

Prepared for the Non-Executives of the
East London NHS Foundation Trust

The Role of the Board in Building and Sustaining Quality: Part 2

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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?

**Now, let's take a
closer look at ...**



...improvement!

All improvement requires two types of knowledge

Subject Matter
Knowledge

Subject Matter Knowledge:

Knowledge basic to the things we do in life. Professional knowledge. Knowledge of work processes.

Science of Improvement (SOI)

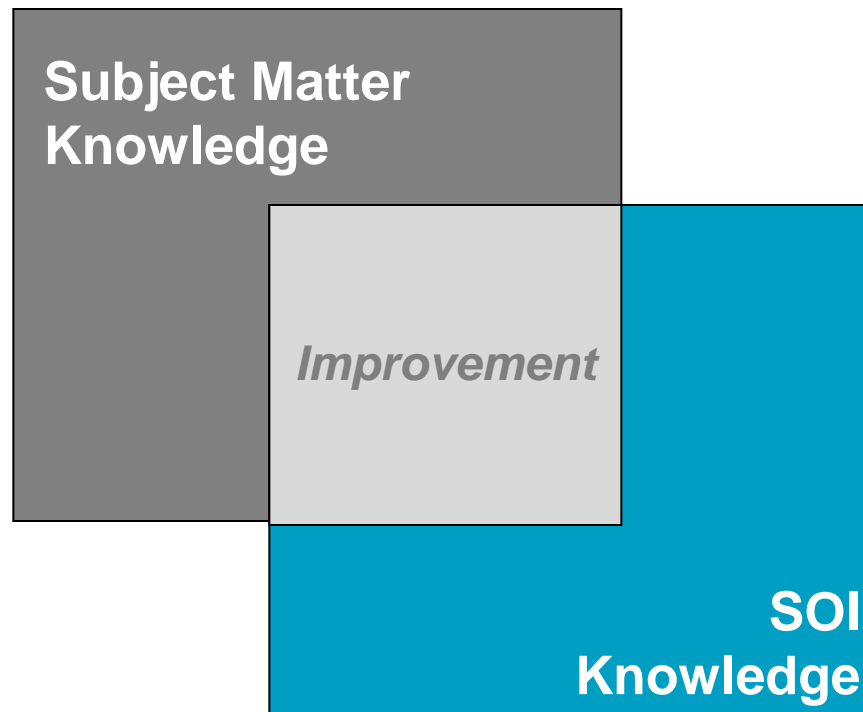
Knowledge: The interplay of the theories of systems, variation, knowledge, and psychology.

SOI
Knowledge



All improvement requires two types of knowledge

Improvement: Learn to combine subject matter knowledge and SOI knowledge in creative ways to develop effective changes for improvement.



And, Good Project Selection!

- QI projects should support the ELFT strategy and objectives. For example:
 - Improvements in quality, patient safety, service or outcomes
 - A need to reduce costs and demonstrate value
 - Responding to external expectations and demands
- Should be completed in 9-12 months or less
- Baseline data should exist and potential measures have been identified
- The team should have reasonable control over the factors that drive improvement
- The project has an assigned sponsor



Not Good Candidates for a QI Project

- Implementing a new a procedure, protocol or policy (e.g., implementing a new computer system)
- Fix a transient problem or an emergency
- A one-time or infrequent training or educational workshop (e.g., create a new on-boarding program)
- Any project where you cannot answer the question *“How will you know a change is an improvement?”*
- Huge (“solving world hunger”) projects with short timeframes
- Politically charged issues
- Improving employee compensation

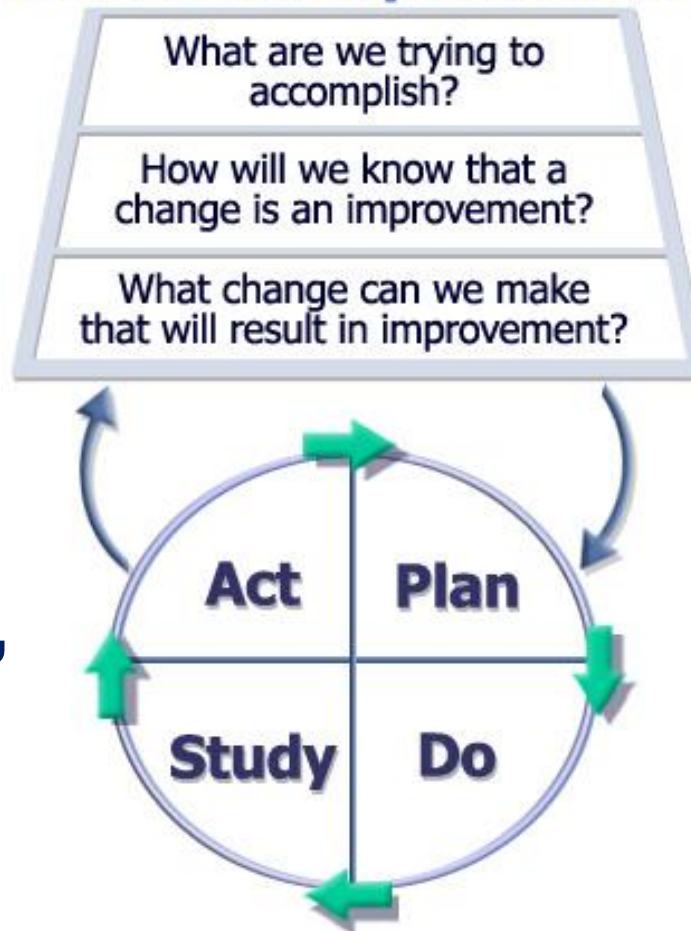


A Model for Learning and Change

**When you
combine
the 3
questions
with the...**

**PDSA cycle,
you get...**

Model for Improvement



**...the Model
for
Improvement.**

Question 1

Requires an Aim Statement

- ✓ **The System** (scope & boundaries)
- ✓ **Numerical *goals*** (How good?)
- ✓ ***Timeframe*** (By when?)
- ✓ ***Guidance*** (constraints in the system or other special considerations that might impede progress)



Question 2

Measurement is Central to the Team's Ability to Improve

- The purpose of measurement in QI work is for learning not judgment!
- **All measures have limitations, but the limitations do not negate their value for learning.**
- You need a balanced set of measures reported daily, weekly or monthly to determine if the process has improved, stayed the same or become worse.
- **These measures should be linked to the team's Aim.**
- Measures should be used to guide improvement and test changes.
- **Measures should be integrated into the team's daily routine.**
- Data should be plotted over time on annotate graphs.
- **Focus on the Vital Few!**



Question 3

Moving from Change Concepts to Ideas

Vague, strategic,
creative



Specific, actionable,
results

Improve process to reduce
anxiety



Give patients and families
access to information



Use beepers for family and
friends waiting



Make beepers available to
families of all surgery patients
for one day next week as first test of
change

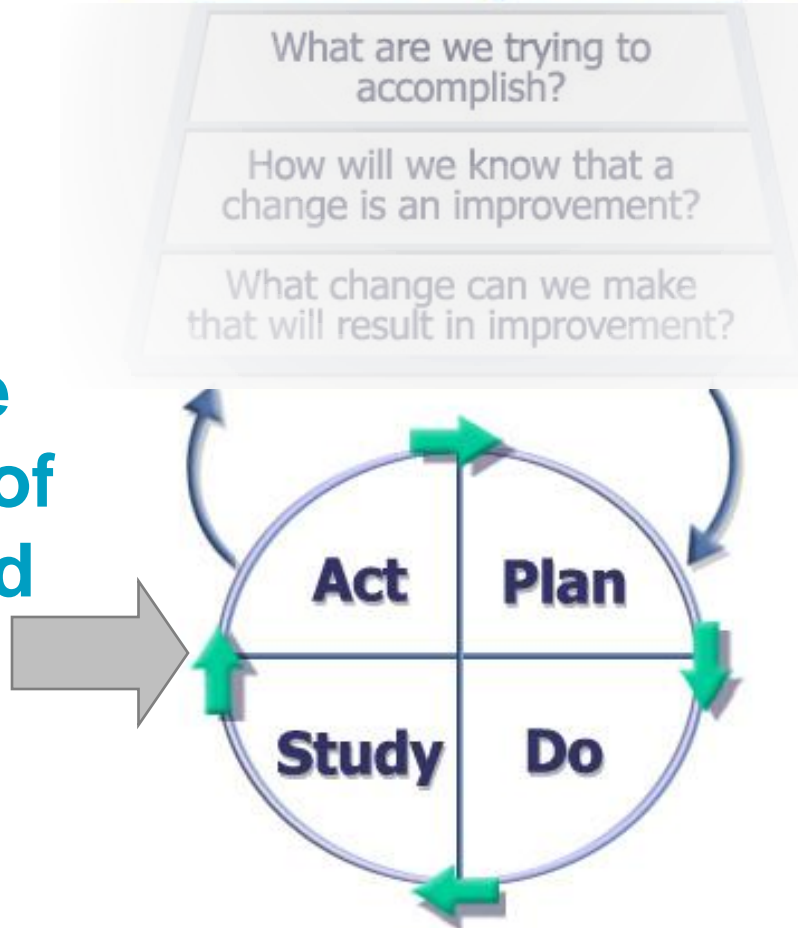
Taking a concept and getting specific. Getting to actionable ideas.



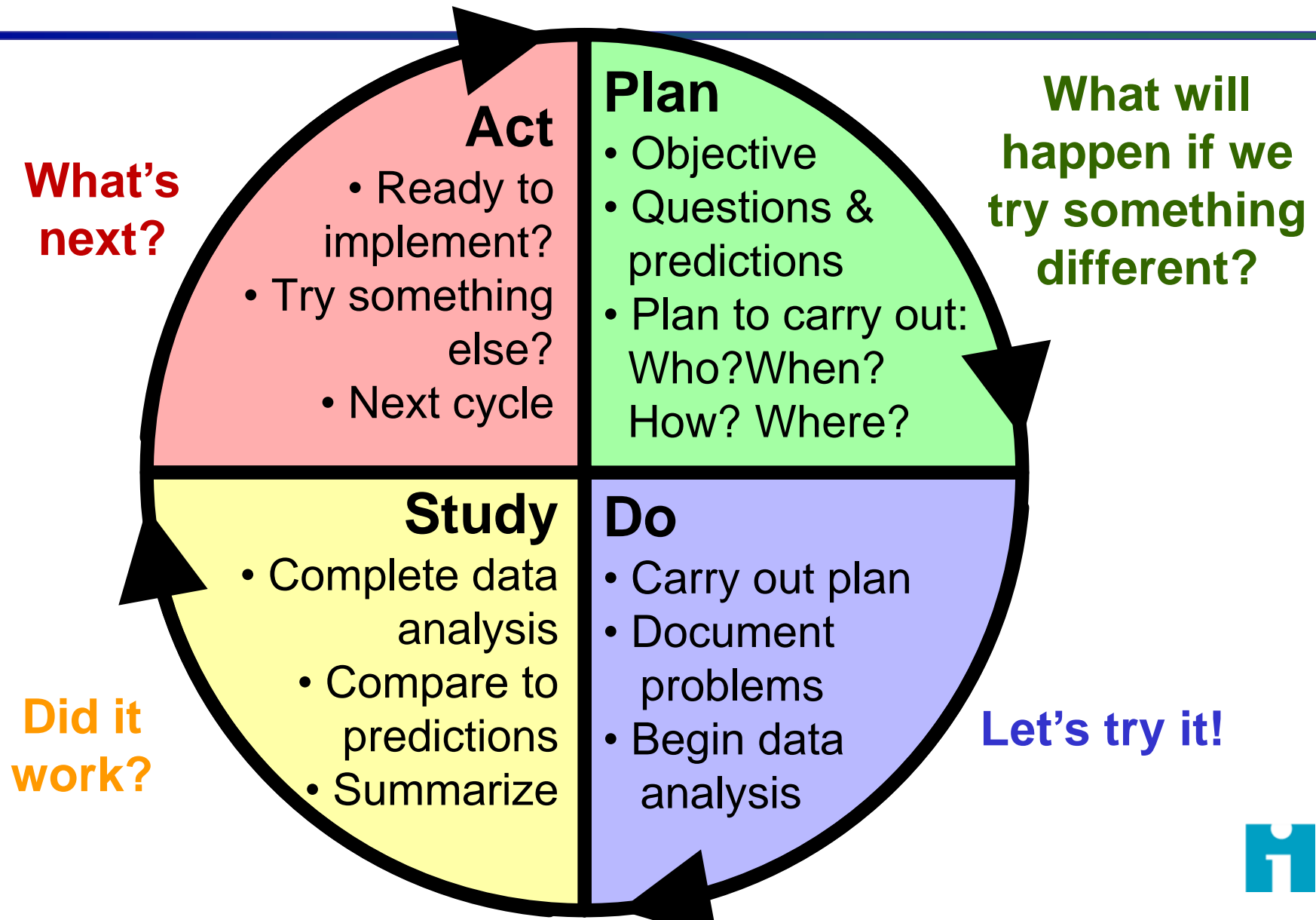
A Model for Learning and Change

Model for Improvement

Now, let's
review the
PDSA part of
the MFI and
tests of
change



The PDSA Cycle for Learning and Improvement



Quick PDSA Quiz

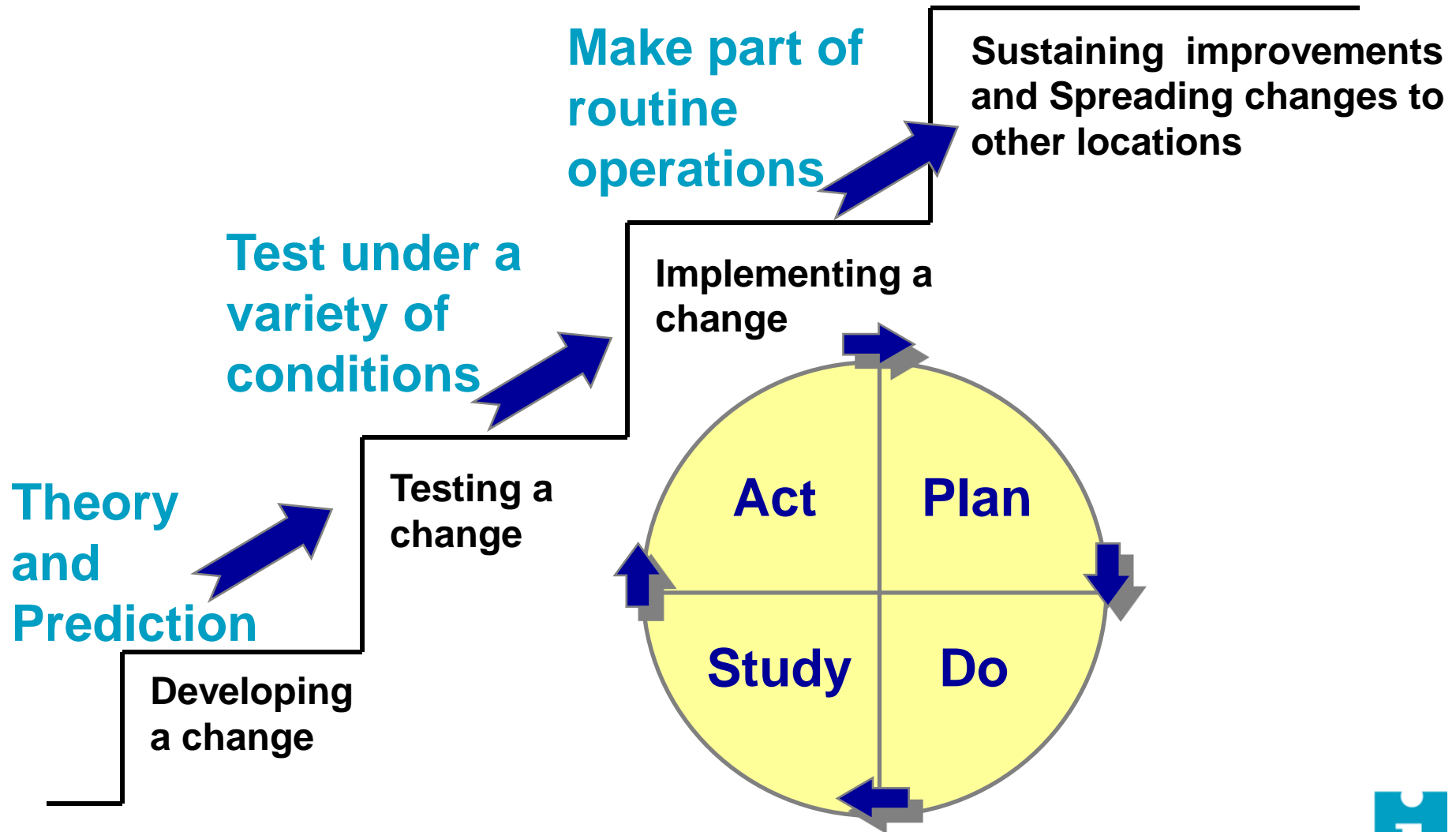
1. How many of you know what PDSA stands for?
2. How many of you have run 1 or more PDSAs in the same day?
3. How many of you ran a PDSA this week (Monday or Tuesday)?
4. If you didn't run one this week when did you last run a PDSA?



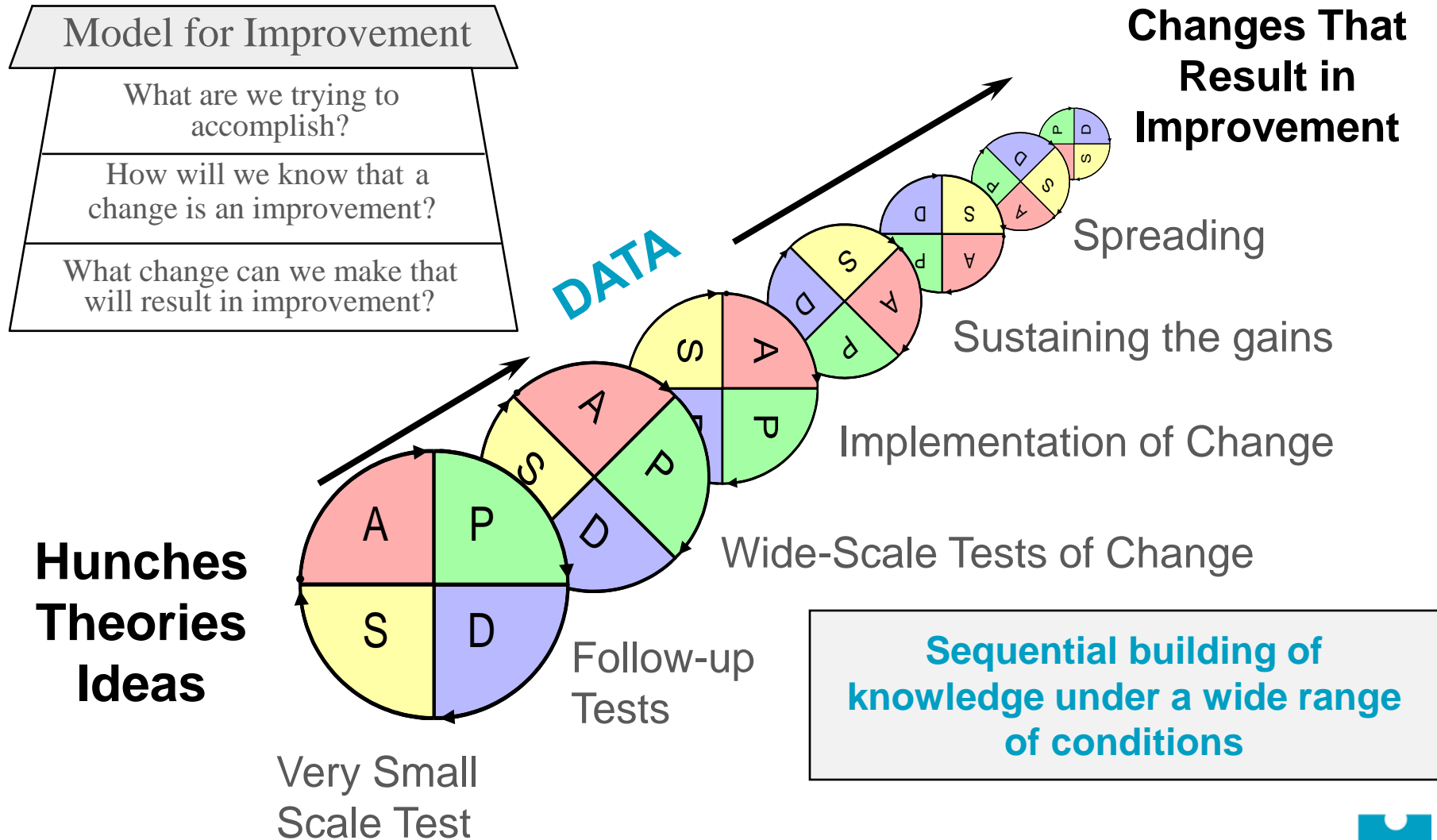
You actually do PDSAs every day



The Sequence of Improvement

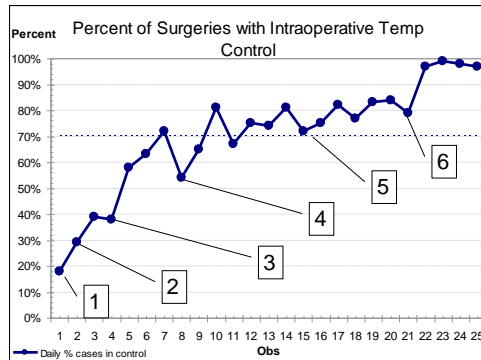


The key is to have repeated use of the PDSA Cycle for testing



PDSA Example

Change Idea: Standardize Intra-operative Temperature Control



Mini-measure tracks improvement cycles

Learning from data

99% Reliability

Cycle 6: Educate staff on new standards

Cycle 5: Standardize and document devices and protocol

Cycle 4: Analyze failures, test variation for selected surgical type

Cycle 3, Day 3: 1st OR is reliable; test with 3 ORs and surgery types

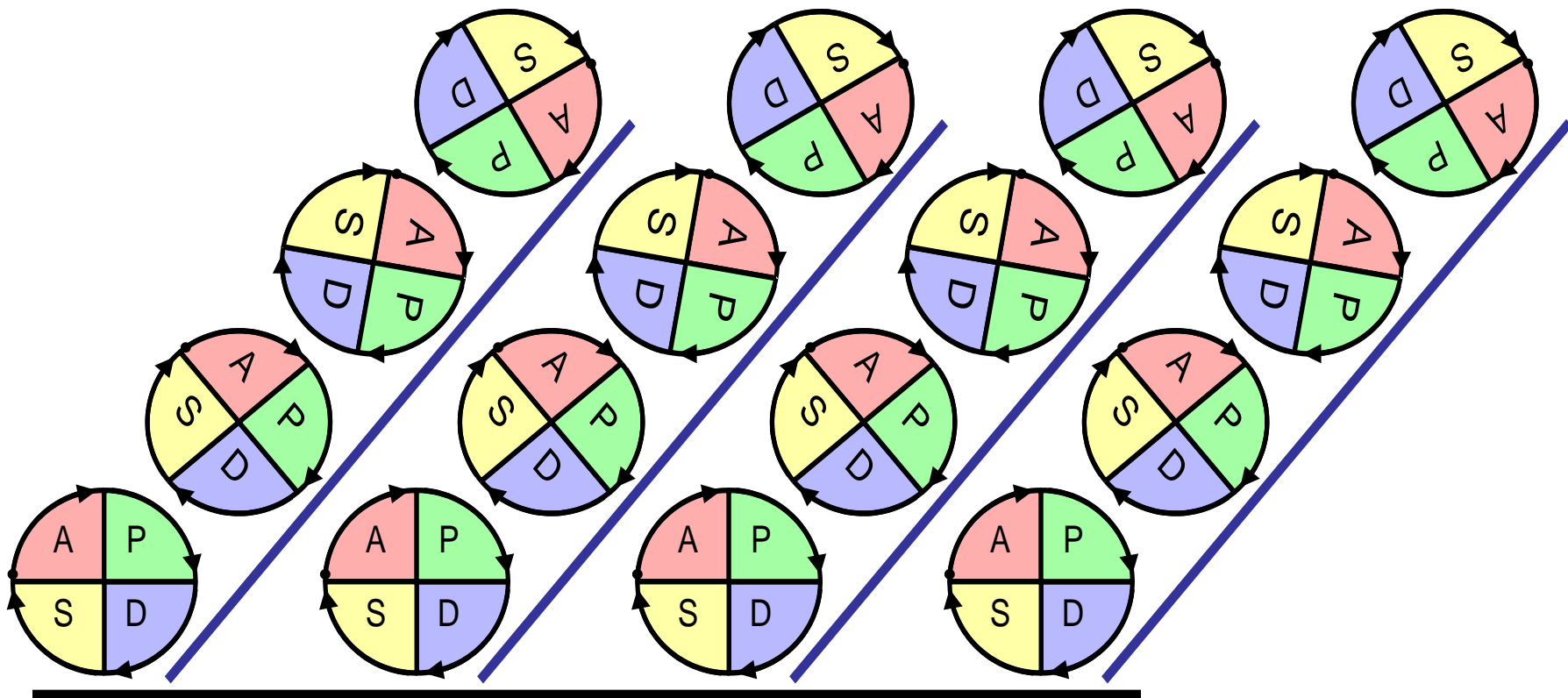
Cycle 2, Day 2: Checklist and stocking process for warming devices in OR

Cycle 1, Day 1: With 1 OR team, assign responsibility for temp monitoring

Organizing the OR team & equipment will achieve reliable temp control



Working in Parallel on Multiple Change Ideas or Drivers



Monitor
Temp

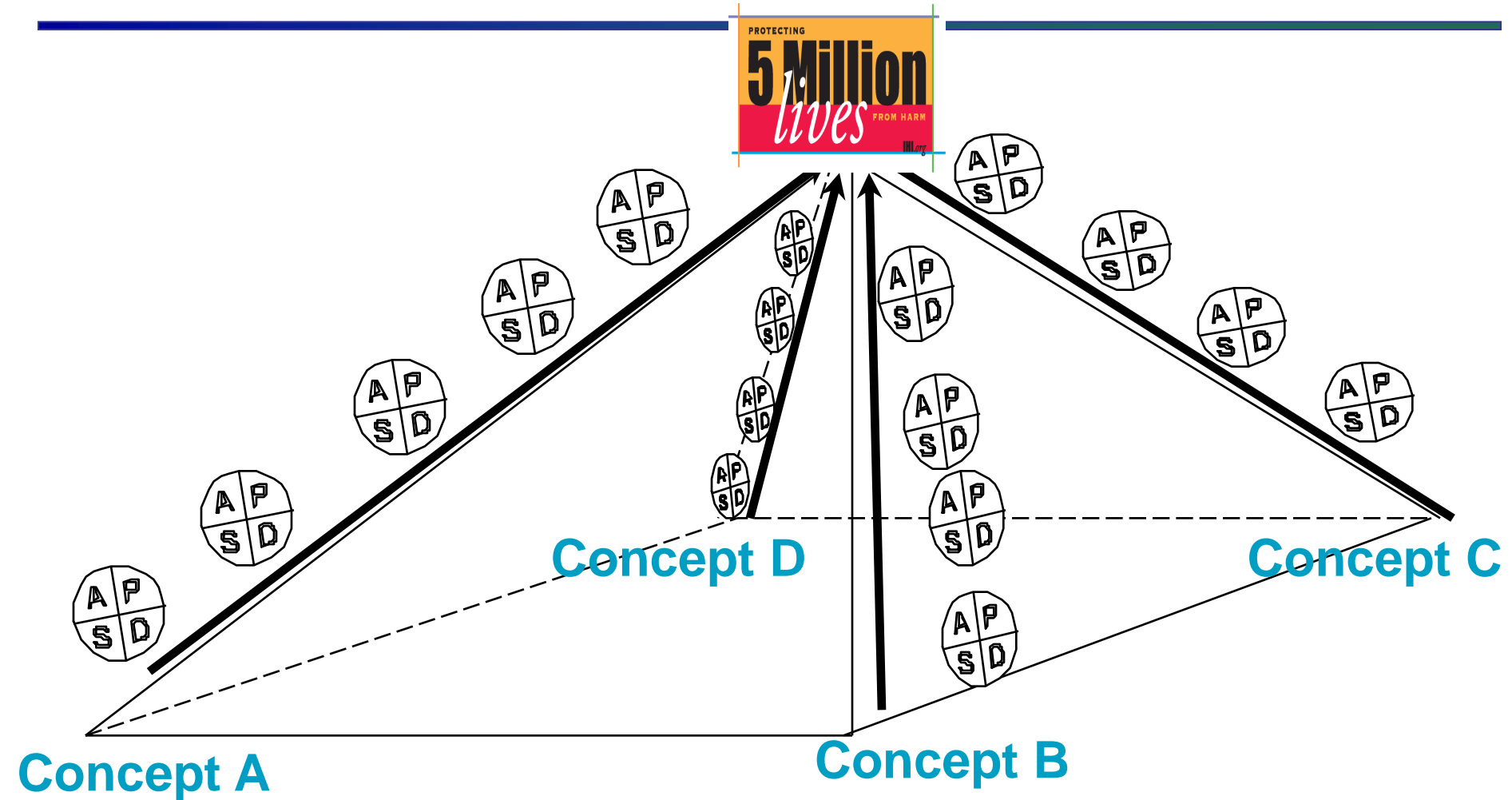
Stock
supplies

Control
Ambient
Temp

Recovery
Transfer



Multiple Change Concepts for a Single Aim



Change Concepts, Theories, Ideas



***“What we gain from
academic studies is
knowledge.***

***What we gain from
experience is wisdom.”***

Mohandas Gandhi



Failed Test...Now What?

Be sure to distinguish the reason:

- Change was not executed
- Change was executed, but not effective

If the prediction was wrong – not a failure!

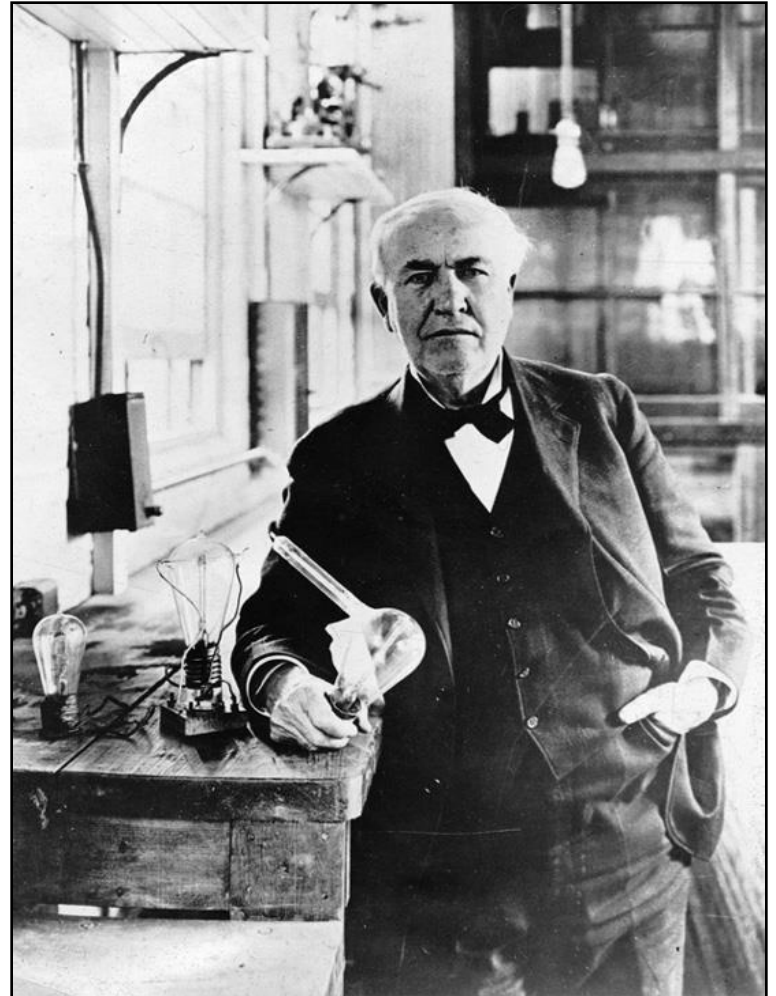
- Change was executed but did not result in improvement
- Local improvement did not impact the secondary driver or outcome
- In either case, we've improved our understanding of the system!



The Value of “Failed” Tests

“I did not fail one thousand times; I found one thousand ways how not to make a light bulb.”

Thomas Edison



It took 40 attempts to create WD-40



The 40th time was the charm for the blue canister that boasts more than 2,000 uses. In 1953, chemist Norm Larsen finally created on his 40th try, a formula to stop corrosion by displacing moisture (hence the name “Water Displacement , 40th attempt).

Sir James Dyson

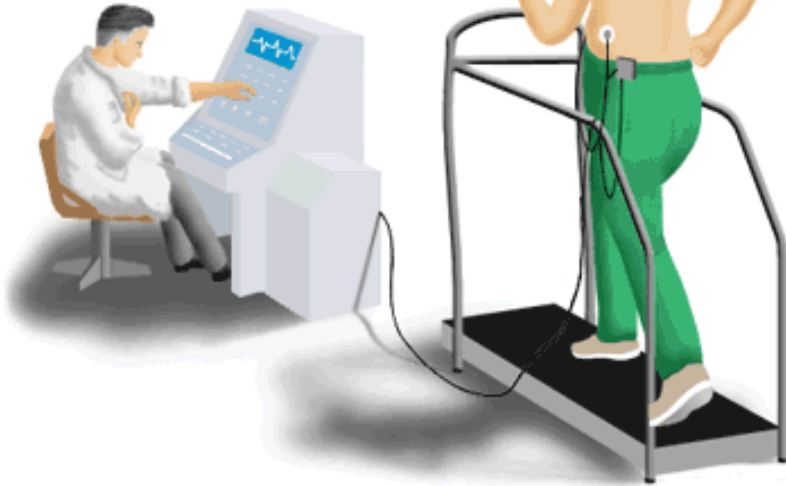
“I made 5,127 prototypes of my vacuum before I got it right. There were 5,126 failures. But I learned from each one.



That's how I came up with a solution. So I don't mind failure. I've always thought that schoolchildren should be marked by the number of failures they've had. The child who tries strange things and experiences lots of failures to get there is probably more creative.”



Increasing the Pace



$$S + P + C = O$$

- **Smaller Scale Tests:** One patient, one staff, try it once to get started
- **Test Multiple Drivers:** Assign individual responsibility for testing changes
- **Test Multiple Change Ideas:** Work in parallel to accelerate learning
- **One or more Tests A Day** keeps improvement in play!

