Leadership for Improvement

Symposium Session
Hong Kong Hospital Convention

David Fillingham

8th May 2014

This session will cover:

- Developing leaders for improvement – a five point plan
  - Deeply understand your service and build an ambitious vision
  - Develop personal mastery of improvement methods
  - Manage change well
  - Adopt an “enthusiastic pragmatist” leadership style
  - Build your own and others resilience

- What kinds of service improvements have you been involved in leading?
- What are the main challenges you have faced in doing this?

Suzanne Lomax, Matron
Bolton NHS Foundation Trust, UK

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Bolton Stroke - Results

	2006	2008
CT Scan within 24 hours	46%	100%
Patients on Acute Stroke Unit	-	99%
Aspirin within 24 hours	63%	100%
Physio within 72 hours Sentinel Audit Score	65% 60%	98% 92%
Mortality rate **Length of Stay** **Sickness absence rate**	122 43 15%	99 22 4%

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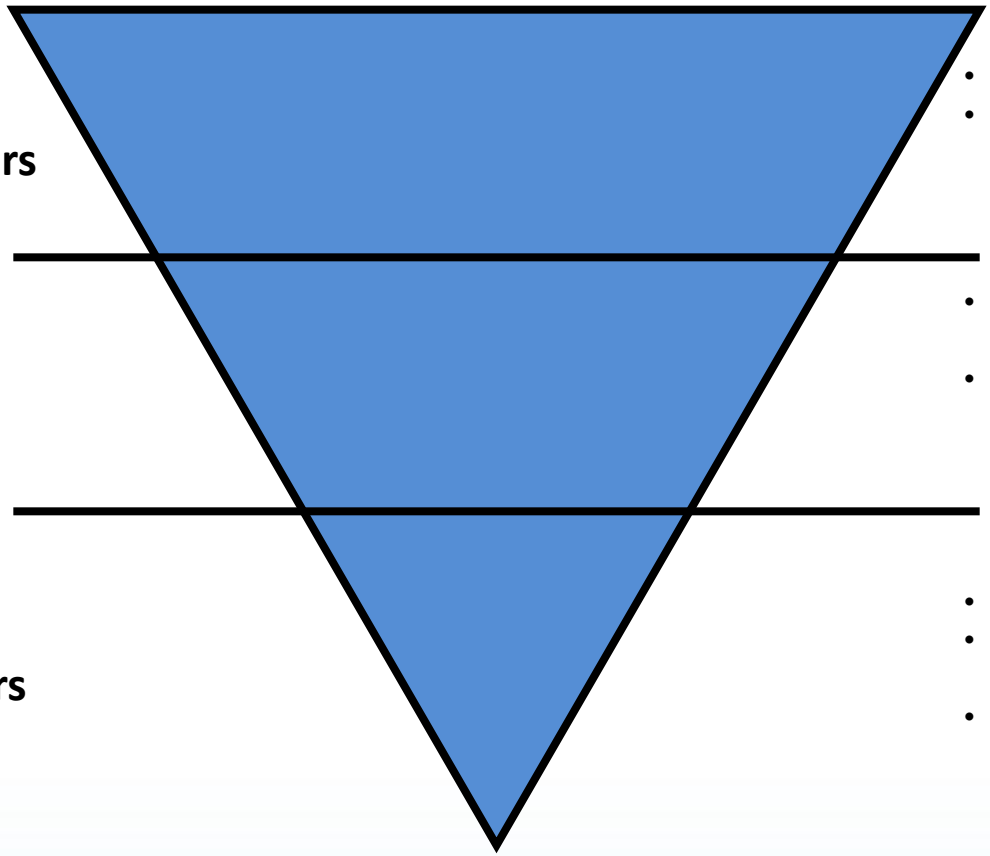
The Stroke Team

Improvement Leaders at Every Level



Front Line Leaders

- Building effective teams
- continuously improving care

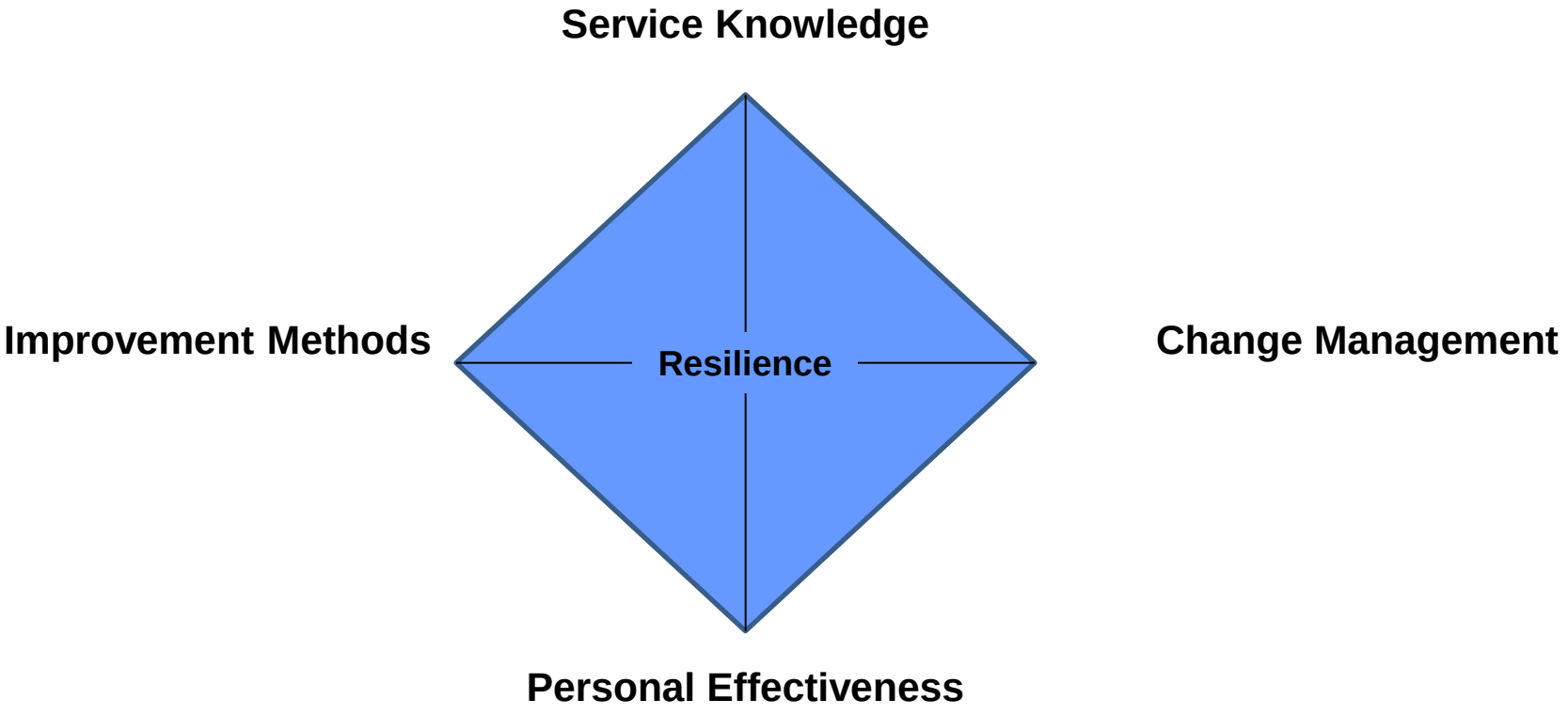
Service Leaders

- Connecting up across a whole patient journey
- Coaching and supporting front line service leaders

Strategic Leaders

- Building will and capability
- Reshaping whole systems of care
- Coaching and supporting frontline and services leaders

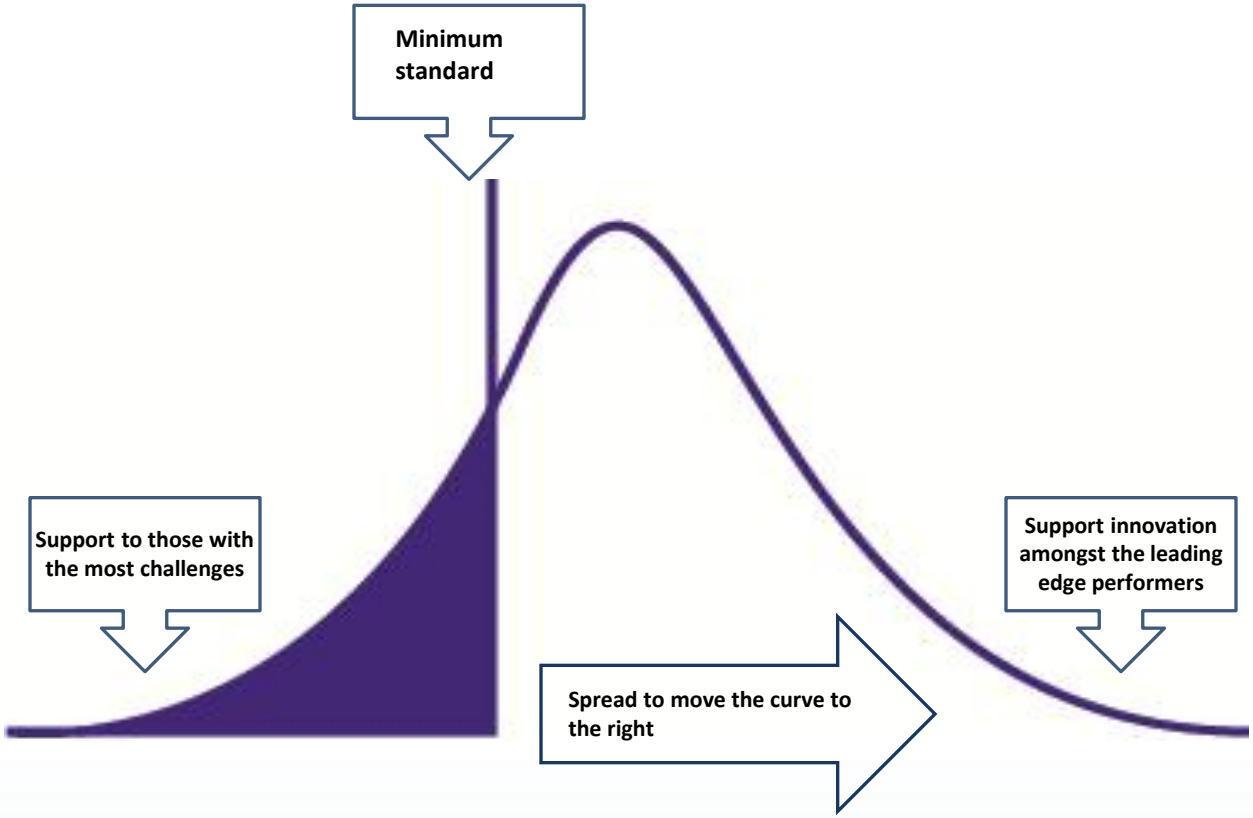
A Development Framework for Leadership for Improvement



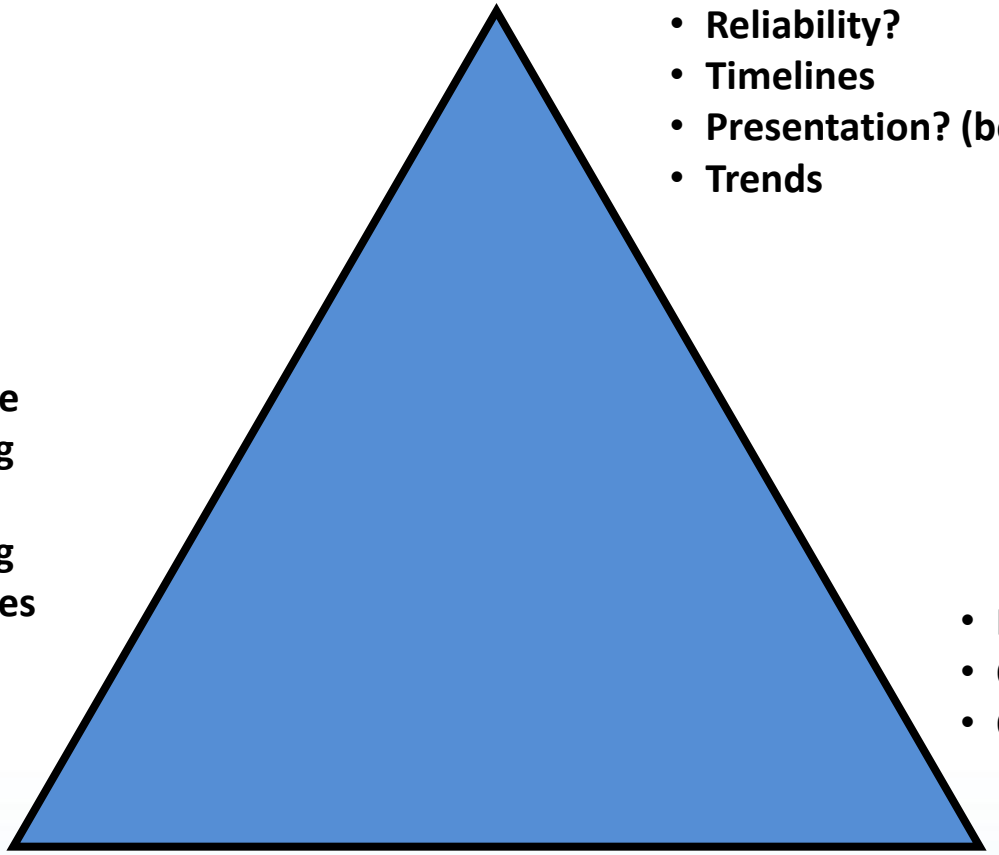
Service Specific Knowledge

- What's the current quality of your service?
- What does 'best' look like… what are our goals for improvement?
- How can we "put the patient in the room"?

The Quality Curve



How do you know?



- Source?
- Reliability?
- Timelines
- Presentation? (beware of traffic lights!)
- Trends

- Visits (announced and unannounced)
- Observations of care
- Shadowing/meeting staff
- Shadowing/meeting patients and relatives
- Engagement in improvement activities

- Patients and families
- Other care givers
- Quantitative 'stories'

TRIANGULATE the different SOURCES

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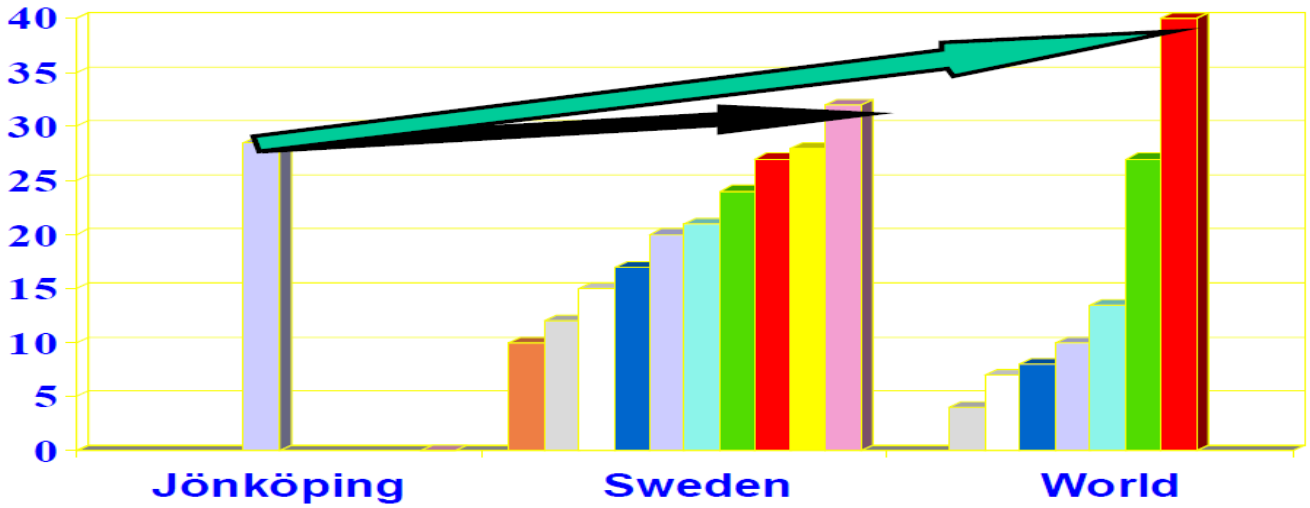
What is best in the world?



Qulturum

LANDSTINGET i Jönköpings län

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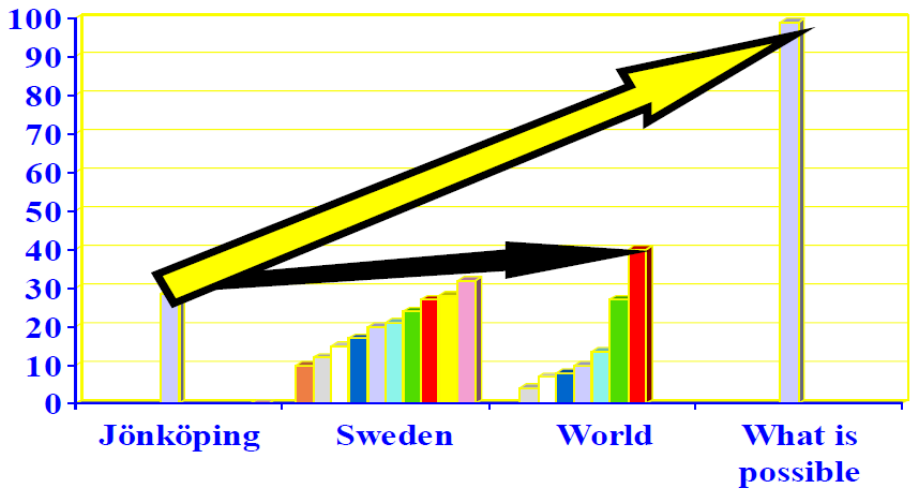
Best possible!



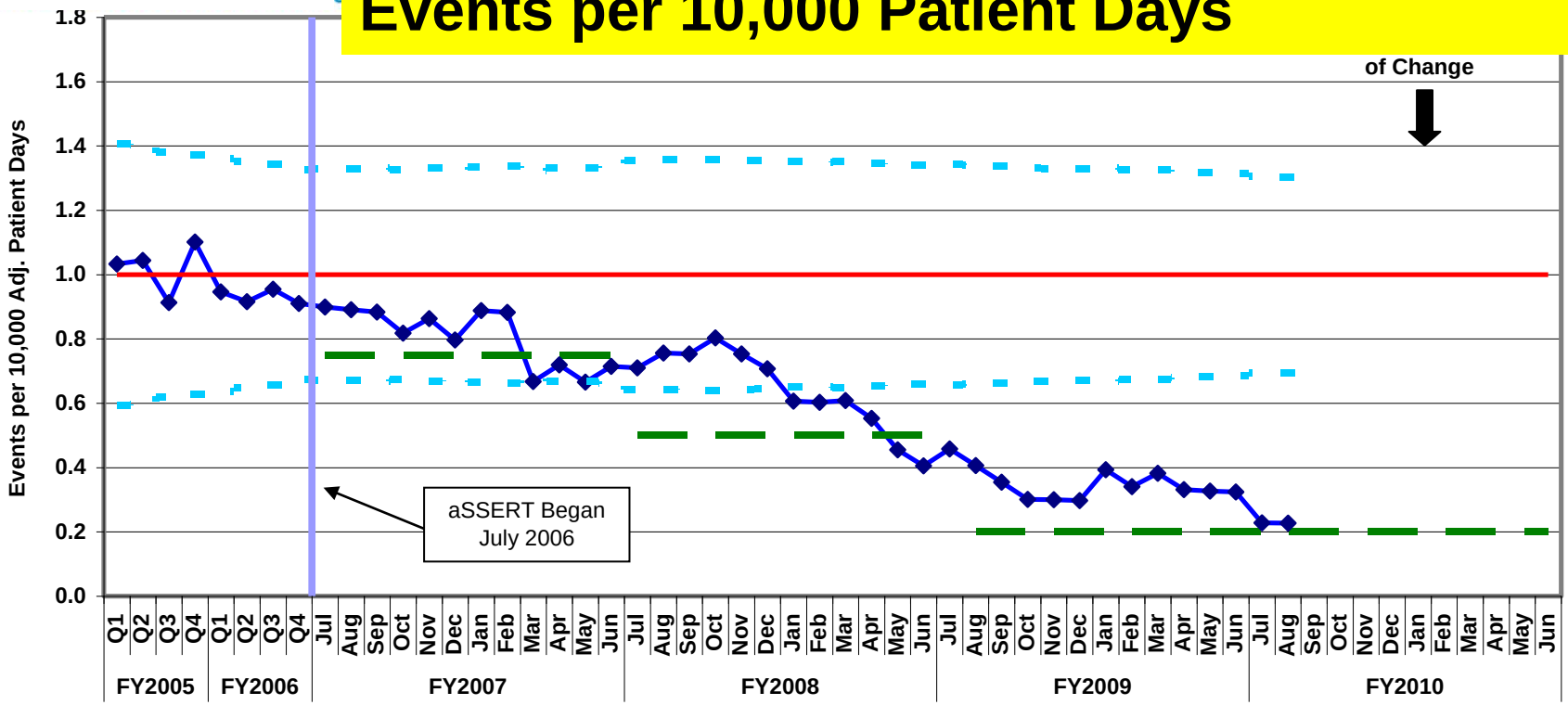
Qulturum

LANDSTINGET i Jönköpings län

Put the “patient in the room”

- Start each meeting with a patient story
- Eliminate the denominator (ask “how many patients is that?”)
- Convert data into names, dates and events… “humanise it”
- Have patients as fully participating members of improvement teams

Aim: Reduce harm to children by 80% in 3 years, as measured by Serious Safety Events per 10,000 Patient Days



** Each point reflects the previous 12 months. Threshold line denotes significant difference from baseline for those 12 months (p=0.05).

** The narrowing thresholds in FY2005-FY2007 reflect increasing census. Adjusted patient days for FY07 were 27% higher than for FY05.

SSEs per 10,000 Adj. Patient Days

Baseline [1.0 (FY05-06)]

Fiscal Year Goals (FY07=0.75 / FY08=0.50 / FY09=0.20)

Threshold for Significant Change

Chart Updated Through 31Aug09 by Art Wheeler, Legal Dept.

Source: Legal Dept.

Baseline SSER, Calendar Year 2008, 46 Events

John B.
9/06/2008
Delay in Dx

Shirley H.
12/23/08
Post Proced Death

Florita H.
7/03/2008
Delay in Tx

Wade W.
7/16/2008
Delay in Tx

Baby Boy S.
8/1/2008
Wrong Pt. Procedure

Joseph R.
9/08/2008
Delay in Dx.

Tamika M
4/21/2008
Med Error

Andrea M.
6/24/2008
Wrong Procedure

Nancy H.
6/18/2008
Med Error

Jimmy P.
7/07/2008
Fall

Joann E.
9/23/2008
Wrong Site Surgery

Cynthia M.
10/27/2008
Med Error

Regina D.
12/9/2008
Wrong Site Surgery

Baby Girl V.
5/12/2008
Mother's Delay in Tx

Kyle W.
9/13/2008
Delay in Tx

Teodur C.
1/29/08, 2/12/2008
Delay in Tx

Alvin G.
8/17/2008
Fall

Nicole S.
1/4/2008
Delay in Dx

Margaret H.
2/6/2008
Med Error

Ursula H.
2/12/2008
Fall

Ms. L.
2/14/2008
Delay in Tx

Sandra M.
12/10/2008
Post Procedure Death

Karen G.
8/5/2008
Proced Cx/Delay in Tx

Cynthia K.
11/10/2008
Delay in Tx

Lance D.
10/30/2008
Delay in Tx

Nicole H.
8/12/2008
Post-proced Cx

Robert S.
10/13/2008
Fall

Mary D.
3/9/2008
Med Error

Baby Boy G.
3/25/2008
Med Error

Lorena W.
11/10/2008
Post Procedure Death

Priscilla W.
8/30/2008
Delay in Tx

Dale W.
10/12/2008
Med Error

Eugene B.
10/27/2008, 10/28/2008
Med Error, Fall

Kathy W.
12/16/2008
Post Proced Loss of Function

Robert B.
12/2/2008
Post Procedure Death

Virginia L.
8/12/2008
Delay in Tx

Helene C.
9/5/2008
Fall

Lester J.
9/5/2008
Fall

Calvin P.
4/4/2008
Med Error

Gwendolyn P.
10/28/2008
Wrong Implant

Chantal E.
6/26/2008
Inapprop Touching

Gary B.
6/13/2008
Fall

Mary C.
12/19/2008
Fall

Douglas T.
10/18/2008
Med Error

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24 Patients & Events – Jan-Dec,2009 vs 46 Total for 2008

Loueene D.
9/23/09
Fall

Beverly S.
2/4/09
Med Error

Robert D.
5/12/09
Post Procedure Death

Karen C.
9/28/09
Delay In Treatment

Peggy P.
7/1/09
Burn

Sharenda W.
2/15/09
Med Error

Edward R.
4/23/09
Wrong Side Procedure

Brenda R.
10/14/09
Delay In Treatment

James H.
10/25/09
Post Procedure Death

Lilliam C.
4/3/09
Retained foreign object

47% Reduction SSER from Dec. 08 Baseline
48% Reduction in # of events year to year

Dorothy R.
1/28/09
Delay In Treatment

Donna S.
6/4/09
Retained foreign object

Monroe K.
5/18/09
Post Procedure Death

Jerry Y.
11/7/09
Fall

Yoland C.
7/7/09
Delay in Treatment

Juanita A.
5/14/09
Delay In Treatment

Johnny B.
11/9/09
Fall

Alma M.
11/6/09
Fall

Scott G.
9/5/09
Delay in Treatment

Michael F.
8/20/09
Retained foreign object

Willie B.
11/5/09
Med Error

Helen C.
11/4/09
Delay In Treatment

Pauline M.
11/2/09
Fall

Ronnie D.
11/3/09
Delay in Treatment

INSTITUTE FOR HEALTHCARE IMPROVEMENT

2010: A 78% reduction from baseline

Lois R.
4/16/10
Surgical Fire

Mary B.
5/22/10
Post Procedure Cx

Lamar A.
6/3/10
Med Error

Bruce C.
5/25/10
Delay In Dx

Marilyn C.
1/21/10
Med Error

Ruby B.
5/30/10
Fall

Sylvia L.
3/31/10
Delay In Dx

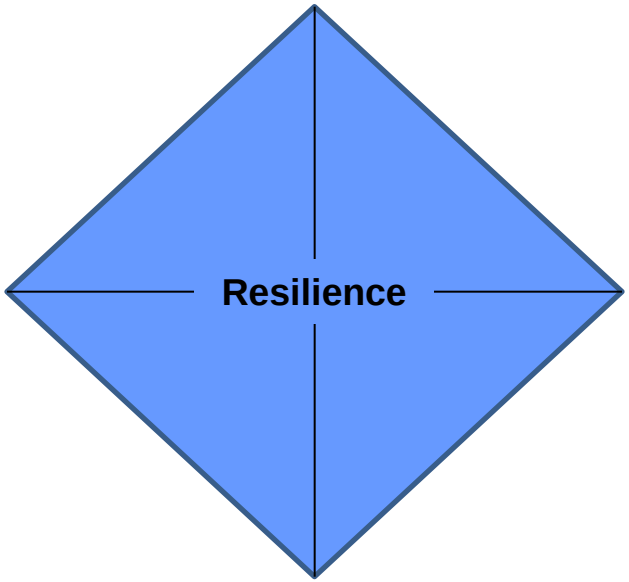
Doyle L.
7/22/10
Med Error

Frank S.
2/22/10
Surgery Cx

A Development Framework for Leadership for Improvement

Service Specific Knowledge

Improvement Methods



Change Management

Personal Effectiveness

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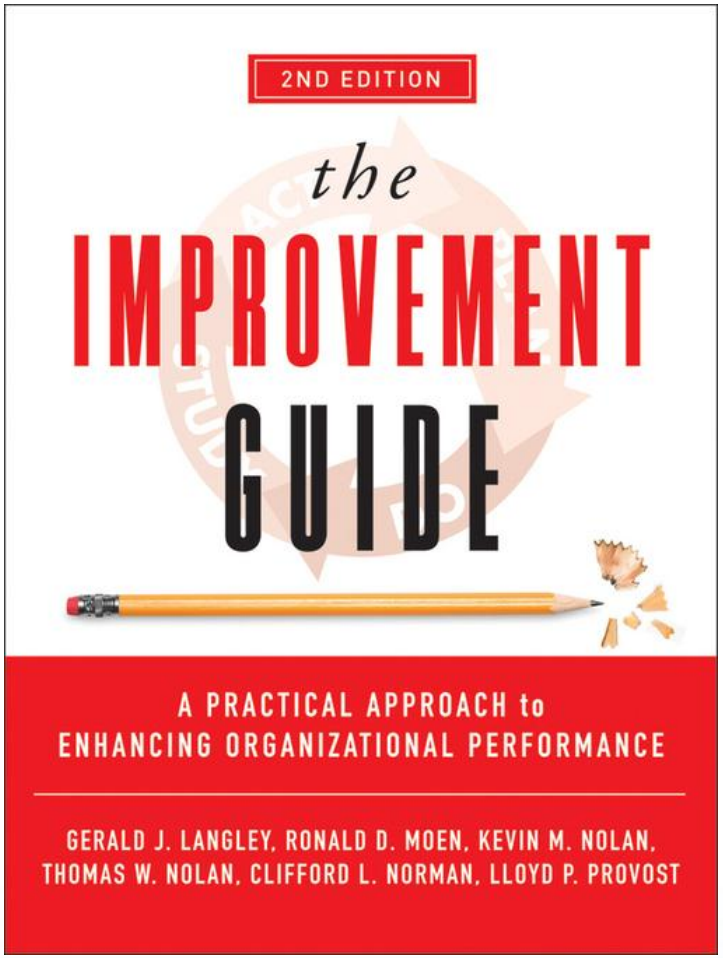

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BICS
Bolton Improving Care System

NHS

Methods and Tools

Developing personal mastery of improvement methods

- Read all you can
- Attend courses
- Visits – to healthcare and non healthcare organisations
- Apply and reflect ("PDSA" yourself!)
- Practice, practice, practice

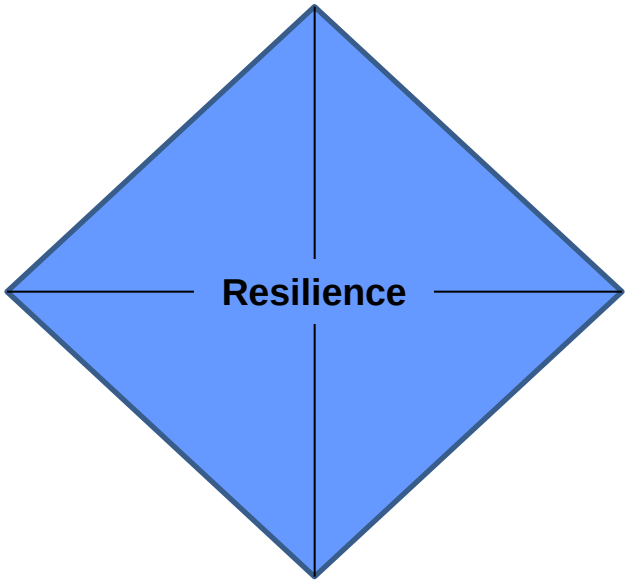
"It's easier to act yourself into a new way of thinking than think yourself in a new way of retiring"

(Toyota)

A Development Framework for Leadership for Improvement

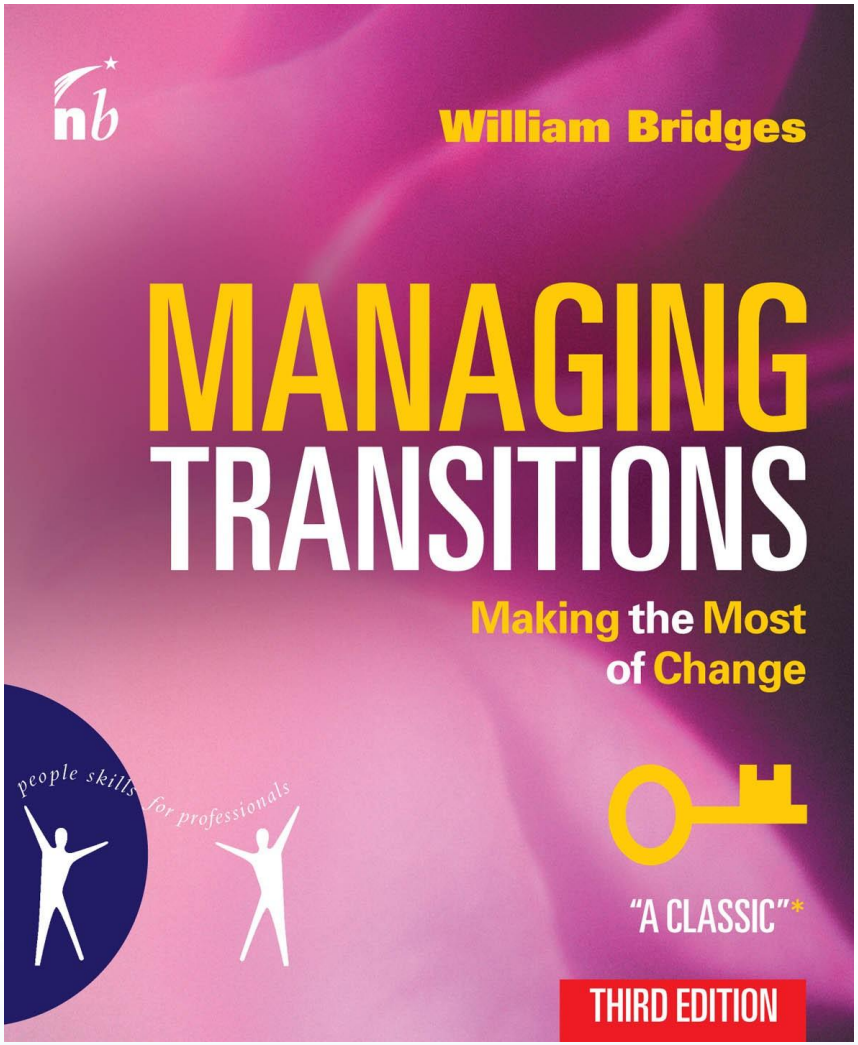
Service Specific Knowledge

Improvement Methods

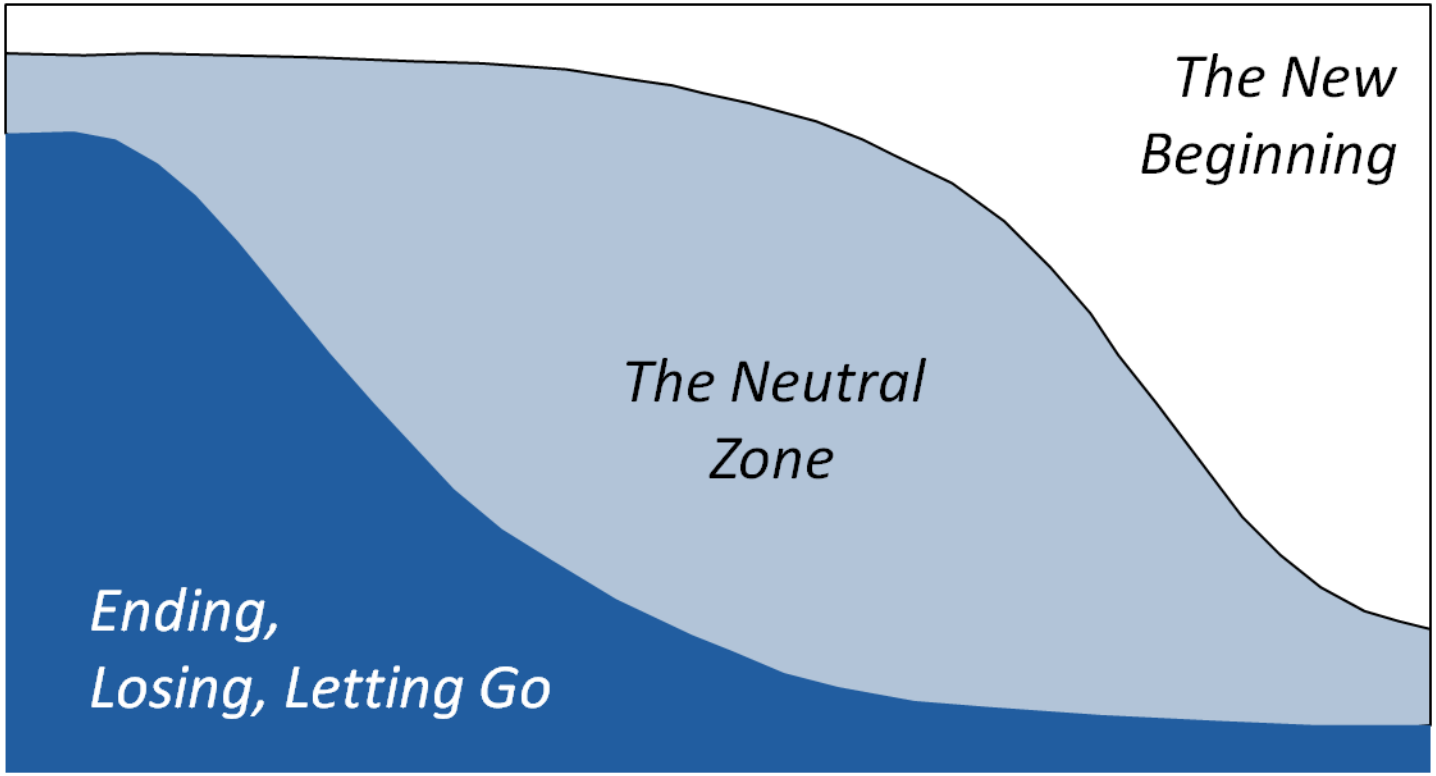


Change Management

Personal Effectiveness



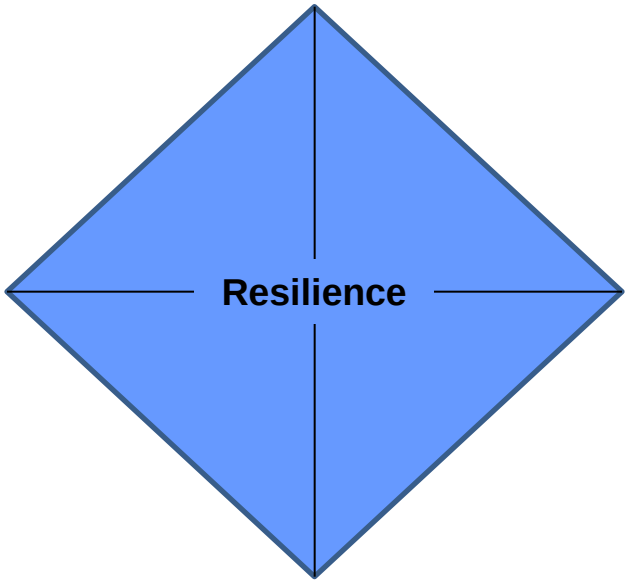
Source:
W Bridges: Managing Transitions


The New Beginning
The Neutral Zone
Ending, Losing, Letting Go

A Development Framework for Leadership for Improvement

Service Specific Knowledge

Improvement Methods



Change Management

Personal Effectiveness

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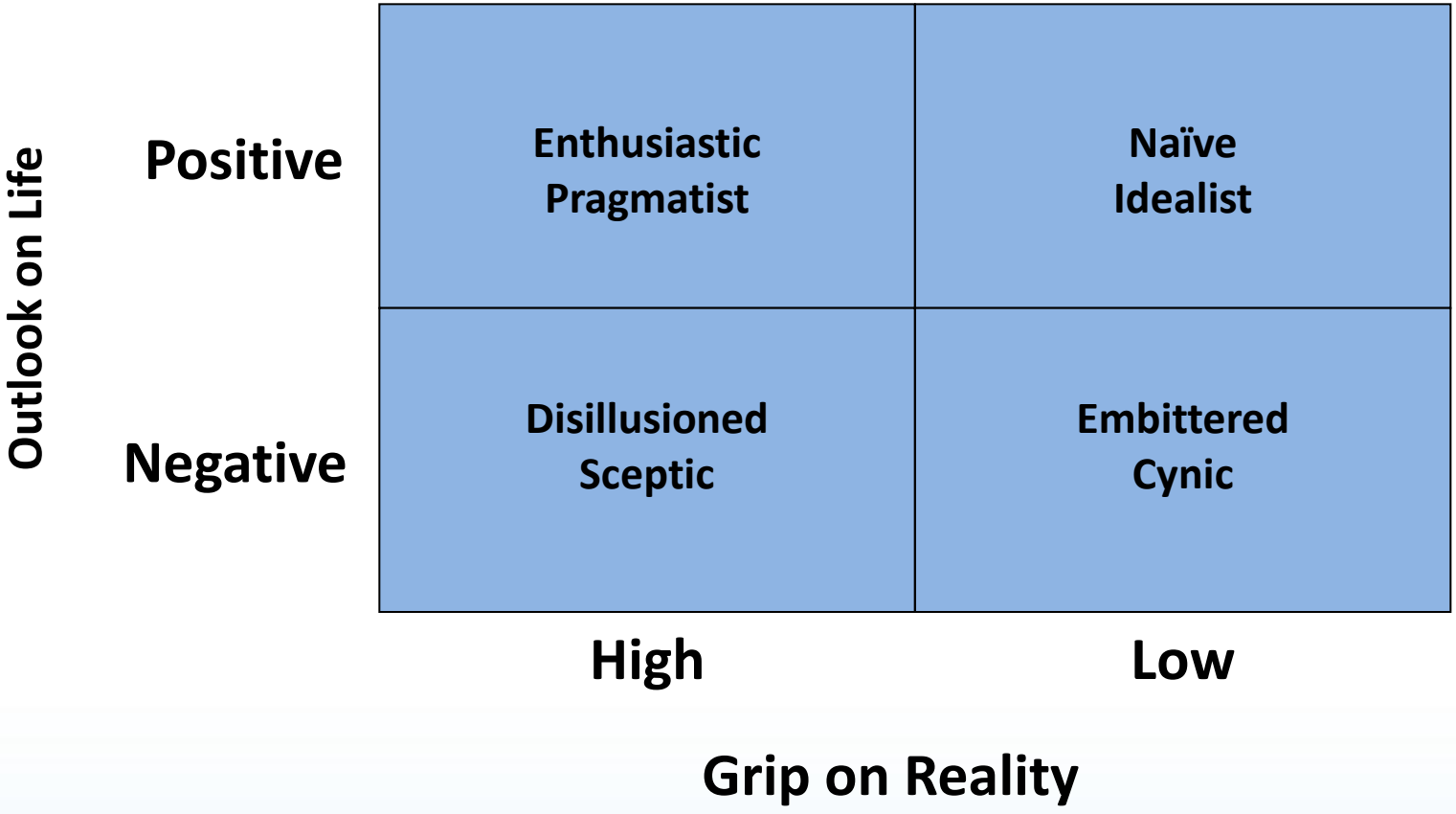
How far is this typical decision making in many healthcare organisations?

- Manager led
- Retreat to the Boardroom
- Little if any data
- Speculation and anecdote
- “Monovoxoplegia”

• Manager led	vs	• Fully engaged front line staff
• Retreat to the Boardroom	vs	• Based in actual work place
• Little if any data	vs	• Data driven/evidence based
• Speculation and anecdote	vs	• Rigorous improvement method
• “Monovoxoplegia”	vs	• Consensus decisions based on cycles of trial and error

Fillingham's Motivational Matrix



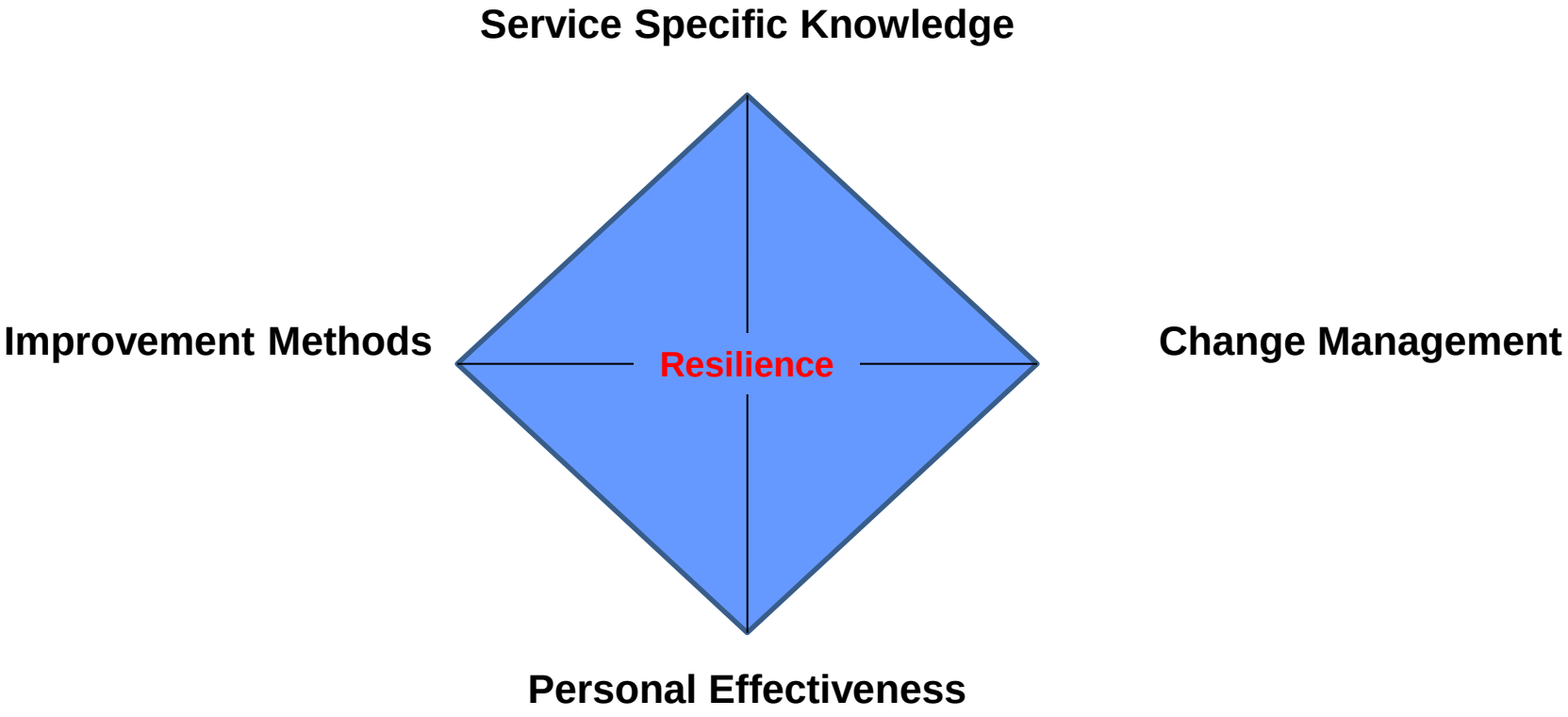
An Enthusiastic Pragmatist:

- Is highly visible… goes to where the work is actually done
- Avoids jargon and “management speak”
- Has integrity and authenticity
- Stays calm in a crisis – “grace under pressure”
- Masters the “honesty/faith paradox”

Converting the Sceptics

- Make it specific to ‘my’ service
- Use rigorous improvement methods
- Robust and convincing data
- Hands on experience… rapid improvement events
- Reinforce through changed management system and leadership style

A Development Framework for Leadership for Improvement



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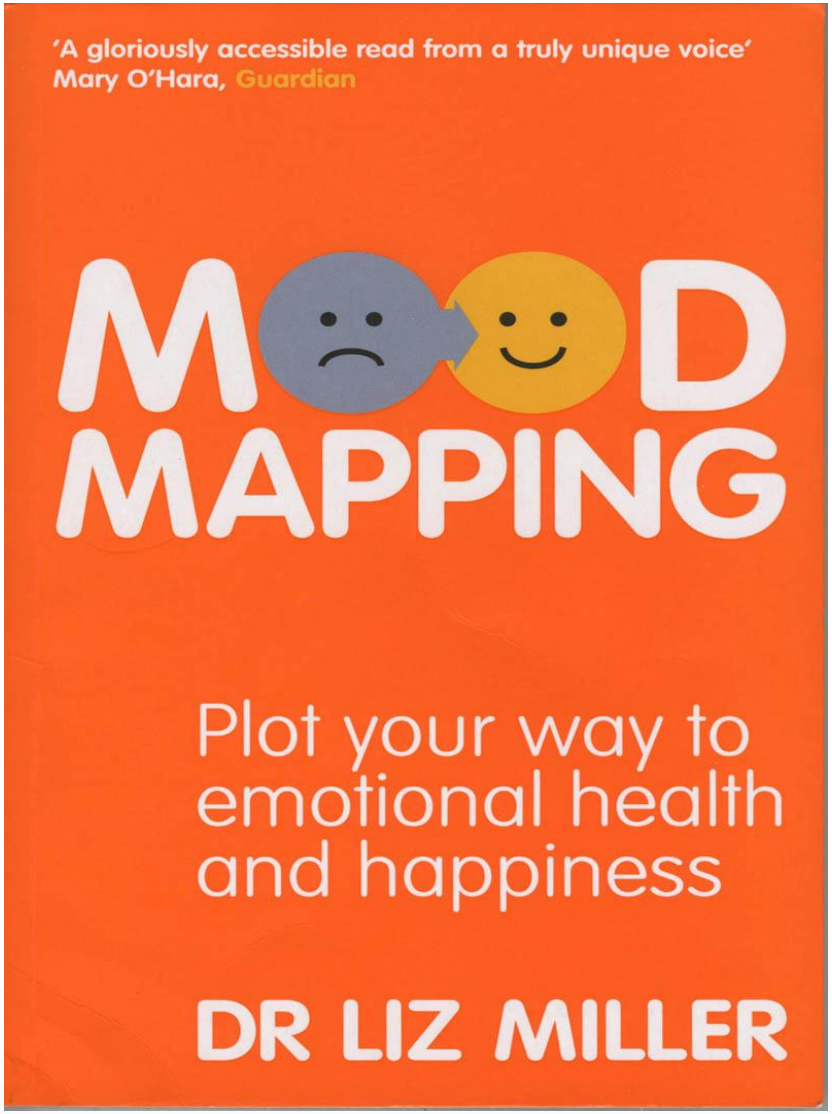

Free resilience report

- http://www.robertsoncooper.com/iresilience

A five point plan for developing as a leader of improvement:

1. Deeply understand your current service and set ambitious goals for improvement
2. Become expert practitioners in improvement science
3. Manage change well
4. Strive to be an “enthusiastic pragmatist”
5. Build resilience… look after yourself and others

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