Leadership for Transformation and Engaging the Workforce in Service Redesign

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“I think there is a continual risk that either we, or those who are watching or commenting on us, immediately defer to discussing new forms of organisation rather than new forms of care.”
## Where We Are Headed....

<table>
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<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>Fragmented Payment</td>
<td>Unified Budgets</td>
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<td>Hospital as the Center</td>
<td>Home as the Hub</td>
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<td>Excellent Soloists</td>
<td>High Performing Teams</td>
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<td>Moving People</td>
<td>Moving Knowledge</td>
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<td>A Sense of Scarcity</td>
<td>A Sense of Abundance</td>
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IHI’s “Leadership Alliance”

New Rules for Radical Redesign in Health Care
Radical Redesign Principles – IHI Leadership Alliance

1. Change the Balance of Power
2. Standardize What Makes Sense
3. Customize to the Individual
4. Promote Wellbeing
5. Create Joy in Work
6. Make It Easy
7. Move Knowledge, Not People
8. Collaborate/Cooperate
9. Assume Abundance
10. Return the Money
The Chain of Effect in Improving Health Care

- **Patient and Community**
  - Experience
  - Aims (safe, effective, patient-centered, timely, efficient, equitable)

- **Micro-system**
  - Process
  - Simple rules/Design Concepts (knowledge-based, customized, cooperative)

- **Organizational Context**
  - Facilitator of Processes
  - Design Concepts (HR, IT, finance, leadership)

- **Environmental Context**
  - Facilitator of Facilitators
  - Design Concepts (financing, regulation, accreditation, education)
Deming’s System of Profound Knowledge

Values

Appreciation of a system

Theory of Knowledge

Understanding Variation

Psychology
Components of “Profound Knowledge”

- Understanding Variation
- Appreciation of a System
- Knowledge of Psychology
- Theory of Knowledge
Knowledge for Traditional Improvement

Subject Matter and Disciplinary Knowledge

Traditional Improvement
Knowledge for Continual Improvement

Subject Matter and Disciplinary Knowledge

Knowledge for Improvement
- Systems
- Variation
- Psychology
- PDSA

Continual Improvement
Appreciation of a System

If you can't describe what you are doing as a process, you don't know what you're doing.

(W. Edwards Deming)
What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

When you combine the 3 questions with the PDSA cycle, you get...

...the Model for Learning and Change

Source: The Improvement Guide p. 10
Four Cases....

- Self Dialysis in Jönköping, Sweden
- Isle of Wight PACS Vanguard: “My Life a Full Life”
- Enhanced Health in Care Homes Vanguards (N=6)
- Neurological Network Vanguard – Walton Centre
Introducing Christian

The Old Way

- Ryhov Hospital, Jönköping, Sweden had traditional hemodialysis and peritoneal dialysis center.
- In 2005, a patient, Christian, asked about doing it himself.
Co-Design of Dialysis Care
Patient Self-Care
How Far Can We Go?

The Self-Hemodialysis Staircase

The staircase is not static. Changes can go both upwards and downwards depending on the patient's condition and motivation. Training and information is provided along the entire staircase.

- Home-HD: Manages everything without supervision.
- "Dresses" and primes the machine at start-up, with some supervision.
- "Dresses" and primes the machine at start-up, with some supervision.
- Manages the machine at start-up and conclusion with supervision.
- Manages the machine at start-up and conclusion with supervision.
- "Dresses" and primes the machine at start-up, with some supervision.
- "Dresses" and primes the machine at start-up, with some supervision.
- Visitor at the Self-Dialysis unit, receiving information about self-dialysis.
- Out-patient clinic
- Emergency care
- Peritoneal dialysis
- Assisted HD

Region Jönköpings län
Self-Dialysis

- Now 60% of Ryhov Hospital dialysis patients are on self-dialysis
- Their aim: 75% of patients
Self-Dialysis Results

- Costs reduced 50%
- Complications dramatically reduced
- Measuring success by “number of patients working”
Leadership Questions: Self-Dialysis

- Systems:
  - Breaking down boundaries.
  - What new system boundaries had to be drawn?

- Variation:
  - Using data for learning, not judgment.
  - How would metrics be used to advance this innovation?

- Psychology:
  - Reducing fear. Creating cooperation.
  - Why did Britt-Marie say “Yes” to Christian?

- Learning:
  - Testing serially over time. Fostering team learning.
  - What informative PDSA cycles were used? By whom?
Using the Chain of Effect Diagnostically

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Each of the PACS have very similar overarching visions for how they want to improve services ... 

- A stronger focus on population health and wellbeing
- More proactive support, particularly for people with multiple chronic conditions
- More joined-up care across physical & mental health and social care
- A shift from hospital care to community and home care wherever possible
- Reduction in reactive care and shift to planned care in lower cost settings

Isle of Wight Vision

- Helping people to care for themselves
- Dealing with crises and getting people back on their feet quickly
- Working closer together in the local area
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<td>Homecare/Community beds</td>
<td>A Dementia-focused social movement, working with the Alzheimer's Association and Yorkshire's Cricket clubs - building resilience in communities through sport to support people with dementia. Using technology to support care home residents by providing a secure video link to senior nurses.</td>
<td>MDT - a proactive care homes support team will provide person-centred care planning and co-ordinated input to the care home staff and residents. Community Anchors - trained individuals helping those in care/nursing homes &amp; ECLS access community assets &amp; networks to reduce social isolation. Introducing holistic assessment tools such the LEAF 7 assessment and Portrait of a life to increase wellbeing and health for those in care homes.</td>
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<td>Virtual Ward MDT / Ward Rounds – GP, Community team &amp; Care Home Staff weekly ward rounds for care planning and MDT for complex decision making</td>
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<td>Outcome Framework based on 'I' statements and Local Metrics</td>
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<td>New care pathway for frail elderly, encompassing homecare/community beds, supported by a growing Provider Alliance Network, and development of outcome-based contractual / payment model.</td>
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<td>Joint commissioning with local authority as lead contractor, using an NHS-standard contract. Underpinned by robust quality monitoring processes. Person-centred outcome measures developed with Age UK and local citizens. Dementia outreach team is commissioned to provide dementia care, case management and training and support for care home staff. The team also run care home managers’ and care coordinators’ forums</td>
<td>Health and social care data integration A complex care framework: Supporting care home staff to be confident in their care for their patients GPs aligned to specific care homes An integrated rapid response team which offers a timely assessment and alternative model of care to hospital admission for appropriate patients who are in a ‘crisis’.</td>
<td>Hospital Transfer Protocol (red bag) Standard Assessment Form End of Life Care Engagement with care homes</td>
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The Emerging EHCH Framework

- Enhanced primary care support for care home residents
  - Access to consistent, named GP
  - Medicines reviews
  - Hydration and nutrition support
  - Out of hours/emergency support

- MDT in-reach support:
  - A single point of access to primary, community, acute, social and other specialist advice
  - Expert advice for those with the most complex needs

- Re-ablement and rehabilitation to promote independence and living at home

- High-quality end of life care and dementia care

- Joined-up commissioning between health and social care
  - Shared contractual mechanisms to promote integration
  - Co-production with providers and networked care homes
  - Access to appropriate housing options

- Workforce
  - Training and development for care staff
  - Shared workforce planning

- Data, IT and technology
  - Linked health and social care data sets
  - Access to the care record and secure email
  - Better use of technology in care homes
Neurological Network Vanguards: The Walton Centre, Liverpool

- **Concern**: Unnecessary back surgery and spinal injections.
- **Response**: Local intervention by neurologists, neurosurgeons, nurses, and other staff. Weekend “school” for 100 patients awaiting unnecessary surgery.
- **Vision**: National programme to reduce ineffective neurosurgical interventions.
Impressions of the Vanguards So Far

Strengths:
- Superb spirit and growing community of practice
- Emerging comprehensive “driver” models

Gaps:
- Institutional memory
- Specific transfers of innovations for tests
- Exchange among Vanguard subgroups
- Statistical thinking and run charts
- Paul Maubach’s concern: Organisation > Forms of Care
- Cataloguing and accessing powerful “change concepts”