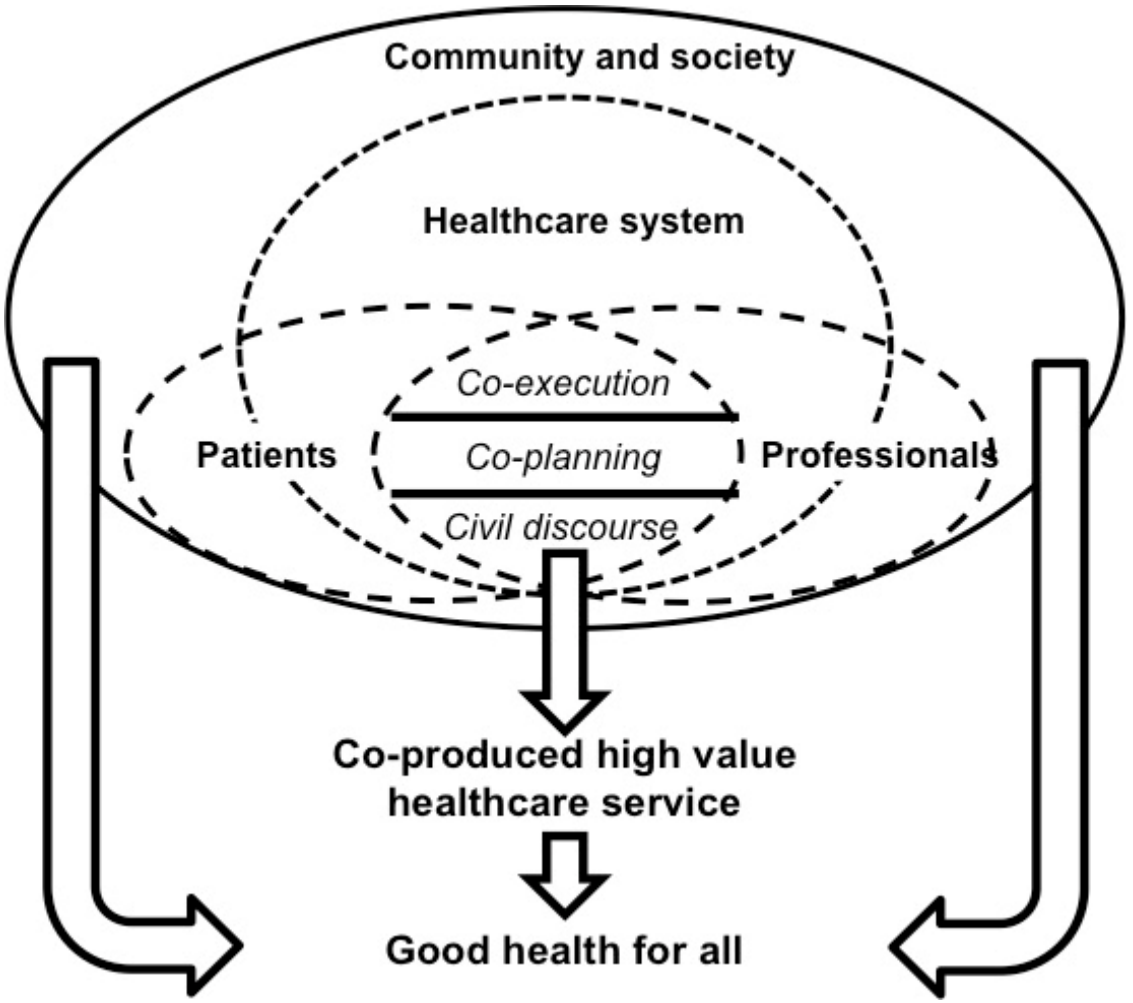
Action

- contextually sensible, timely steps
- science-informed
- good resource-use
- empirically evaluated

…at an individual level



…at a macrosystem level



M. Batalden, et al

Safety

Patient safety

"Patient safety is a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery.

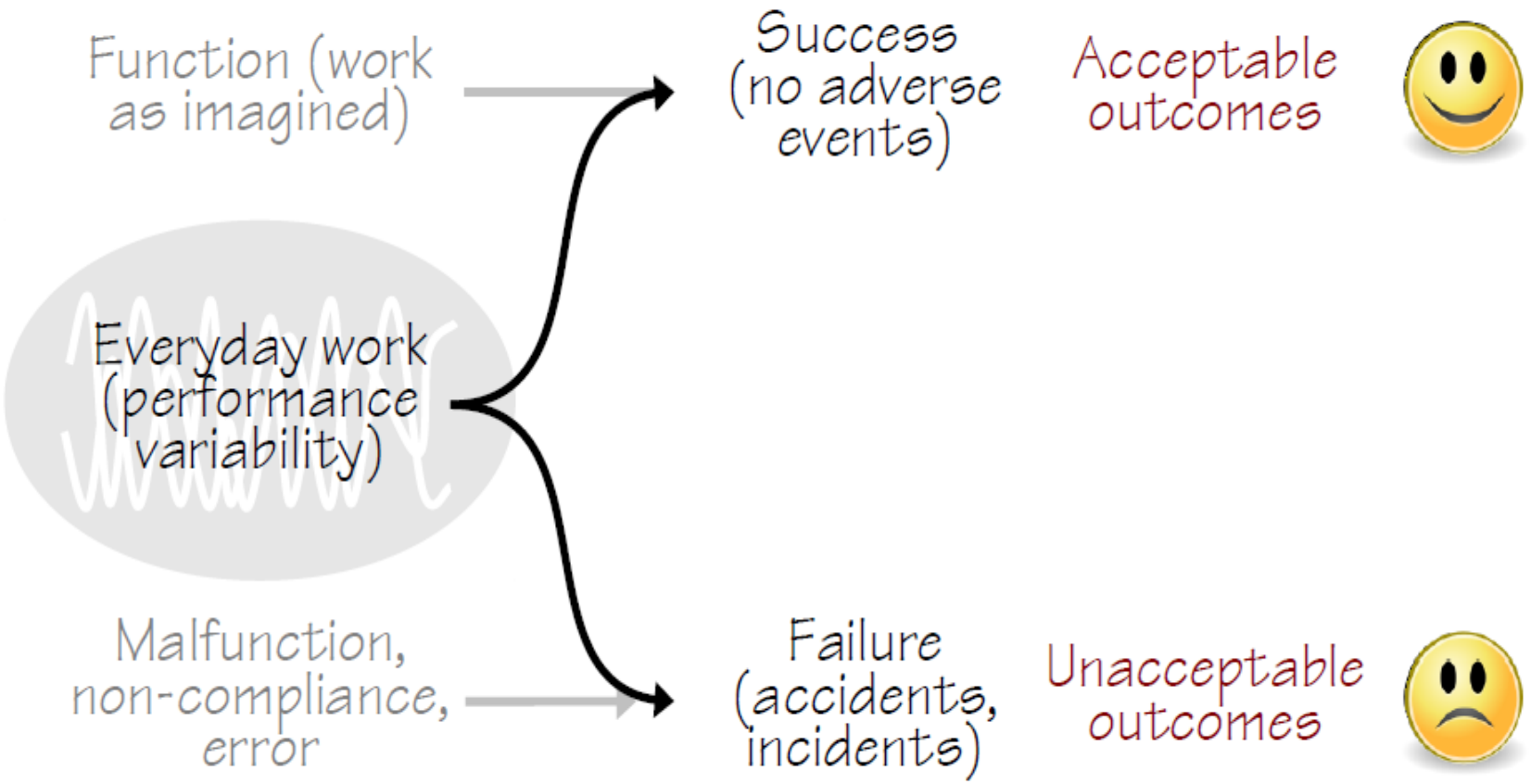
Patient safety is also an attribute of healthcare systems; it minimises the incidence and impact of, and maximizes recovery from, adverse events."

What does it mean to be safe?

Patient safety is the absence of preventable harm to a patient during health care.
Patient safety is the coordinated efforts to prevent harm, caused by the process of health care itself, from occurring to patients.

We always notice when something unexpected happens (accident, incident, harm). We react to it, as individuals and organisations.

Same process, different outcomes

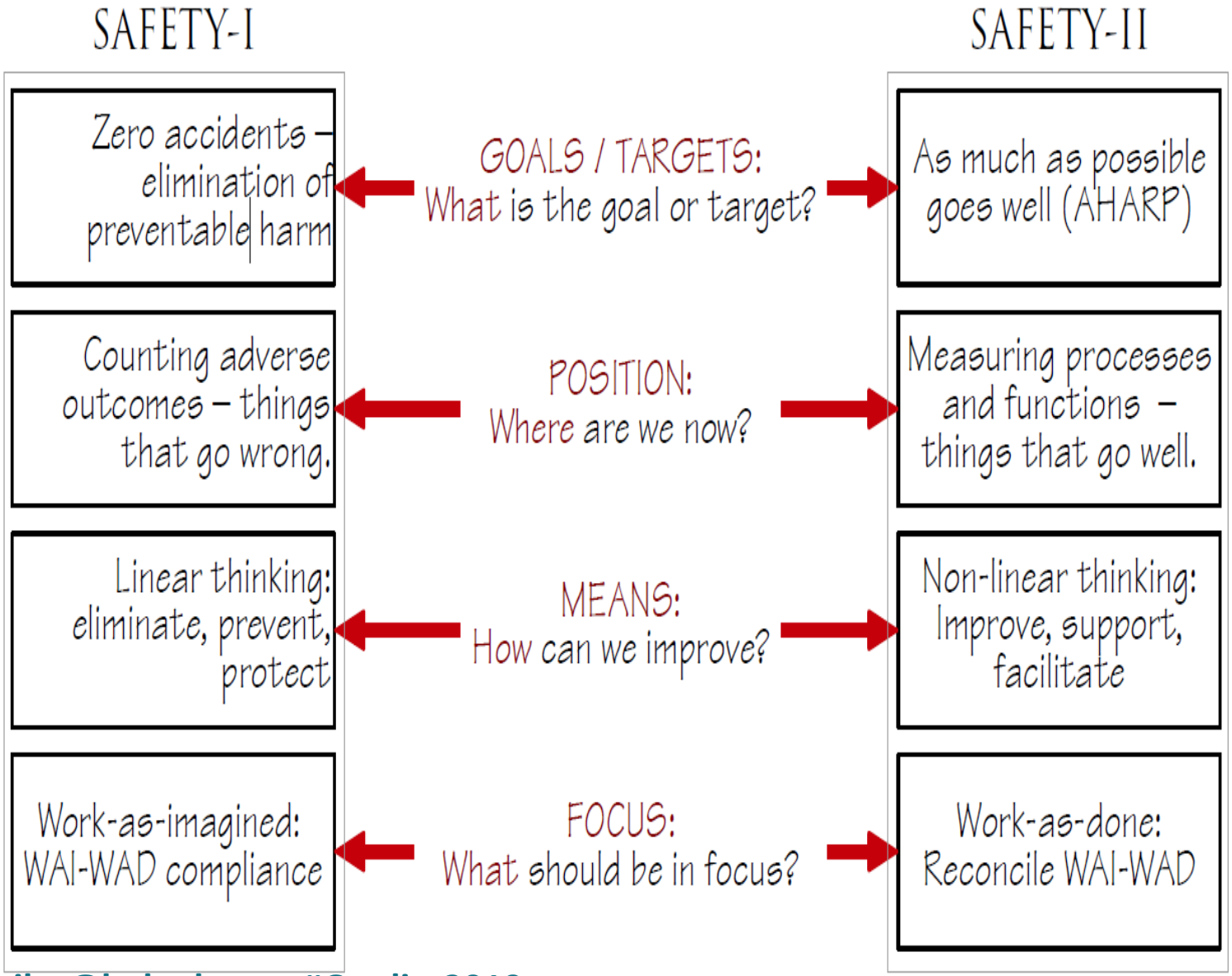


What happens when "nothing" happens?

	Things can go wrong because	"Nothing" happens because
Safety -I (protective safety)	Physical items will always eventually fail.	Systems are well designed and perfectly maintained.
	Humans do commit performance errors and always will.	Procedures are complete and correct.
	Systems include unintended and unrecognised functions.	People behave as they are expected to - as they are taught
	Combinations of components can hide sneak faults and other flaws.	Designers can foresee and anticipate every contingency.
Safety -II (productive safety)	Humans find ways to overcome design flaws and hindrances.	Humans find ways to overcome design flaws and hindrances.
	Humans adjust their performance to meet demands	Humans adjust their performance to meet demands
	Humans interpret and apply procedures to match conditions	Humans interpret and apply procedures to match conditions
	Humans can detect and correct when things go wrong	Humans can detect and correct when things go wrong

Safety I and Safety II

Let´s talk!



A new safety mindset

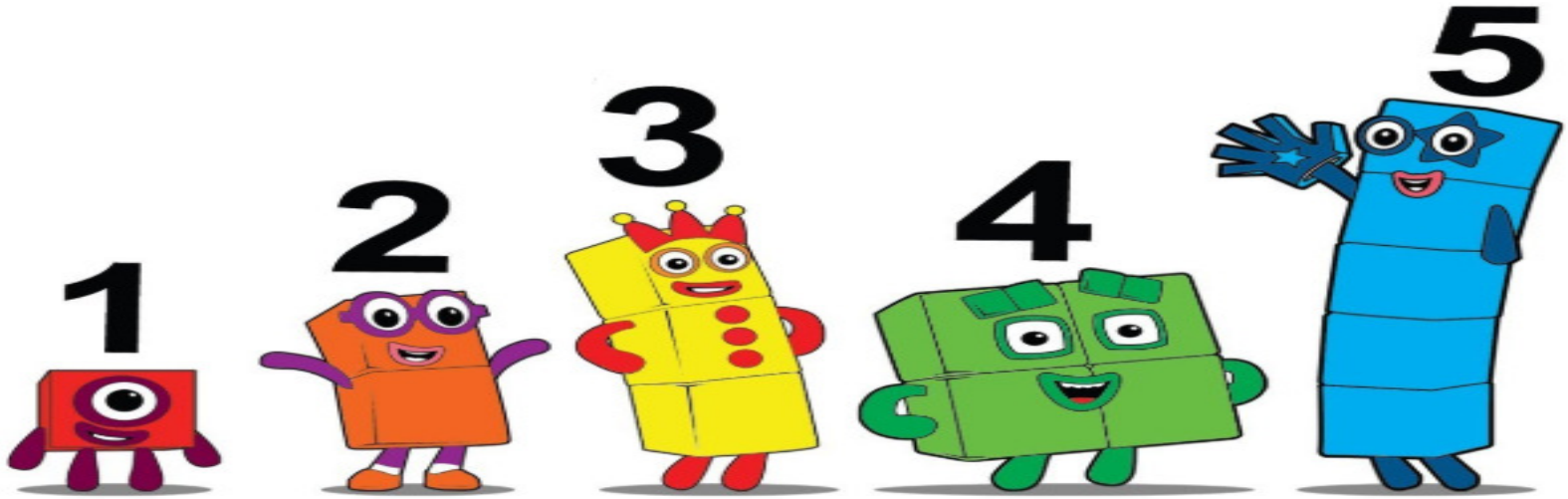
- Focus on what is right rather than what is going wrong,
- Change the definition of security from "avoid something goes wrong" to "make sure everything goes right."
- Specifically, the new safety awareness ability to succeed under varying conditions, so that the number of deliberate and acceptable results is as high as possible.

We will accelerate our efforts

- We are moving from reactive approaches to proactive approaches and methods
- We have a center for learning and innovation in patient safety
- We have an academy which is jointly owned by the college, region and municipalities

A human spectrogram

What is your level of skill and confidence in quality improvement ?



Very low

High

Our finale: “Snowstorm”

- **Write down one key thing you have learnt from this workshop on a sheet of white paper**

Our finale: “Snowstorm”

- **Write down one key thing you have learnt from this workshop on a sheet of white paper**
- **Screw the paper up**

Our finale: “Snowstorm”

- **Write down one key thing you have learnt from this workshop on a sheet of white paper**
- **Screw the paper up**
- **On the signal, throw your paper snowball in the air**

Our finale: “Snowstorm”

- **Write down one key thing you have learnt from this workshop on a sheet of white paper**
- **Screw the paper up**
- **On the signal, throw your paper snowball in the air**
- **Pick up a snowball that lands near you and read it aloud to the rest of your table**