Cultural Change for Quality, Patient Safety and Value

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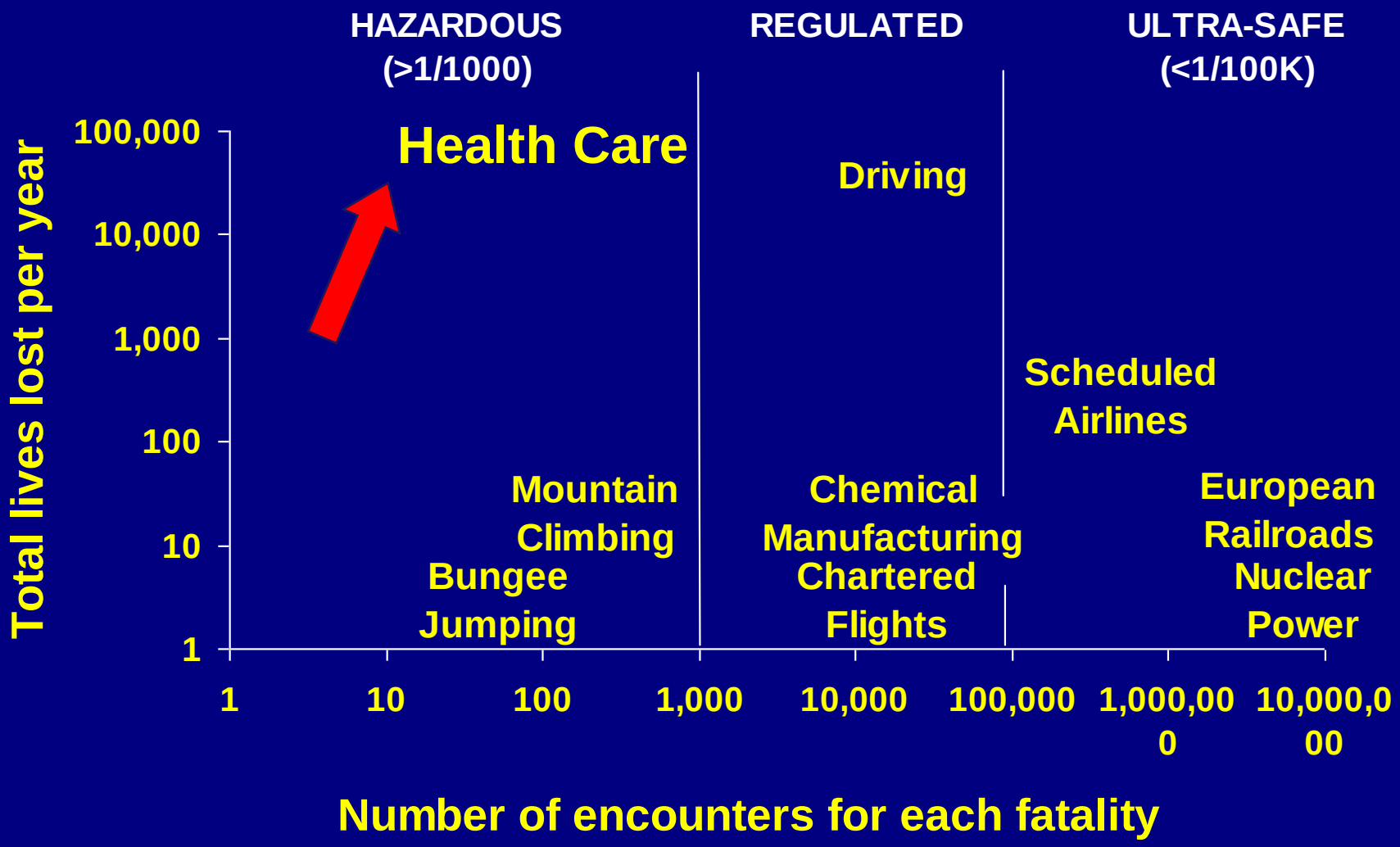
Safety is the coming issue

- Traditional healthcare concerns are being addressed
- Infection control issues have focussed attention on one major safety issue
- There is growing academic attention on the issues of safety
- There is more data in the public domain

How Hazardous Is Health Care?

(Leape and Amalberti)



…and where have we been as a leadership community?

- Selective (NB our application of *Primum non nocere*)
- Slow
- Driven by external not internal motivations
- Lacking in knowledge
- Culturally careless


NHS
N838MJ

Initiatives for Safety

- Clear, tough targets
- Regulation – e.g. Hygiene Codes
- Incentives – e.g. non payment for harm
- Information – e.g. public data sets
- Quality Improvement work

Not knowing what to do is no longer an excuse

But the issue is how to do it

And that is about culture

Creating a culture of safety: Eight suggestions

1. **Re-learn to be horrified by harm and communicate that throughout your organisation**

ACTUAL - Untoward incident alert at [redacted] Hospitals NHS Trust. Type: Unexpected Death of Inpatient (not in receipt) (log numbe...

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Reply | Reply to All | Forward

Extra line breaks in this message were removed.

From: URHM.DOH_DMZ.DOH_EXT.DOH@dh.gsi.gov.uk Sent: Mon 14/01/2008 17:56
To: Sarah Mussett; Katherine Fenton; Jim Easton; Diana Emerick-Law; Olga Senior; Olga Senior
Cc:
Subject: ACTUAL - Untoward incident alert at [redacted]ls NHS Trust. Type: Unexpected Death of Inpatient (not in receipt) (log number: 2008/366)

Please follow one of the links below to open the incident form (log number: 2008/366)

http://nww.steis.doh.nhs.uk/steis/untoward.nsf/0/2D7917E3407F4434802573D0006276A1?opendocument

or

http://nww.steis-classa.dh.nhs.uk/steis/untoward.nsf/0/2D7917E3407F4434802573D0006276A1?opendocument

2. Learn to love the routinely good but hate mediocrity

Hating mediocrity

3. Actively support safety driven challenges to inappropriate use of hierarchy

15:59:51 CA It's spooled. Real cold, real cold.
15:59:58 F/O **God, look at that thing. That don't seem right, does it? Uh, that's not right**
16:00:09 CA Yes it is, there's eighty
16:00:10 F/O **Naw, I don't think that's right. Ah, maybe it is.**
16:00:21 CA CAM-1 Hundred and twenty.
16:00:23 F/O CAM-2 **I don't know**
16:00:31 CA Vee-one. Easy, vee-two
16:00:39 [Sound of stick shaker starts and continues until impact]
16:00:41 TWR Palm 90 contact departure control.
16:00:45 CA Forward, forward, easy. We only want five hundred.
16:00:48 CA Come on forward....forward, just barely climb.
16:00:59 CA Stalling, we're falling!
16:01:00 F/O Larry, we're going down, Larry....
16:01:01 CA I know it.
16:01:01 [Sound of impact]

4. Be conscious about how your leadership reaction to incidents drives culture

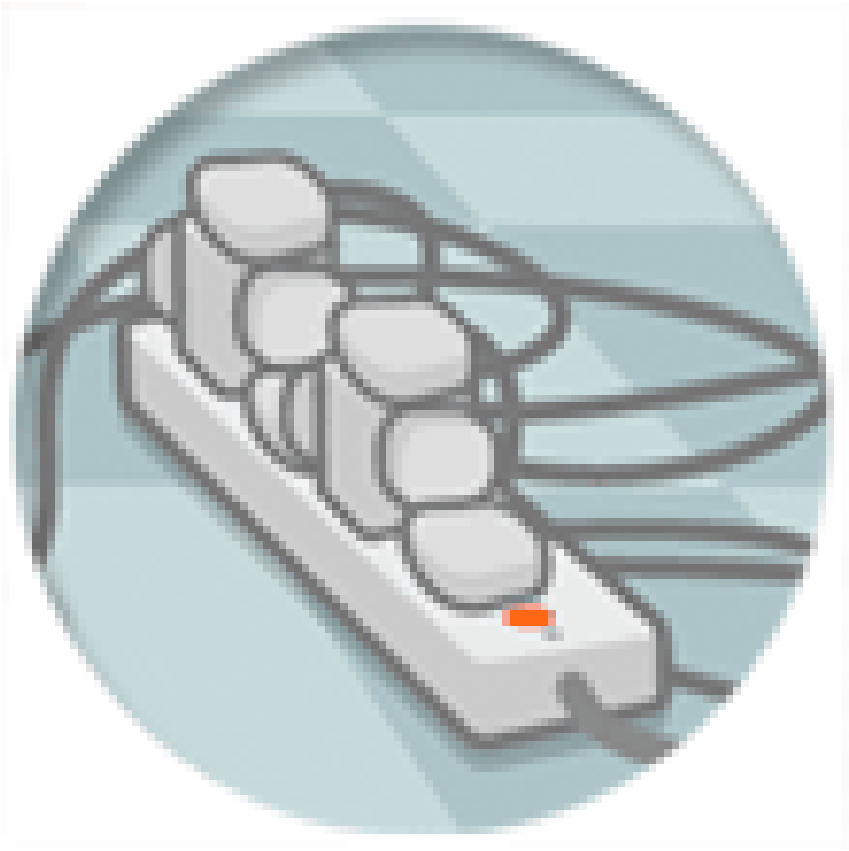
Punishment

Sanctions

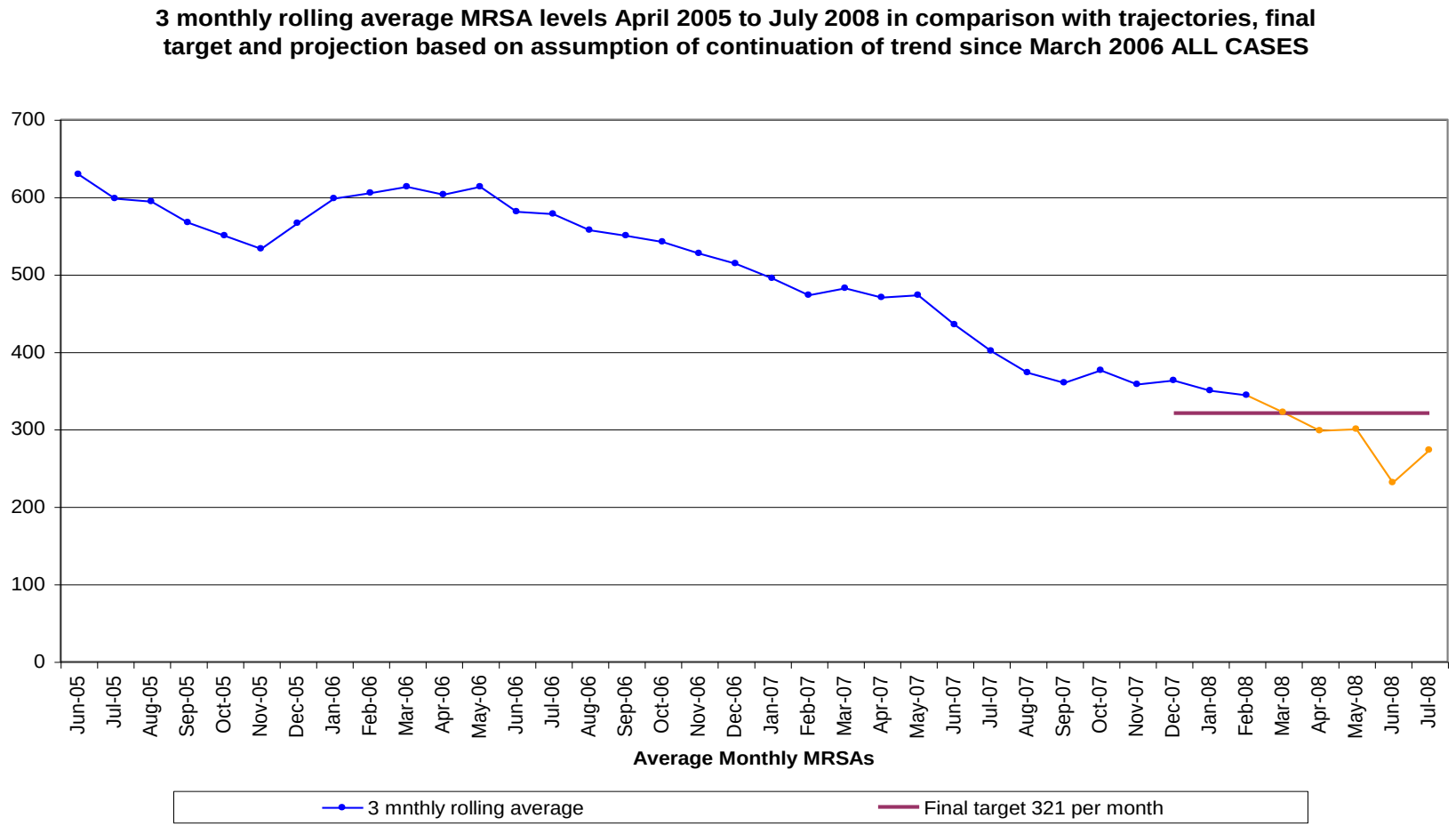
Protection

Rewards

5. Deliver on small changes

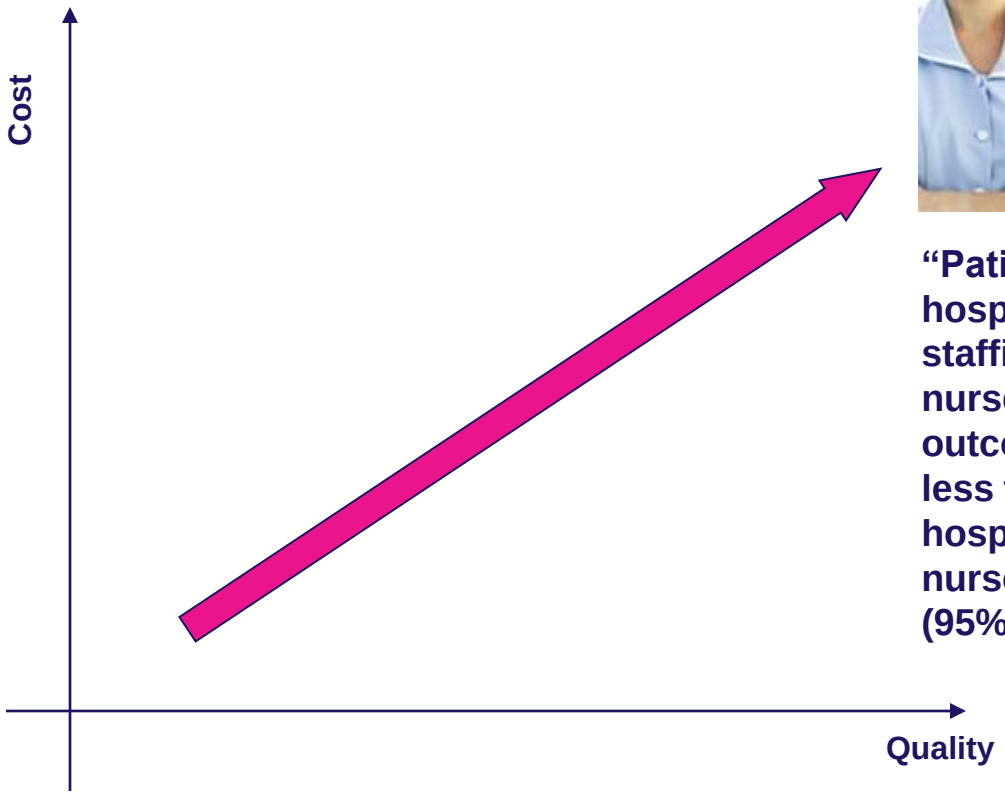


6. Set the right targets at the right level



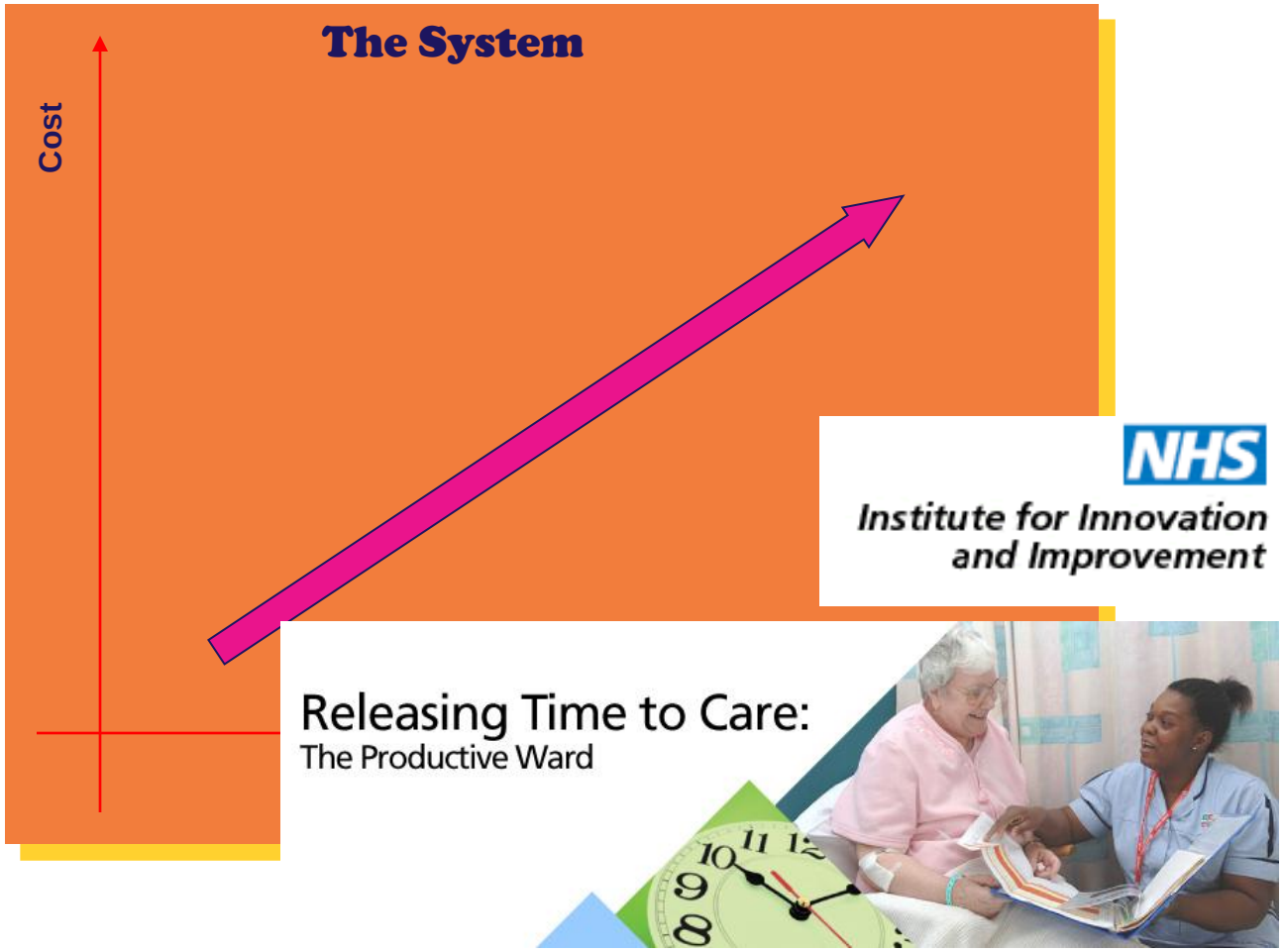
7. Tackle the cost/quality belief system

Our cost/quality belief system



“Patients and nurses in the quartile of hospitals with the most favourable staffing levels (the lowest patient-to-nurse ratios) had consistently better outcomes than those in hospitals with less favourable staffing. Patients in the hospitals with the highest patient to nurse ratios had 26% higher mortality (95% CI: 12-49%)”*

Rafferty, Clarke, Coles, Ball, et al. Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records, International Journal of Nursing Studies. Oxford: Feb 2007. Vol. 44.



http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

8. Model Learning and Spread

Conclusions

- Safety – it was the coming issue – it's here
- There is no shortage of well evidenced interventions that will drive safety improvement
- Take leadership action on culture to drive these interventions into reality