Session Objectives

After this presentation, participants will be able to:

• Discuss and exchange ideas that build on the five key essentials that drive all QI efforts
• Make a plan to test the five key essentials in their own QI programs
### Our plan for the High Five

**Context**
- Is everything ... islands of excellence
- Where are the bright spots and how do we build on these?
- Strong and loose ties

**Making Change Happen**
- Understanding self and others-Team dynamic
- Mindfulness, emotional intelligence: FEELINGS matter at work
- Make the right thing easy to try, easy to do and easy to try!

**Methods tools and techniques**
- Improvement science e.g. Model for improvement, lean
- Triple aim (patient experience, ROI, improved clinical outcomes)
- Community asset management

**Measuring Results**
- Measurement MATTERS
- Generate light not heat! Measures for improvement
- Dash board of measures- Run and control charts
- Info graphics

**Holding the Gains**
- Deep and broad understanding of what it takes to sustain change... reliability and resilience in care delivery ...Sensitive to operations (Safety II)
- Acknowledge and monitor spread
- Celebrate Success

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**People at the Center**

- Are people at the center of your services .... Staff Patients and carers

**Lets here some examples**

- Chat to your neighbor share the ways you think people are at the center of your care system
What matters to you

• Asking what matters
• Listening to what matters
• Doing what matters

• video

We challenge you to ask the next patient you care for, ‘what matters to you?’

You can ask patients and colleagues

• To finish the sentence ..........today would have been better if .................
Context

• For quality improvement to flourish it must be carefully cultivated in a rich soil bed (a receptive organisation), given constant attention (sustained leadership), assured of appropriate amounts

Context considerations for change
Where are you trying to change practice?

- When you see results somewhere else and try it in your area is it working?

- Again share at your table
  - when you have been successful in improvement what did you do?
MAKING CHANGE HAPPEN

Who wants change?

Who wants to change?
Roger’s Adopter Categories

<table>
<thead>
<tr>
<th>Innovators (2.5%)</th>
<th>Early Adopters (12.5%)</th>
<th>Early Majority (34%)</th>
<th>Late Majority (34%)</th>
<th>Laggards (16%)</th>
</tr>
</thead>
</table>

Roger’s Adopter Categories

Values to Action

**Action inhibitors**
- Inertia
- Apathy
- Fear
- Self-doubt
- Isolation

**Action motivators**
- Urgency
- Anger
- Hope
- You can make a difference
- Inclusion

Us as change leaders

Improving Access | Improving Care | Improving Outcomes
By what method

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

ACT  PLAN  DO  STUDY

The PDSA Cycle

What’s next?

Act
- Ready to implement?
- Try something else?
- Next cycle

Plan
- Objective
- Questions & predictions
- Plan to carry out: Who? When? How? Where?

Study
- Complete data analysis
- Compare to predictions
- Summarize

Do
- Carry out plan
- Document problems
- Begin data analysis

Did it work?

What will happen if we try something different?

Do It !!!

TO BE CONSIDERED A PDSA CYCLE...

The test was planned (including a plan for collecting data).

The plan was attempted (do the plan). (Make a prediction)

Time was set aside to analyze the data and study the results.

Action was rationally based on what was learned.

Source: Improvement Guide pp..60-61

Start Small

• 1 patient
• 1 day
• 1 admission
• 1 clinician
YOU CAN ONLY LEARN AS QUICKLY AS YOU TEST.

Start Small

- 1 person
- 1 day
- 1 case
- 1 staff member

Move to 3, 5, 7..., as confidence grows
Cycles of Tests Build Confidence

Changes that will result in improvement

Learning from data

Proposals, theories, hunches, intuition

MEASURING RESULTS
The Three Faces of Performance Measurement


<table>
<thead>
<tr>
<th>Aspect</th>
<th>Improvement</th>
<th>Accountability</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>Improvement of care</td>
<td>Comparison, choice, reassurance, spur for change</td>
<td>New knowledge</td>
</tr>
<tr>
<td>Methods:</td>
<td>Test is observable</td>
<td>No test, evaluate current performance</td>
<td>Test blinded or controlled</td>
</tr>
<tr>
<td>• Test Observability</td>
<td>Accept consistent bias</td>
<td>Measure and adjust to reduce bias</td>
<td>Design to eliminate bias</td>
</tr>
<tr>
<td>• Bias</td>
<td>“Just enough” data, small sequential samples</td>
<td>Obtain 100% of available, relevant data</td>
<td>“Just in case” data</td>
</tr>
<tr>
<td>• Sample Size</td>
<td>Hypothesis flexible, changes as learning takes place</td>
<td>No hypothesis</td>
<td>Fixed hypothesis</td>
</tr>
<tr>
<td>• Flexibility of Hypothesis</td>
<td>Sequential tests</td>
<td>No tests</td>
<td>One large test</td>
</tr>
<tr>
<td>• Testing Strategy</td>
<td>Run charts or Shewhart control charts</td>
<td>No change focus</td>
<td>Hypothesis, statistical tests (t-test, F-test, chi square), p-values</td>
</tr>
<tr>
<td>• Determining if a Change is an Improvement</td>
<td>Data used only by those involved with improvement</td>
<td>Data available for public consumption and review</td>
<td>Research subjects’ identities protected</td>
</tr>
<tr>
<td>• Confidentiality of the Data</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Testing and Implementing a Change Idea

<table>
<thead>
<tr>
<th>BELIEF</th>
<th>COST OF FAILURE</th>
<th>Current commitment within organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No commitment</td>
</tr>
<tr>
<td>Low degree of belief</td>
<td>Cost of failure</td>
<td>Very small scale test</td>
</tr>
<tr>
<td>that change idea will lead to</td>
<td>large</td>
<td>test</td>
</tr>
<tr>
<td>improvement</td>
<td>Cost of failure</td>
<td>Very small scale test</td>
</tr>
<tr>
<td>small</td>
<td>test</td>
<td>test</td>
</tr>
<tr>
<td>High degree of belief</td>
<td>Cost of failure</td>
<td>Very small scale test</td>
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### Measurement for Improvement

3 types of measures – outcome, process and balancing

**Pragmatic Actions:**
- Tests Observable
- Bias Stabilised
- Just Enough Data
- Adapts with Change
- Rapid Cycle Change Sequential Tests
- Run or Control Charts
Example of 3 Step Design in Implementing the Ventilator Bundle

Example of using 80% and 95% change concepts to initially reach a reliability of 80% then additionally using a robust change concept (redundancy) to reach 95% reliability in the 4 elements of the ventilator bundle (Baptist Memorial, Memphis)

Holding the gains
Making change happen...or not

• Singular piecemeal efforts will not work
• Education alone will not change behaviour
• Measurement is not change
• Exhortation and incentivisation alone work only if you believe that poor motivation is the root cause of the problem

*If you want different results, change the system!*

Starting Labels of Reliability

• Chaotic process: Failure in greater than 20% of opportunities
• 80 or 90%: 1 or 2 failures out of 10 opportunities
  *(lacks consistent clear understanding of the process, 5 front line process users can not easily articulate the process)*

• 95% or better: 5 failures or less out of 100 opportunities
  *(has some variation but 5 front line users can easily articulate the process)*

*(These are IHI definitions and are not meant to be the true mathematical equivalent)*
Car service

Brakes | Tyres | Oil | Filters
---|---|---|---
Car 1 | Yes | No | Yes | Yes
Car 2 | Yes | Yes | Yes | Yes
Car 3 | Yes | Yes | No | Yes
Car 4 | Yes | Yes | Yes | Yes
Car 5 | Yes | Yes | Yes | Yes

4 times out of 10 you don’t get a proper service
The Man in the Mirror

I'm gonna make a change, For once in my life
Take a look at yourself, and
Then make a change

Buzz

• People centered create a new connection
• Share with them 1 change you are going to try
• Keep a note of What I learned / What I shared
• If not
You...........................................
Who

Making it stick

• What have you changed in practice that has been sustained?
• How do you think that happened?
• What are the key characteristics?
• Discuss with your neighbor
What Prevents Action

- Let’s *Change the Conversation*
- Everyone knows *what they don't want*
- Let’s start to focus and describe *what we want*
- What would be happening if things *were going great* and what behaviours get results?
- Need to be *specific when* solving people problems
- Create opportunities for teams to *describe* and *develop their own* solutions

Share and Exchange

People at the center

- Our contacts
- [Pat.oconnor@nhs.net](mailto:Pat.oconnor@nhs.net)
- [Peter.lachman@gosh.nhs.uk](mailto:Peter.lachman@gosh.nhs.uk)