Adapt, Improve, Achieve: RCVS Knowledge quality improvement stream at SPVS VMG Congress 2020

Podcast transcript: Shobhan Thakore discusses getting the team on board to own and deliver quality improvement

Introduction
Welcome to an 'Adapt, Improve, Achieve' session by RCVS Knowledge, which was recorded at SPVS VMG Congress on the 25th January, 2020 at Celtic Manor Resort, Newport. It was part of the quality improvement stream. In this session, we will hear from Shobhan Thakore on getting the team on board to own and deliver improvement. Shobhan is the Clinical Lead for the Scottish Quality and Safety Fellowship Programme. He discusses recent initiatives introduced to the NHS to help engage the team, manage expectations, work with them to respond to change, and how to deal with fear of blame. Shobhan discusses how a structured approach to quality improvement is being used to help improve the delivery of healthcare.

Shobhan Thakore
[applause] Thank you. It's great to see so many of you here. I know what it's like to get up first thing in the morning for a session immediately after a banquet the night before. So it's good to see so many of you looking bright-eyed this morning. So yes, I'm Shobhan. I am an Emergency Medicine Consultant. I work in Tayside in Scotland. I live in Dundee. I'm based in Tayside. As you can see, it's the centre of Scotland. It's quite a large geographical area. We've got the challenges of urban populations as well as big rural spread.

My jobs are that I work in emergency medicine about 40% of the time. I'm clinical in the ED [emergency department], so I work with a team there of about a hundred people, and have experienced there running improvement projects with the team. The other picture there is of our Improvement Academy, ‘cos my other role in Tayside is as Associate Medical Director for Quality Management – which means having an oversight of the use of quality improvement methods and improvement science across the board, and how we can use that effectively.

As already mentioned, my other role is as the lead for the Scottish Quality and Safety Fellowship Programme. And you've had a bit of an outline there about what we do. It's an international programme and it's for all clinicians. It mainly takes from Scotland, Northern Ireland, Ireland, Denmark and Norway. But we've had a total of nine countries that have come in and out of the programme over the years. And we train people up to be leaders in improvement.

And I guess that's where the background for the talk comes from, in that, one of the common questions I'm asked is, "Why is my improvement project not working? Why can't I get the team to do what I want them to do? Why are things just not progressing?" And actually that relates back to this, which is a

quote from Peter Drucker who is a management specialist, if you like, who says that "culture eats strategy for breakfast". So, you could have the best strategy in the world, in your eyes, but if you haven't engaged your team, you're not going to get anywhere. And that applies to improvement. And then we think about what does culture actually mean? Well, there's millions of definitions for culture that are really complex, but some of the easiest - one on the easiest ones I've heard is that culture is just a collection of behaviours. It's the result of a collection of behaviours. And who are responsible for the behaviours? Well, people. So if you just reduce that all down, then it's people that eat improvement for breakfast. So you really need to engage your people. And you really need to have your team engaged in what you're trying to do, and your project has to be meaningful to them.

So hopefully over the next 40 minutes or so, we'll cover what's been described in terms of the current challenges that we see in human healthcare. A term that I'm only just becoming used to, having been here for about 24 hours - human healthcare. And consider the importance of team engagement in that context, where we are at the moment and see how much of that resonates with you. And then talk about five steps for effective engagement, things that you could do - that you should do - if you're trying to bring in improvement projects. And that's really based on my experience, it's based on the teaching that we give on the Fellowship Programme. And it's also a little bit based on some of the publications out of places like The Health Foundation, from IHI [Institute for Healthcare Improvement] and various other quality improvement bodies around the world.

So where should I start? We'll start with the challenges in the NHS. So the challenges in the NHS could take up the rest of the talk. But just to kind of bring it down to a few, we have an ageing population; we have more complex needs. I read somewhere that I think 30% of everybody aged over 75 are on 10 medicines or more. That's a huge number of people just teetering, that we're just kind of balancing. We have issues with recruitment. We have issues with retention. We have issues with deprivation. Dundee has massive issues with deprivation. We have social isolation, and we have the thing that's plastered all over the news all the time, which is our funding – do we have enough money or don't we have enough money?

So those are the challenges. And what's our approach been? There's been different eras in healthcare in terms of how we've approached the challenges of delivering healthcare. I feel that where we are at the moment is a kind of management-driven idea, that we can have a reductionist approach almost. Where we treat healthcare like it's a machine. And so if you could just reduce that machine to a series of processes, and you make each one of those processes efficient, then the whole machine will be efficient. And you can process your units really quickly in high volume, as quickly as you need to. And the real problem with that is that our units are people. And the units that we're trying to process are really complex beings. People on 10 medicines a day. It's not quite so easy to just reduce all that down to simple processes. And if we were doing that, if we're reducing it down, if this worked, then really we would be the most efficient and productive area of industry in the world. But the evidence doesn't really suggest that.

So if you look at evidence that's published by the OECD [Organisation for Economic Co-operation and Development], there's research evidence published by Don Berwick and others which suggests, which asks us to consider how much we do that adds no value. And you think about how much we spend that adds no value. And this is true of every industry, but the estimates within healthcare is anything from

20% to 50% of what we spend is potentially adding no value. For lots of different reasons. I'd like to think the NHS is at this end of the scale rather than at that end of the scale. But there's still a significant amount of waste in the system.

And we talk about Trusts being in huge financial pressures. We as an organisation, we're in huge financial pressure. NHS Tayside has 14,000 staff, it has a billion pound budget, and we were 40 million overspent, which is 4% and we have potentially got this waste in our system. And improvement, well it can help to identify this and make it better. I can talk about data and talk about data, till I'm blue in the face. And it just doesn't mean anything sometimes. So maybe what I should do is illustrate what I mean by that waste by giving you an example.

So this is an example from own family. Um, an 87-year-old woman whose husband had died very recently, and after 52 years of marriage, that's quite a shock. She was struggling with that. But what she focused on was the fact that she was getting up a lot at night, and she was peeing. So she focused on the fact she was peeing at night. She went to see the GP because she was peeing at night. A very good GP who tested her for infection, treated her empirically for infection just in case. Then referred her in for a urology appointment. And urologists saw her, the gynaecologists saw her, they had urodynamic studies, lots of tests done, at the end of which they didn't really find very much going on. So a letter was sent from the urologist to the GP, both under pressure to see lots of patients as quickly as possible, saying well we think it may be worth starting a couple of medicines. One, a bladder-stabilising agent and the other was a type of diuretic, which was an unusual combination. But that was the letter that arrived.

The GP was keen for her to get some relief from these symptoms that have been going on for months, and were making her feel really tired. They phoned her up and said, well, we've got this advice in, so to save us time, I've just sent the prescription to the pharmacist. You just go and pick up the medicines and make a start and hopefully you'll start to feel better.

Off she went dutifully as an 87-year-old to pick up the medicines, and starts them within 48 hours. They cause her to have a syncopal episode where she loses consciousness, falls to the floor, when she comes around, she's got a very painful right leg. She's had a knee replacement in that leg. She can't get back up. Ambulance takes her to hospital. She's found to have a periprosthetic fracture around that right knee. The orthopaedic surgeons have a very complex procedure to do now in an osteoporotic 87-year-old to revise that knee replacement, put a longer stem in, but they do it. She's in hospital for four weeks. She gets lots of physiotherapy. She comes home, she needs social care at home. And then one day it starts to get sore and within a space of a few hours, she's not able to walk on it. GP sees her, sends her back into hospital. Orthopaedics have a look at her, don't like the look of it, take her into theatre, open it up and she's got a septic prosthesis. Pus in the joints. Not really a lot of surgical options left. So essentially they washed it out, closed it up. Everybody does this, start her on IV antibiotics, she'll be on antibiotics for the next six months. Again in hospital, three or four weeks, come home, more social care.

At the end of all of that, that's several months. At the end of all of that, she's an 88-year-old lady now, who's dependent on walking with a frame, who's less confident. Still pretty stubborn and therefore keeps getting on with things, but is just less physically able. She's lost a lot of muscle bulk. She's not the same woman that she was. And that all started because of a prescribing decision that was taken and some harm came from that prescribing decision. And so that simple decision at the beginning caused

that journey. And I'll just say who that was, probably comes no surprise, but that's my mum. Hansa Thakore, who's now 90, still going about with a frame. Sometimes I find her in the house – she's supposed to obviously use the frame to walk – sometimes she puts it on her shoulder and just walks. [audience laughter] I'm not sure that that's really what that's intended for. But anyway, so waiting for the next fall, which will be caused by her- anyway. So she's doing well but that's mostly down to her own stubbornness, you could say. And actually, so the prescribing decision caused that. 11% of acute admissions are caused by harm from prescribing.

And if we go back to the beginning of that story - that point where the GP phoned up to say we've been recommended that you start this medicine. If you'd had a face-to-face consultation, they would've found out, my mum had been reflecting on what's been going on, had recognised that she'd been lonely cos my dad wasn't there. Had been drinking lots of tea because she were just on her own, and stopped drinking tea. Actually stopped drinking fluid after six o'clock and was sleeping. So we create harm; we create problems for our system.

But it is a complex world. The trouble is, what we've done is that machine approach of just process, process, process and we're kind of losing the patient voice in all of that. So what we did for my mum's journey - my mum won't show up in any statistic for that hospital or for that GP because actually we hit the targets. She was seen in the target time, in Outpatients by the urologist. Success for the system. But we're not thinking about it in the right way. We are hitting the targets and missing the point, because we're missing the message about complexity. We cannot just reduce everything to a series of processes because humans are more complex than that; teams are more complex than that.

So a quick word on complexity. What do I mean by complexity? We have three different types of processes. You have simple things, complicated things and complex things. And a lot of you I'm sure are very familiar, so I'll breeze through this. If I was to throw you my car keys and take you to my car and say, unlock my car, that is a simple problem for you to face. Because you look at the key, that's the button that normally unlocks the car. It doesn't matter that it's not your own car. If you are driving your car and a warning light comes up on the dashboard, you kind of think, well, there's something mechanical probably not right in the car. If you're a trained mechanic, you could probably work out the process and work out what was wrong with the car and fix it. It's not simple, but it's knowable.

But your car journey to work each day could be completely different, even though you take the same road and take the same route. And the journey to work is far less knowable and far less predictable because you don't know exactly when the traffic lights are going to change. You don't know that another car is going to break down, there's going to be a massive queue behind it. You don't know that a child's going to run out in front of your car. That's a much more complex situation because it's not as knowable, it's not as predictable. And that's what healthcare is like. And we always say that healthcare is the most complex industry in the world. I'm talking about human healthcare. And I can speak to my patients and they're only one species, so y'know, how complex is my world compared to yours?

And the thing about complex problems is that they need complex solutions. The problem is when we try to shoehorn in a simple solution to a complex problem. And if you actually want to solve complex problems, there's lots of advice around how you do that. But these four points in particular [indicates slide]: you have to seek the solution from the people at the front line - the people that are most effected

by the issue. And those people are the people who are delivering the care at the point of delivery, and the people who are receiving care at the point of delivery. You have to focus on the relationships between people, because that's where things fall down a lot of the time. As leaders, you can't really pretend that you can sit in an office, removed from where the actual front line work is going on, and just direct things, because it's too complex. You can't possibly know the complexity and the challenges around all of that. And you can't then protocolise everything, you have to have some flexibility. So you have to think about minimum specs. What's the minimum standard we're looking for here? And then allow a bit of flexibility for people to practice and use their judgement.

So complex problems require complex solutions. And that means it is about [indicates slide] - don't worry, you don't have to read that. Um, complex problems require complex solutions and a lot of that requires us to engage with people. And so it is all about people. This is a quote from Victor Montori, who's a professor of Medicine in the Mayo Clinic. The Mayo Clinic is a big American healthcare organisation and very well known for their focus on staff wellbeing. I'll break down some of the things that he has said. He says healthcare is a bit different in some ways because it's about caring and learning - it's a caring and learning system. And in that way the care is delivered by people, so it's driven by people.

We have systems and technology in place, and all of that should be there to back people up and support people. And I don't know what your patient administration systems are like, but ours don't always feel like they're doing that. And if you then surround those people by a culture that is not supportive, does not feed their motivation for being there in the first place, does not make them feel like they're doing the job they were trained to do, then you will wear them out, and there will be a spent force in your system. And if you think about it, it's your people that are the final common part of any pathway of whatever you are trying to deliver. That person, that last person who's actually delivering the care, is the face of your system. So if you treated the person well, then you can have confidence that your system is delivering something that is high quality. But it's all about people.

And if you keep grinding down, and if people keep feeling like they're not doing the job they were trained to do, they're not getting the satisfaction, you end up with people who are burning out. And when we look at what that means – what does it mean to someone to be burnt out? This starts to come out in people: exhaustion, a detachment. You imagine somebody that's supposed to be caring for someone, who is detached and callous and uncaring, because the system has ground them down. And that is a huge issue within human healthcare. And I don't know what kind of issue is within your world as well, but that is a massive problem. And at a system level, if we get it wrong across a whole system, then you end up with something like the Mid Staffs [Mid Staffordshire hospital] situation, that you may know or may not know about within the NHS, where a whole system was failing.

So how do we change? Sounds a bit depressing, doesn't it? But how can we change and how can we do things better? Even within that system, how can we do things better? Because in NHS Tayside, there are pockets of excellence, and there are pockets where we're doing things brilliantly, but they're also pockets that still need to get better. And that's the same with every big system and every organisation.

But how do we change? It helps to have the right methods to use with your teams on the front line, but it also helps to actually have some national permission to do it differently. And it helps to have a

national permission that kind of counterbalances that pressure that is on targets, and on finance. That counterbalances it with a pressure for quality and experience. And I think that's what we're trying to do in Scotland with Realistic Medicine.

So Realistic Medicine is rolling out across all clinical professions now in Scotland and we're being asked to think differently about the care that we deliver. We are being asked to think about shared decision-making differently, thinking about a personalised approach to the care that we're providing. And you'd like to think that in human healthcare, where you can actually speak to the person you're trying to care for, that would be self-evident. But actually when you're working in a system that just wants you to process, it's not actually.

I have to stop and do this: [indicates slide] reduce waste and harm, unnecessary variation in outcomes – why do we have them? How can we look at them differently? How do we all become improvers and innovators? And we do it by supporting our workforce. What's become evident is – it's great to have that strategy, but it's about people. So you have to support your workforce and you have to do that with some compassionate leadership. And so as well as just focusing on those six things, we're now focusing on the groundwork to get people in a place to engage. So that's good. So that's national permission. It's great to have that. We're still left with that question of, "How do I get my team to do what I want them to do?"

So here we're getting into the area of where we can give you some tips that might be helpful. Firstly, let's just change the question. Because clearly that is not the right question. The question should be, how do I enable my team? And how do I enable my team to realise their potential? How do I get them to realise their potential, work with a sense of purpose, and get that sense of wellbeing at work? So that they deliver high quality and high value care. A bit more of a mouthful, admittedly. But, that's really what we should be aiming to do. So let's get the question right in the first place. And before we set off on the five different tips, let's talk a bit about the basics.

So this is Maslow's Hierarchy of Needs, which gives you a sense of how you can maybe get people in your team to that point where they're fully engaged, they're coming forward with ideas, and they're really proactive. Actually, they can get to that point if they feel some sense of accomplishment and have prestige. If they have pride in what they're doing, feel like they belong to a team, feel like they belong to something they can believe in. And that's the thing that we could maybe look at in the next five points. But before that even, there are some very basic needs that you need to ask yourself about. About the people that you're working with, in the area you're working in.

Basic needs around physiological wellbeing - and that is obvious - you've got to be warm, you've got to be hydrated. We know that if you begin to become dehydrated, your cognitive function starts to fall away as well. And you have issues around patient safety, and the safety of your decision-making. So clearly it must be self-evident that we would provide water to people. But just last week I heard about a theatre in our area where they'd taken away the drinking fountain, the plastic bottle, but hadn't replaced it with anything. And so there's no easy access to water, in theatre, for people that are going in and out between cases.

Simple things like that need to be dealt with, before we can get into the more complex stuff. Safety! I work in an A&E department. We have good relations with security and the police, just in case we need them. We don't need them very often. If we did need them, at least our staff know that we can access them quickly. That kind of thing needs to be sorted out first. So I'm not going to speak any more about that. The rest is really about how you then build the rest on top of it.

[1. Unleashing Intrinsic Motivation]

So the first point would be how do we unleash intrinsic motivation? How do we get to the basis of 'why'. Some of you may have read this book in the past: Simon Sinek and *Start With Why*. And it is really about connecting with what motivates people to come to work. And he speaks about companies understanding what they do, understanding how they do it, but not really understanding why the people who work there are coming to work every day. And he uses Apple as an example.

And so what we mean by the 'what' for Apple? The 'what' for Apple is we produce great computers and we want to sell you a computer. How do Apple do it? Well, they design amazing products. They use all these aluminium bodies and it looks great, it feels great, it feels different to other computers. And it's reliable. That's the 'how'. That's not the reason that people go to work for Apple. The people that go to work for Apple, don't go to work for Apple because they want to sell computers, is the idea. The idea is they go to work for Apple because they believe in challenging the status quo. They've had enough of their old PCs. They didn't like them. They want to do things differently. They have design thoughts. They want to design differently, they want to be innovative, they want to challenge the status quo. And they want to think differently, and they want to be supported in thinking differently. That's why they work for Apple. So it's about the 'why'.

The trouble is you've got big teams. I've got a hundred people in our team, and we don't all have the same 'why'. So we have different personality types in our team. So [indicating slide] the bit on the right there is the kind of Myers-Briggs personality types. And there's many different ways of typing your personality. I'm an INTJ and the first thing anybody does when they get their Myers-Briggs personality type is immediately the first thing you do is find out what Star Wars character you are. [audience laughter] So that's the first thing you do.

So I went in, thinking, "Yes! Han Solo. Luke Skywalker, Princess Leia. That'd be fine. One of the heroes." I'm Palpatine [audience laughter] but I have to work with people that are Han Solo and people that are Princess Leia and people that are Luke Skywalker and people who are Jar Jar Binks. Right. So I have to work with that range of folk. But what I need to do is find the commonality between all of those people. What motivates all of those people? And it starts with a relatively simple question and it starts with asking people what matters to them. We do this on a regular basis in the department to just keep in contact with each other. We've had a lot of new staff starting and it's just to understand what motivates people to come to work.

And when you're having the, "What matters to you?" conversation around what motivates them, then you need to look out for the answers. It has to be a reasonably structured conversation. This is Marshall Ganz. Marshall Ganz is a leader in the American Civil Rights movement. His expertise is in mobilising people and understanding their motivations so you can mobilise them. He's credited for a lot of the

design of Obama's first presidential campaign, if you remember that. So he kind of knows what he's talking about. And he would suggest that when you're having these conversations, these are the things you should be wondering around.

It should be, what's your story? What matters to you personally? What's important to you? But also what's important to you now? Why is it important now and why are we important to you? Why is your place in this team important? Or your place in this group important. So you ask the question, pick out the answers, and pick out what is actually motivating factors and bring them together as a team and create a vision. Create a vision for your practice. Create a vision for your department. Create a vision that people can get behind. And that then allows you to start to engage people in improvement work.

[2. Courageous Conversations]

Number two: courageous conversations. Because if you're going to start asking people what matters to them, you may as well be ready for the responses sometimes. And when you start discussing improvement ideas, you will get a huge variety of responses. [indicates slide] So this is the diffusion curve idea where, what you have is a lot of people that will say, "Yeah! Really enthusiastic. Yeah. And we could do that and we could do this." Then you'll get some people who say, "Yeah, but maybe we could do that differently or we could do this a different way." And then there's some people, I don't like the term laggards, but there are some people who would be termed "I don't think so. Not going to work." Real mood-hoovers in the room.

Everybody has them. Everybody recognises it. But the real skill is knowing that actually you can't surround yourself with people that say "Yes and--". If you surround yourself with people that say, "Yes and--", it's great, you'll feel amazing. But effectively you're getting groupthink. You're getting just consensus without any critical evaluation of your idea. So you have to engage with people along the curve. And you'll think there are some really difficult personalities in there. You're right.

So maybe the next question is, do you need to actually engage with all of them? And so when you're planning your improvement effort, it's sometimes useful to have a grid like this [indicates slide] where you're kind of gauging how impactful that person might be. And what power they have in the system that you're trying to change. And we sometimes get Post-its and put people's names up and work out where they sit in these grids. And then work out how closely we need to actually keep them informed, how closely they need to be part of the team. So you don't necessarily have to have the same level of conversation with everybody. So work that out.

And then think to yourself, if I'm getting a bit of a reaction, what is it that I've triggered in that person? So this is Cathy MacDonald, she's one of the people that comes to teach on the Fellowship Programme. Cathy is an ex-police officer and her specialist area in the police was hostage negotiation, but also just crisis negotiation. So people threatening suicide, people threatening to jump off a bridge, that kind of thing. She would be the person that would go and speak to them. So she knows what to look out for, when you're having these difficult conversations, and you've flicked something within them. She talks about core emotional needs and everybody has these core emotional needs. And if things aren't being received well, have you threatened one of the core emotional needs? The need to be appreciated, the need for some autonomy, the need for affiliation. A sense of belonging, sense of the role, your purpose

and your status is important to everybody. And just think about what you've said, and how you framed your question.

And finally, courageous conversations are important, but also don't get too upset when you have the first conversation and it hasn't gone well. Because sometimes it is just a phase. It's well known that, actually, the reaction to change is a bit like a grief reaction for some people. They are so used to the status quo, that when you start to give it up, they actually go through something akin to a grief reaction. They have some anger, they have some frustration, they're not sure why we have to change. You have to work your way through that with them. And that might mean conversations outside of the group, one-to-ones in an office somewhere. But you just stick with it and give them the time to come to terms with it. Maybe show them some quick wins. And then maybe we start to move through the transitions.

So from all of that, some practical tips would be: don't have accidental conversations with people. When you think you're going to have a difficult conversation, have a planned conversation, give it the time, give it the space. Set out a room, go and sit down, get away from the crowd, make sure you're not going to be interrupted. Be open and be honest. Don't try and bend everything to their will and don't be so rigid that you're not willing to listen to what their view is. And listen for the emotion behind their response, and try and spot what you may have triggered.

[3. Co-design]

Third is co-design. So I work in Dundee, and Dundee is a UNESCO City of Design, believe it or not. I didn't know that until a few months ago. There's a UNESCO City of Design. We have a lot of design expertise in Dundee. It's got a great reputation actually. We've got a lot of people that are interested in service design as a particular discipline. And this is from the Design Council. [indicates slide] This is the Double Diamond approach.

What often happens in improvement is that – which is why you end up with that first question we spoke about – is that you come up with an idea that you want to test. And you come up with a smart aim around the idea that you want to test. The problem is, you haven't done this bit [indicates slide]. So the Double Diamond would suggest that what you don't start with, is an idea of what you want to test. You start off by trying to define the problem that you're trying to solve. And you go through a phase of discovery, where you engage with more and more people that are affected by it directly, as we spoke about with complexity. You ask all those people, gather their views, and then come back in to decide what your aim might be. So it's that first bit of the Double Diamond that we're not very good at.

So in ED we wanted to find out what the patient experience was, and we spoke about it as a team, and we decided that the patients probably were going to complain about waiting times. We don't even have bad waiting times, but we expected complaints about waiting times, complaints about the attitudes of staff, and maybe the cleanliness of the department. But that was us starting here in the middle [indicates slide] and deciding what we thought the problem was and then beginning to design solutions around our perceived issue. We started here, so we actually got some students and they actually sat in the waiting room and had conversations with people. And what we found is that people loved the staff, people loved the treatment they got. People thought everything was spotless and clean. They weren't bothered by a bit of mud the floor because somebody's just been in there with their boots on. They

expected to wait, they didn't mind waiting. They understood that there would be some people coming in that were more urgent than them, that had to be seen first.

But the big thing about the waiting thing is that they were bored. They were bored whilst they were waiting and they didn't know what the next step of the process was. So instead of working on how you reduce waiting times, in a department that already does pretty well at that, we started working on wall art that described the process of coming through an A&E department. What you might expect to happen next, what the different coloured uniforms mean. And now we've got an animation to describe what going through an A&E department is like. And we can start to broadcast that in the waiting room, as something to look at. If we hadn't done it this way, we would have come up with all the wrong solutions because we were looking at the wrong problem.

[4. Dynamic Improvement]

Dynamic Improvement, very briefly, this is not a talk about improvement science and how to apply it. Essentially dynamic improvement means using improvement science, and it means getting the team involved in testing things. Small tests of change with dynamic measurements, so you can see changes from week to week and you can feel like you're doing something. You're not saying something, doing an audit, and then several months later, after no one is sure what's happened in between, re-auditing it. You're doing something that's far more dynamic and far more involving than that.

[5. Distribute Power]

And finally – and it should come from everything that's come before – is the idea that you distribute power. And that trying to improve things is not something you hold close to you, it's something you distribute. Because power is relational. We spoke about relationships, the importance of those relationships as a part of a complexity. And actually power, in this sense, is generated by people believing that they have the ability to act, both individually and together, against a common goal to improve the quality that they're providing. That's the power you're trying to create.

And so if you're trying to do that, you need to ask yourself some questions. What change are we looking for? What is the problem we're trying to fix? Who has the knowledge? And it's usually the people who are directly affected by it. What did they want to see changed? Not, what do I want to see change. And what help do they need from me to enable that change? Is it my knowledge of methodology? Is it a contact I have in a business unit, that can provide them with data that they don't know how to get otherwise? And then give them the power to change.

So as a large scale example - just cos lots of improvement things talk about individual projects in individual areas. We'd done this on a larger scale, looking at unscheduled care in medicine in Tayside. So unscheduled care in medicine means people becoming unwell unexpectedly and ending up in hospital. Particularly illness coming into hospital, infections, et cetera. And it's the typical thing you see on the news. People queuing outside of departments on ambulances, on trolleys inside of A&E departments, being boarded to other wards. Because if you don't have enough beds, you end up with a medical problem, but being looked after by an orthopaedic team in an orthopaedic ward. All poor quality experience for people. So that's typical unscheduled care. So we thought we'd try to do this differently. And so we engaged with the people that deliver that care, the individual teams and say, "What is it you

think needs to change?", against this overarching vision of making sure people aren't on trolleys and aren't boarded out and are in the place they need to be, if they need to be there.

And so we've got about 50 improvement projects. We devolved responsibility for those improvement projects. We said these ones are in keeping with this overarching vision, so let's run these 50 improvement projects. That's 18 months, two years of work. So we've gone from where we used to be, to this. [indicates slide] So we're in a system that has an ageing population, has multiple complex needs, where the rest of every other board is seeing increasing demand.

We've seen 8% reduction in referrals to hospital because we've worked with primary care. We've seen far more people discharged immediately, within 24, 48 hours, so they don't end up in a big inpatient ward and habituated to being in hospital. 90% reduction in Medical Boarders. So that's the people that end up in the wrong ward. Actually, we've gone from having 110% occupancy of the beds, down to 90% occupancy with 12 fewer beds. It made the whole system much more efficient, effective, productive, but delivering high quality care with a better experience for patients and staff. And so it kind of brings the entire thing back together, in terms of what you need to do is engage your teams. And then you have the financial benefit, by focusing on the quality.

So just briefly to recap, we have five tips. I thought maybe we could just turn them into lay terms. And so under the 'Unleashing Intrinsic Motivation', which is very grand sounding, essentially means talking about quality. Because that's what essentially starts to matter to people. When you ask the question, that's what they really want. 'Courageous Conversations' is really just be open and honest and respectful. 'Co-design', let's understand the problem before we go in with a solution. 'Dynamic Improvement', let's inject some energy and let's make people feel like they're involved on a regular basis in what's going on. And 'Distribute Power', let's trust and support our colleagues to deliver what we want them to deliver, and what they want to deliver.

And at the end of all of that, if we managed to do that, then hopefully we end up with a happy team. So this is our team. [indicates slide] This is the ED team from Ninewells Hospital in Dundee out for our Christmas night out. And I can tell you we were in a lot worse state than you are this morning the following day. [audience laughter] But if you have a really engaged team, who are really committed to quality, who are supported and doing what they do, then you'll hopefully end up with happier patients and happier families around it. So hopefully that's been useful, even though I come from human healthcare. Hopefully that's been useful for you and obviously I'm happy to take questions. Thank you. [applause]

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