Prepared for the Board of
East London NHS Foundation Trust

The Role of the Board in Building and Sustaining Quality: Part 1

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Executive Director
Institute for Healthcare Improvement

06 Jan 2015

East London NHS
NHS Foundation Trust

QUALITY IMPROVEMENT PROGRAMME

Setting the Context for Change:

National and Local Perspectives

Kevin & Amar

How did we get here?

Human Factors

James Reason

1990-1998

On Organisation with a Memory

Liam Donaldson

Chief Medical Officer

2000

Francis Report

Keogh Reviews

Berwick Report

2013

PATIENT SAFETY FIRST

Our quality improvement programme

Why?

The strategic case for change

Make quality our absolute priority

- Improving quality of care is our core purpose
- Of greatest importance to all our stakeholders
- Build on the excellent work already happening to improve quality

National drivers

- The need to focus on a more compassionate, caring service with patients first and foremost
- More structured and bottom-up approach to improvement

Enable our staff to lead change

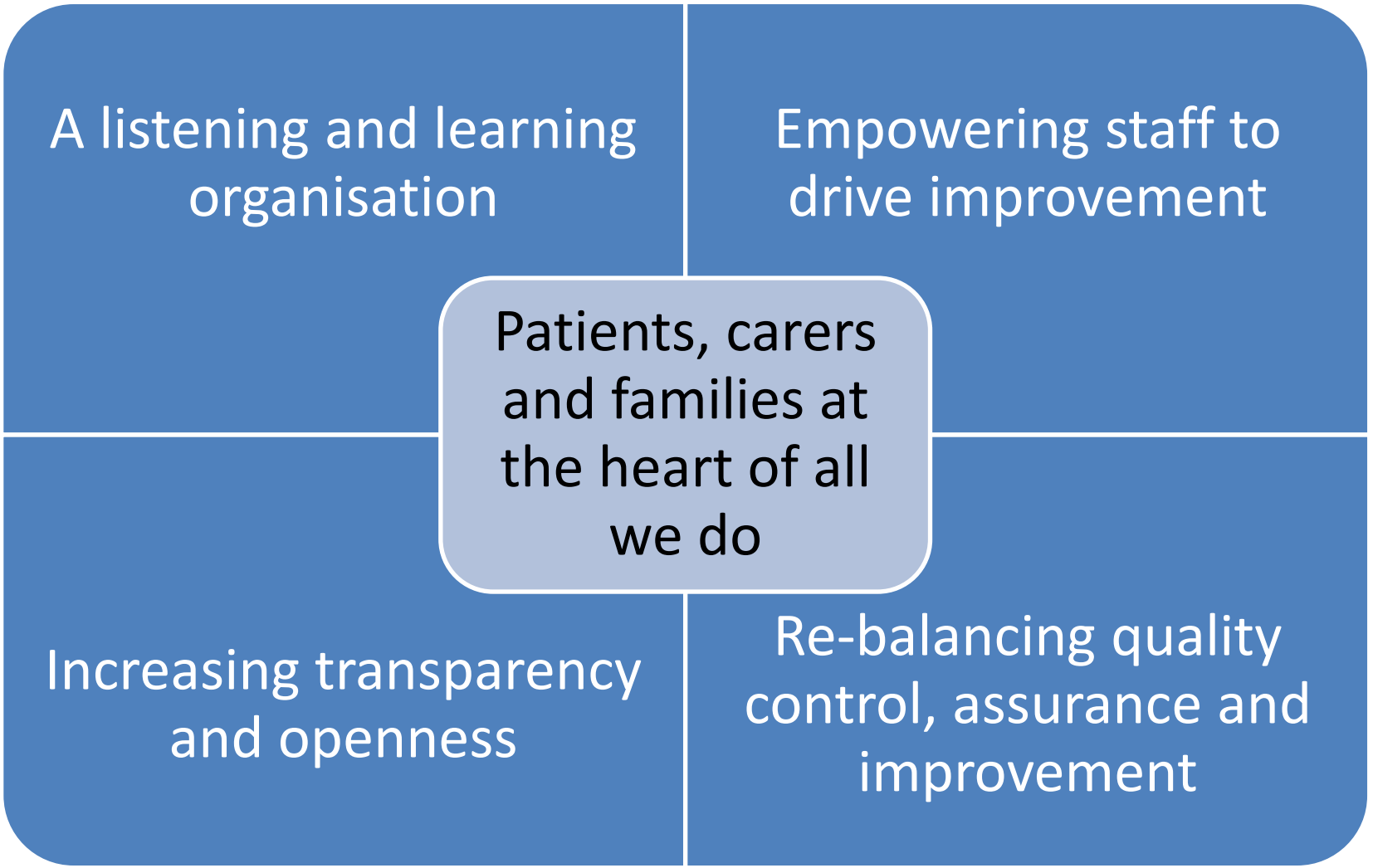
- The desire to engage, free and support our staff to innovate and drive change
- Engaged and motivated staff leads to improved patient outcomes

The economic climate

- The need to do more with less

  – improving quality whilst reducing cost

The culture we want to nurture

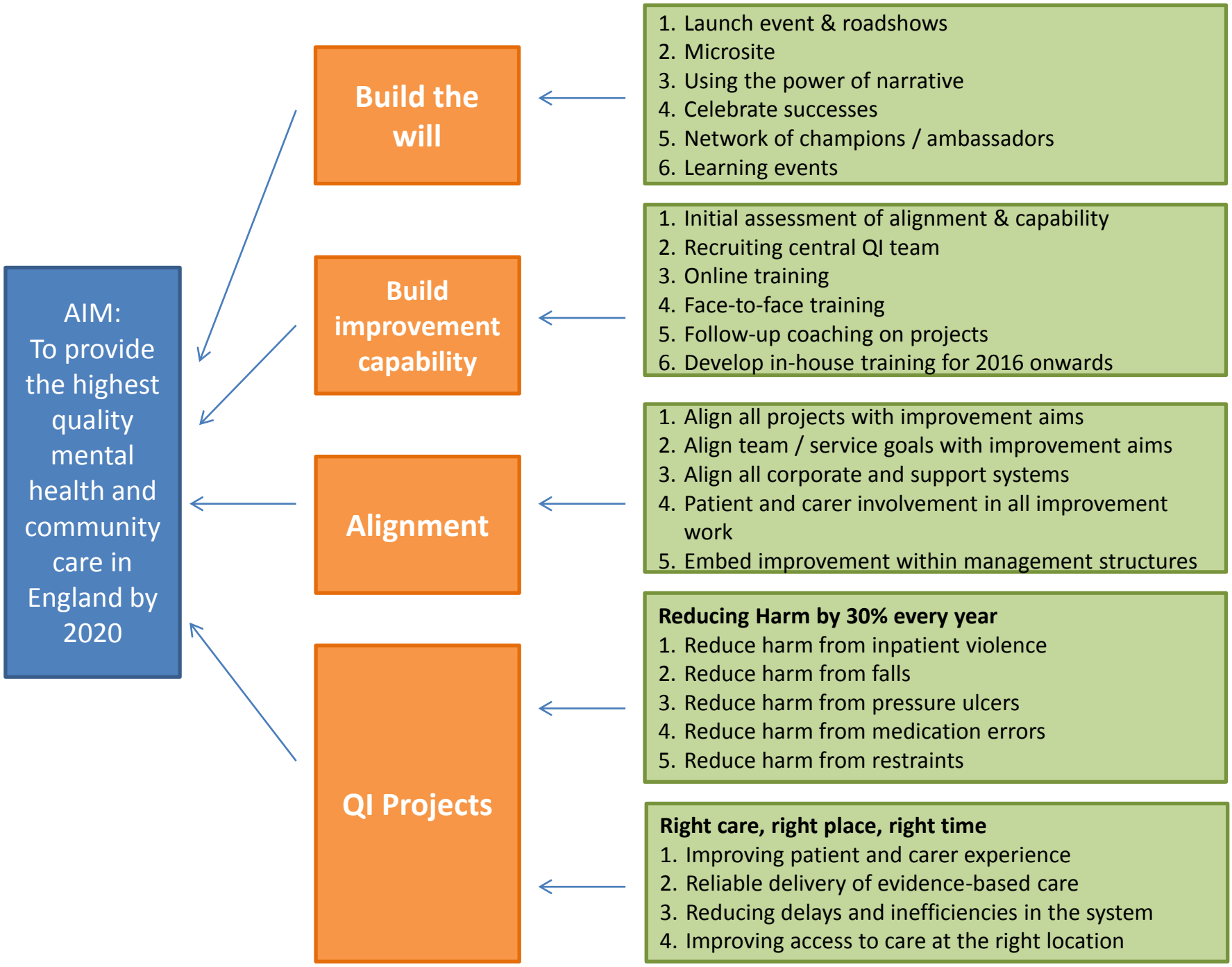



Continuous improvement
Assurance & performance management
Research & innovation

Our quality improvement programme

How?


Two stretch aims
The mission
Reduce harm by 30% every year
Right care, right place, right time
To provide the highest quality mental health and community care in England
Quality improvement strategy
Long-term mission and stretch aims


AIM:
To provide the highest quality mental health and community care in England by 2020
Build the will
1. Launch event & roadshows
2. Microsite
3. Using the power of narrative
4. Celebrate successes
5. Network of champions / ambassadors
6. Learning events
Build improvement capability
1. Initial assessment of alignment & capability
2. Recruiting central QI team
3. Online training
4. Face-to-face training
5. Follow-up coaching on projects
6. Develop in-house training for 2016 onwards
Alignment
1. Align all projects with improvement aims
2. Align team / service goals with improvement aims
3. Align all corporate and support systems
4. Patient and carer involvement in all improvement work
5. Embed improvement within management structures
QI Projects
Reducing Harm by 30% every year
1. Reduce harm from inpatient violence
2. Reduce harm from falls
3. Reduce harm from pressure ulcers
4. Reduce harm from medication errors
5. Reduce harm from restraints
Right care, right place, right time
1. Improving patient and carer experience
2. Reliable delivery of evidence-based care
3. Reducing delays and inefficiencies in the system
4. Improving access to care at the right location

AIM:
To provide the highest quality mental health and community care in England by 2020

Build the will

QI microsite the online hub for the programme has 22000 page views in 2014 **qi.eastlondon.nhs.uk**

Bespoke QI learning events for staff, service users, commissioners, governors

QI launch event and roadshows attended by over 1000 staff, service users and carers

Staff and service user newsletter reaches 4000 people every month

AIM:
To provide the highest quality mental health and community care in England by 2020

Build improvement capability

Face to face improvement training - hundreds of staff, services users, Governors to be trained over the next few years

Support for improvement work from the **Trust's QI team**

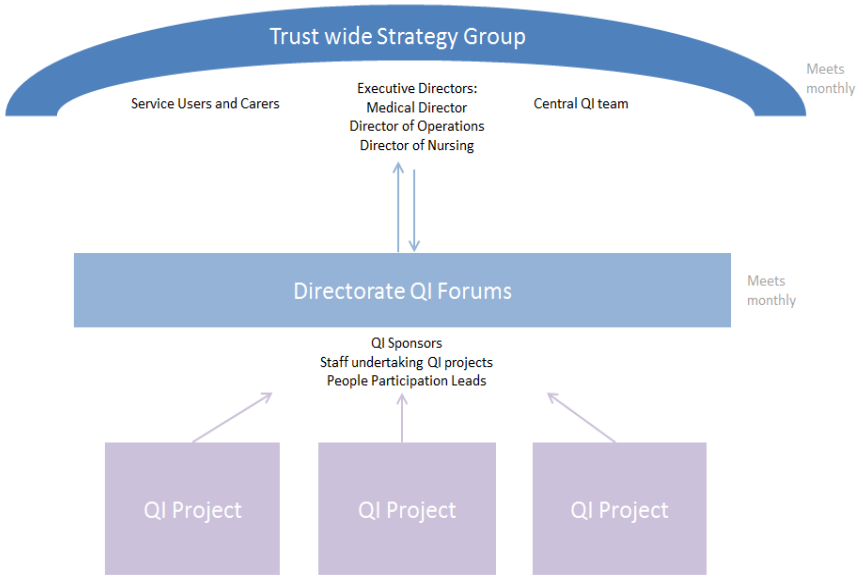
IHI Open School online training resource available to all. Providing essential skills to support people leading quality improvement.

Partnership with IHI on delivery of QI training to staff and Trust Board, and strategic guidance from IHI executive team

Quality improvement programme-project support structures

AIM:
To provide the highest quality mental health and community care in England by 2020

Alignment



A process is in place for teams to submit project ideas to the QI team, who will help with planning, structure and measurement, and ensure projects are aligned with our high-level aims.

AIM:
To provide the highest quality mental health and community care in England by 2020

QI Projects

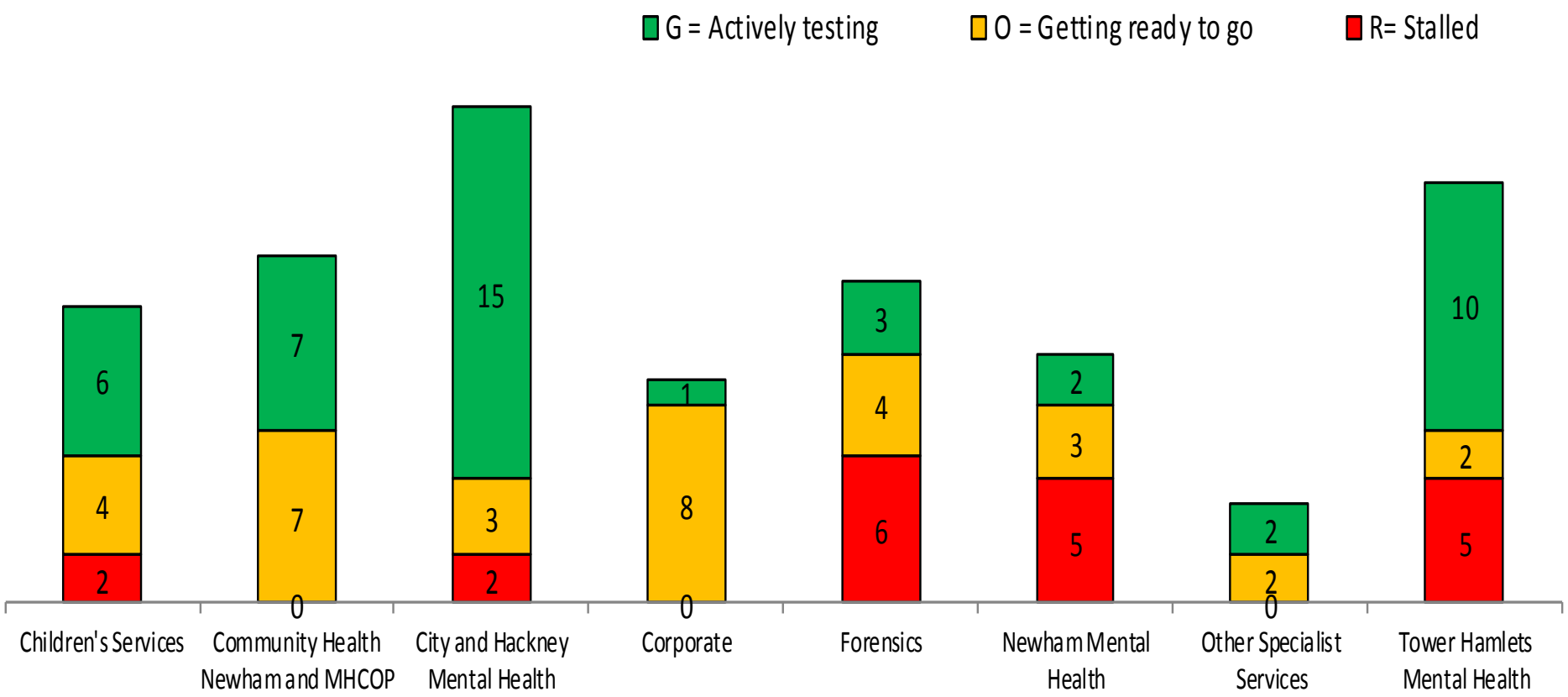
QI Projects – 80+ active projects across Trust Directorates, teams are working on improvement projects that support our ambition to **Reducing Harm by 30% every year** and deliver **Right care, right place, right time**

Improving Physical Health Monitoring Following Rapid Tranquillisation

Reducing violence on inpatient wards

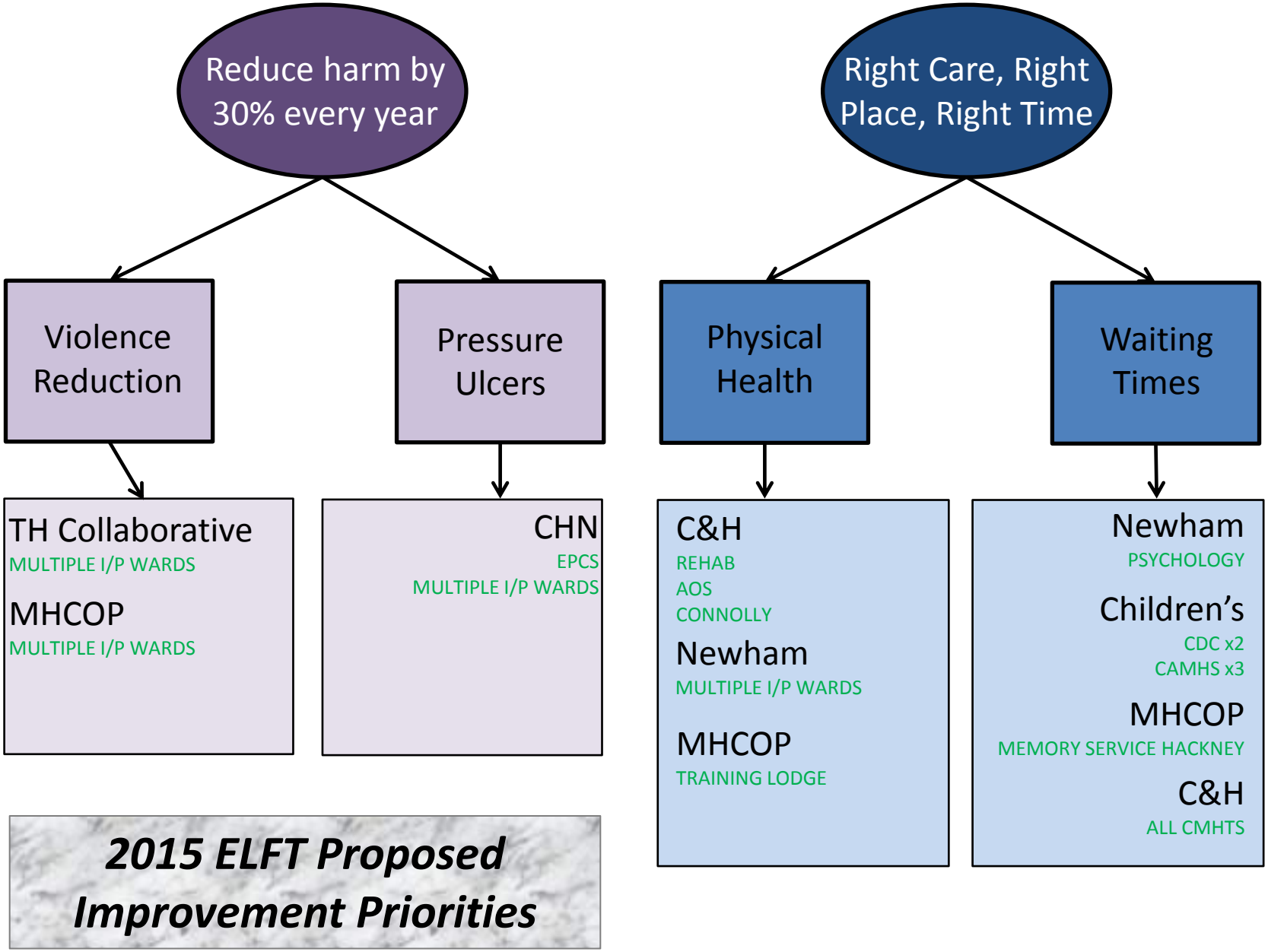
Improving the handover process for on-call doctors

Activity and Status by Directorate



QUALITY IMPROVEMENT PROGRAMME

East London NHS
NHS Foundation Trust



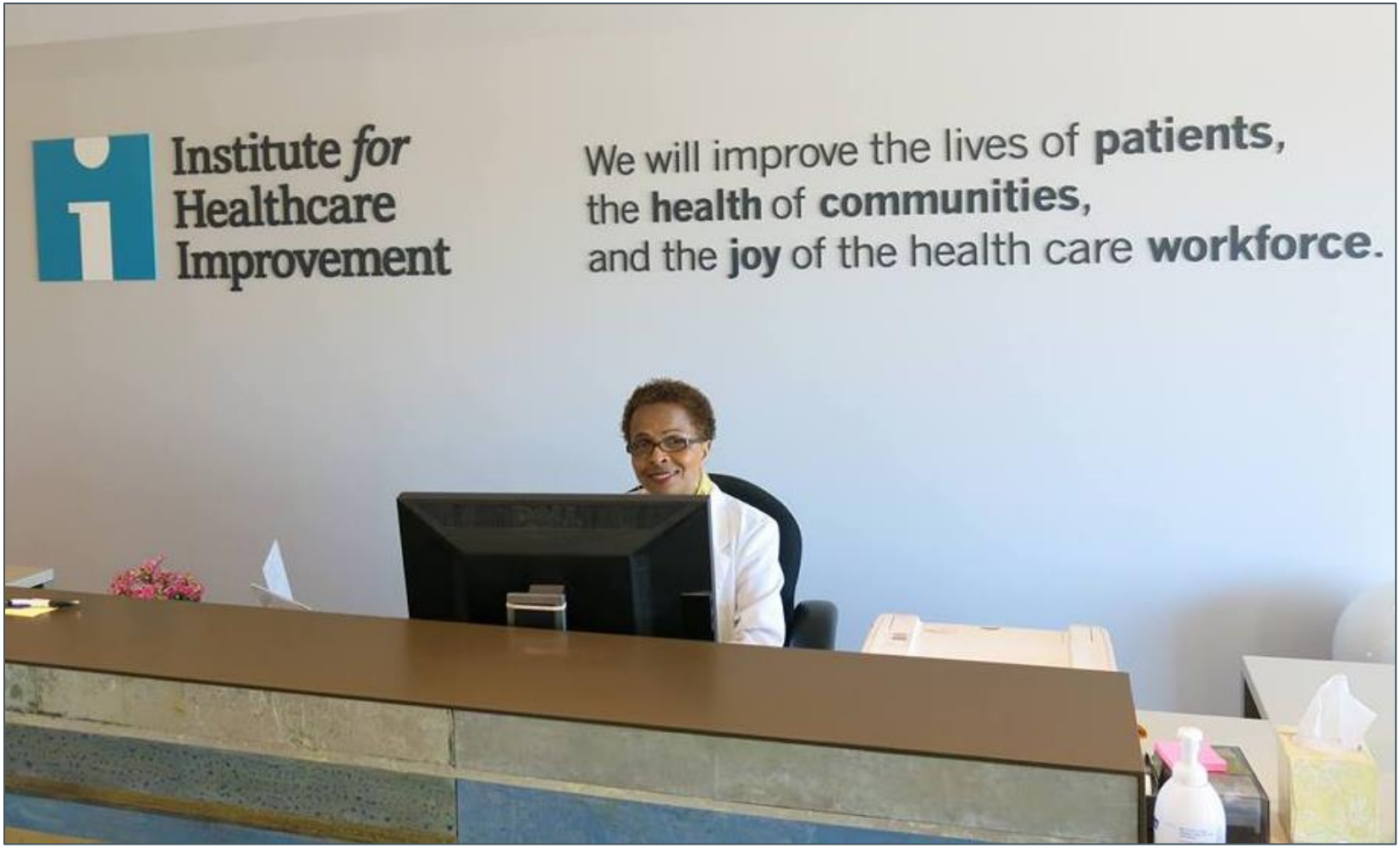
2015 ELFT Proposed Improvement Priorities

East London NHS
NHS Foundation Trust

QUALITY IMPROVEMENT PROGRAMME

Why are we partnering with the Institute for Healthcare Improvement?

Our Mission:
To improve health and health care worldwide



About IHI

Our Mission

To improve health and health care worldwide.

Our Vision

Everyone has the best care and health possible.

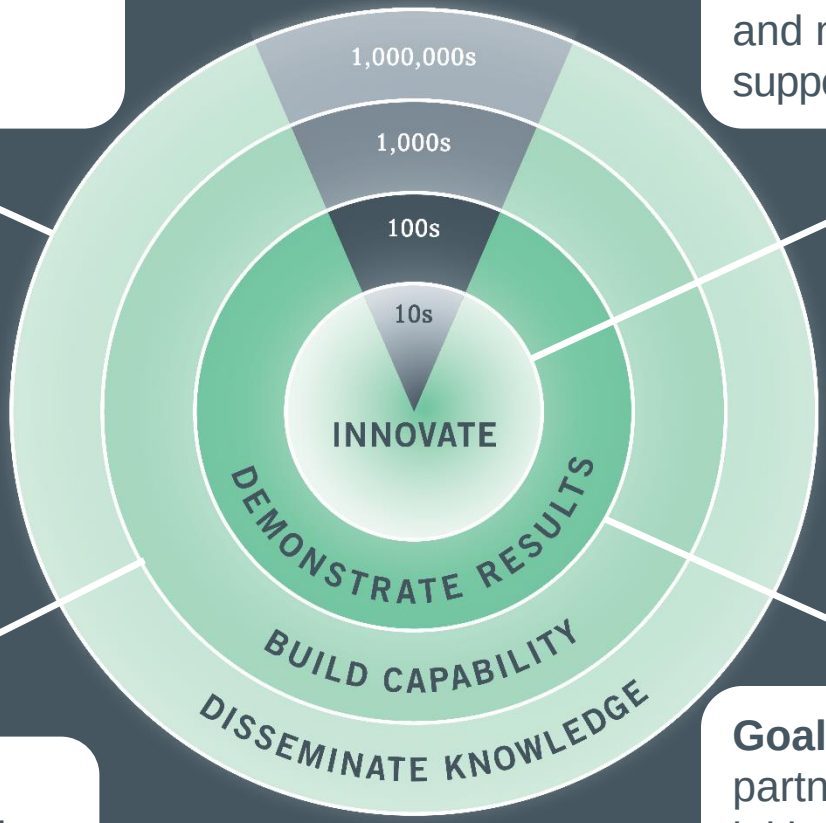
Who We Are

IHI is a leading innovator, convener, partner, and driver of results in health and health care improvement worldwide.

The Way We Work: A Leverage Strategy

Goal: Build reach and will to accelerate the pace of improvement worldwide

Goal: Harvest, create, and test bold, innovative ideas and new models of care that support our strategic initiatives

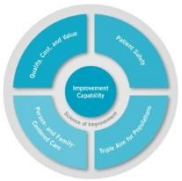


Goal: Offer programming to transfer knowledge and build improvement capability

Goal: Leverage strategic partnerships and key initiatives to achieve ambitious improvement goals

Who, What and Where are we?

- An Innovator
- A Convener
- A Partner
- A Driver of Results



- Quality, Cost, and Value
- Patient Safety
- Triple Aim for Populations
- Person and Family-Centered Care
- Improvement Capability

- North America
- Latin America
- Europe
- Middle East
- Africa
- Asia Pacific

QI + Joy in Work

We accomplish this work with…

Thought leadership and innovation

- Triple Aim
- 100,000 Lives Campaign
- 5,000,000 Lives Campaign
- WIHI (our radio station)
- Breakthrough Series College
- Global Trigger Tool & Bundles
- Patient Safety Officer Training
- Improvement Advisor Programme

Ground breaking initiatives

- Safer Patients Initiative (UK)
- Scottish patient Safety Program
- Open School
- Project Fives Alive!
- Maternal and Child Health (Malawi)
- The Conversation Project

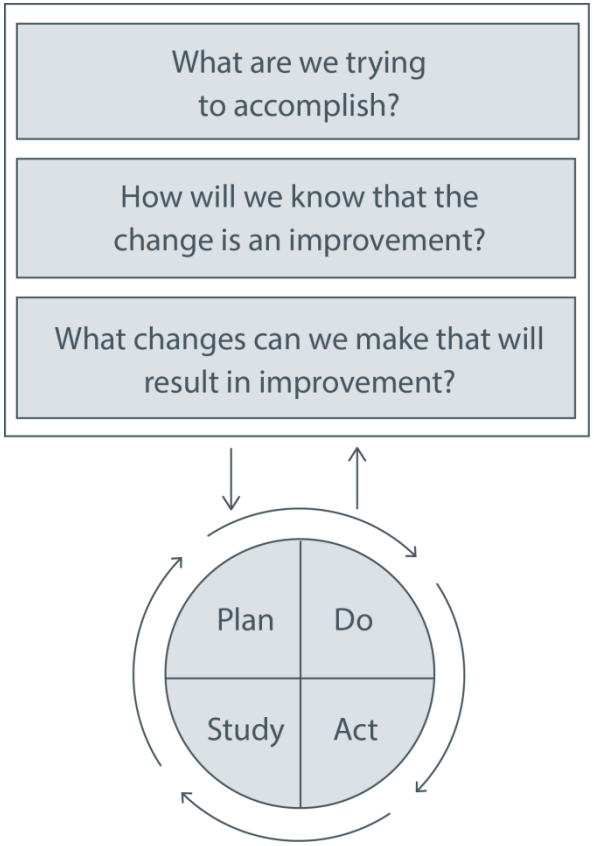
Global conferences and meetings

- National Forum on Quality Improvement (26+ years)
- International Summit on Improving Patient Care in the Office Practice and the Community (16+ years)
- International Forum on Quality and Safety in Healthcare (18+ years)
- Latin America Forum
- The APAC Forum on Quality Improvement in Health Care
- Middle East Forum on Quality and Safety in Healthcare (3 years)
- Strategic Partner Camps

We use a Proven Methodology: The Science of Improvement

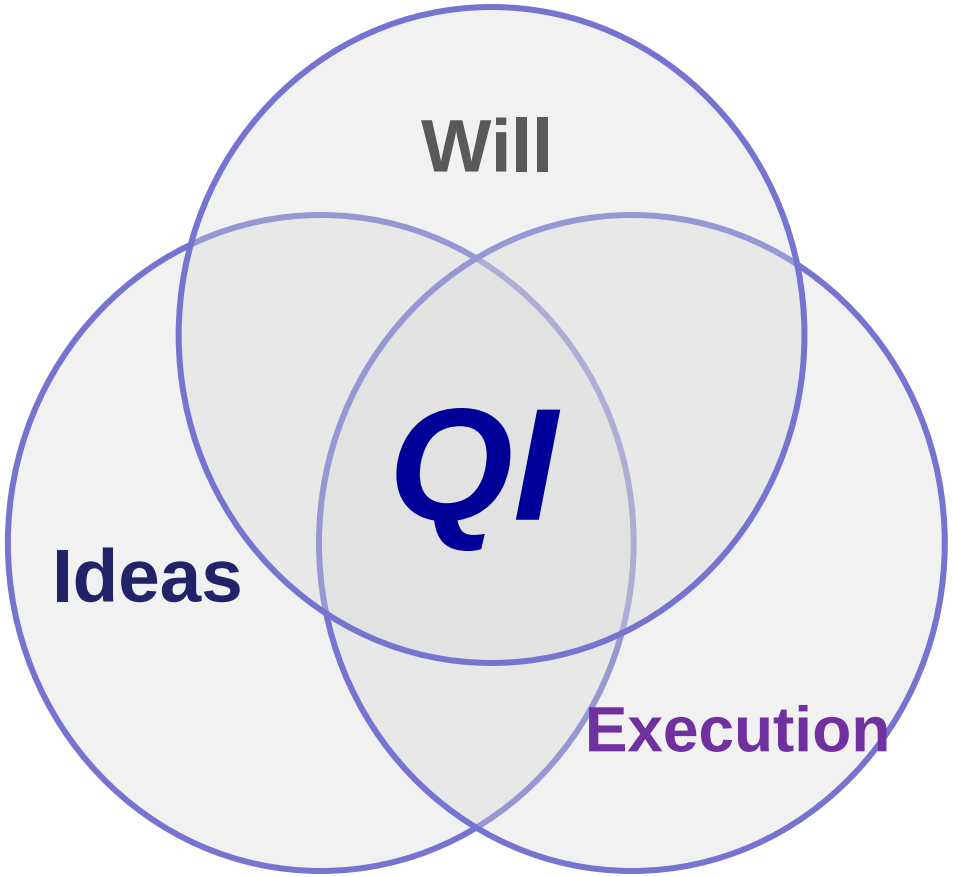
W. Edwards Deming
1900-1993

API's Model for Improvement



The Primary Drivers of Organizational Improvement

Having the *Will* (desire) to change the current state to one that is better



Developing *Ideas* that will contribute to making processes and outcome better

Having the capacity and capability to apply QI theories, tools and techniques that enable the *Results* to be achieved.

We have a highly committed Board of Directors

James M. Anderson
Cincinnati Children's Hospital Medical Center

Maureen Bisognano
Institute for Healthcare Improvement

Tom Chapman
The HSC Foundation

Michael Dowling
North Shore-LIJ Health System

Elliott Fisher, MD, MPH
The Dartmouth Institute for Health Policy and Clinical Practice

Terry Fulmer, PhD, RN, FAAN
Northeastern University

A. Blanton Godfrey, PhD
North Carolina State University

Jennie Chin Hansen
American Geriatrics Society

Helen Haskell
Mothers Against Medical Errors

Brent James, MD, MStat
Intermountain Healthcare

Gary Kaplan, MD
Virginia Mason Medical Center

Arnold Milstein, MD, MPH
Pacific Business Group on Health

Rudolph Pierce, Esq.
Goulston & Storrs (ret.)

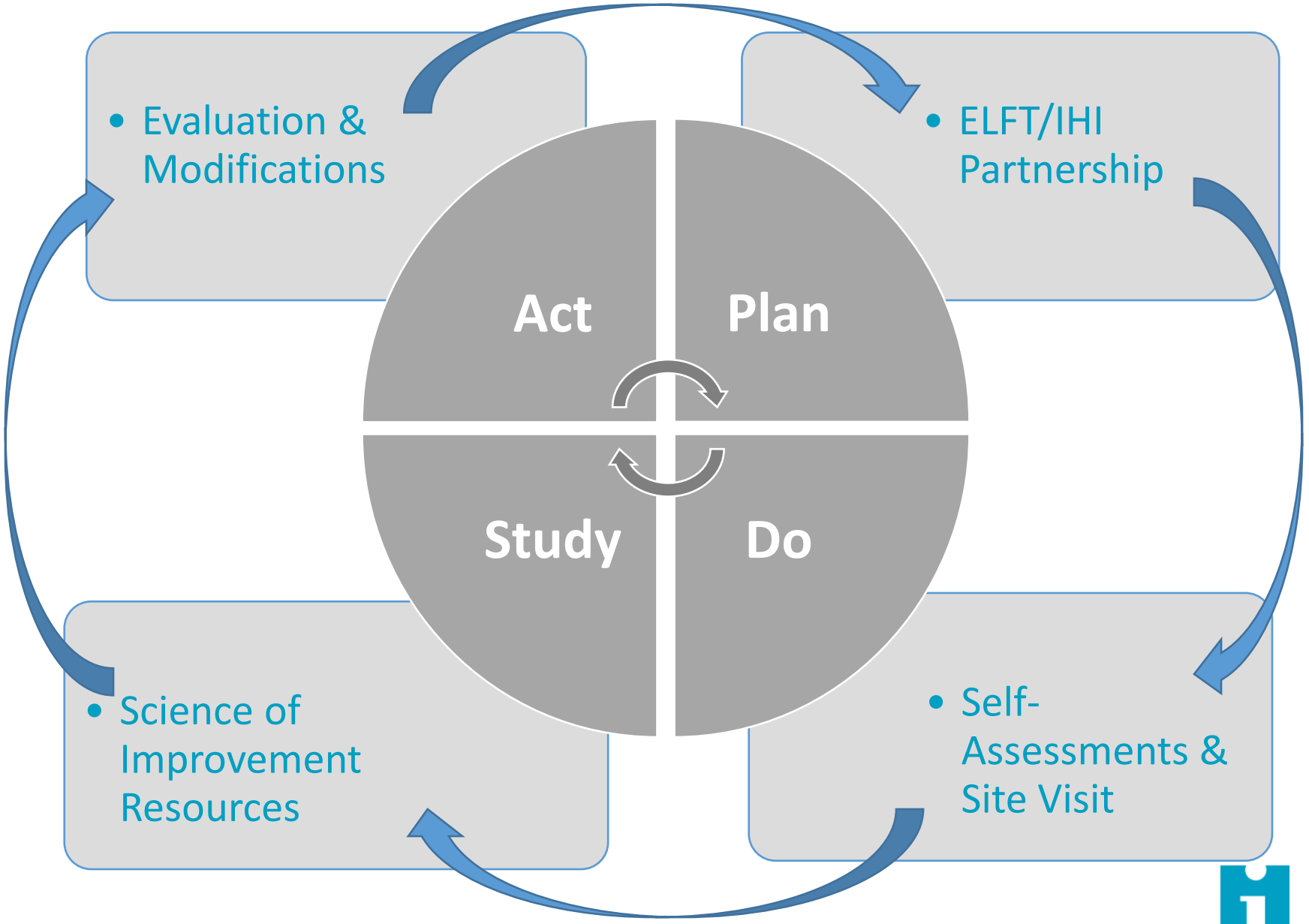
Mark D. Smith, MD, MPA
California Healthcare Foundation

Nancy Snyderman, MD, FACS
NBC News and University of Pennsylvania

Diana Chapman Walsh, MS, PhD
Wellesley College (ret.)

And a Passionate Staff!

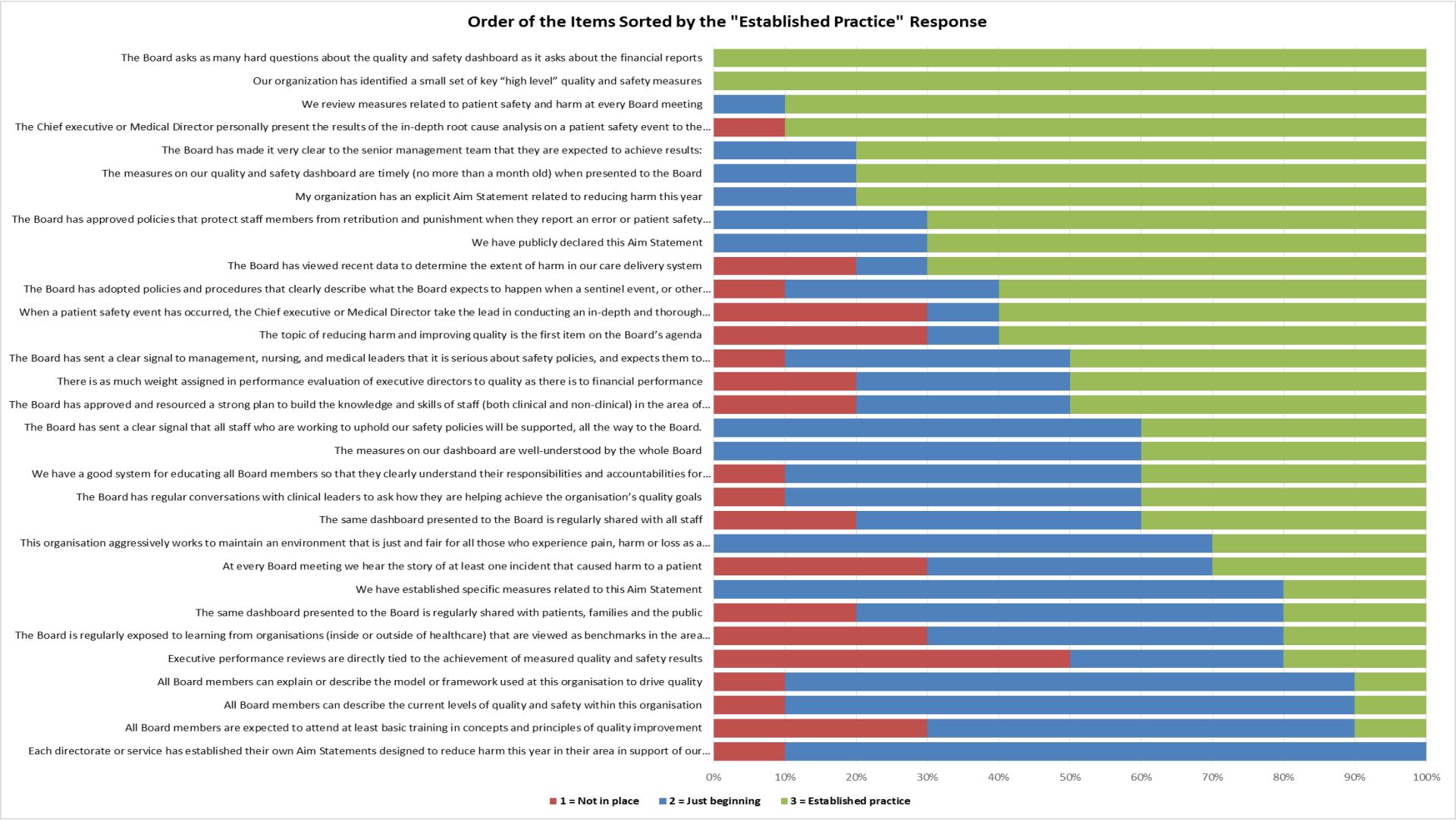
ELFT/IHI Partnership



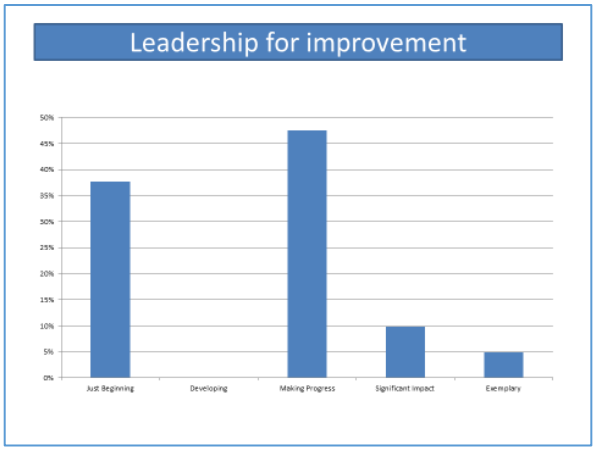
ELFT/IHI Partnership Design: Phase 1

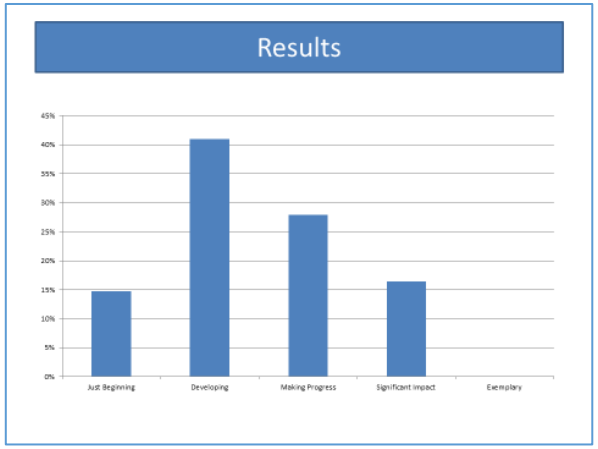
- Building on ELFT's strong QI foundation
- Adapting IHI programs and resource materials to match ELFT's needs
- Self Assessments as a starting point
  - From The Top (n=10)
  - Improvement Capability Assessment Tool (n=62)
  - Written comments
  - Strategic phone calls with leadership
- IHI Science of Improvement resources
  - IHI Open School
  - Improvement Science in Action Workshop (July 30-31, August 1)
  - Readings & Videos
  - Project based and results focus

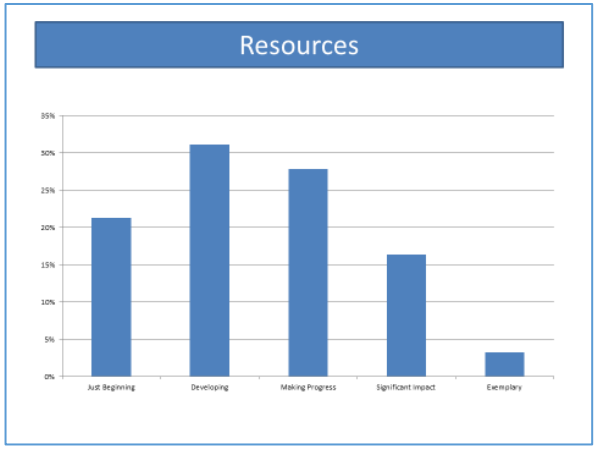
Executive and Non-Exec Directors responses to the Leadership Self-Assessment Tool

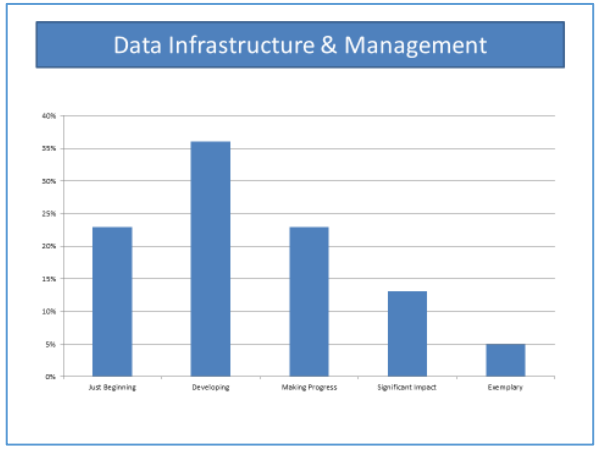


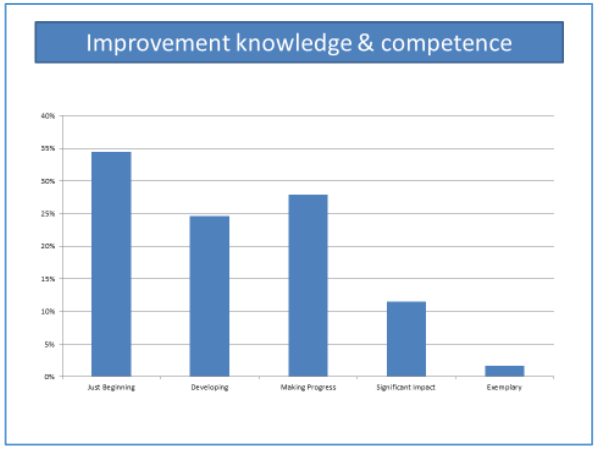
IHI Improvement Capability Tool
Overall Results for ELFT by Category (N = 62)







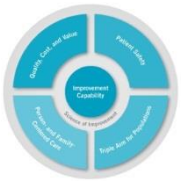




The key in looking at these six categories of organizational assessment is to look at the general patterns of the bars. Are there groupings? All the bars going up or down? Is one response category much higher than the others?

The Major Focus Areas for Today

- An Innovator
- A Convener
- A Partner
- A Driver of Results



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- Improvement Capability

- North America
- Latin America
- Europe
- Middle East
- Africa
- Asia Pacific

QI + Joy in Work

Questions Guiding Today's Workshop

(With special thanks to Marie, Robert, Kevin and Amar)

Question 1: What is the difference between a quality improving Board, and a Board that is looking for assurance? How do we strike the balance between assurance and improvement?

Question 2: How can we make sure that QI is part of all strategies that the Board signs off? How do we make QI our business strategy?

Question 3: How do we get everyone to have a basic knowledge of the science of improvement? What is the role of the Board in building capacity and capability for QI?

Question 4: How can the Board be assured that we are moving towards our improvement aims?

Question 5: How do we use all of this data we have to make an impact on our QI efforts? How do analyse the data from a QI perspective and what questions do we ask about the results?

Question 6: How do we scale up all of this local improvement work to something that is meaningful at Trust-level? What are the big dots, and how do we aggregate all the work up to move the big dots?

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The Role of Leadership in Accelerating the Quality Journey

What is Quality?

- **We want to know what <u>you think</u> is the definition of quality.**
- **Use the sticky notes on your table.**
- **Fill in the following statement:**

  Quality is _____.
- **Place your note(s) on the designated flipchart.**

Quality is…

- a combination of value and outcome in the eyes of the consumer
- a product or service delivered with 100% satisfaction the first time, every time
- a product or service that provides an expected value
- a product that lasts, for the best price
- a satisfied customer
- a very good product or service - one you would want again
- above standard results or outcomes
- an excellent product or service delivered by professional, friendly, knowledgeable people in a timely manner at the appropriate time
- an unending struggle for excellence
- accurate results to health care consumers
- anticipation and fulfillment of needs
- A vision which provides growth and satisfaction for the customer or consumer of our service
- attentive and excellent patient care
- attention to detail, timeliness, competence
- being the best, best of the best!
- being present for every experience
- best result possible in a given category

Dr. Deming's Perspectives

"Quality is meeting and exceeding the customer's needs and expectations and then continuing to improve."

"A product or service possesses quality if it helps somebody and enjoys a good and sustainable market."

W. Edwards Deming

A useful working definition…

Leadership is a process of social influence, which maximizes the efforts of others, towards the achievement of a goal.

Kevin Krause

Kevin Kruse Forbes.com What is Leadership April 9, 2013

Deming's Questions for Leaders…

- ***What business are we in?***
- ***What product or service would help our customers more?***
- ***Who is responsible for quality?***
- ***Where is quality made in this organization?***
- ***Where does poor quality come from? People or processes?***
- ***Can quality be delegated?***

Reference: W. Edwards Deming. *The New Economics*, 2nd edition. The MIT Press, 1994.

Interdependent Dimensions of High-Impact Leadership

1. **New Mental Models**
   How leaders think about challenges and solutions
2. **High-Impact Leadership Behaviors**
   What leaders do to make a difference
3. **IHI High-Impact Leadership Framework**
   Where leaders need to focus efforts

Source: Swensen S, Pugh M, McMullan C, Kabcenell A. *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*. Cambridge, MA: Institute for Healthcare Improvement; 2013. Available on www.ihi.org.

#1 High-Impact Leadership: New Mental Models Defining Quality Old Way and the New Way

A Health Care System's Model

Courtesy of Michael Pugh, IHI Senior Fellow

A Mental Model Many Leaders Have

Inputs

Patients
Staff
Supplies
Equipment
Facilities

A Black Hole

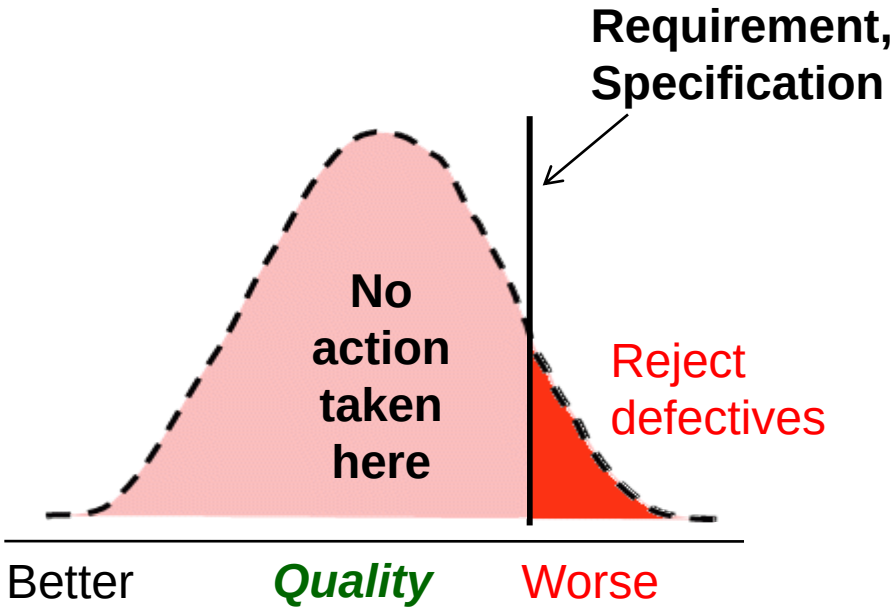
(stuff happens)

Outputs

Care Outcomes
Harm Rate
Patient Satisfaction
Cost per Case

Courtesy of Michael Pugh, IHI Senior Fellow

A New Mental Model
Defining Quality Old Way versus New Way

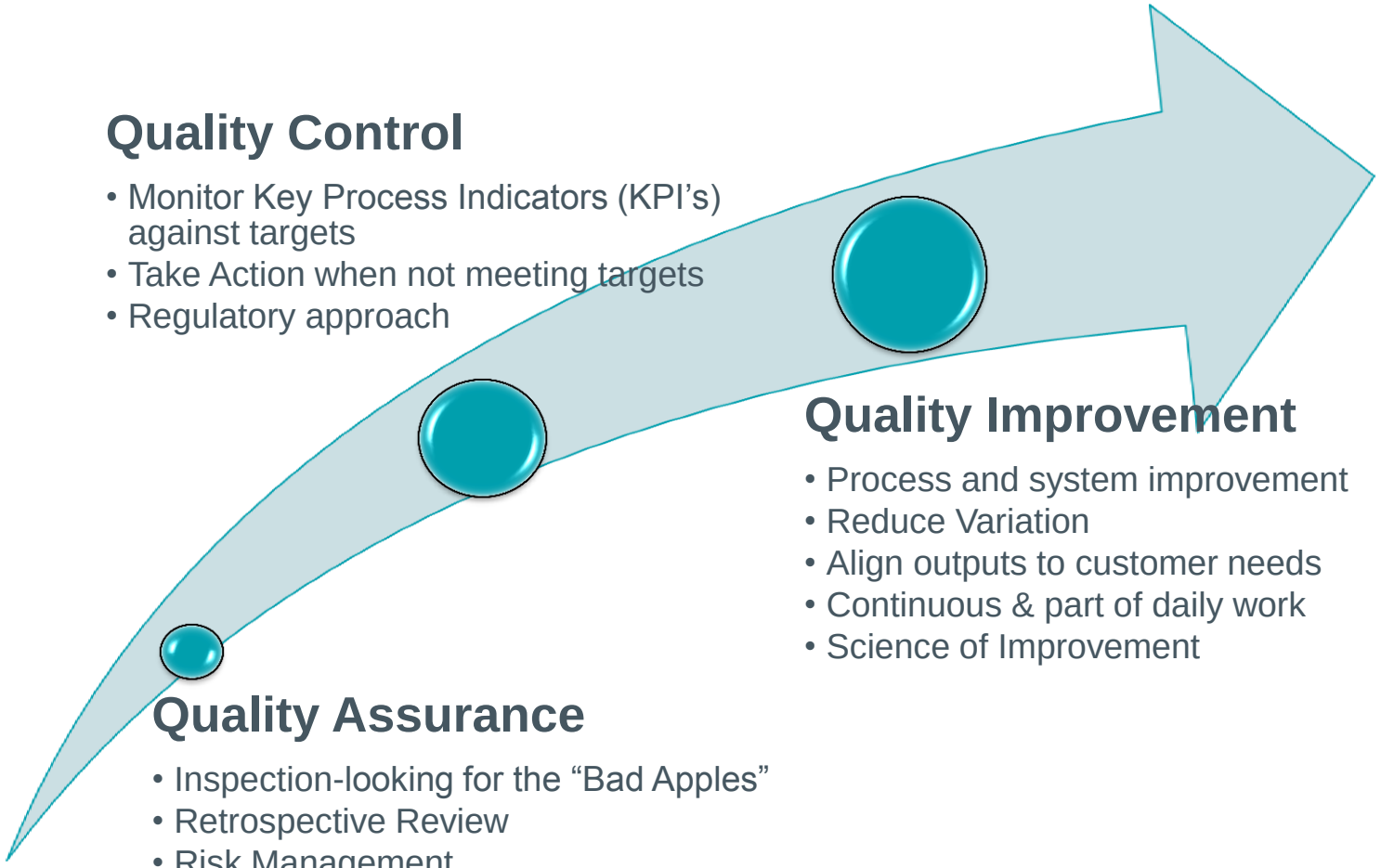


Old Way
(Quality Assurance)

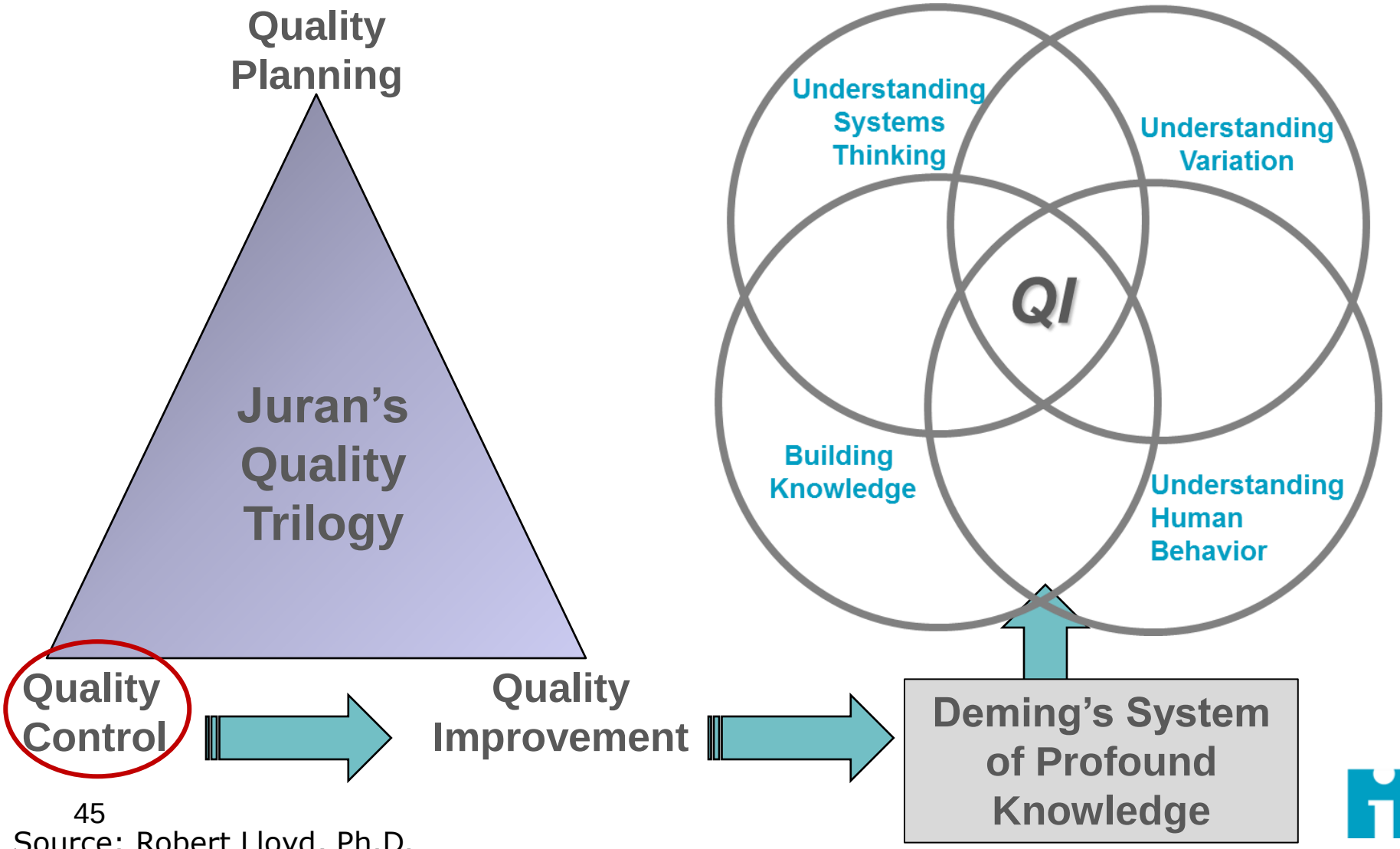
New Way
(Quality Improvement)

Source: Robert Lloyd, 2009

Mental Models & Quality Theories



Connecting Juran's and Deming's approaches to Quality



Source: Robert Lloyd, Ph.D.

A Proven Model: The Science of Improvement

W. Edwards Deming
1900-1993

Four Components of Improvement

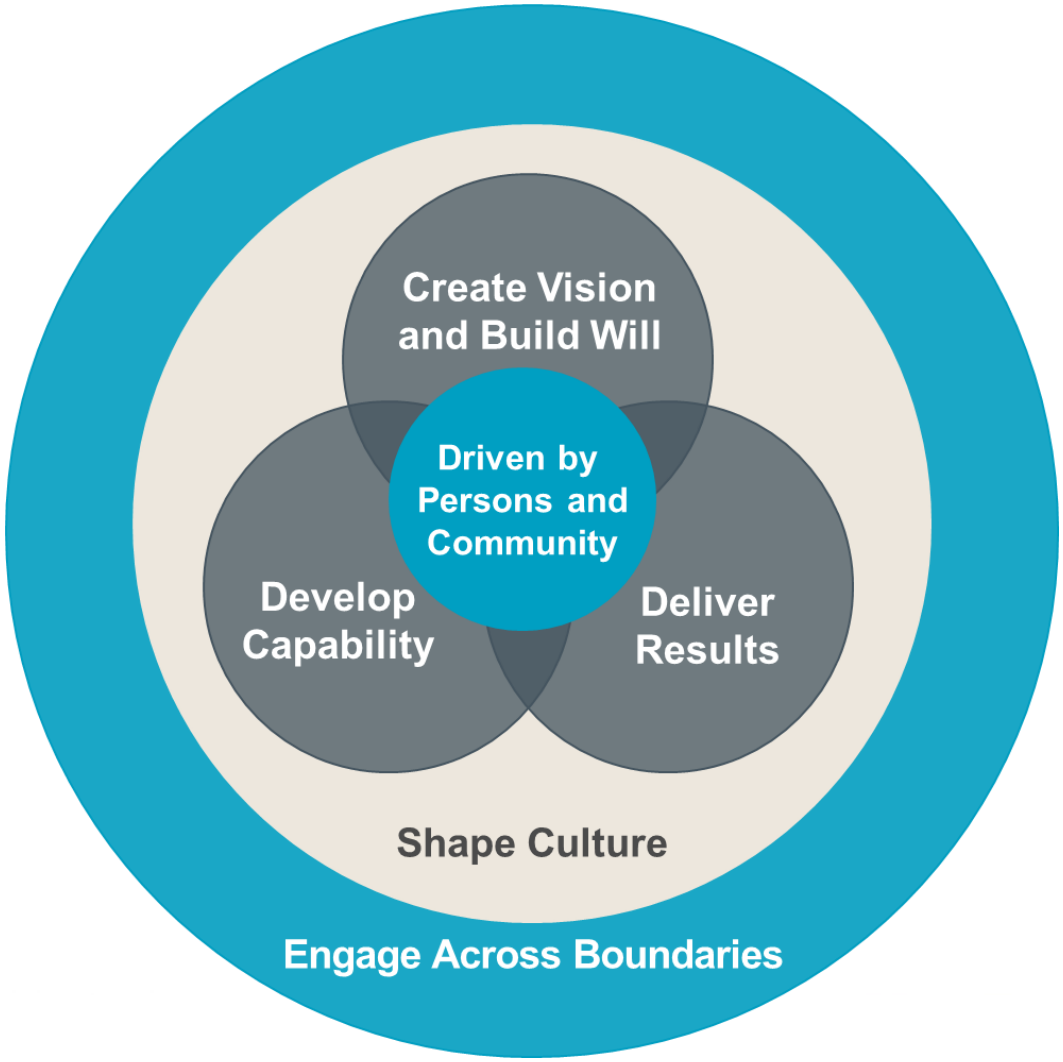
- Appreciation of a System/System Thinking
- Understanding Variation
- Theory of Knowledge (PDSA)
- Psychology of People

#2 High-Impact Leadership Behaviors
What leaders do to make a difference

1. Person-centeredness	Be consistently person-centered in word and deed
2. Front Line Engagement	Be a regular authentic presence at the front line and a visible champion of improvement
3. Relentless Focus	Remain focused on the vision and strategy
4. Transparency	Require transparency about results, progress, aims, and defects
5. Boundarilessness	Encourage and practice systems thinking and collaboration across boundaries

Swensen, Pugh, McMullan, Kabcenell. *High-Impact Leadership: Improve Care, Improve the Health of Populations & Reduce Costs*. Institute for Healthcare Improvement; 2013. Available: www.ihi.org.

#3 IHI High-Impact Leadership Framework Where Leaders Need To Focus Their Efforts



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#3 IHI High-Impact Leadership Framework Where Leaders Need To Focus Their Efforts

Driven by Persons and Community

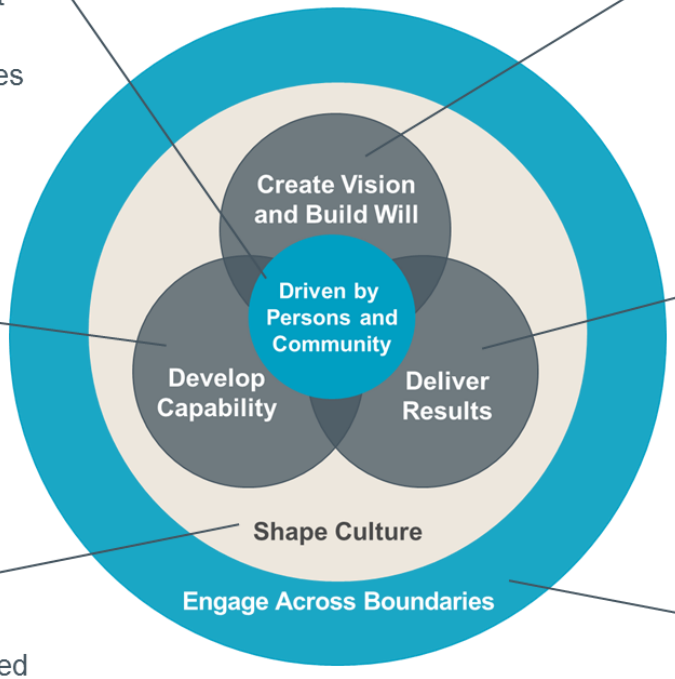
- Include patients on improvement teams
- Start meetings with patient stories and experience data
- Use leadership rounds to model engagement with patients and families

Develop Capability

- Teach basic improvement at all levels
- Invest in needed infrastructure and resources
- Integrate improvement with daily work at all levels

Shape Culture

- Communicate and model desired behaviors
- Target leadership systems and organizational policies with desired culture
- Take swift and consistent actions against undesired behaviors



Create Vision and Build Will

- Boards adopt and review system-level aims, measures, and results
- Channel leadership attention to priority efforts
- Transparently discuss measures and results

Deliver Results

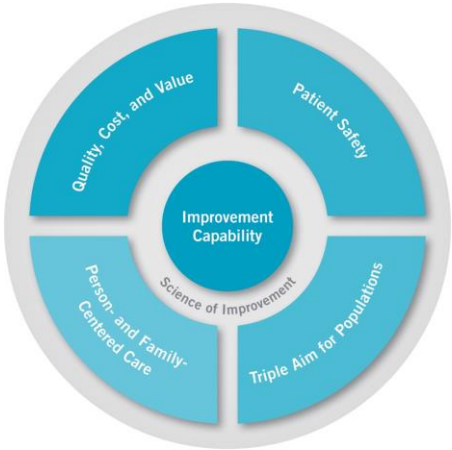
- Use proven methods and tools
- Frequently and systematically review efforts and results
- Devote resources and skilled leaders to high-priority initiatives

Engage Across Boundaries

- Model and encourage systems thinking
- Partner with other providers and community organizations in the redesign of care
- Develop cross-setting care review and coordination processes

Swensen S, Pugh M, McMullan C, Kabcenell A. *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*. Cambridge, MA: Institute for Healthcare Improvement; 2013. Available on www.ihi.org.

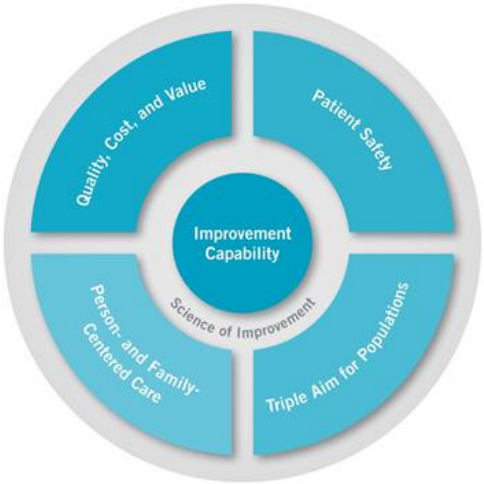
Engage Across Boundaries



- Establish a shared purpose
- Communicate a shared vision
- Ask questions and listen to responses
- Build consensus
- Show respect for the partner's business models and constraints
- Adopt a collaborative approach and demonstrate patience
- Volunteer resources when needed
- Ensure that the "right people" are in the room

Create Vision & Build Will

- Leaders and Board members develop a clear and consistent Vision that focuses on quality
  - Adopt bold, specific, system-level Safety, Quality, and Experience strategic aims
  - Oversee system-level measures of progress toward those aims, using a strategic dashboard
- Leadership “ownership” of safety and quality results
- Systematic reviews of results and progress
- Leadership visibility in improvement work
- Sense-making for the organization (setting priorities)
- Leadership models systems thinking



Leaders need to…

- Adopt bold, specific, system-level strategic aims
- Oversee system-level measures of progress toward those aims, using a “strategic dashboard” of measures
- Develop a strong *Quality Committee*
- Build Will by:
  - Starting every meeting with a patient story
  - Using data for improvement not judgment (assurance)
  - Stressing the need for transparency at all levels of the organization
  - Facing up to the difficult conversations (build dialogue)

Dialogue #1: The Role of Leadership

- What percentage of your time do you *personally spend* on assurance, and how much on improvement?
- What percentage of the *Board's time* is spent on assurance versus improvement?
- How well do we balance and align our assurance work with our improvement aims?

Dialogue #2:
Where Leaders Need To Focus Their Efforts

For each aspect of *Focusing Your Efforts*, please indicate the level of progress you feel exists here at ELFT.

Area of Focus	Not Yet Started	In Progress	Established Practice
Create Vision and Build Will			
Develop Capability			
Deliver Results			
Driven by Persons and Community (Listening to the Voice of the Customer)			
Shape a Culture of Quality			
Engage Across Boundaries			

Swensen S, Pugh M, McMullan C, Kabcenell A. *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*. Cambridge, MA: Institute for Healthcare Improvement; 2013. Available on www.ihi.org.

Dialogue #3: Leaders need to Build Will

For each aspect of *Building Will*, please indicate the level of progress you feel exists here at ELFT.

Building Will by:	Not Yet Started	In Progress	Established Practice
Starting every meeting with a patient story			
Using data for improvement not judgment (assurance)			
Stressing the need for transparency at all levels of the organization			
Facing up to the difficult conversations (building dialogue)			

Questions Guiding Today's Workshop

Question #1: What is the difference between a quality improving Board, and a Board that is looking for assurance? How do we strike the balance between assurance and improvement?

Question #2: How can we make sure that QI is part of all strategies that the Board signs off? How we make QI our business strategy?

Question #3: How do get everyone to have a basic knowledge of the science of improvement? What is the role of the Board in building capacity and capability for QI.

Question #4: How can the Board be assured that we are moving towards our improvement aims?

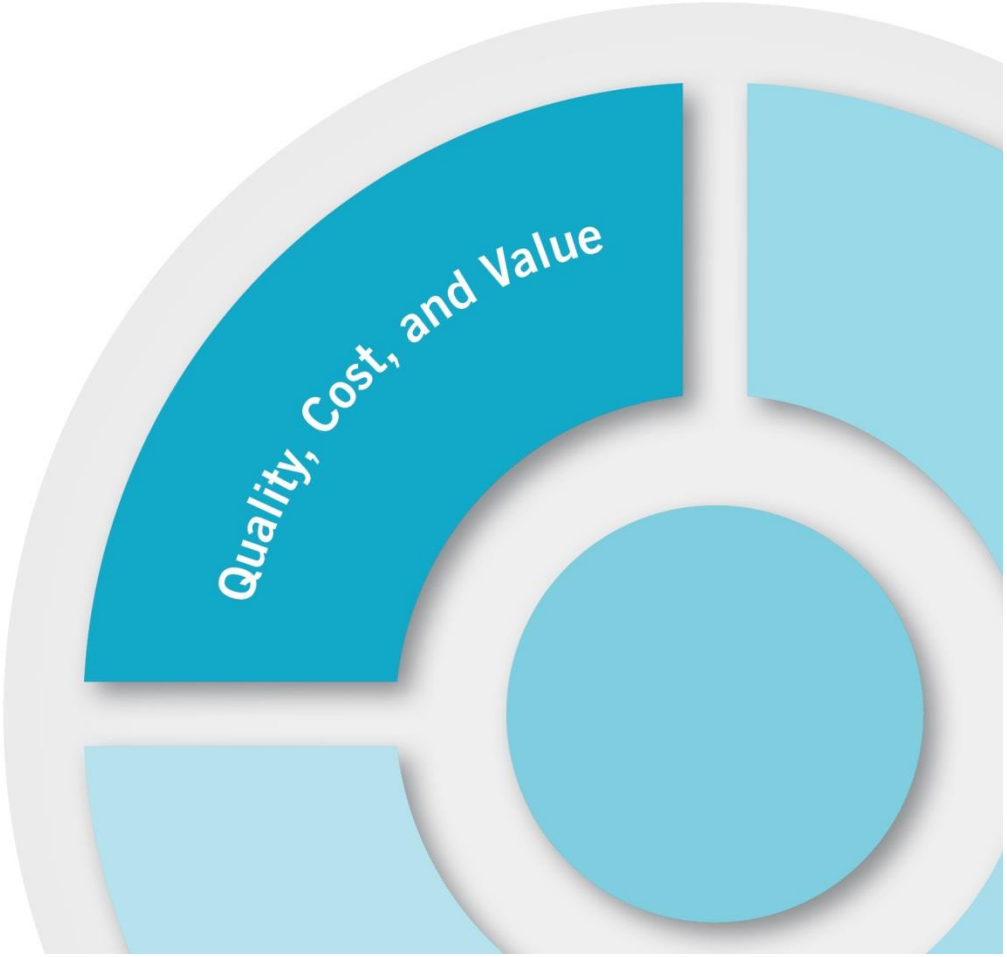
Question #5: How do we use all of this data we have to make an impact on our QI efforts? How do analyse the data from a QI perspective and what questions do we ask about the results?

Question #6: How do we scale up all of this local improvement work to something that is meaningful at Trust-level? What are the big dots, and how do we aggregate all the work up to move the big dots?

Quality, Cost, and Value

Our Goal:

Encourage, empower, and enable health care delivery systems to provide truly value-based care that ensures the best health care We strive to call out and address disparities in health and health care wherever they exist.



Fitting the pieces together!

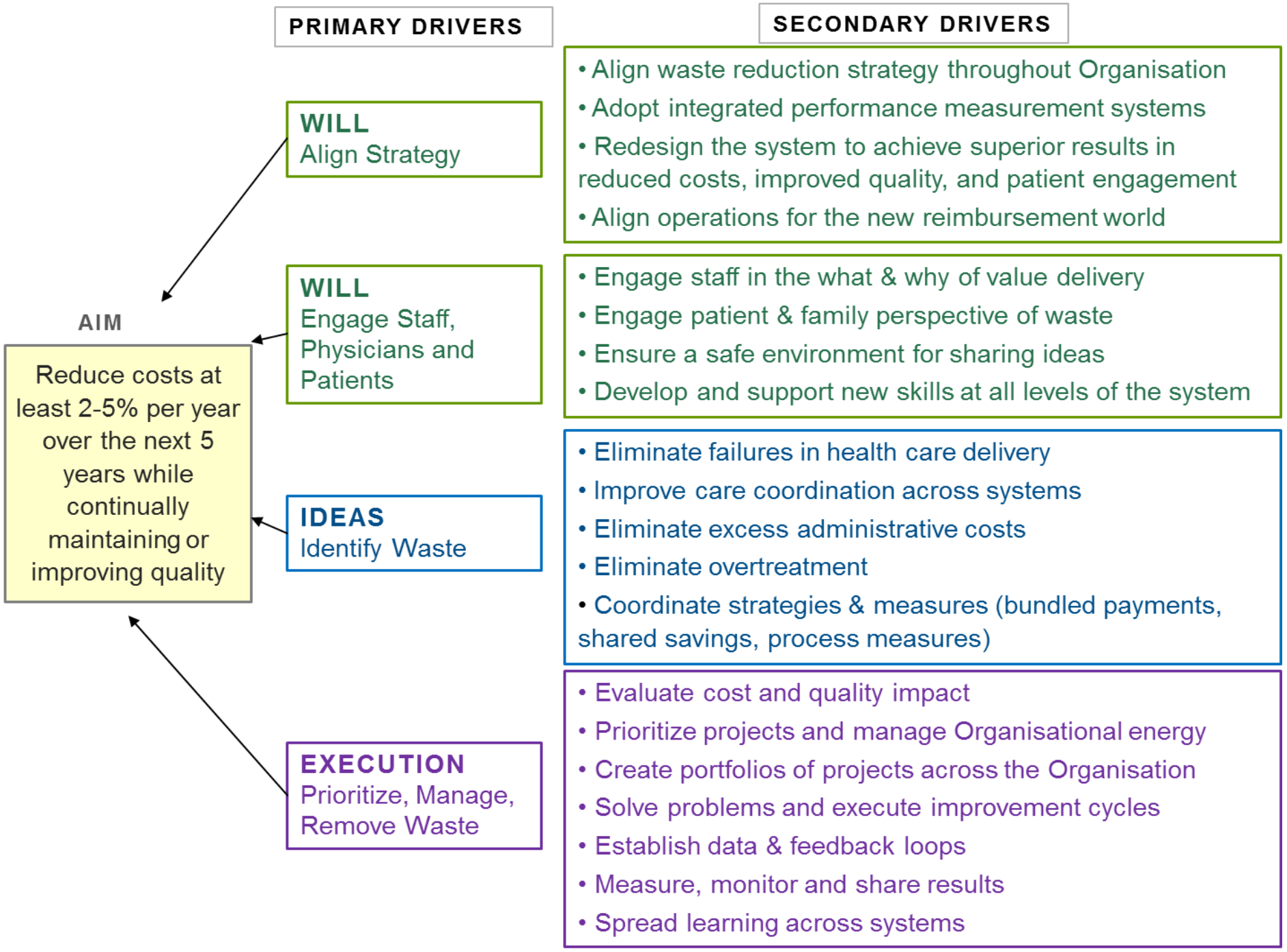
IHI's *Business Case* for Improving Quality

- The systematic identification and elimination of harm and waste, while maintaining or improving quality.

- Express the improvement aim in terms of harm or waste reduction:
  - ❑ **Calculate the cost of the harm or waste**
  - ❑ **Add back any costs incurred in the improvement**

- Assure the cost drop to the "bottom line"

Source: Martin LA, Neumann CW, Mountford J, Bisognano M, Nolan TW. *Increasing Efficiency and Enhancing Value in Health Care: Ways to Achieve Savings in Operating Costs per Year*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2009. (Available on www.IHI.org)


PRIMARY DRIVERS
SECONDARY DRIVERS
WILL
Align Strategy
• Align waste reduction strategy throughout Organisation
• Adopt integrated performance measurement systems
• Redesign the system to achieve superior results in reduced costs, improved quality, and patient engagement
• Align operations for the new reimbursement world
WILL
Engage Staff, Physicians and Patients
• Engage staff in the what & why of value delivery
• Engage patient & family perspective of waste
• Ensure a safe environment for sharing ideas
• Develop and support new skills at all levels of the system
AIM
Reduce costs at least 2-5% per year over the next 5 years while continually maintaining or improving quality
IDEAS
Identify Waste
• Eliminate failures in health care delivery
• Improve care coordination across systems
• Eliminate excess administrative costs
• Eliminate overtreatment
• Coordinate strategies & measures (bundled payments, shared savings, process measures)
EXECUTION
Prioritize, Manage, Remove Waste
• Evaluate cost and quality impact
• Prioritize projects and manage Organisational energy
• Create portfolios of projects across the Organisation
• Solve problems and execute improvement cycles
• Establish data & feedback loops
• Measure, monitor and share results
• Spread learning across systems

Value-based Health Care Delivery

The central goal in health care must be **value for patients**, not access, volume, convenience, quality, or cost containment

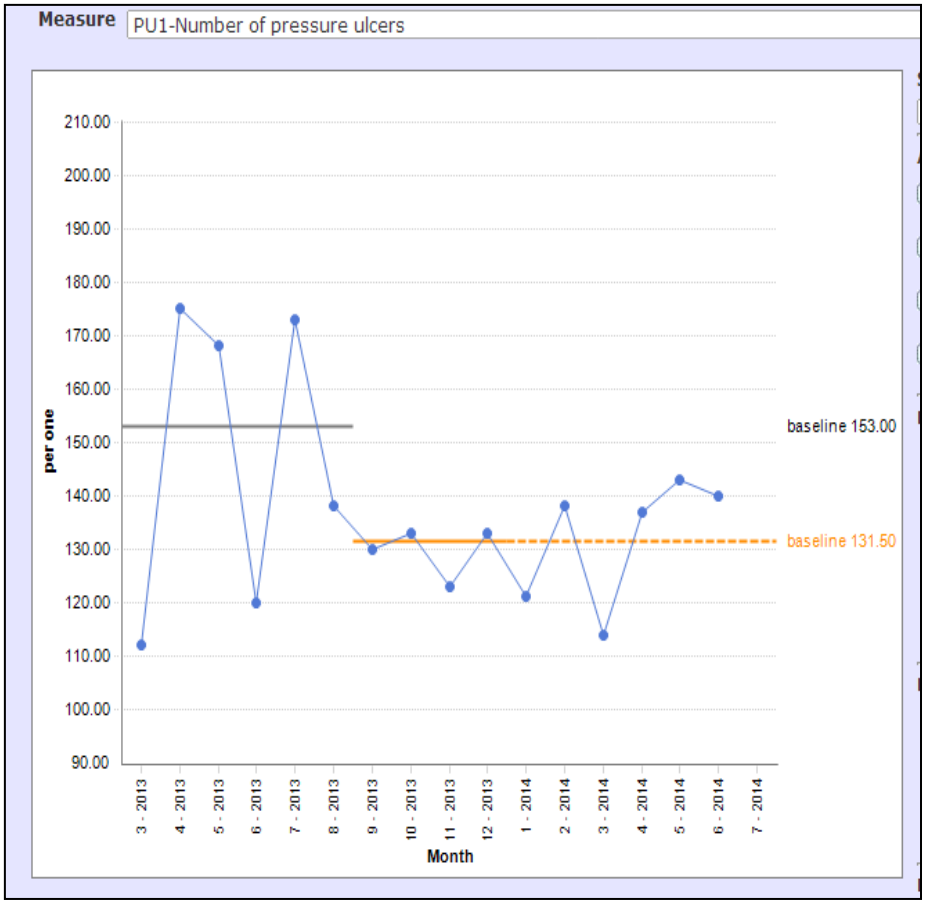
$$\text{Value} = \frac{\text{Health outcomes}}{\text{Costs of delivering the outcomes}}$$

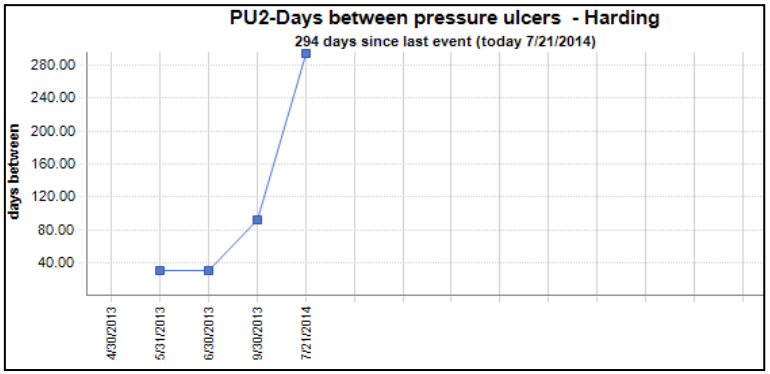
The Value approach requires that we measuring two fundamental parameters:

1. Outcomes: the **full set of patient health outcomes** over the care cycle

2. Costs: the **total costs of resources** used to care for a patient's condition over the care cycle

Example of Quality as a Business Strategy
MH in South of England, 2013-14 (Pressure Ulcers)





Section A: Total number of pressure ulcers

How many pressure ulcers does your organisation treat? (enter a number and press ENTER) 153

Click to estimate section B

Section B: Pressure ulcers by grade

How many pressure ulcers *of each grade* does your organisation treat?

Grade 1	50
Grade 2	70
Grade 3	33
Grade 4	0
Total	153

Click here to print

The default numbers are based on percentages from the academic research study. Please overwrite if you are confident your numbers are different.

(Total of section B must be the same as the number in section A)

Section C: Results: Estimated cost of pressure ulcer care at 2008/09 prices
(rounded to the nearest thousand £s)

	Central	Lower range	Higher range
Grade 1	72,000	59,000	87,000
Grade 2	419,000	339,000	507,000
Grade 3	328,000	266,000	397,000
Grade 4	-	-	-
Total	819,000	664,000	991,000

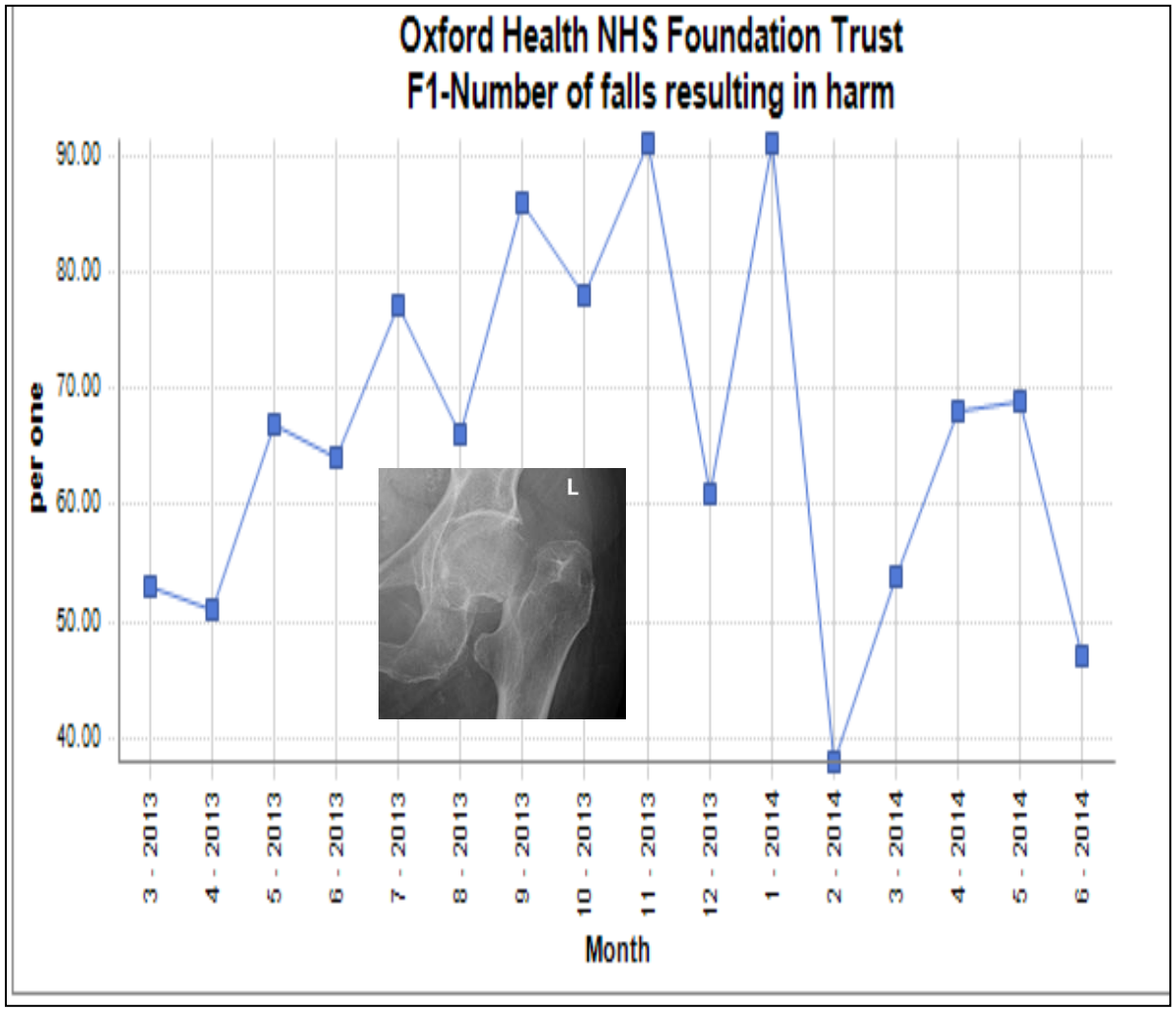
Section D: Potential savings if the number of pressure ulcers is reduced

Enter a planned percentage reduction in the green box, to see the impact on number of ulcers, and cost pressures: 25 %

ulcers would mean 38 fewer pressure ulcers and a potential cost saving of £265k

https://www.gov.uk/government/publications/pressure-ulcers-productivity-calculator

At what cost? Unreliable Medical Care



Cost of a hip fracture

- £13,000 for the event
- £64,000 over average remaining life-time of the patient

Source 1000- lives Wales

Deming's Chain Reaction for Improving Value

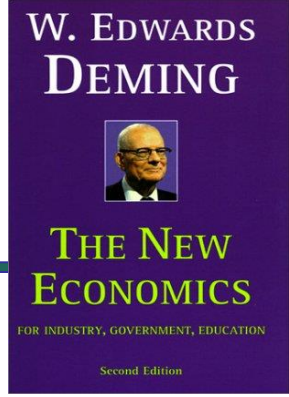
Sources: Deming, W.E. *Out of the Crisis*. MIT Press, Cambridge, 1992:3. Langley, G. et. al. *The Improvement Guide*. Jossey-Bass Publishers, 2009: 311.

What is Quality as a Business Strategy (QBS)?

Throughout the 1980's. Dr. W. Edwards Deming reached thousands of people with his message to transform their Organisations to ones based on his concepts of quality. This transformation required a new style of management as well as new philosophies, knowledge and methods. QBS began as a template to help Organisations incorporate these philosophies and concepts into the ways they managed their Organisations, Quality as a Business Strategy includes philosophies, concepts and specific methods for incorporating these changes.

Deming's view of our progress

NE p.37

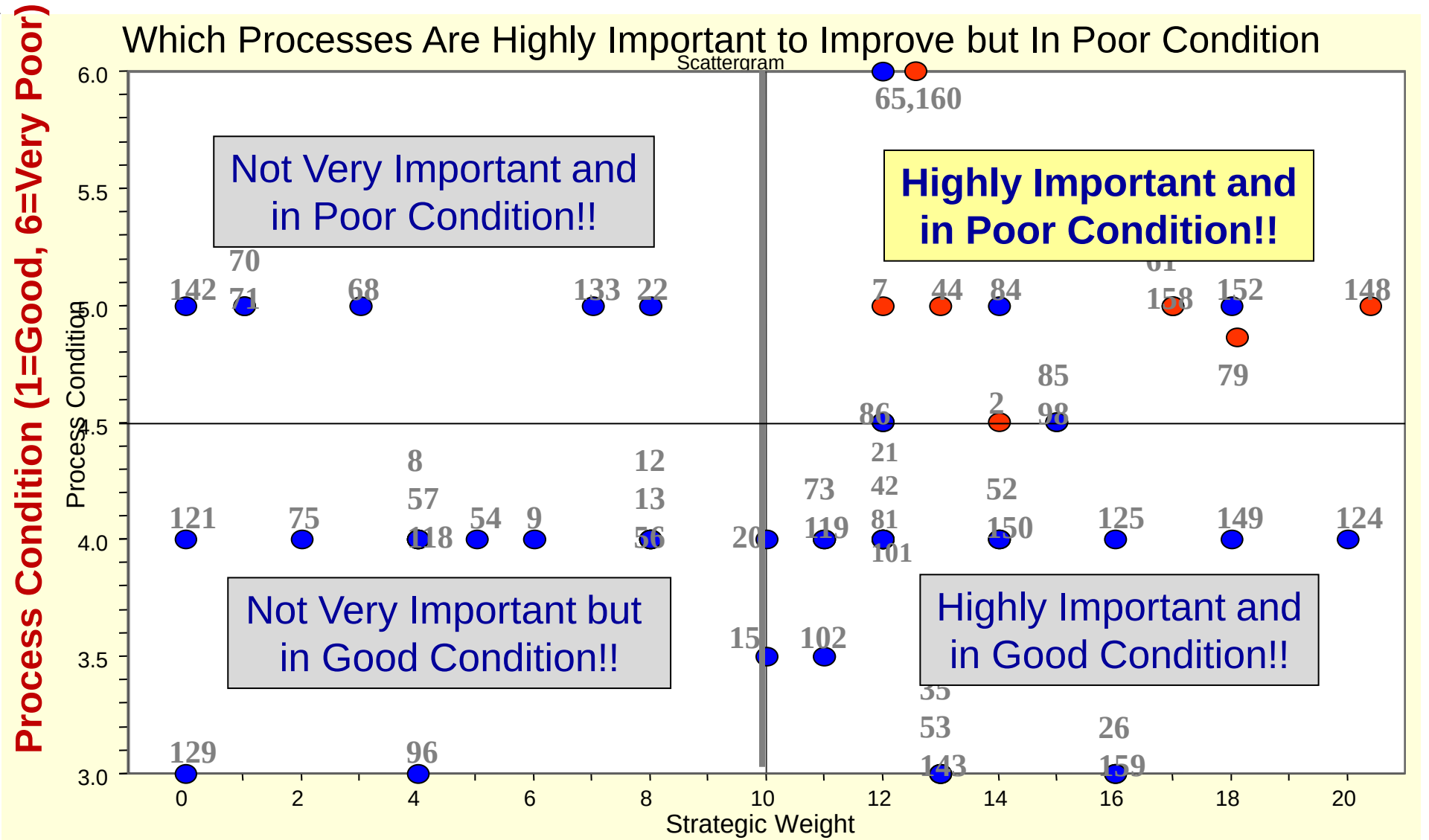


Application	Has Penetrated?	Magnitude
Overall business strategy and planning	Not Yet	Here are the big gains; 97% Waiting to be achieved!
Company-wide systems (personnel, training, systems of reward, merit pay, annual appraisal, pay for performance, legal, financial, purchase of materials, equipment, and services)	Not yet	
Unique processes that produce figures	Yes	3%

Basic Elements of QBS

- A foundation of ***continuous matching of products and services to a need through design and redesign of processes, products, services.***
- ***An Organisation that performs as a system*** to achieve this matching with the need as the target
- ***A set of methods*** to ensure that changes result in real improvements to the Organisation

What Does QBS Get Us?



Strategic Weight: Importance to Improve If To Meet Strategic Goals

What Does QBS Get Us? FOCUS!

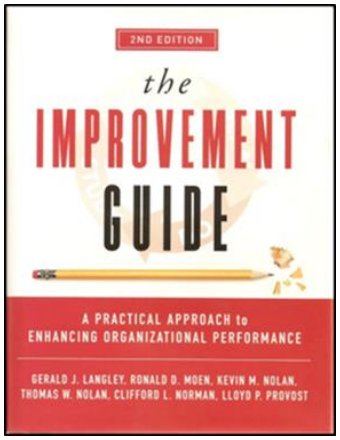
Leadership Environment Conducive to QBS

- Creating the desire for continuous improvement
- **Creating an environment that nurtures respect among people**
- Providing encouragement
- **Promoting cooperation**

The Improvement Guide , 2009, chapter 13

Five QBS Activities for Leaders

1. Establishing & communicating the purpose of the Organisation (mission & vision)
2. Viewing the Organisation as a system



3. Designing & managing a system for gathering information (patient focus)
4. Conducting planning for improvement and integrating it with business planning
5. Managing individual and team improvement activities

See The Improvement Guide , 2009, chapter 13 for details

QBS - Five Activities for Leaders

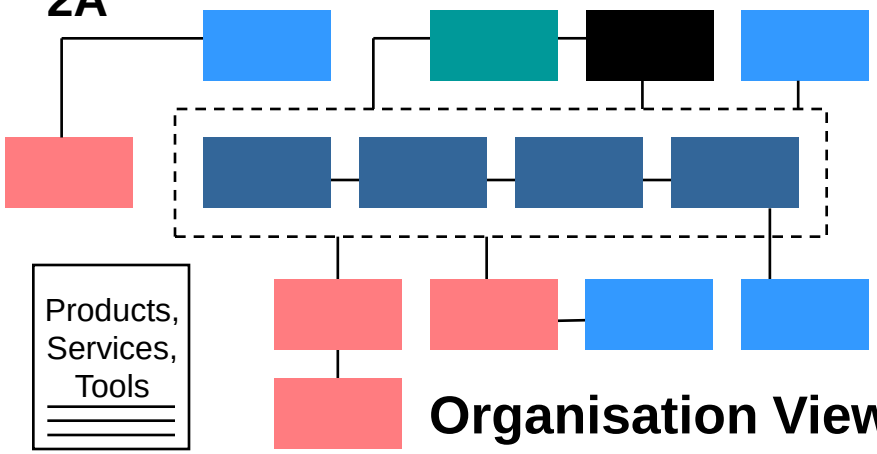
Purpose
Mission
Vision
Beliefs
1

System for Obtaining Information
(Customer Focus)
3

Planning
- Strategic Objectives
- Improvement Efforts
- Resources

4

2A

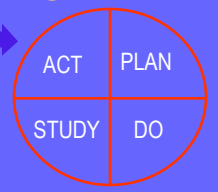


2B

Business Perspective	Customer Perspective
Operations Perspective	Employee Perspective

Organisation Viewed as a System

Three Basic Questions 5



Managing Improvement Efforts

The Improvement Guide p..260

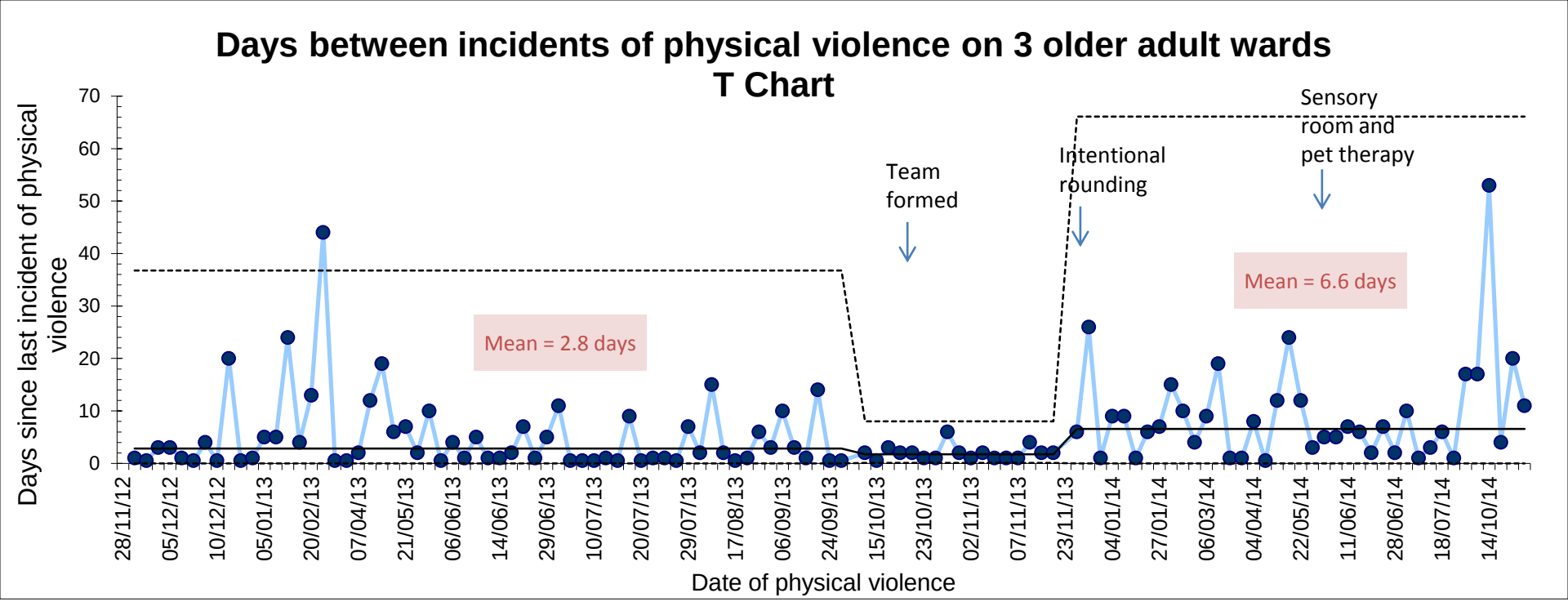
A Key to Success:
Engaging Front-line and Finance Staff
to Lower Costs and Drive Quality

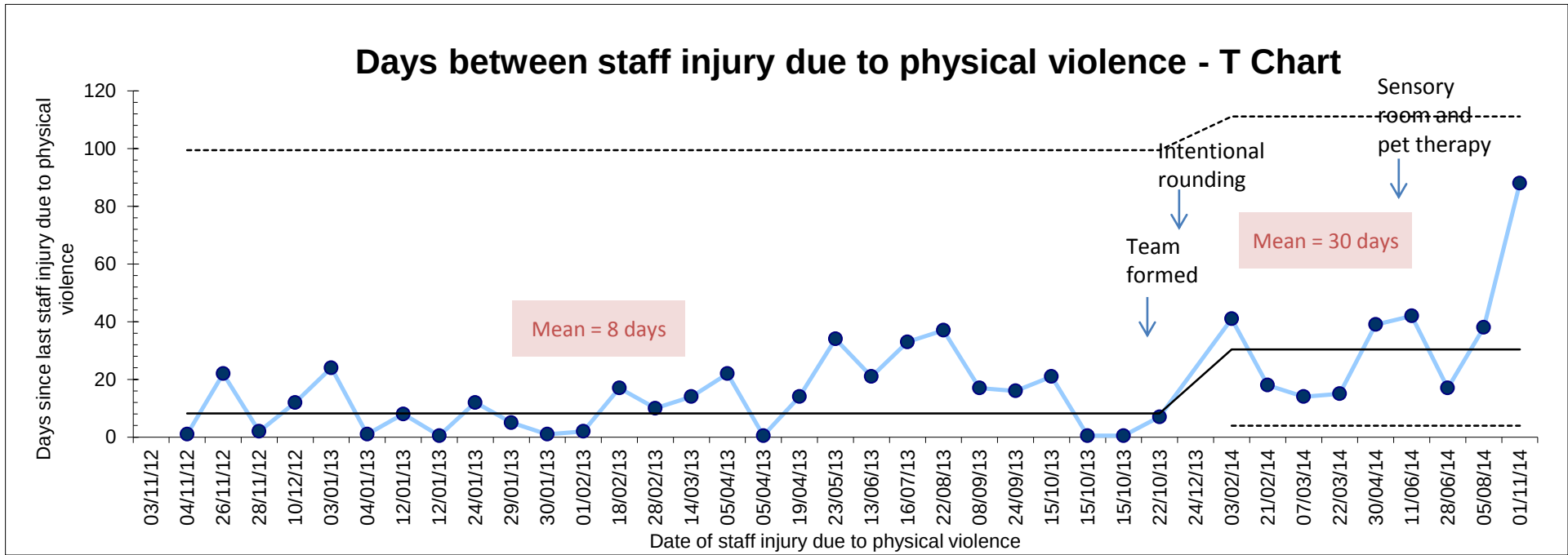
Engaging Front-line and Finance Staff

Institute for Healthcare Improvement

From the Bedside to the Balance Sheet

Engaging Front-Line and Finance Staff to Lower Costs and Drive Quality


Days between incidents of physical violence on 3 older adult wards
T Chart
Days since last incident of physical violence
70
60
50
40
30
20
10
0
Team formed
Intentional rounding
Sensory room and pet therapy
Mean = 2.8 days
Mean = 6.6 days
28/11/12
05/12/12
10/12/12
05/01/13
20/02/13
07/04/13
21/05/13
06/06/13
14/06/13
29/06/13
10/07/13
20/07/13
29/07/13
17/08/13
06/09/13
24/09/13
15/10/13
23/10/13
02/11/13
07/11/13
23/11/13
04/01/14
27/01/14
06/03/14
04/04/14
22/05/14
11/06/14
28/06/14
18/07/14
14/10/14
Date of physical violence


Days between staff injury due to physical violence - T Chart
Days since last staff injury due to physical violence
120
100
80
60
40
20
0
Intentional rounding
Sensory room and pet therapy
Team formed
Mean = 8 days
Mean = 30 days
03/11/12
04/11/12
26/11/12
28/11/12
10/12/12
03/01/13
04/01/13
12/01/13
12/01/13
24/01/13
29/01/13
30/01/13
01/02/13
18/02/13
28/02/13
14/03/13
05/04/13
05/04/13
19/04/13
23/05/13
13/06/13
16/07/13
22/08/13
08/09/13
24/09/13
15/10/13
15/10/13
15/10/13
22/10/13
24/12/13
03/02/14
21/02/14
07/03/14
22/03/14
30/04/14
11/06/14
28/06/14
05/08/14
01/11/14
Date of staff injury due to physical violence

At what cost? Crisis & Restraint

Face down restraint

Total number of incidents of face down physical restraint by one or more members of staff	
Number of respondents	27 (50 per cent of all trusts)
Total	3,439
Range	Highest 923; lowest 0 (in 4 Mental Health Trusts)
Median	65

It was like a rugby scrum... They got on top of me and held my face down to the floor... with my arms behind my back. There was someone on every limb... it stayed with me.

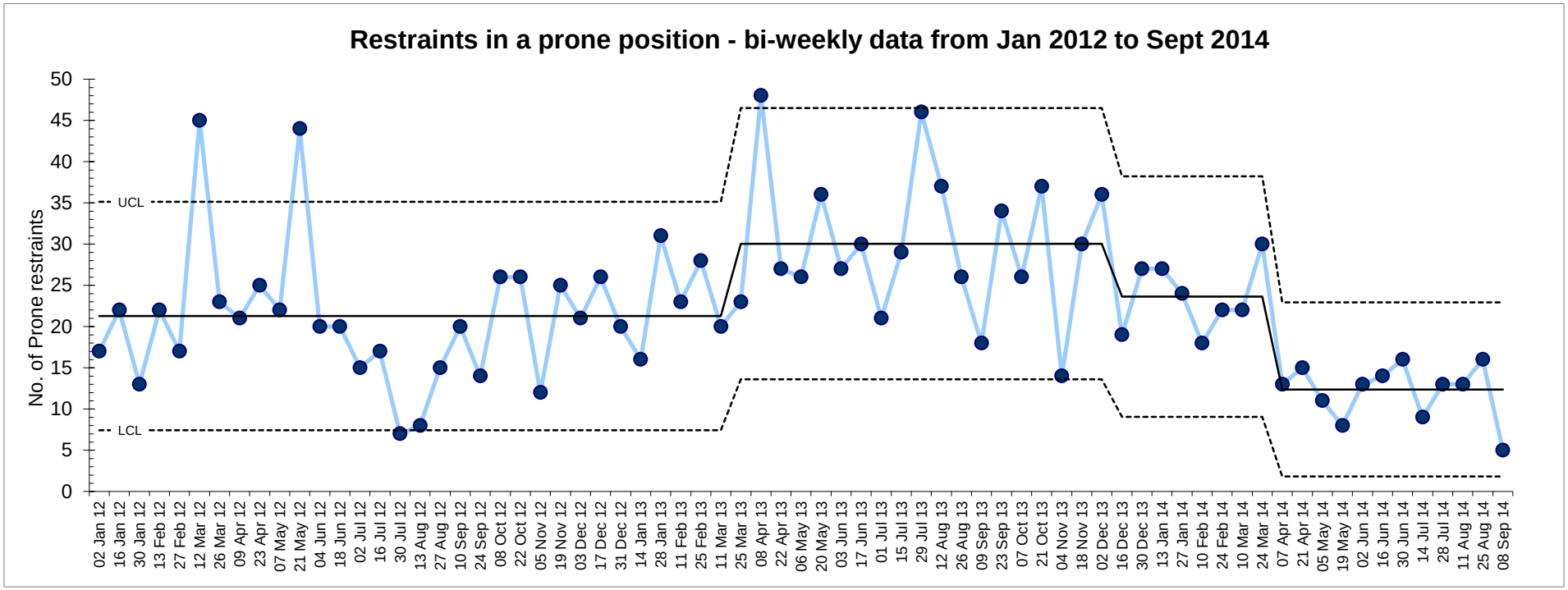
Example

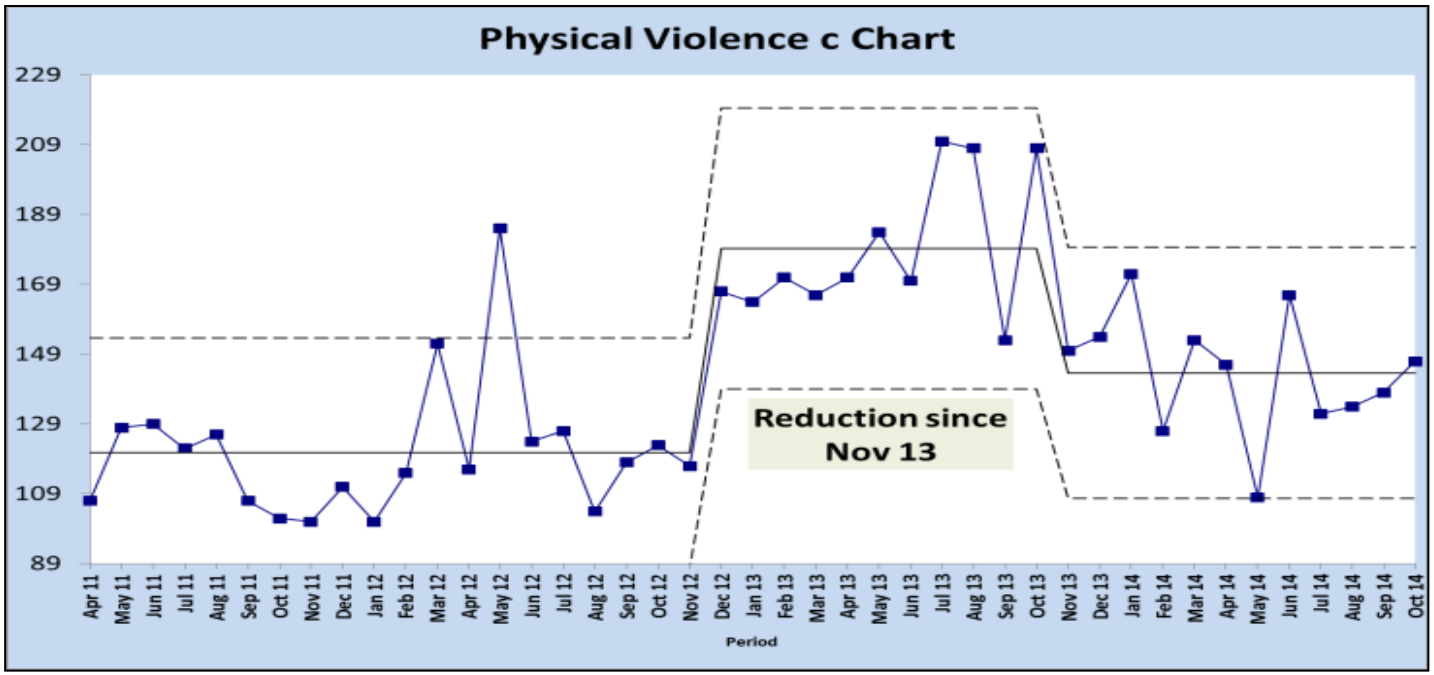
North Central London reduced ambulance conveyance to A&E after analysing activity over a three month period. They found that 57 hours of emergency ambulance time was spent conveying 133 people, mostly from three outer London boroughs, in mental health crisis to A&E departments. Following a workshop in which it was demonstrated that those people did not receive a good service, two boroughs set up 'frequent attender forums', hosted by A&E departments with mental health and substance misuse leads actively involved in agreeing how to better meet individual needs of people using services.

LondonHealth PROGRAMMES

2. Mental health models of care for London

http://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf


Restraints in a prone position - bi-weekly data from Jan 2012 to Sept 2014
No. of Prone restraints
UCL
LCL
0
5
10
15
20
25
30
35
40
45
50
02 Jan 12
16 Jan 12
30 Jan 12
13 Feb 12
27 Feb 12
12 Mar 12
26 Mar 12
09 Apr 12
23 Apr 12
07 May 12
21 May 12
04 Jun 12
18 Jun 12
02 Jul 12
16 Jul 12
30 Jul 12
13 Aug 12
27 Aug 12
10 Sep 12
24 Sep 12
08 Oct 12
22 Oct 12
05 Nov 12
19 Nov 12
03 Dec 12
17 Dec 12
31 Dec 12
14 Jan 13
28 Jan 13
11 Feb 13
25 Feb 13
11 Mar 13
25 Mar 13
08 Apr 13
22 Apr 13
06 May 13
20 May 13
03 Jun 13
17 Jun 13
01 Jul 13
15 Jul 13
29 Jul 13
12 Aug 13
26 Aug 13
09 Sep 13
23 Sep 13
07 Oct 13
21 Oct 13
04 Nov 13
18 Nov 13
02 Dec 13
16 Dec 13
30 Dec 13
13 Jan 14
27 Jan 14
10 Feb 14
24 Feb 14
10 Mar 14
24 Mar 14
07 Apr 14
21 Apr 14
05 May 14
19 May 14
02 Jun 14
16 Jun 14
30 Jun 14
14 Jul 14
28 Jul 14
11 Aug 14
25 Aug 14
08 Sep 14


Physical Violence c Chart
Reduction since
Nov 13
229
209
189
169
149
129
109
89
Apr 11
May 11
Jun 11
Jul 11
Aug 11
Sep 11
Oct 11
Nov 11
Dec 11
Jan 12
Feb 12
Mar 12
Apr 12
May 12
Jun 12
Jul 12
Aug 12
Sep 12
Oct 12
Nov 12
Dec 12
Jan 13
Feb 13
Mar 13
Apr 13
May 13
Jun 13
Jul 13
Aug 13
Sep 13
Oct 13
Nov 13
Dec 13
Jan 14
Feb 14
Mar 14
Apr 14
May 14
Jun 14
Jul 14
Aug 14
Sep 14
Oct 14
Period

Dialogue #4:
QBS Five Activities for Leaders

For each aspect of *Building Will*, please indicate the level of progress you feel exists here at ELFT.

Five QBS Activities for Leaders	Not Yet Started	In Progress	Established Practice
Establishing & communicating the purpose of the Organisation (mission & vision)			
Viewing the Organisation as a system			
Designing & managing a system for gathering information (patient focus)			
Conducting planning for improvement and integrating it with business planning			
Managing individual and team improvement activities			

QBS Evaluation Grid

Source: ©2014 IHI Improvement Advisor Professional Development Program and Associates in Process Improvement

Area	Score=0	Score=2	Score=4	Score=6	Score=8	Score=10
Purpose	No written statements	Statement exists	Mission and tenets defined and visible	Communicated and understood by employees	Used to align and guide the business	Fully integrated into the structure
System	Work as a process is not understood	Major processes and products have been documented	Relationships between processes are documented	Systems thinking and language is common	Systems diagrams are used in business.	Management systems have integrated the systems view
Whole System Measures	Financial data is viewed periodically	Financial and other operational measures are used	Family of measures is assembled	Balances set of measures reported graphically	Set of measures aligned and variation understood	Measures are integrated into management systems
Information	Information is gathered on ad hoc, reactive basis	System is based on passive information	System is well documented and includes active sources	Information is documented and communicated	Comprehensive system with analysis/synthesis for decision making	Marketing leads and integrates information system
Planning for improvement	No formal planning; reactive culture	Planning for improvement is done on an informal basis	A formal, documented process exists for planning improvement	Integrated process identifies objectives, efforts, and resources	All other planning processes are defined and linked	Planning system is improved and integrated in all areas
Managing improvement efforts	No system exists to manage improvements	Improvements recognized on an as-needed basis & resources assigned	Leaders provide formal guidance for individuals and teams	Improvements are guided by planning; leaders are learning	The impact of improvement is understood and managed	Improvement system is integrated in business and regularly improved
Model for improvement	No standard approach to improvement efforts	Various approaches are used for improvement	Training on the Model and expectation of its use	Theory behind the Model is understood	Improvements are managed as PDSA cycles	Model is routinely used by all levels of the Organisation
Management system	Structure does not exist to make improvement key a focus of daily work	The need for improvement is recognized and responsibility assigned	A formal system for improvement is defined	Top management assumes responsibility for integrating improvement	Improvement is linked to planning and other key business activities	Improvement is completely integrated into all aspects of operating & developing the business

Dialogue #5: Quality as a Business Strategy at ELFT

- What is our current business planning cycle?
- To what degree does improvement fit into this business cycle? How could the connection be made more explicit?
- How do we set annual improvement priorities that shape our QI work? Who do we need to engage in defining these priorities?
- How does QI fit with our annual cost reduction requirement? We have agreed that QI will start delivering cash releasing cost savings from 2016-17 financial year. How do we start identifying areas of waste, and aligning QI work with these areas of opportunity.

Questions Guiding Today's Workshop

Question #1: What is the difference between a quality improving Board, and a Board that is looking for assurance? How do we strike the balance between assurance and improvement?

Question #2: How can we make sure that QI is part of all strategies that the Board signs off? How we make QI our business strategy?

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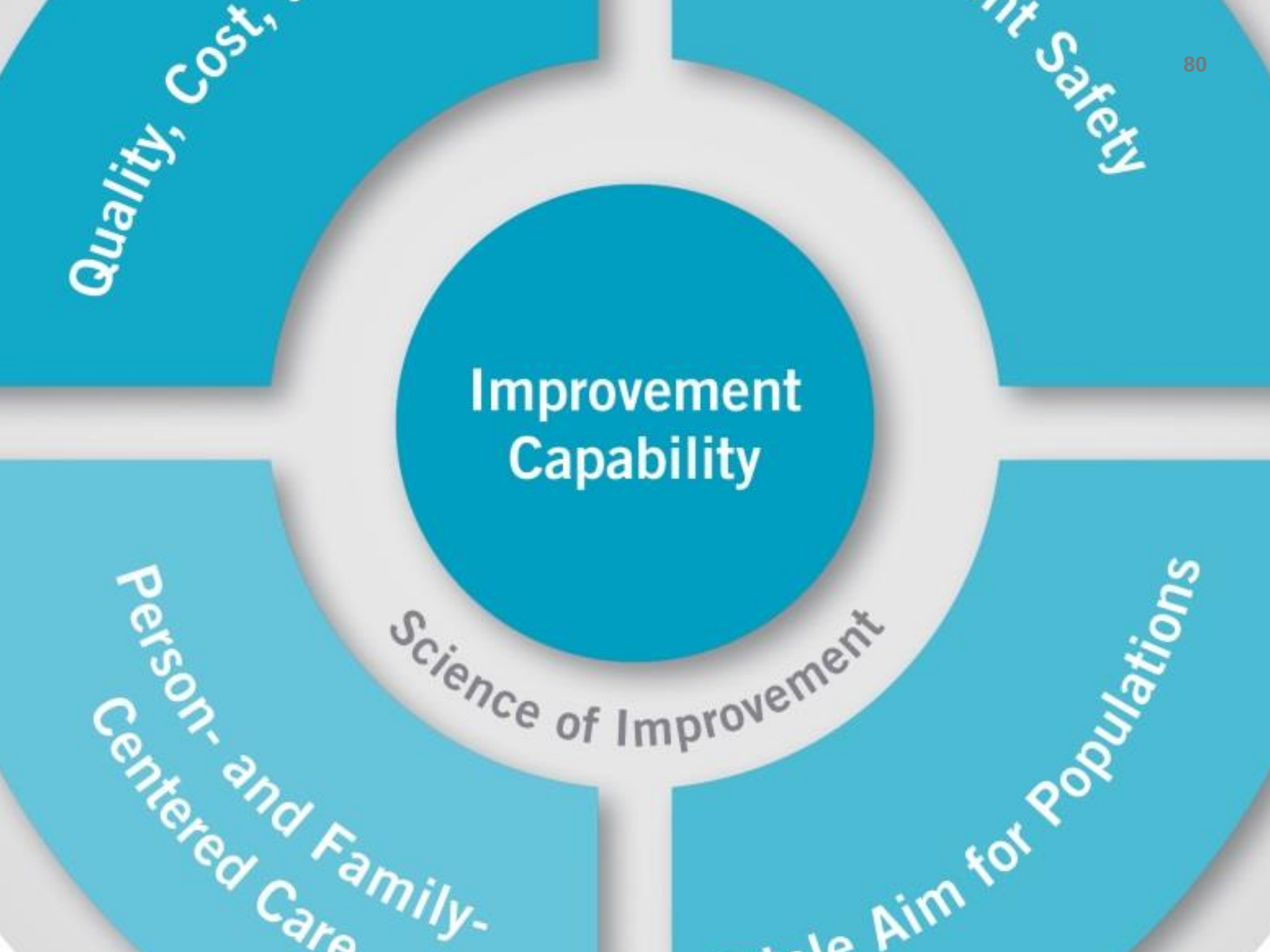
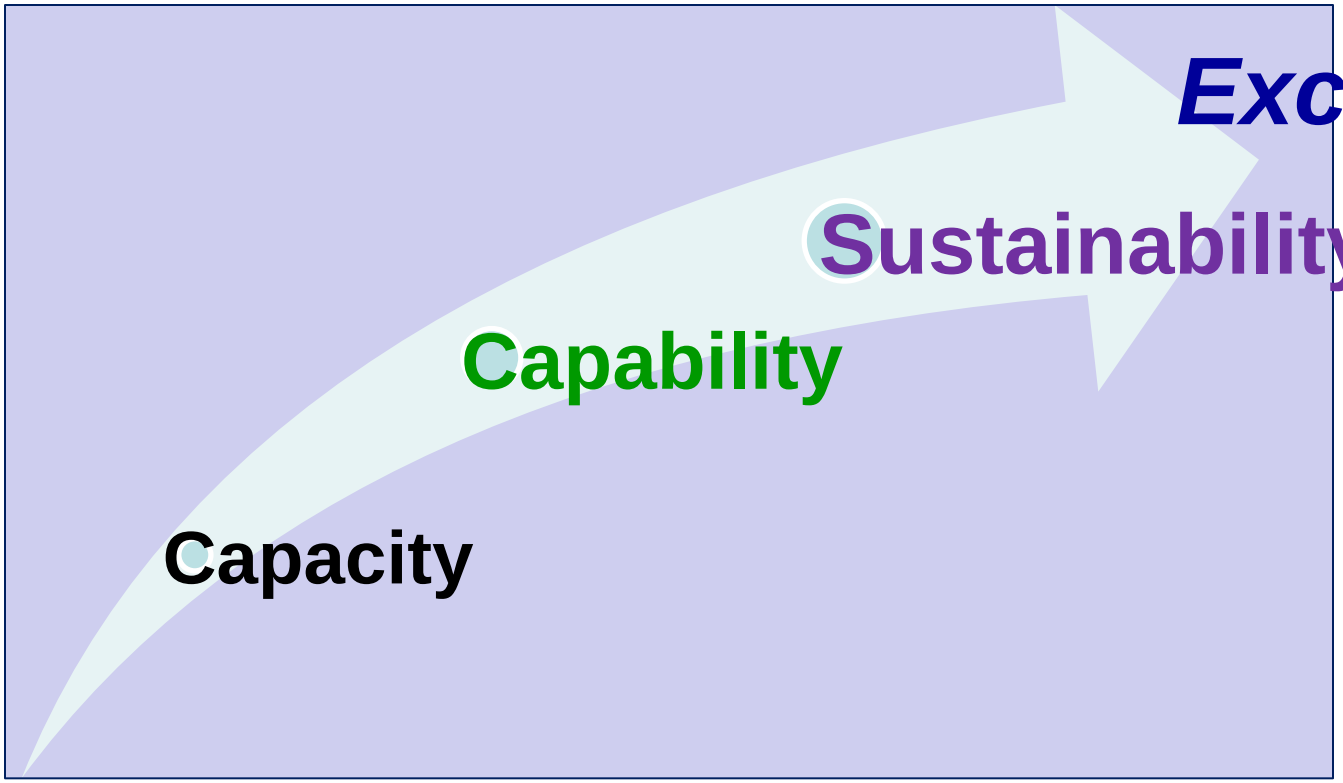

Quality, Cost,
nt Safety
Improvement Capability
Science of Improvement
Person- and Family-Centered Care
le Aim for Populations

The Leadership Challenge

To build a renewable infrastructure that produces a highly reliable quality and safety system by (fill in the date).

How good?
By when?

The Journey To Organizational Excellence



"We are what we repeatedly do.
Excellence then, is not an act but a habit!

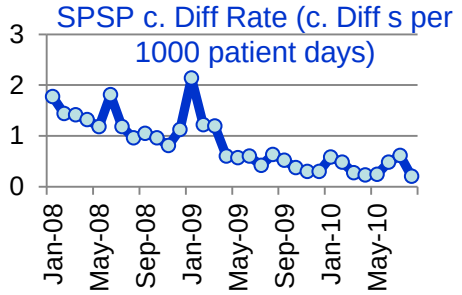
Aristotle (384 – 322 BC)

Capacity versus Capability

Capacity (potential energy)

- *The ability to receive, hold or absorb*
- *The maximum or optimum amount of production*
- *The ability to learn or retain information.*
- The power, ability, or possibility of doing something or performing
- A measure of volume; the maximum amount that can be held

Capability (kinetic energy)



- The power or ability to generate an outcome
- The ability to execute a specified course of action
- The sum of expertise and capacity
- Knowledge, skill, ability, or characteristic associated with desirable performance on a job, such as problem solving, analytical thinking, or leadership
- Some definitions of capability include motives, beliefs, and values

How can we build skills to transform the healthcare system?

Journal of Research in Nursing
15(2) 139–148

DOI: 10.1177/1744987109357812
jrn.sagepub.com
SAGE

Helen Bevan
NHS Institution for Innovation and Improvement, University of Warwick Campus, Coventry, UK

Abstract
Across the world, healthcare organisations are implementing radical change strategies in the face of unprecedented financial challenge. In this context, a focus on building capacity and capability for improvement is a key strategy. Global analysis shows that the most common characteristic of healthcare organisations that deliver outstanding performance in cost and quality is a systematic approach to capability building for improvement. The paper looks at where to start in order to build improvement skills at every level of the healthcare system and empower frontline staff to make changes that will deliver results. The current situation of the English NHS is used to illustrate the points made. What will it take to skill up and mobilise the entire healthcare workforce, to create a mass movement of change agents, to sustain the energy for change for the longer term and deliver the transformational results in cost and quality that are sought for patients and populations?

Keywords
healthcare improvement, capacity and capability, change management, quality improvement, mindset shift

The context

Across the globe, healthcare systems face unprecedented financial challenges. The National Health Service (NHS) in England is no exception. The English NHS is one of the largest health systems in the world, with 1.4 million staff, providing comprehensive care to a population of 54 million people. There is a gap of up to £20 billion between the current trajectory of NHS spending and what is likely to be available over the next three years (NHS Chief Executive, 2009). Significant efforts are being made to address this. However, the agenda is not just about working with fewer financial resources. Within the NHS, there is a strong national commitment to quality as the biggest strategic priority (Department of Health, 2008). It means that the strategy to reduce costs must also improve quality. The overall challenge is how to utilise improvement approaches to deliver higher quality, safer care at lower cost.

Corresponding author:
Helen Bevan, NHS Institution for Innovation and Improvement, University of Warwick Campus, Coventry, UK.
Email: helen.bevan@institute.nhs.uk

"A focus on building capacity and capability for improvement is a key strategy. Global analysis of healthcare systems that deliver outstanding performance in cost and quality shows their most common characteristic is a systematic approach to capability building for improvement."

Helen Beven
Journal of Research in Nursing
15(2) 139-148, 2010.

Key Terms

Capacity – having the right number and level of people who are actively engaged and able to take action.

Capability – the people have the confidence and the knowledge and skills to lead the change and take action.

Helen Beven, "How can we build skills to transform the healthcare system?" *Journal of Research in Nursing,* 15(2) 139-148, 2010.

Key Questions for Building Capacity and Capability

1. Will you involve everyone or just a few targeted groups?
2. Who needs to know what? (the dosing formula)
3. What methods do you plan to use to build capacity and capability?
4. Do you have a model or framework to guide your journey?
5. How will you make sure the learning system can be sustained?

Adapted and expanded from a conversation with Tom Nolan, Associates in Process Improvement on material he presented at the IHI Strategic Partners Roundtable, April 17-18, 2006.

Key Questions for Building Capacity and Capability

1. Will you involve everyone or just a few targeted groups?
2. Who needs to know what? (the dosing formula)
3. What methods do you plan to use to build capacity and capability?
4. Do you have a model or framework to guide your journey?
5. How will you make sure the learning system can be sustained?

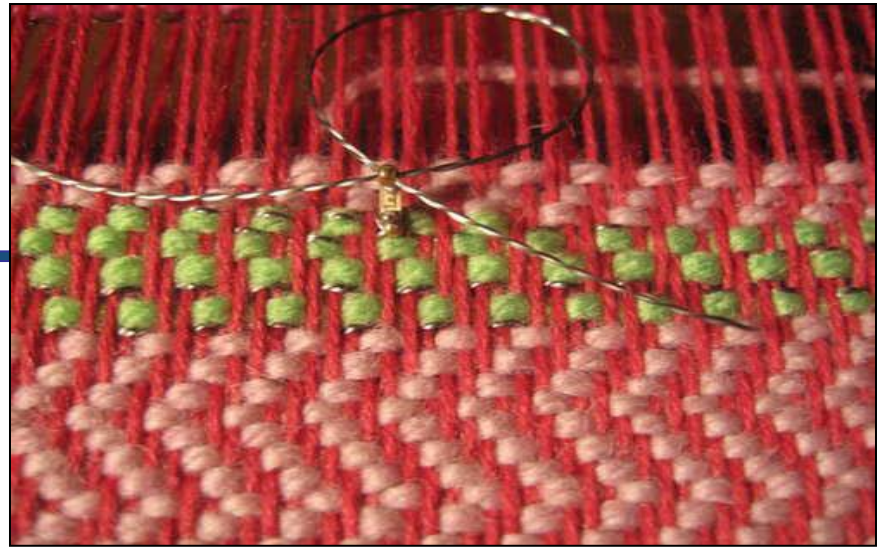
Adapted and expanded from a conversation with Tom Nolan, Associates in Process Improvement on material he presented at the IHI Strategic Partners Roundtable, April 17-18, 2006.

Key Question #1

Will you involve everyone or just a few targeted groups?

Non-executives?
Executives?
Governors?
Managers?
Senior clinicians?
Front Line Workers?
Improvement Advisors (IAs)?

Adapted from Tom Nolan, Associates in Process Improvement presented at the IHI Strategic Partners Roundtable, April 17-18, 2006



Improvement concepts, methods and applications must be woven into the fabric of daily life and *at all levels of the organization*.

- **From point where care is delivered,**
- **To management meetings and strategy sessions**
- **And, in the board and governance level decisions**


Therefore, a cascading system to build capacity and capability is needed!

Many organizations start the cascade at the top…

While others believe that the cascade should start at the staff level…

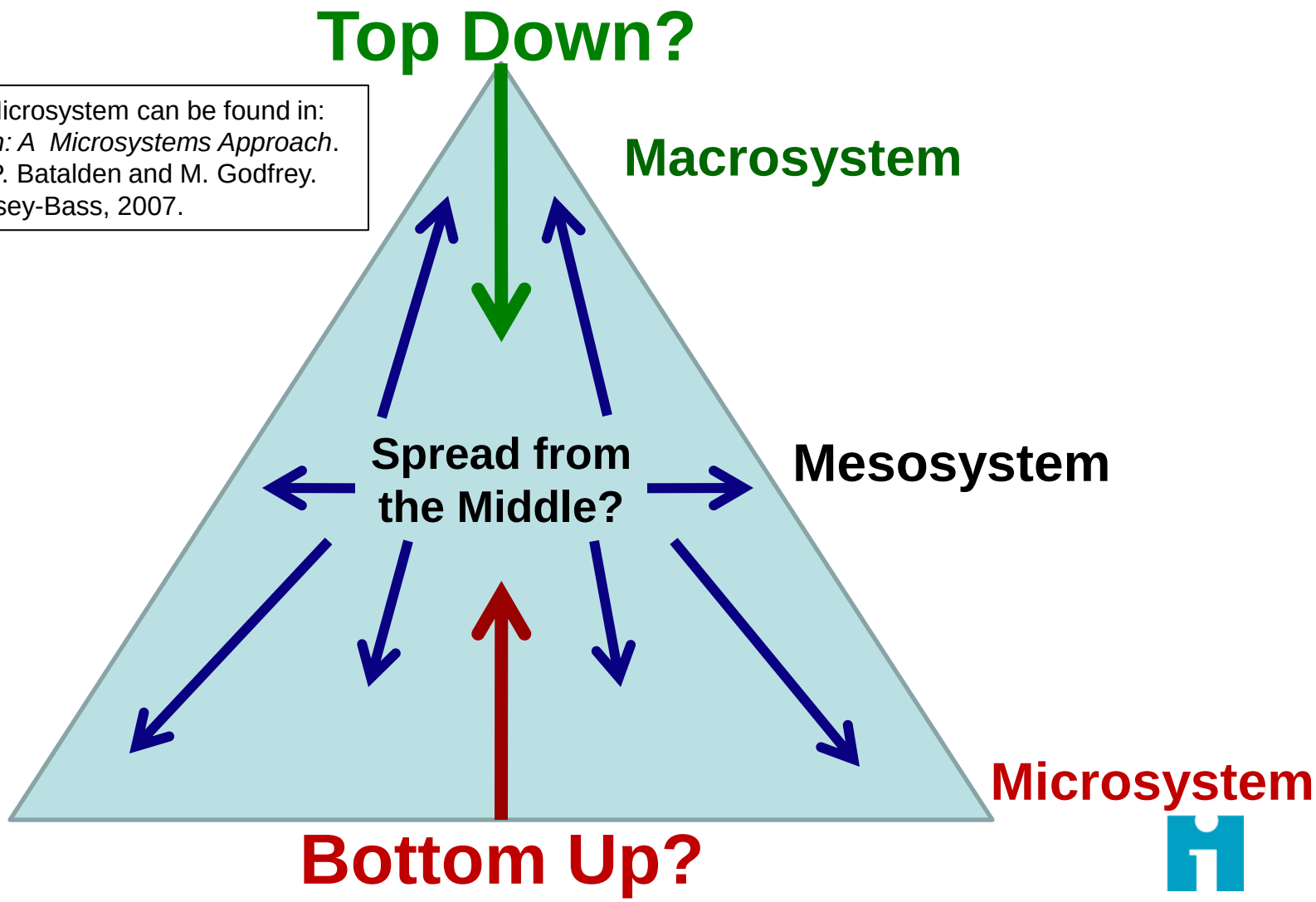
upward!

percolate

…and

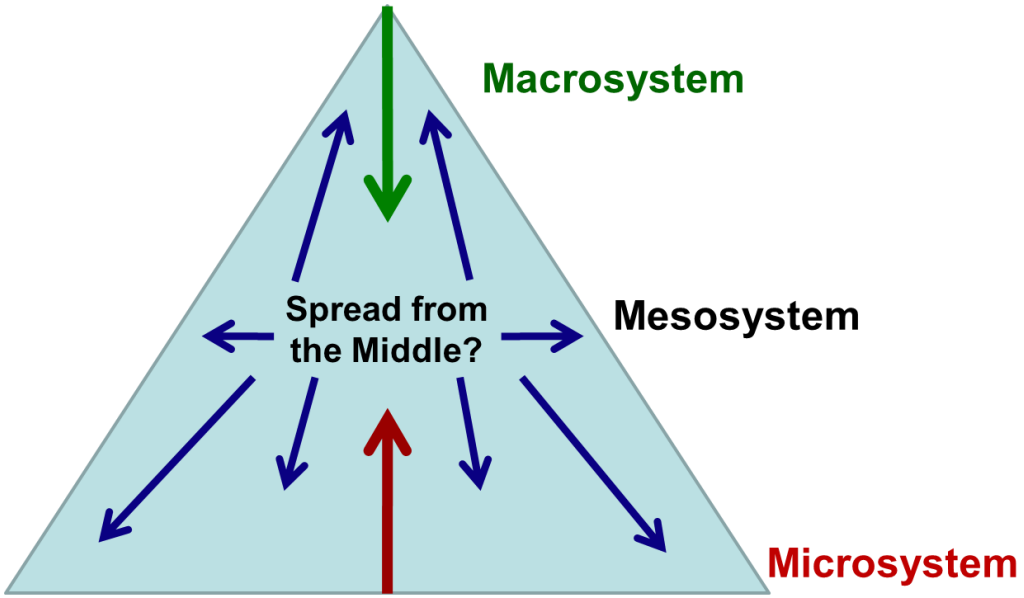
But successful organizations cascade down and percolate up throughout the entire organization

Details on the Microsystem can be found in:
Quality by Design: A Microsystems Approach.
By E. Nelson, P. Batalden and M. Godfrey.
Jossey-Bass, 2007.



Key Question #2
Who needs to know what? (the Dosing Formula)

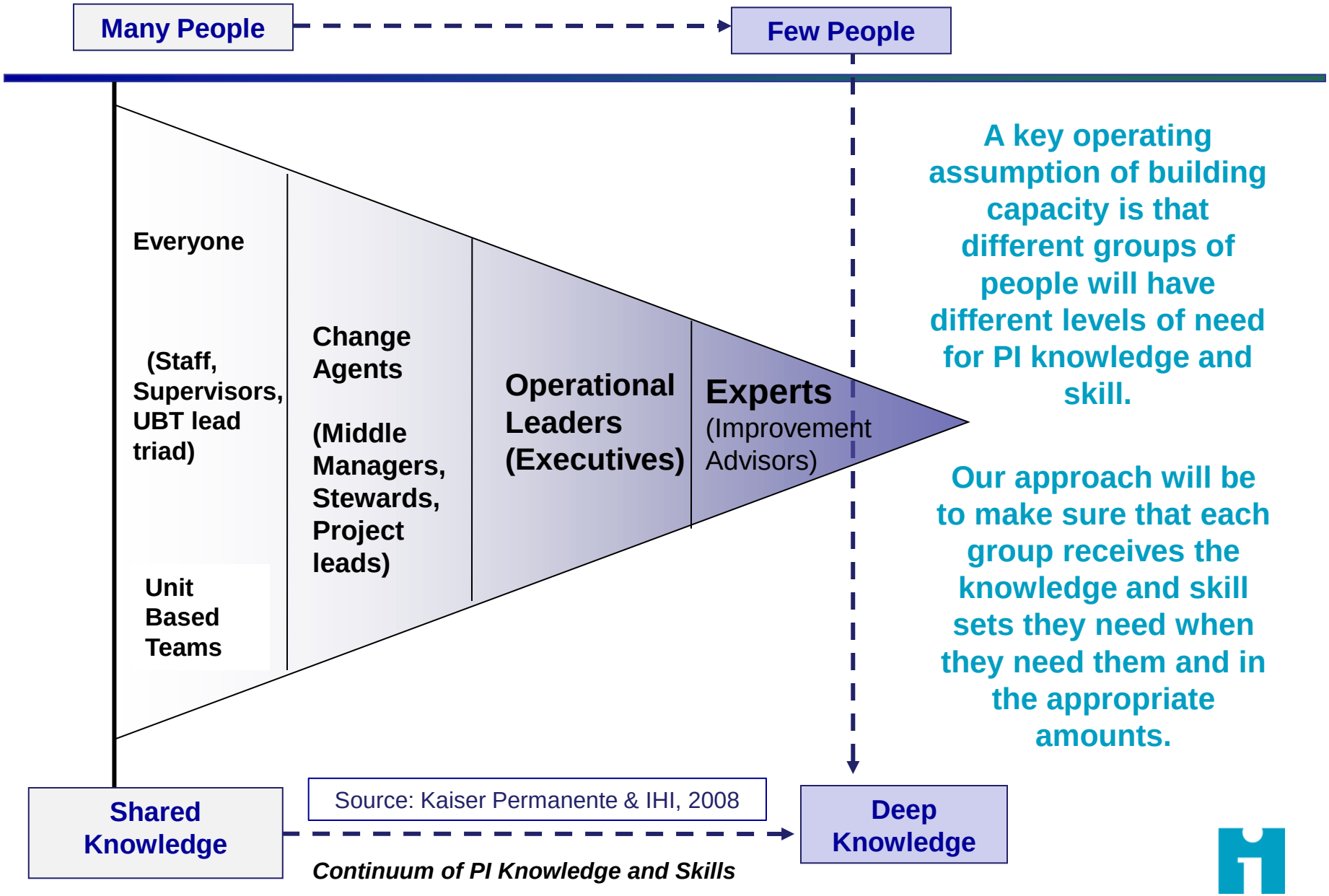
Different levels of knowledge and skill in the Science of Improvement are required at different levels of the organization.



The Dosing Formula

- Not everyone in the organization needs to have expert level of knowledge about the SOI
- Determining who needs to have what levels of knowledge about the SOI is a key leadership responsibility
- It is not enough to fill people with new levels of knowledge and skill. We must allow them to have the time to apply the new knowledge and skill to daily work.

The Dosing Formula: Who needs to know what?



A key operating assumption of building capacity is that different groups of people will have different levels of need for PI knowledge and skill.

Our approach will be to make sure that each group receives the knowledge and skill sets they need when they need them and in the appropriate amounts.

Source: Kaiser Permanente & IHI, 2008

Continuum of PI Knowledge and Skills

Who needs what?
(The Dosing Formula)

This Exercise is designed to create a dialogue on what we call the “dosing formula.” That is, which groups of individuals within your organization need to have what levels of knowledge and skill to successfully build a sustainable infrastructure that produces highly reliable QI excellence?

The worksheet on the next page provides a list of *Skills & Knowledge* (the rows) associated with organizations that have demonstrated QI excellence. For each of the listed *Skills & Knowledge* items indicate the level or “dose” of *Skill & Knowledge* you think each group (the columns) needs using the following response scale:

1 = They need to know the basic terms, concepts and methods when they hear them
2 = They need to be able to explain the terms, concepts and methods to others
3 = They need to be able to teach the terms, concepts and methods to others
4 = They need to be seen as an organizational lead and champion for the terms, concepts and methods

Who needs what?
(The Dosing Formula)

Skills & Knowledge	Non-Execs, Board of Directors	Senior Management	Clinical Leadership	Middle Management,	Frontline Staff	QI Experts (IAs)
Models for QI (theory & concepts)						
Leadership for improvement & cultural transformation						
Teamwork and Facilitation						
Gathering information						
Analyzing and interpreting data						
Presentation skills						
Understanding variation						
QI tools and methods						
Change management						
Patient-centered care						

ELFT Dosing Formula Results

Where are we?

On track to train over 400 people through 5 six-month waves of learning between 2014-16. First 3 waves delivered with the IHI

On track. All senior staff being encouraged to join QI training over next 2 years

New need recognised. Developing Improvement coaches rogramme will train 30 QI coaches in 2015

On track. Most Executives will have undertaken the ISIA, and all will have received Board training with the non-Executives

Currently have 3 improvement advisors, with 1.5wte deployed to QI. Will need to build more capacity at this level.

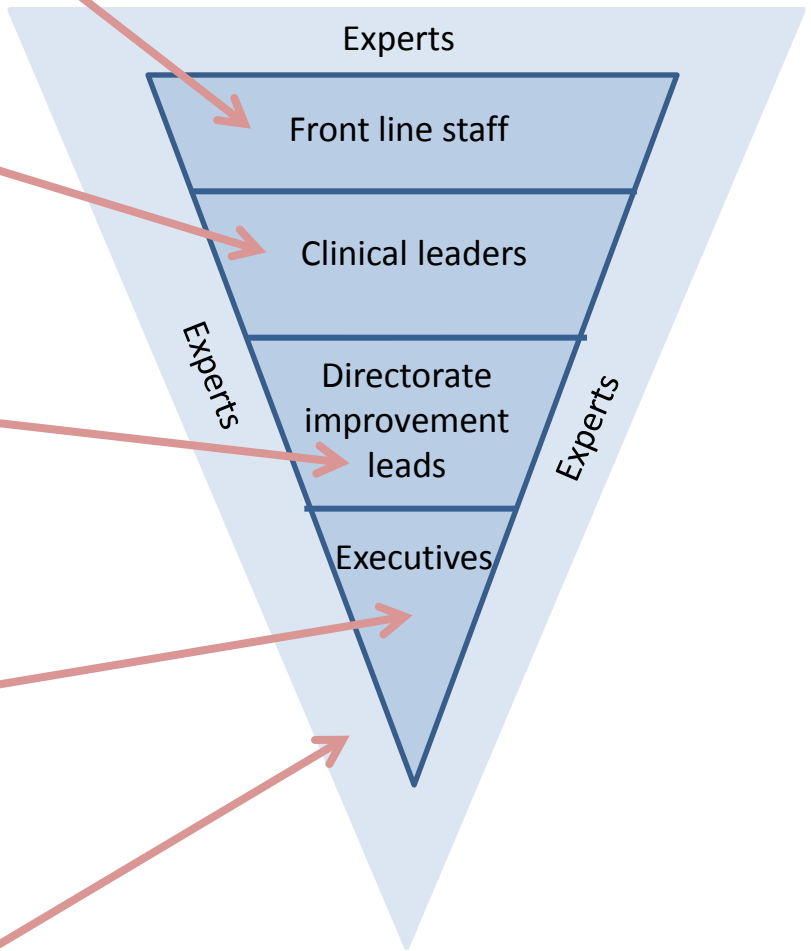
Estimated number = 3300
Requirement = introduction to quality improvement, identifying problems, change ideas, testing and measuring change
Time-frame = train 10-20% in 2 years

Estimated number = 250
Requirement = deeper understanding of improvement methodology, measurement and using data, leading teams in QI
Time-frame = train 30-50% in 2 years

Estimated number = 25-30
Requirement = deeper understanding of improvement methodology, understanding variation, coaching teams and individuals
Time-frame = train 100% in 2 years

Estimated number = 10
Requirement = setting direction and big goals, executive leadership, oversight of improvement, being a champion, understanding variation to lead
Time-frame = train 100% in 2 years

Estimated number = 5
Requirement = deep statistical process control, deep improvement methods, effective plans for implementation & spread
Time-frame = train 100% in 2 years



The Key Components for Building Capacity and Capability

S + P + C* = O

Structure + Process + Culture* = Outcomes

Sources: Donabedian, A. (1966). "Evaluating the quality of medical care." Milbank Memorial Fund Quarterly 44(3): Suppl:166-206. Donabedian, A. *Explorations in Quality Assessment and Monitoring. Volume I: The Definition of Quality and Approaches to its Assessment.* Ann Arbor, MI, Health Administration Press, 1980.

*Added to Donabedian's original formulation by R. Lloyd and R. Scoville, 2011 to make the role of culture more explicit..

East London NHS
NHS Foundation Trust

ELFT Support Structures for QI

QI Sponsors vs QI Team Support

QI Sponsor	QI Team Support
• Senior member of staff from project's local directorate • Not necessarily an expert in improvement methodology • Here to help mentor and support you in the project • Help over come any barriers you may experience • Championing cause	• QI fellow/Improvement Advisor linked with every QI project • Provide advice and support on any aspect of QI methodology

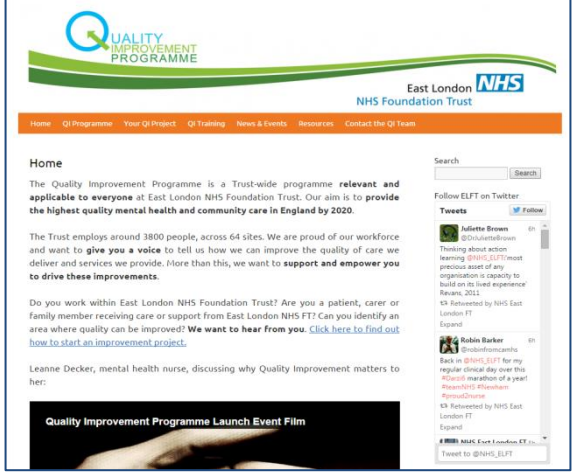
Project Sponsor

S + P + C =O

QI Team

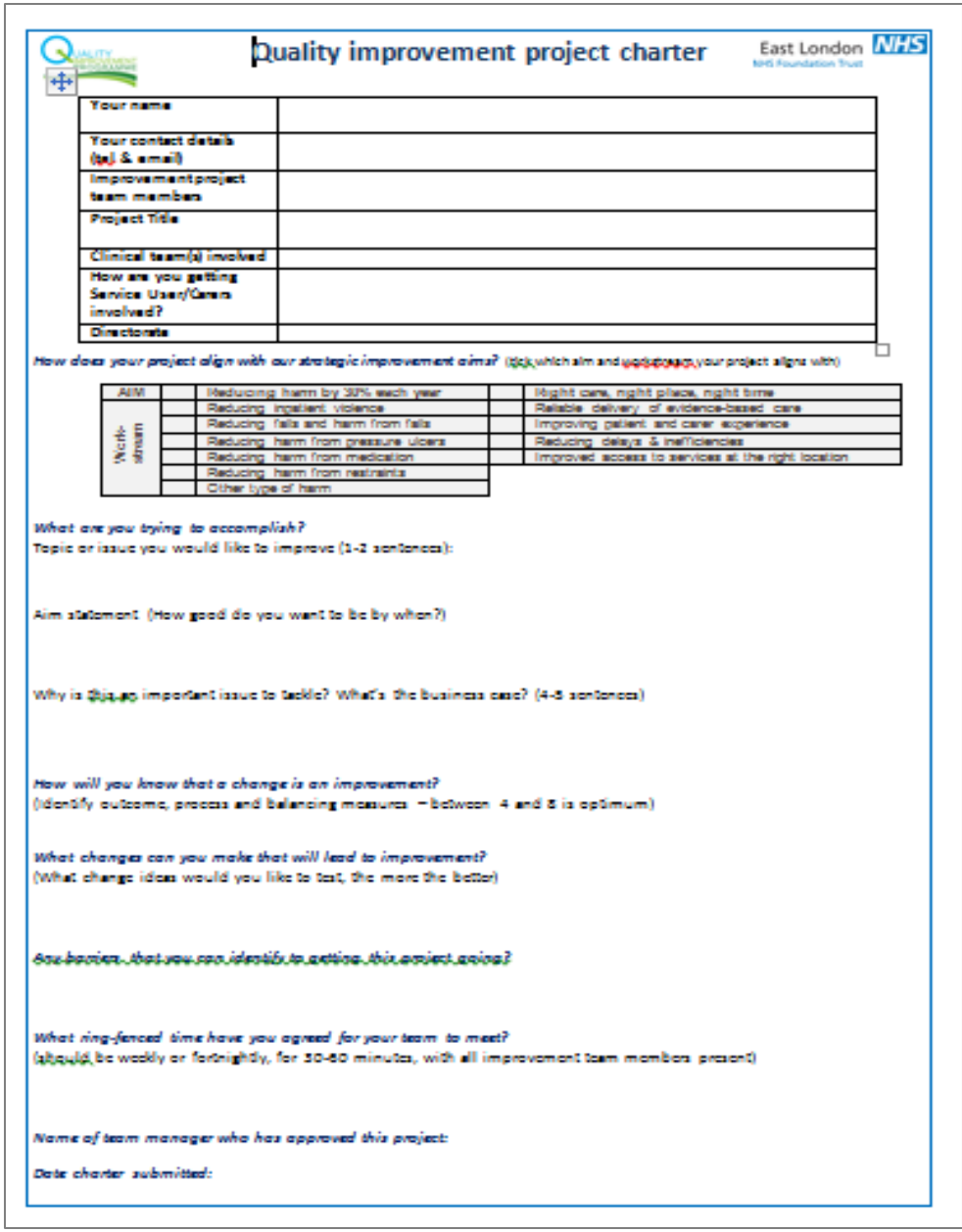
QI Forums

QI Resources



QI Project Roles

1. Team Lead
2. Project team
3. QI sponsor
4. QI support



Quality improvement project charter

East London NHS Foundation Trust

Your name	
Your contact details (tel & email)	
Improvement project team members	
Project Title	
Clinical team(s) involved	
How are you getting Service User/Carers involved?	
Directorate	

How does your project align with our strategic improvement aims? (tick which aim and workstream your project aligns with)

AIM		Reducing harm by 30% each year		Right care, right place, right time
Work-stream		Reducing inpatient violence		Reliable delivery of evidence-based care
		Reducing falls and harm from falls		Improving patient and carer experience
		Reducing harm from pressure ulcers		Reducing delays & inefficiencies
		Reducing harm from medication		Improved access to services at the right location
		Reducing harm from restraints		
		Other type of harm		

What are you trying to accomplish?
Topic or issue you would like to improve (1-2 sentences):

Aim statement (How good do you want to be by when?)

Why is this an important issue to tackle? What's the business case? (4-6 sentences)

How will you know that a change is an improvement?
(Identify outcome, process and balancing measures – between 4 and 6 is optimum)

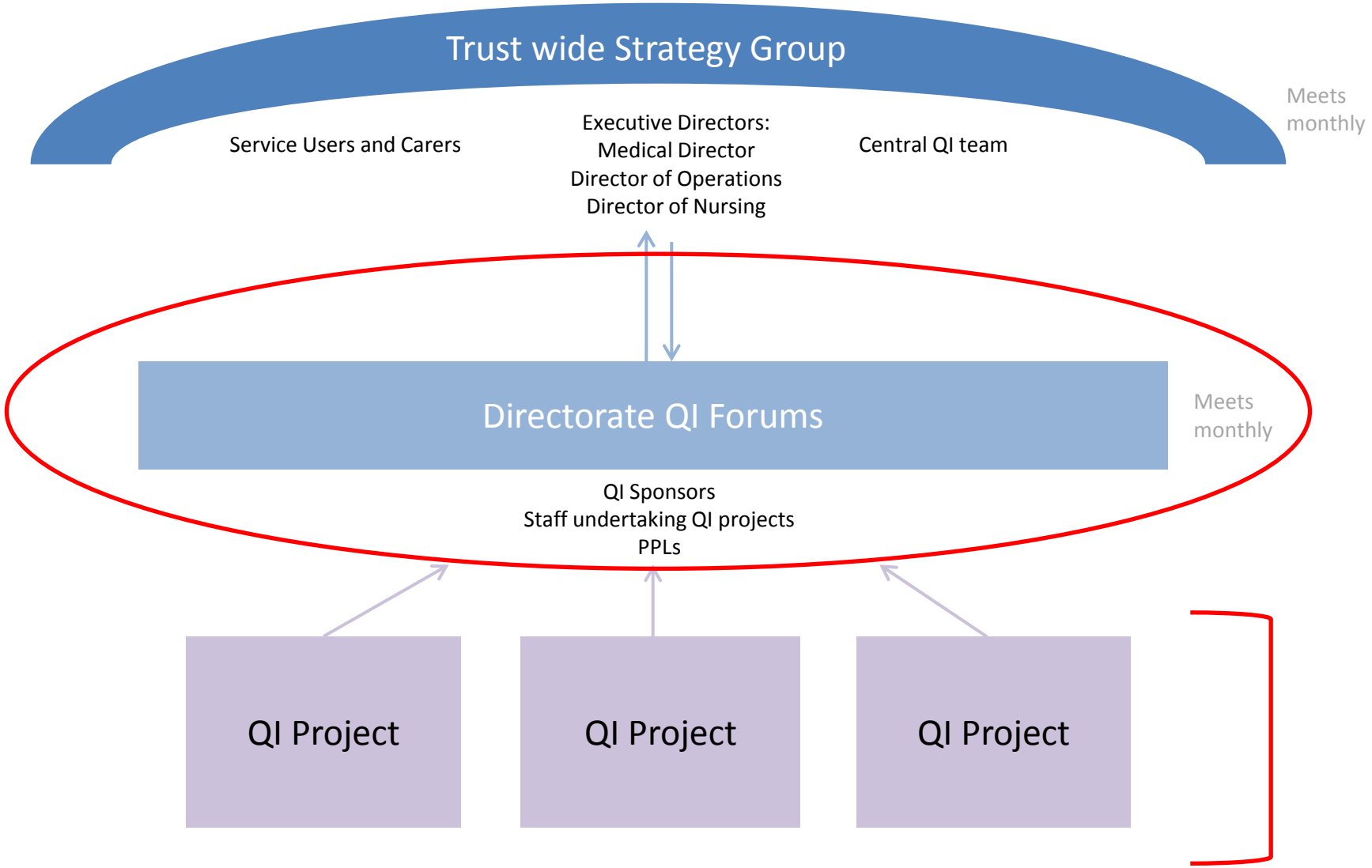
What changes can you make that will lead to improvement?
(What change ideas would you like to test, the more the better)

Any barriers that you can identify to getting this project going?

What ring-fenced time have you agreed for your team to meet?
(should be weekly or fortnightly, for 30-60 minutes, with all improvement team members present)

Name of team manager who has approved this project:

Date charter submitted:



Quality improvement programme-project support structures

Directorate QI Forums

1. Run monthly in all directorates
2. Attended by QI sponsors, QI team and project team members
3. Prioritise, monitor and supervise projects
4. Identify and shape future QI priorities
5. Allow different QI team project members to learn from each other

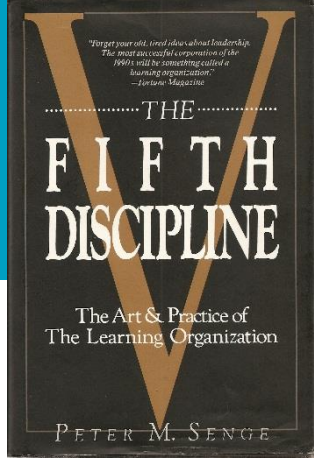
Dialogue #6: Building Capacity and Capability

- Is ELFT building **both** capacity and capability for quality?
- Is one aspect a bigger challenge than the other?
- How do we find resources to develop support structures and processes we need to achieve our quality priorities (e.g., providing protected time to lead or be a member of a QI team)?
- How do we find the space and resources to support ongoing operations **PLUS** support improvement work?

Capacity – having the right number and level of people who are actively engaged and able to take action.

Capability – the people have the confidence and the knowledge and skills to lead the change and take action.

Dialogue #7: Building a Learning Organization



- "The organizations that will truly excel in the future will be organizations that discover how to tap people's commitment and capacity to learn at *all* levels of an organization." (Peter Senge)
- The ***Disciplines of the Learning Organization*** include:
  - Systems Thinking
  - Personal Mastery
  - Mental Models
  - Building Shared Vision
  - Team Learning

Which of these disciplines does Senge call "the fifth discipline?"

- Senge would ask leaders "*Does your organization have a learning disability?"* Learning organizations demand a new view of leadership.
- Imagine that your organization is an ocean liner, and that you are "the leader." **What is your role?** (The captain? The helmsman? The head engineer? The social director? The chef?)

Questions Guiding Today's Workshop

Question #1: What is the difference between a quality improving Board, and a Board that is looking for assurance? How do we strike the balance between assurance and improvement?

Question #2: How can we make sure that QI is part of all strategies that the Board signs off? How we make QI our business strategy?

Question #3: How do get everyone to have a basic knowledge of the science of improvement? What is the role of the Board in building capacity and capability for QI.

Question #4: How can the Board be assured that we are moving towards our improvement aims?

Question #5: How do we use all of this data we have to make an impact on our QI efforts? How do analyse the data from a QI perspective and what questions do we ask about the results?

Question #6: How do we scale up all of this local improvement work to something that is meaningful at Trust-level? What are the big dots, and how do we aggregate all the work up to move the big dots?

Discussion Questions for Today

Question #4: How can the Board be assured that we are moving towards our improvement aims?

Question #5: How do we use all of this data we have to make an impact on our QI efforts? How do analyse the data from a QI perspective and what questions do we ask about the results?

Question #6: How do we scale up all of this local improvement work to something that is meaningful at Trust-level? What are the big dots, and how do we aggregate all the work up to move the big dots?

These questions are very interrelated and will form, therefore, the remaining content of this workshop.

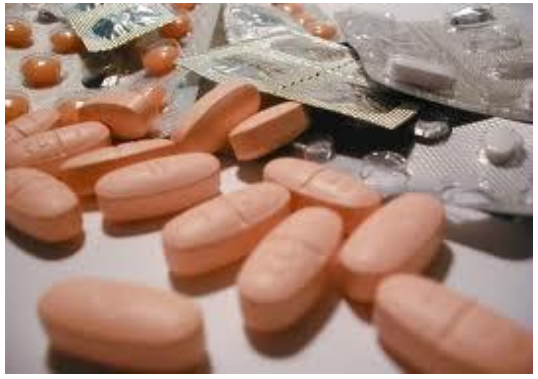
Question #4: How can the Board be assured that we are moving towards our improvement aims?

Milestones in the Quality Journey	1	2	3
Quality is understood by all members of the organisation as our prime business strategy			
Measures are a direct extension of ELFT's strategic aims and business strategy			
Appropriate and realistic targets and goals are established for each of our measures			
Data are collected in a manner that enables time series analysis of the measures (e.g., by day, week or month; no quarterly data!)			
Statistical analyses of the measures are made by using statistical process control (SPC) methods			
Leaders and managers make decisions about the performance of measures by using principles of common and special causes of variation			
Management has put in place strategies to close the gap between the current capability of our processes and the targets and goals we aspire to achieve			
Management and the board understand that ELFT's outcome measures (i.e., the 'big dots') will not move until all the process measures (i.e., the 'smaller dots') are aligned and integrated as a system			
Resources, structures and processes are in place to create capacity and capability for quality and safety throughout ELFT			

Response Options:

1 = Not Started Yet 2 = In progress 3 =Established Practice

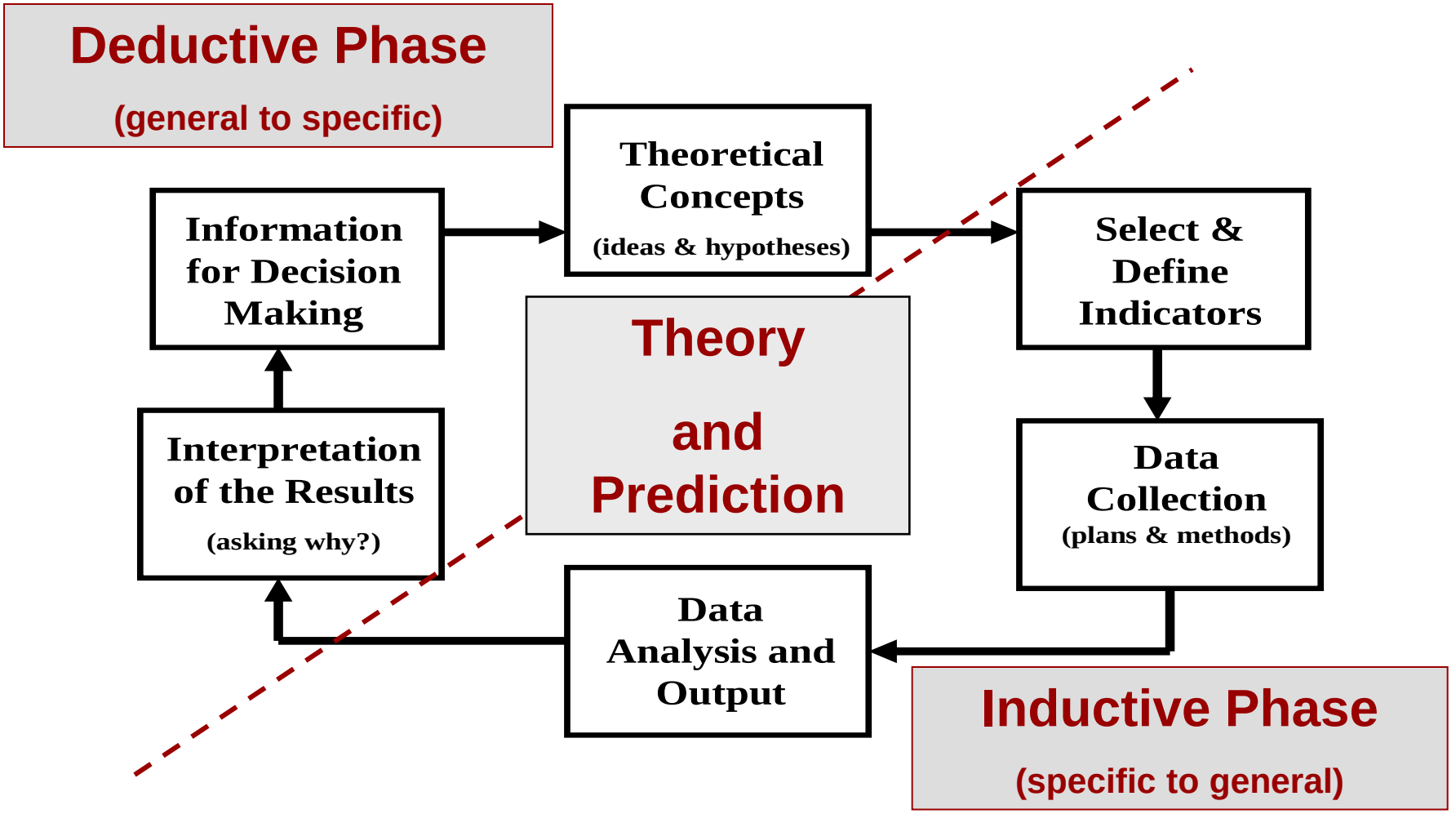
So how <u>do</u> you improve?



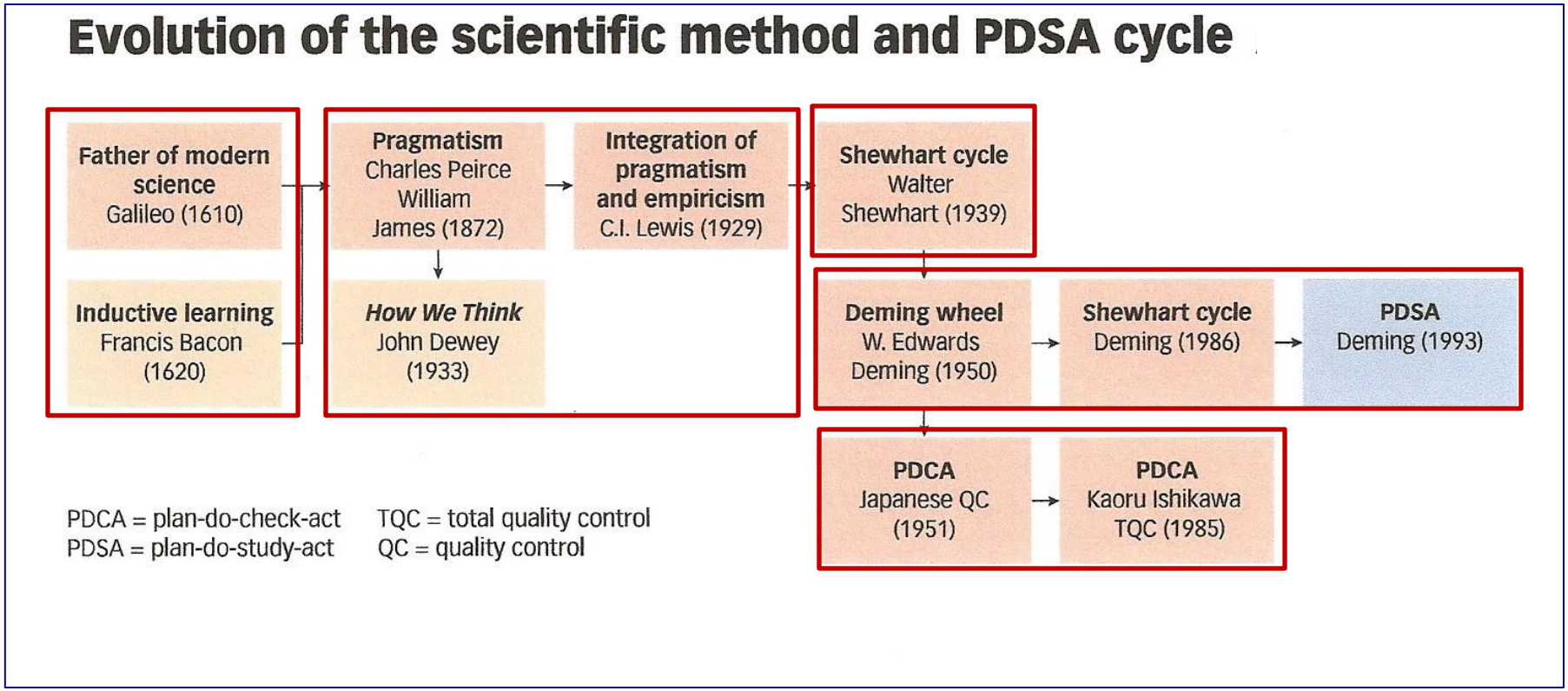
Which of these ideas is the best way to improve?

- Build Skills?
- Increase Knowledge?
- Hard work?
- Build Relationships?
- Attention to detail?
- Write More Policies?
- Design a Study?
- Work more hours?
- Pay Attention?
- More Resources?
- Hire More Staff?
- Power & Control?
- Collect Data?
- Hope & Luck?

The Scientific Method provides the foundation for all improvement

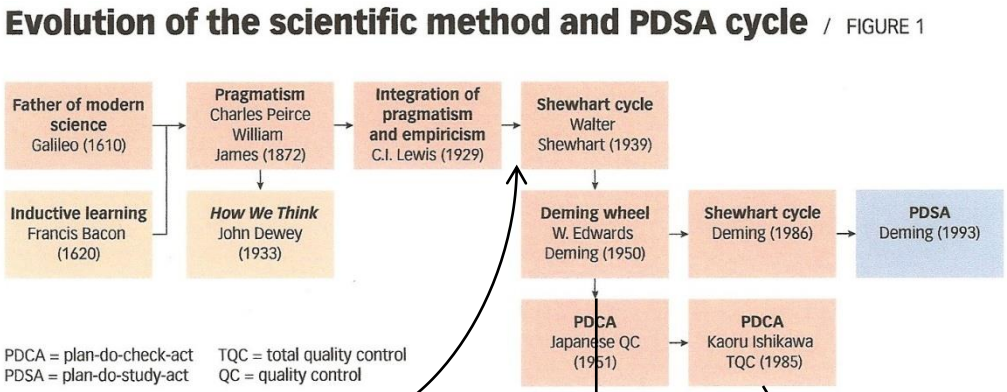


Understanding the Timeline is Critical



Source: Moen, R. and Norman, C. "Circling Back: Clearing up Myths about the Deming Cycle and Seeing How it Keeps Evolving," *Quality Progress* November, 2010:22-28.

Adding Six Sigma & Lean to the Timeline



Scoville & Little *Comparing Lean and Quality Improvement* (2014)

Bill Smith (1986) Motorola Six Sigma

Mikel Harry (1988) Motorola- MAIC

Forrest Breyfogle 111 (1992)- Integration

Michael George (1991)- Integration

F.Taylor-The Principles of Scientific Management (1911)

Toyoda Family Kiichiro Toyoda Sakichi Tooda

Taiichi Ohno 1950-1980 Toyota Production System

Womack & Jones

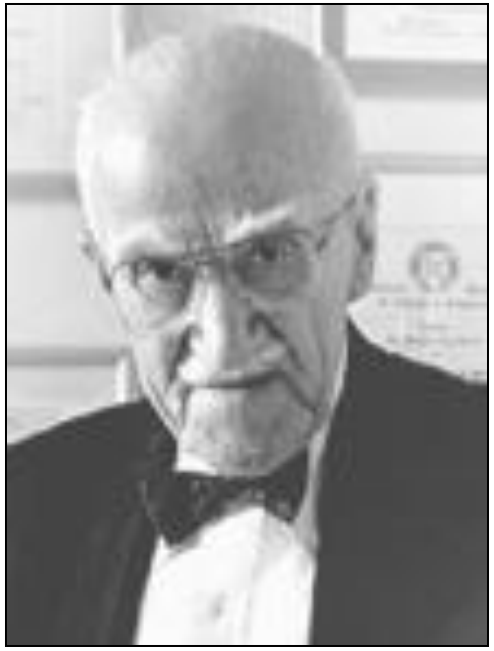
Three of the Quality Pioneers provided guidance and direction

W. Edwards Deming

(1900 - 1993)

Walter Shewhart

(1891 – 1967)



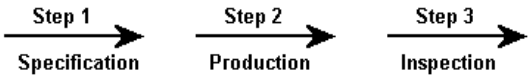
Joseph Juran

(1904 - 2008)

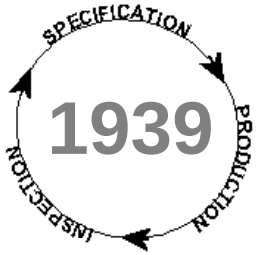
Walter A. Shewhart (1891 – 1967)

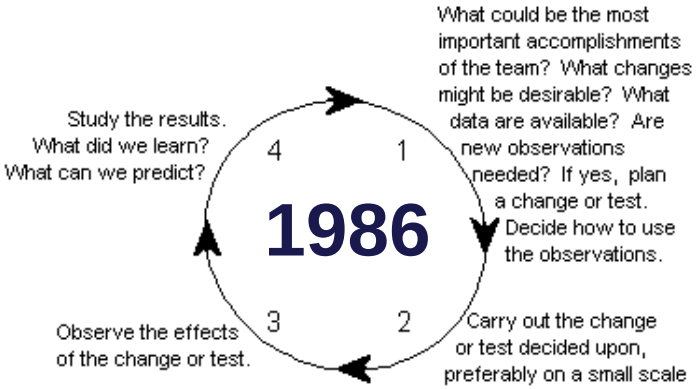
Development of the Shewhart Cycle

Old Shewhart Cycle

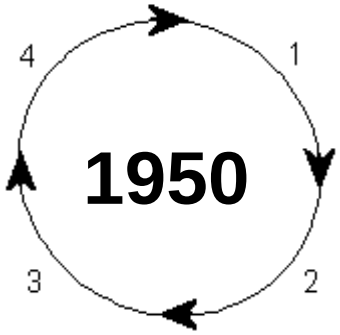


New Shewhart Cycle



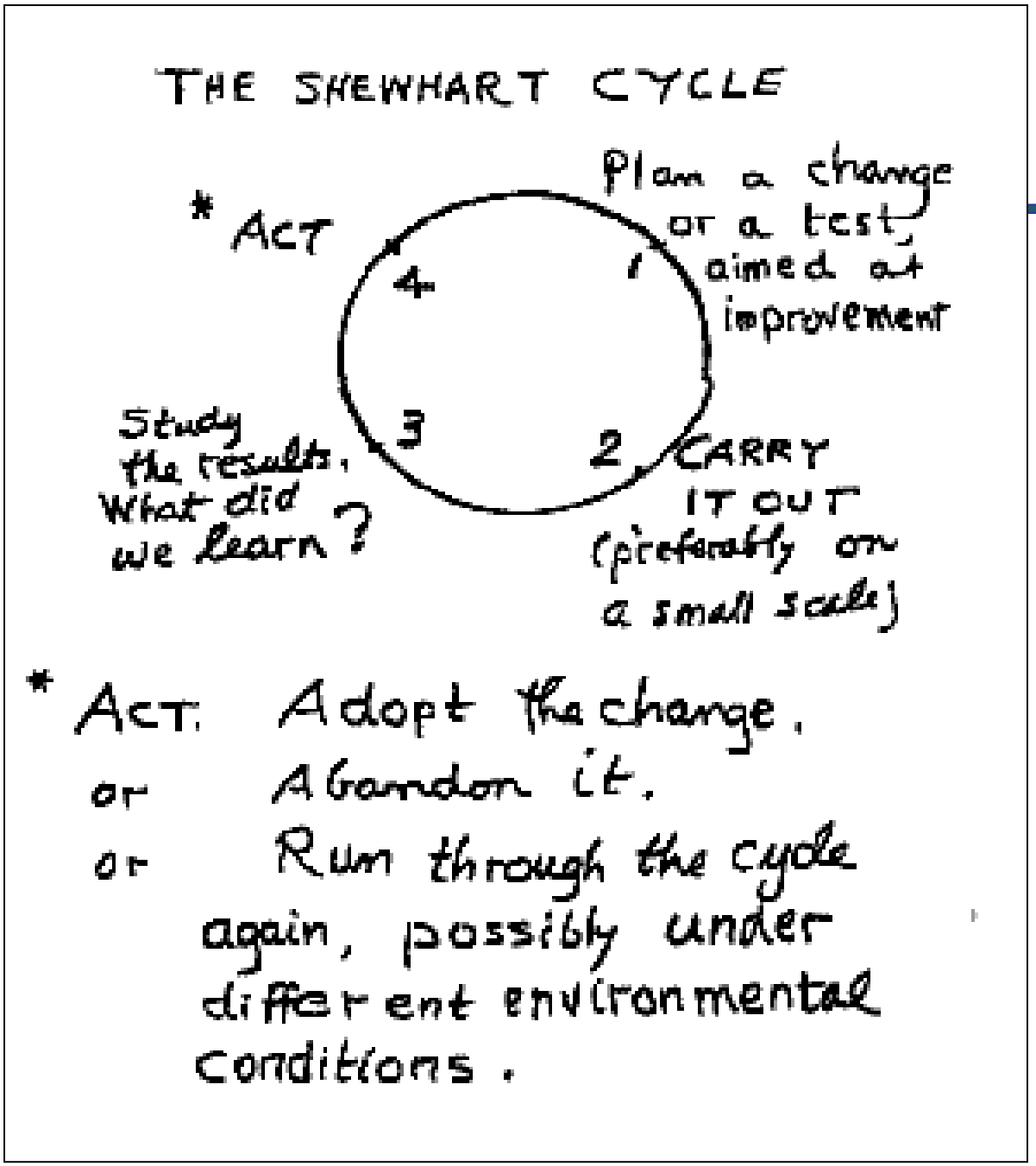


Step 5. Repeat Step 1, with knowledge accumulated.
Step 6. Repeat Step 2, and onward.



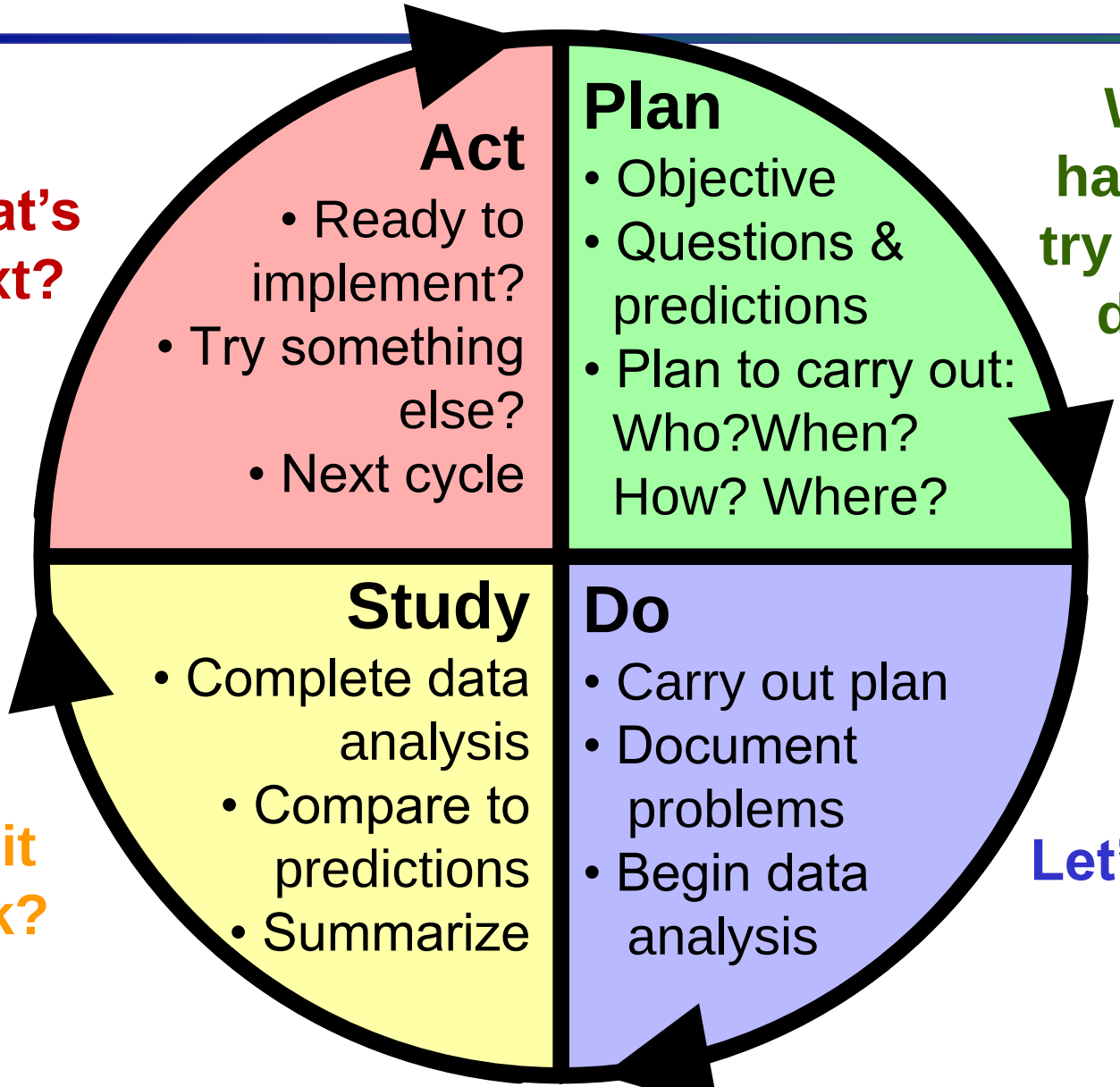
The Deming Wheel

1. Design the product (with appropriate tests).
2. Make it; test it in the production line and in the laboratory.
3. Sell the product.
4. Test the product in service, through market research. Find out what user think about it and why the nonusers have not bought it.



Deming's Sketch of the Shewhart Cycle for Learning and Improvement, 1985

The Cycle for Learning and Improvement

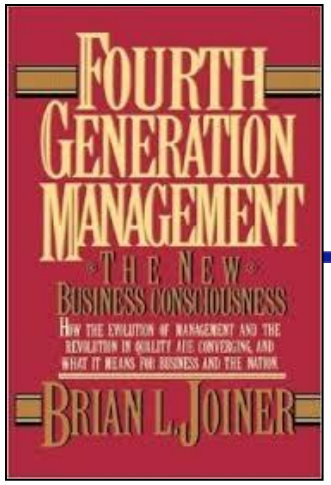


What's next?

What will happen if we try something different?

Did it work?

Let's try it!



Dr. Brian Joiner

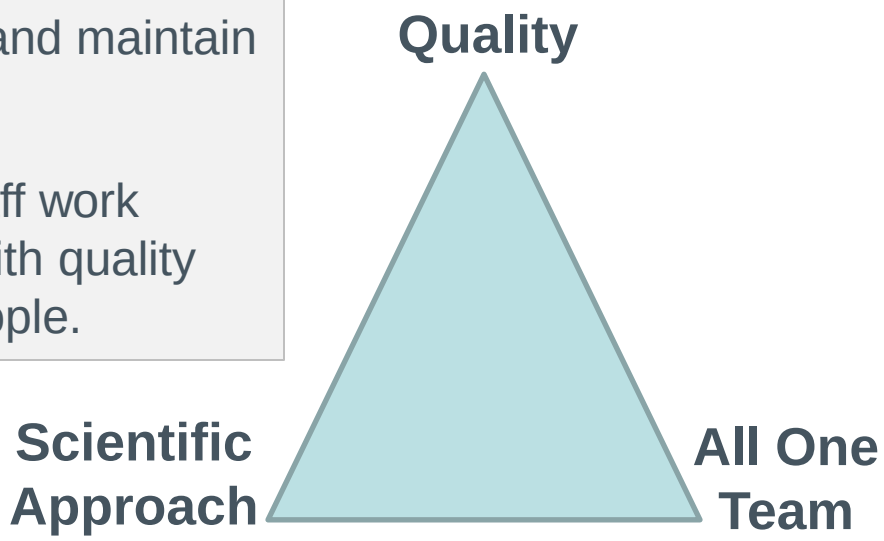
Dr. Brian Joiner, a student of Dr. Deming's, described four generations of management:

- **First Generation**: do it yourself.
- **Second Generation**: Master craftsperson takes on apprentices but remains the model and arbiter of production (and quality).
- **Third Generation**: manage by results—usually by specifying the goals required without detailing the methods (by what method?).
- **Fourth Generation**: simultaneous focus on three chunks of work: quality, the scientific approach and all one team, the Joiner Triangle (see next page for details).

The Joiner Triangle

the Joiner Triangle provides a framework for implementing Quality Improvement. It consists of:

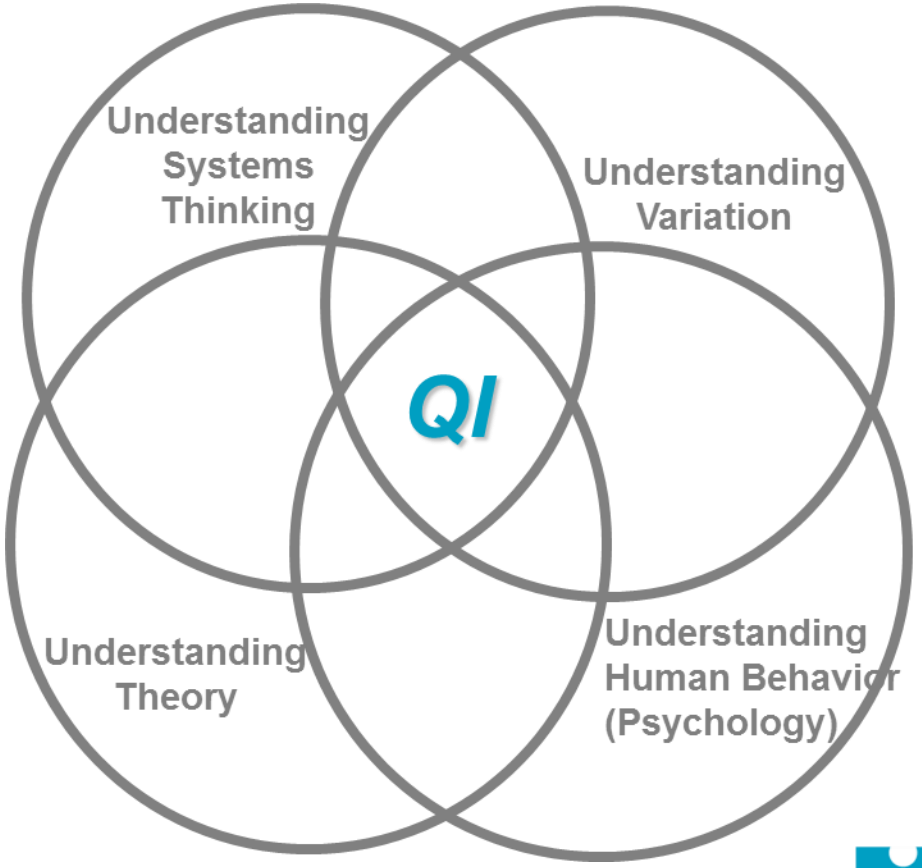
- **Quality** as seen through the eyes of our customers
- The **Scientific Approach** as the methodology for solving problems and making decisions; iterative learning, using data effectively, to build and maintain effective methods.
- The **All One Team** aimed at unifying staff work efforts, getting all employees involved with quality efforts, collaboration and respect for people.



Two of the leading Quality Models

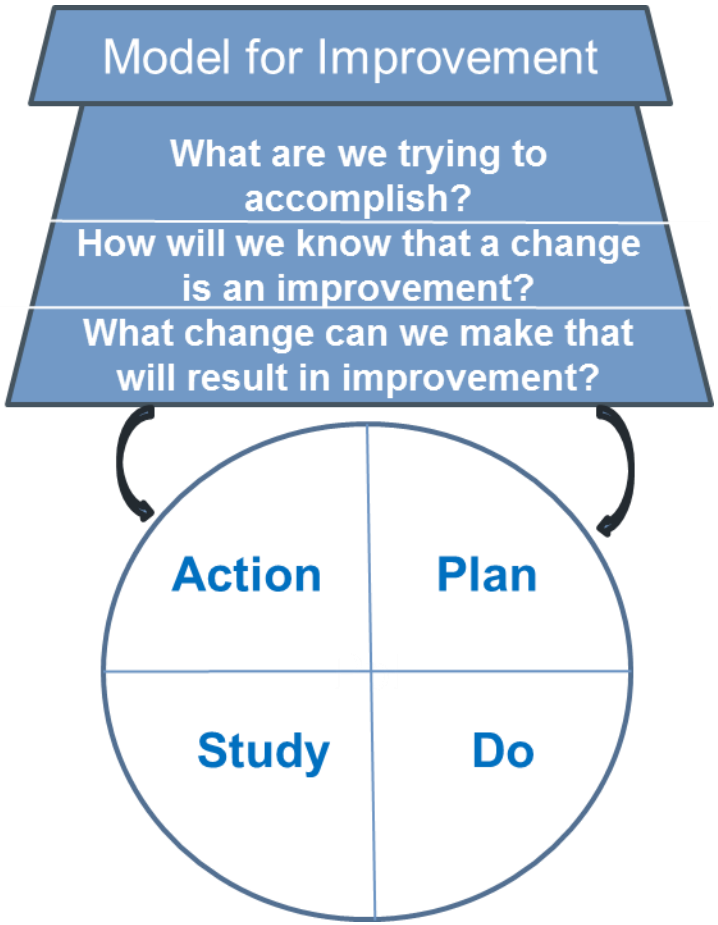
Juran's Quality Trilogy

Deming's Profound Knowledge



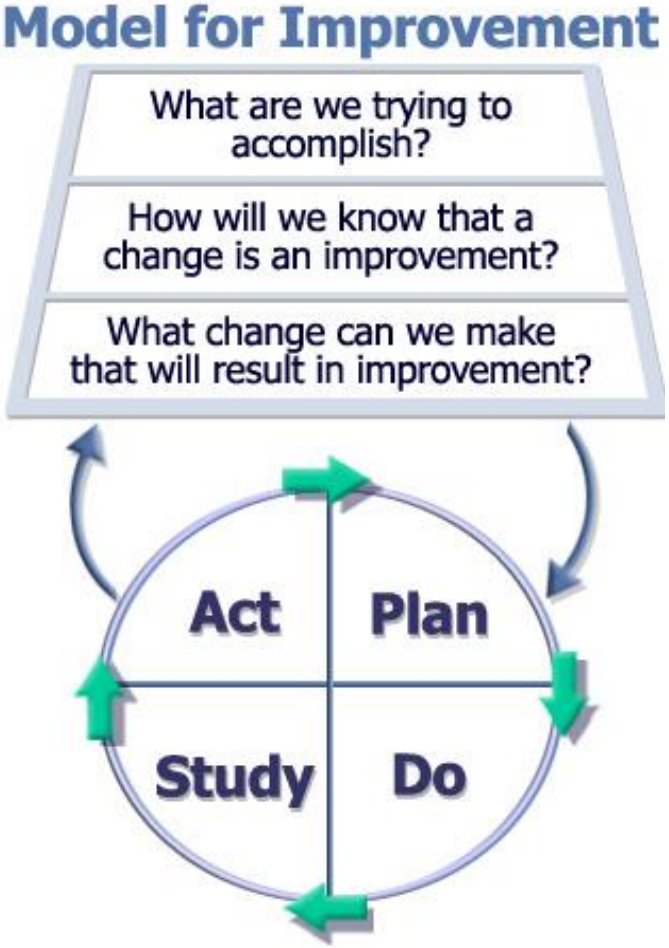
API added three basic *questions to supplement the PDSA Cycle. The PDSA Cycle is used to develop, test, and implement changes.*

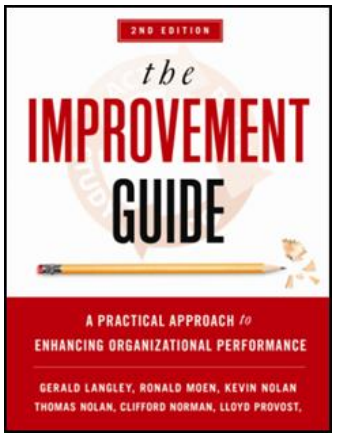
- Is applicable to all types of organizations.
- Provides a framework for the application of improvement methods guided by theory.
- Emphasizes and encourages the iterative learning process of deductive and inductive reasoning.
- Allows project plans to adapt as learning occurs.



The IHI Approach

When you combine the 3 questions with the…





PDSA cycle, you get…

…the Model for Improvement.

Appendices

A. Robert Lloyd, PhD, Faculty Bio
B. IHI Goals by Work Area
C. Quality Models & Approaches Across the Years
D. Evolution of Quality Management (over time)
E. Evolution of Quality Management (1950-1974)
F. Evolution of Quality Management (1978-2014)
G. Evolution of Quality Management in Healthcare
H. Choosing a Quality Model

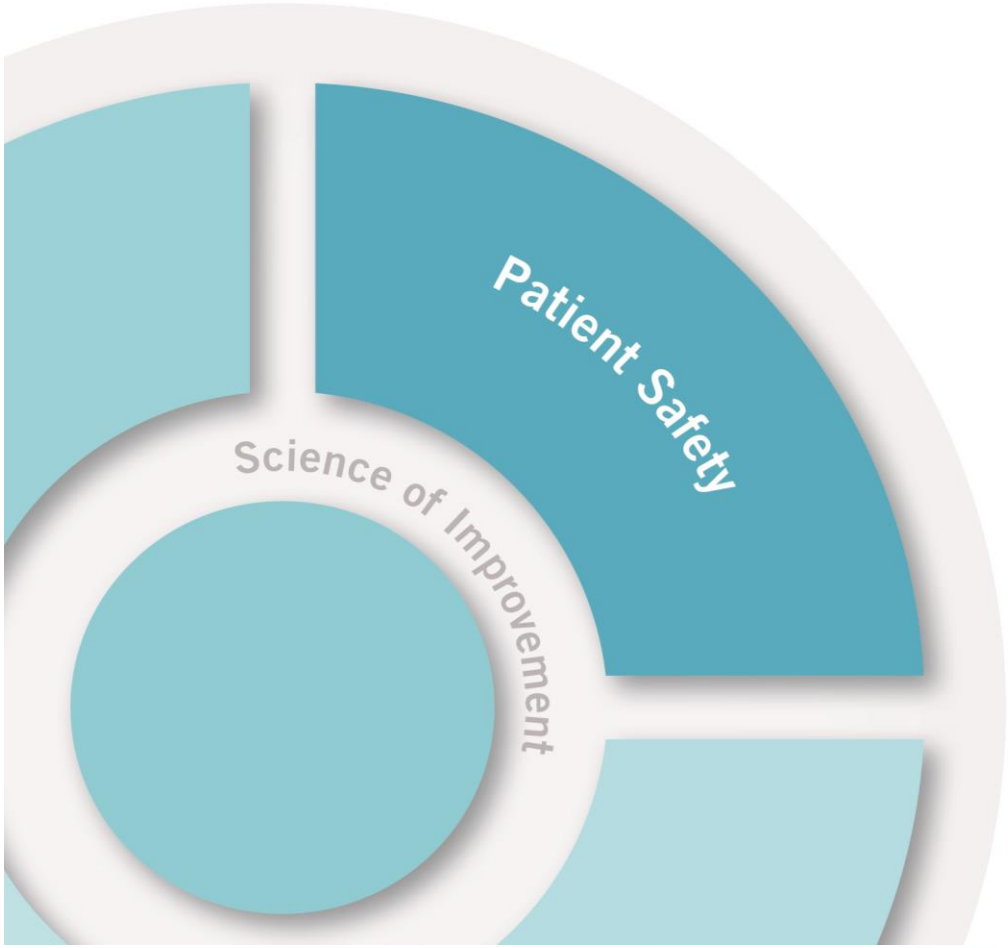
A.

IHI Faculty Bio
Robert Lloyd, Ph.D.

Robert Lloyd, PhD, Executive Director Performance Improvement, Institute for Healthcare Improvement provides leadership in the areas of performance improvement strategies, statistical process control methods, development of strategic dashboards and capacity and capability building for quality improvement. He specializes in helping senior leaders and board members understand their role in the quality journey. Dr. Lloyd also serves as faculty for the IHI Improvement Advisor (IA) Professional Development programme and helps to lead IHI initiatives and demonstration projects in the US, Canada, the UK, Sweden, Denmark, Africa, the Middle East and New Zealand. Dr. Lloyd is the author of two books and numerous articles and chapters on quality measurement and improvement. He lives in Chicago, Illinois with his wife Gwenn, daughter Devon and Cricket the family Shih Tzu.

B.

Patient Safety

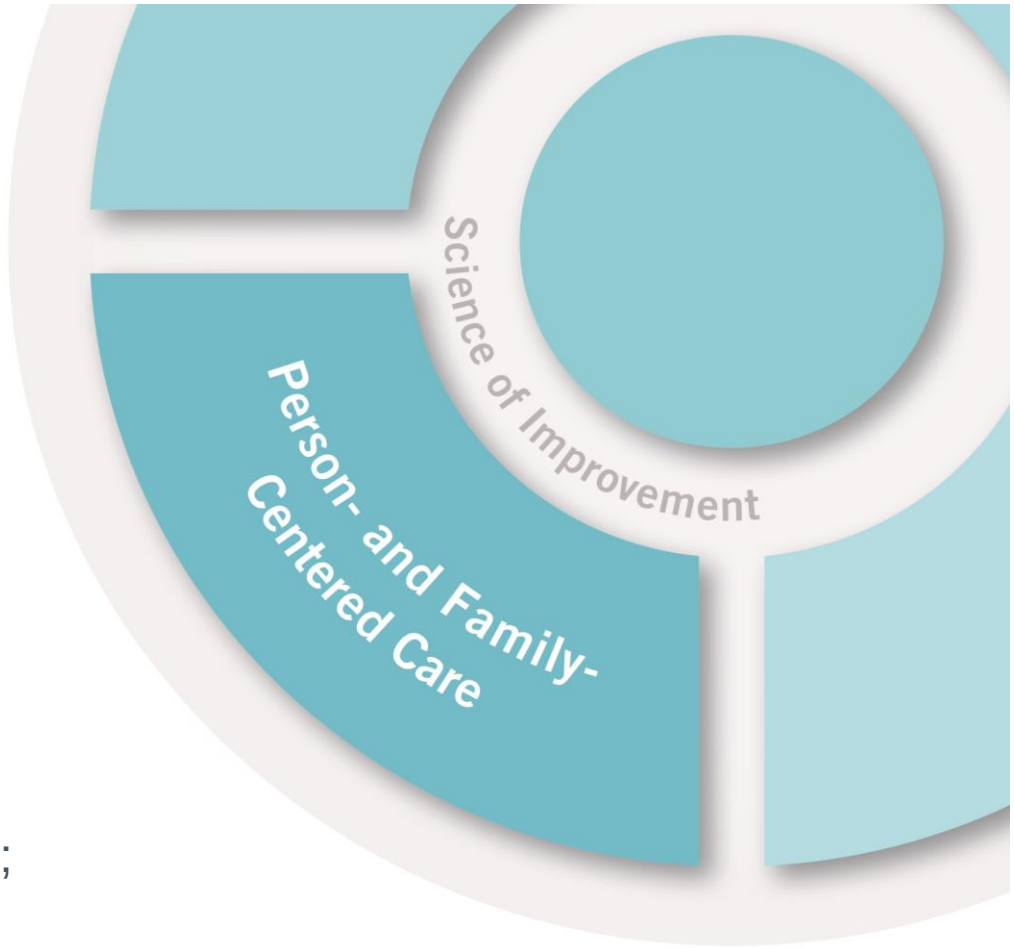


Our Goal:

Work with countries, regions, organizations, and individuals to build safety into every system of care, ensuring that patients receive the safest, most reliable care across the continuum.

B.

Person- and Family-Centered Care

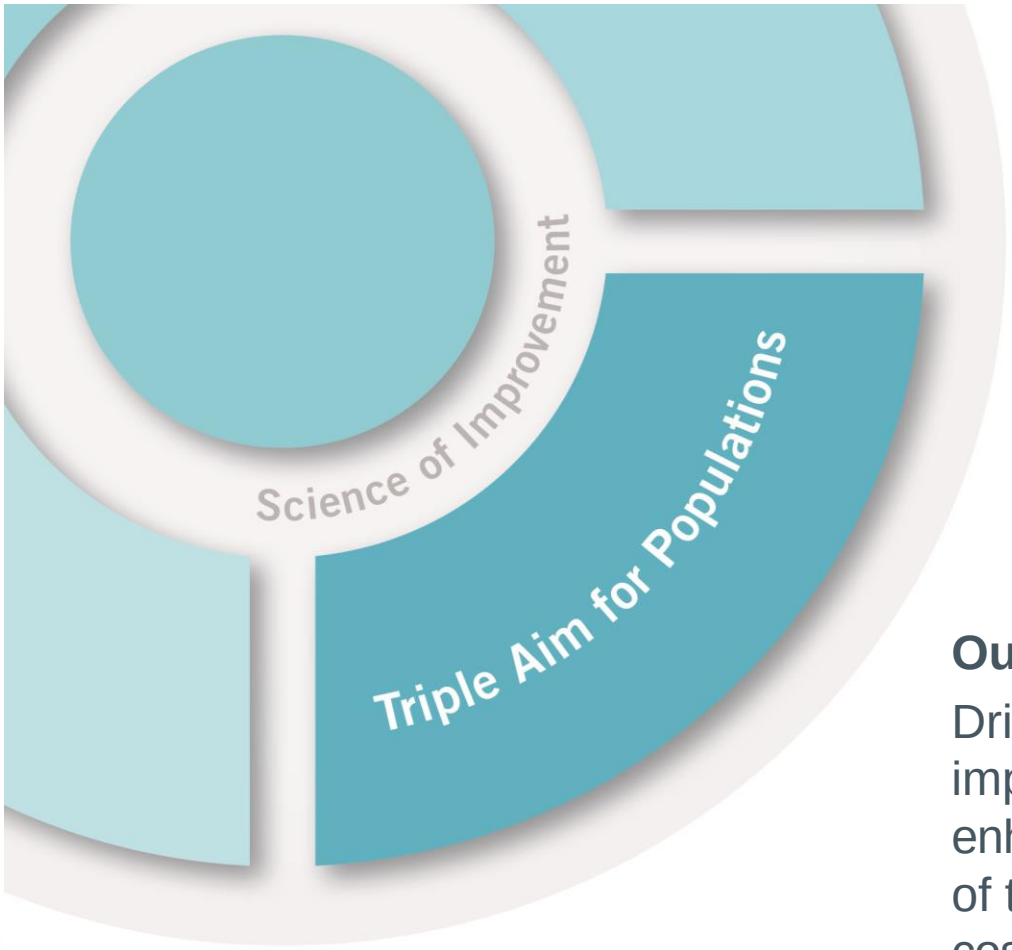


Our Goal:

Usher in a new era of partnerships between clinicians and individuals where the values, needs, and preferences of the individual are honored; the best evidence is applied; and the shared goal is optimal functional health and quality of life.

B.

Triple Aim for Populations



Our Goal:

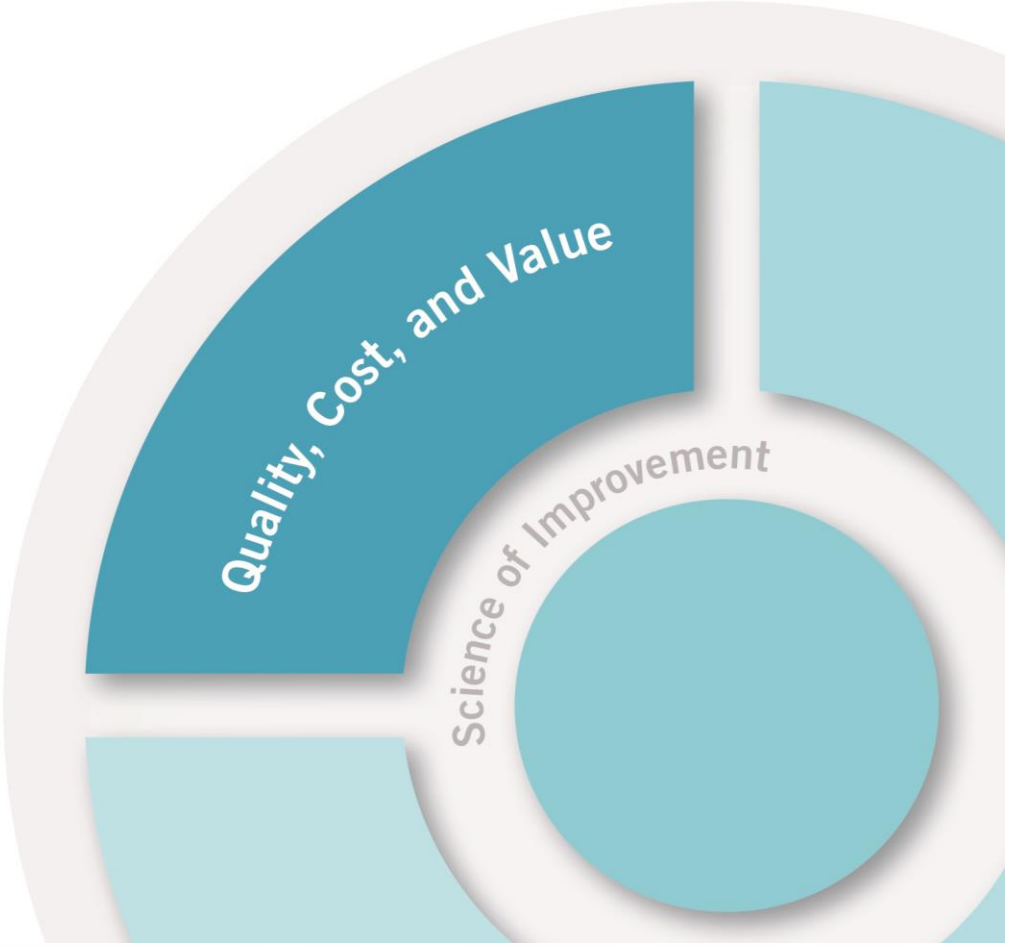
Drive the Triple Aim, simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities.

B.

Quality, Cost, and Value

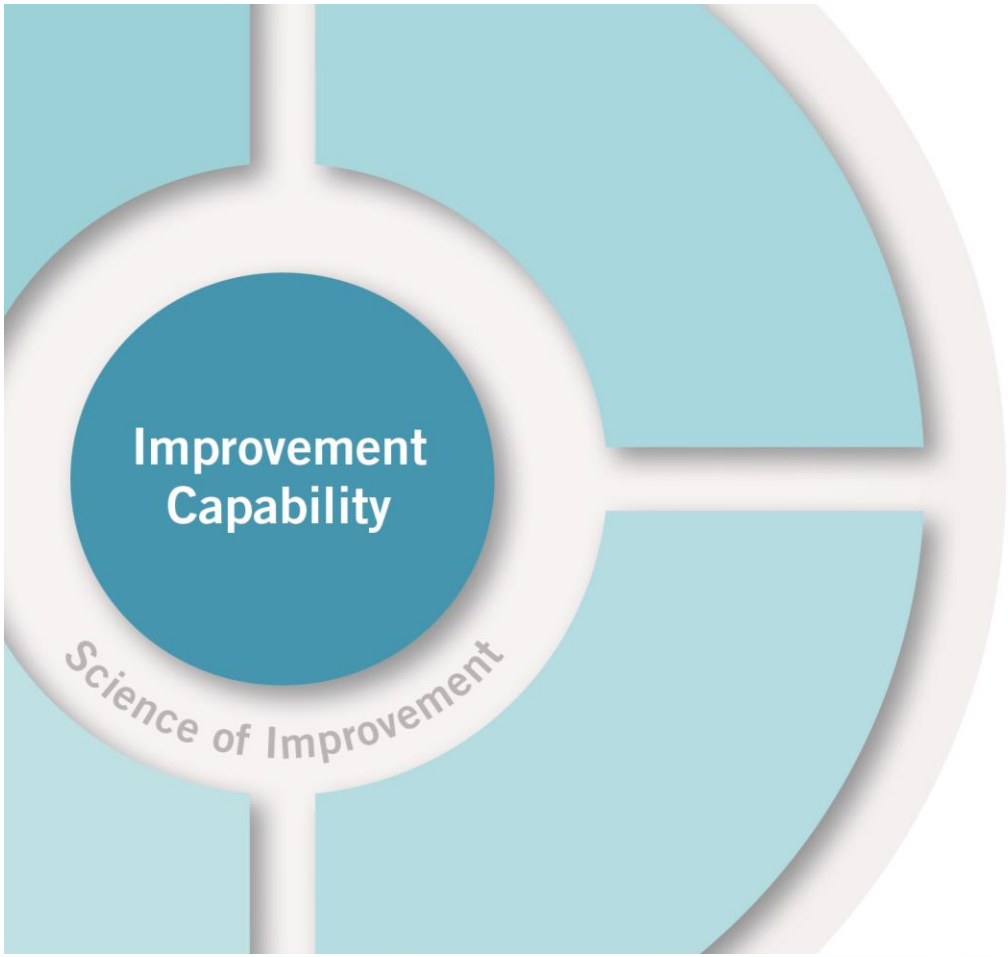
Our Goal:

Encourage, empower, and enable health care delivery systems to provide truly value-based care that ensures the best health care We strive to call out and address disparities in health and health care wherever they exist.



B.

Improvement Capability



Our Goal:

Build practical improvement capability based on the science of improvement into every organization, health care executive, and professional, while driving innovation to dramatically improve performance at all levels of the health care system.

C.

Quality Models & Approaches Across the Years

Human Factors (Ancient Greece, early 1900s)

International Organization for Standardization (ISO) (1926)

Toyota Production System (1950s)

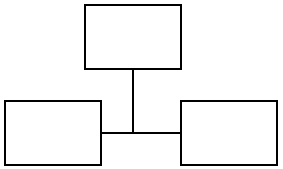
Six Sigma (Motorola, 1980s)

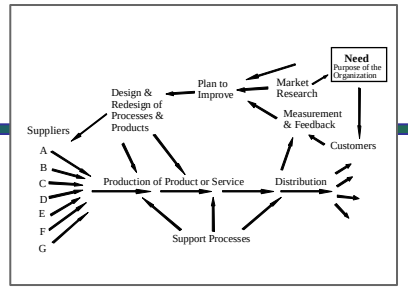
Baldrige Criteria (1987)

European Foundation for Quality Management (EFQM) (1988)

Model for Improvement (1996)

D. Evolution of Quality Management





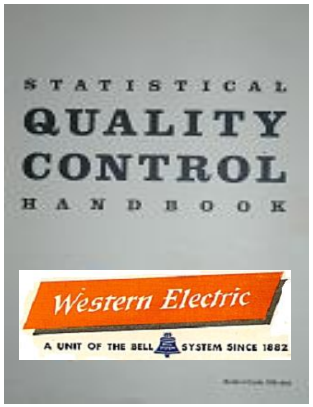
Evolution of Quality Management	Age of the Craftsman B.C. - 1800's	Age of Mass Production Early 1800's - Present	Age of Quality Management 1950's - Present
Theory of Management	* Person doing the work manages the entire job, from planning to job completion. * Craftsman is responsible for communication with suppliers and customers. * Rewards are tied to the customer.	* Scientific study is used for simplification of methods for individual tasks. * Planning is separated from execution. * Focus of management is on production at low cost. * Rewards are tied to the individual.	* Management views all work as processes that link to form a system. * The focus of management is on improving the system. * Improvement requires partnership between suppliers and customers. * Rewards are tied to the customer and teamwork.
Impact on Quality	* Quality = High cost. * Responsibility for quality belongs to the craftsman. * Direct customer feedback provides the definition of quality.	* Quality = High cost and low productivity. * Simplification objective establishes the Q.C. Department to measure and report. * Focus is on reducing costs. * Quality is achieved by inspection and sorting.	* Quality = Low cost and high productivity. * Quality is the focus of the organization. * Quality is defined by the need of the customer. * Q.C. Department assumes the role of consultant for improvement activities.

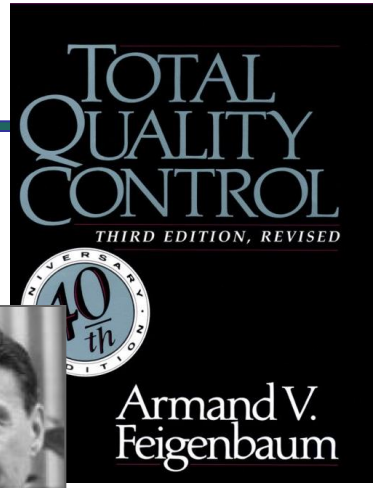
Source: Ron Moen, Associates in Process in Improvement

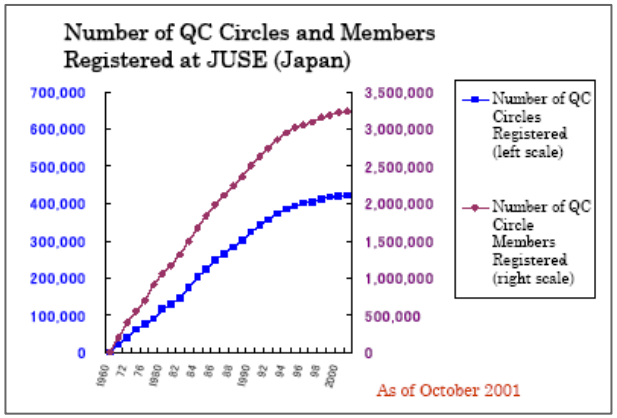
E.

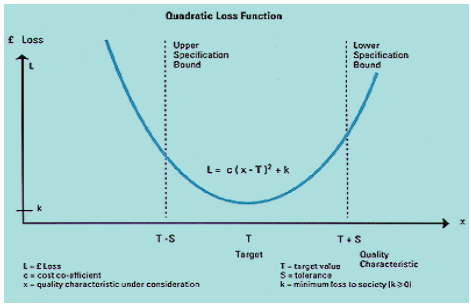
Evolution of Quality Management (1950-1974)

- 1951 – *Total Quality Control* published by Armand Feigenbaum
- 1956 – Western Electric *"Statistical Quality Control Handbook"*
- 1958 – Genichi Taguchi begins teaching his methods of loss function and robust design.
- 1962 – Quality Circles start. Kaoru Ishikawa asked a number of Japanese companies to participate in an experiment.
- 1974 – Kaoru Ishikawa publishes *Guide to Quality Control,* 7 simple tools for improvement.







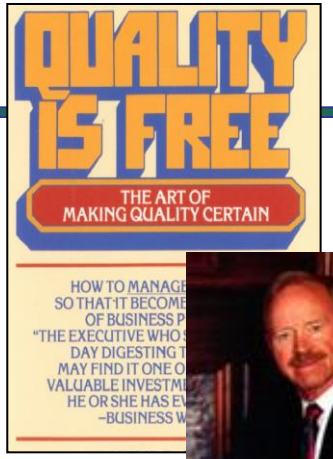


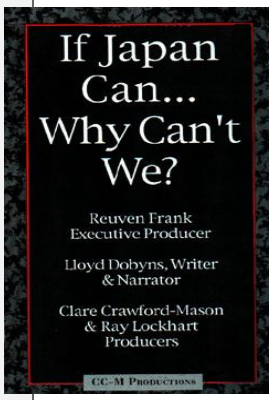
Source: Ron Moen, Associates in Process in Improvement

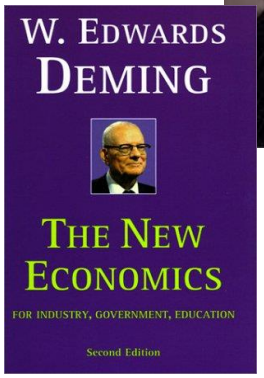
F.

Evolution of Quality Management (1978-2014)

- 1978 – George Box, William G. Hunter and J. Stuart Hunter publish their landmark book *Statistics for Experimenters*
- 1979- Philip Crosby publishes *Quality is Free*
- 1980 - Quality revolution begins in US
  - NBC airs *If Japan Can, Why Can't We?"*
  - Deming consults for Ford and GM
- 1987 - Malcolm Baldrige National Quality Award is established.
- 1994 – Deming publishes the *New Economics* which emphasizes the use of the System of Profound Knowledge.
- Present - Quality programs spread to Service Industries under a variety of names, tools and approaches.
  - Proliferation of quality programs: TQM, Six Sigma, Kaizen, SQC, SPC, Taguchi Methods, Benchmarking, CQI, Lean Six Sigma, etc.
  - Attempts are being made to package the various contributions from the past into an overall "one best approach."







Source: Ron Moen, Associates in Proc

G.

Evolution of Quality Management in Healthcare

B.C. – Hippocrates (3rd century B.C.). Medicine was and is taught and learned as a craft.

1973 – Avedis Donabedian proposed measuring the quality of healthcare by observing : structure, processes, and outcomes.

1970s – Quality Assurance (QA) of hospital care using structural standards

1980s – QA by government and insurers. The regulatory route relied on punishment and blame.

1986 – Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) announced its Agenda for Change and stated that the “philosophical context” for the Agenda of change is set by the theories of Continual Quality Improvement (QI).

1986 – National Demonstration Project (NDP) on Quality Improvement in Healthcare. A demonstration project to explore the application of modern quality improvement methods to healthcare.

1990 – NDP report: Berwick, D, Godfrey, J and Roessner, J. *Curing Health Care. Jossey-Bass, 1990.*

1991– Don Berwick founded the Institute for Healthcare Improvement (IHI) committed to redesigning health care delivery systems in order to ensure the best health care outcomes at the lowest costs.

1993 – IHI adopts API *Model for Improvement* as its foundation for Improvement.

H.

Choosing a Quality Model

The choice of a quality system, approach or model should be driven by the objectives of the organization, its culture and its products or services!

The decision should NOT be driven by how popular a particular approach is or even if it has been used successfully in other settings.

 Institute for Healthcare Improvement, 2004