Can we really learn from the past?

Learning Lab

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SL19
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Proposition
Scotland's Context
Your System
Framework
Take Home Plan
Aims
Our agenda

Scotland as a case study

A framework to organise our thinking

Past
Present
Future

Our proposition
Let’s be the best

#THFSMP  #qff5  #IHIForum
A framework for the measurement and monitoring of safety

- Past harm
- Reliability
- Integration and learning
- Anticipation and preparedness
- Sensitivity to operations

Source: Vincent C, Burnett S, Carthey J. The measurement and monitoring of safety. The Health Foundation, 2013
Proposition: Learning through a focus on the past is only part of the story
HARM
What do you think about our plan for our time together?
In times of change, learners inherit the Earth. . .

while the learned find themselves beautifully equipped to deal with a world that no longer exists.

Eric Hoffer
"...everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it."

What is “quality improvement” and how can it transform healthcare?
Batalden,P; Davidoff,F Qual Saf Health Care. 2007 February; 16(1): 2–3
Scotland as a case study
Incidence rates of BSI, VAP and CR-BSI
Scotland, 2011 - 2015

Source: Scottish Intensive Care Society Audit Group 2015
Percentage of rated tags that are positive | SC

Month

NHS SCOTLAND
Our wider context
• 5.37 million population
• £13.4 billion health and social care budget
• 14 territorial boards
• Integrated health and social care
• Healthcare Improvement Scotland
PART 1

ORGANISATION

§12H "Duty of quality.

(1) It shall be the duty of each Health Board, Special Health Board and NHS trust and of the Agency to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals.

(2) The reference in subsection (1) to health care which a body there mentioned provides to individuals includes health care which the body provides jointly with another person to individuals.

(3) In this section "health care" means services for or in connection with the prevention, diagnosis or treatment of illness.[]
Involving people

Improvement programmes

Policy & Legislation

Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016

PART 2

DUTY OF CANDOUR

Duty of candour procedure

Incident which activates duty of candour procedure

The measurement and monitoring of safety
Improvement Focused Governance

What Non-Executive Directors need to know
Information is Collected and Presented

Information on Impact is Reported Against Priorities

The Impact of Actions is Measured and then Monitored

Information is Interpreted to Identify Areas for Action

Actions Arising from Review of Information are Documented
Healthcare Improvement Scotland – strategic approach

Making care better many parts, one purpose
Healthcare Improvement Scotland – strategic approach

Making care better
many parts, one purpose
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What happens where you are?
REALISING REALISTIC MEDICINE

‘REALISTIC’
1. HAVING OR SHOWING A SENSIBLE AND PRACTICAL IDEA OF WHAT CAN BE ACHIEVED OR EXPECTED.
2. REPRESENTING THINGS IN A WAY THAT IS ACCURATE AND TRUE TO LIFE.

CREATING CONDITIONS

COMMUNICATE

CONNECT

COLLABORATE

CULTURE

THE VISION
BY 2025, EVERYONE WHO PROVIDES HEALTHCARE IN SCOTLAND WILL DEMONSTRATE THEIR PROFESSIONALISM THROUGH THE APPROACHES, BEHAVIOURS AND ATTITUDES OF REALISTIC MEDICINE
How safe is our care?

What is safe?
Could a framework help?
Proposition
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The measurement and monitoring of safety

Drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring.
Measuring and monitoring safety

Integrity and learning
Are we responding and improving?

Past harm
Has patient care been safe in the past?

Reliability
Are our clinical systems and processes reliable?

Anticipation and preparedness
Will care be safe in the future?

Safety measurement and monitoring

Sensitivity to operations
Is care safe today?
A framework for the measurement and monitoring of safety

Source: Vincent C, Burnett S, Carthey J. *The measurement and monitoring of safety.* The Health Foundation, 2013
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The past

- Past harm: Has patient care been safe in the past?
- Integration and learning: Are we responding and improving?
- Safety measurement and monitoring
- Reliability: Are our clinical systems and processes reliable?
- Anticipation and preparedness: Will care be safe in the future?
- Sensitivity to operations: Is care safe today?
DISCUSSION

1. How do you know that care has been safe in the past?

2. How do you know your systems and processes are reliable?
COUNTDOWN
A framework for the measurement and monitoring of safety

Source: Vincent C, Burnett S, Carthey J. The measurement and monitoring of safety. The Health Foundation, 2013
The present

- **Past harm**: Has patient care been safe in the past?
- **Integration and learning**: Are we responding and improving?
- **Safety measurement and monitoring**
- **Reliability**: Are our clinical systems and processes reliable?
- **Anticipation and preparedness**: Will care be safe in the future?
- **Sensitivity to operations**: Is care safe today?
Royal Hospital for Sick Children, Yorkhill
PICU Total Delayed Discharges (+ 4 hrs)

Hospital Huddle started 7th Jan 2013

1st Median=49
2nd Median=25
How do you know if care is safe today?
A framework for the measurement and monitoring of safety

Source: Vincent C. Burnett S. Carthey J. 
*The measurement and monitoring of safety.*
The Health Foundation, 2013
The future

- Past harm: Has patient care been safe in the past?
- Reliability: Are our clinical systems and processes reliable?
- Anticipation and preparedness: Will care be safe in the future?
- Safety measurement and monitoring
- Integration and learning: Are we responding and improving?
DISCUSSION

1. How do you know that care will be safe in the future?

2. How do you respond and improve?
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A framework for the measurement and monitoring of safety

Source: Vincent C, Burnett S, Carthey J. The measurement and monitoring of safety. The Health Foundation, 2013
Integration and learning
Are we responding and improving?

Past harm
Has patient care been safe in the past?

Reliability
Are our clinical systems and processes reliable?

Anticipation and preparedness
Will care be safe in the future?

Sensitivity to operations
Is care safe today?
Past harm
Has patient care been safe in the past?

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Is care safe today?

Anticipation and preparedness
Will care be safe in the future?

Integration and learning
Are we responding and improving?

Adapted from Dr Jane Carthey
‘What does good look like for you and for the people you serve?’
• Structure conversations about safety
• Surface gaps in understanding
• Identify barriers to improvement
• Enable learning
‘Whatever your point of concern, whether individual, team, or organisation – what ought the totality of your efforts look like to give you the best possible chance of learning and improving’
Switch Gear from Past

Indicators

Prediction

Leading

Lagging
Consider what set of information you need. Do you have the collective wherewithal to gather, process, analyse, interpret and learn from that information?

Have you got the right interactions in place from which to learn?
We believe you should learn from the past, but not in isolation.
Measurement and Monitoring of Safety Framework e-guide
Better Questions Safer Care
Thank you

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