QI, Safety Systems and Just Culture in the NHS

Margaret Mary Devaney and Anita Malana

Margaret Mary

Good morning guys, it's a real real privilege to be here. My name is Margaret Mary. So I work in the NHS and I hope the next 30-35 minutes gives a nice flavour of our experiences of trying to implement quality improvement, build capability, the capacity things that Tom's just touched on and all within a safer system and a just culture and I'll explain kind of what that's meant to us recently in our experiences. With me is Anita. I'm really, really chuffed to bits that she can make it today, because up until yesterday I didn't know for definite if she could. And she's very courageously going to share a story with you and with us around her experience of being part of a just culture, having the courage to take quality improvement forward and actually what that's meant for her as a person, her team and our patients. So thank you Anita.

Okay, so how do we approach improvement in NHS at the minute? Normally it's for the wrong reasons, normally it's because of external scrutiny or you know there's some pressures for our regulators, commissioners to tell us we need to improve which is really not a good starting point to take quality improvement forward. We have learned as we've been involved in things that actually your intrinsic motivation to do these things is way more powerful and keeping it patient focused, team focused, person focused is 10 million steps ahead to get by and win hearts and minds. And actually people will be motivated and bought in to do this right from the off. But often in the system that we work in the NHS, we don't always have that privilege. We really need to fight for that and have that voice, which can be a tough cookie sometimes.

So just to give you an example, my personal experience of taking forward quality improvement was from the death of a 23-year-old girl. We missed sepsis in her and she was dead 40 hours later. As an organisation we were asked to just improve sepsis. I've given you an example here that might resonate with you, to reduce the number of safety incidents related to surgical site infections for example. So just redesign your antibiotic stewardship, that sounds quite easy, that should be quite easy to do, we'll reduce our surgical site infections. That was kind of our story with sepsis. Just tell people to do sepsis and manage sepsis better.

But wow, it's really not that simple, you know, I don't know any healthcare professional and I've worked in many organisations now who are trying to do this type of stuff, who have ever, ever come out of it said, that was an easy job, we should have done that a long time ago. It's more like this.

To get where you need to go is messy and it's complicated and there's systems and processes that you have not got a clue that you're going to be interacting with. And it's overwhelming. You know, where do you start when things are so, so tough and so complicated to get through. There's people's behaviours, a whole science in itself. There's the capability that Tom's touched on. Where are our skills and knowledge to do this? Some of us are absolutely brilliant clinicians, but quality improvement's a whole other kind of set of tools that we needed to learn. And then there's all the different layers in the system. So we have teams, divisions, specialities, executives, sites, groups, you know, it goes on and on and on. So to do this and do it well, and learn as we are going is really, really complicated and things are changing all the time around about you. So you need to be quite agile in understanding where your system's kind of going. So it is messy and it is hard work, but it can be done and it's really rewarding when it is done well.

So we've kind of learned that we need to move away from the kind of scrutiny, you must do type attitude. And I've sat in lots of meetings in the NHS where really nice, sensible people have come up with a brilliant plan and just told people to do it. And then, you know, come back a year later and say, well, why didn't that work? We told you what to do. And we're working differently now. So we're in meetings designing things, thinking about things, asking ourselves, do we get the right people around the table to help us understand what the problems are, not necessarily the most senior people all the time. And we are asking for design and testing. It's not going to work the first time. It's definitely not going to work the second or third. This is iterative learning, and it's snowball so you get to the right place. And with data helping you drive things forward, you can understand where your variation is, where things are good, where things need to improve. And eventually over time through this kind of iterative cycle, you have got a package of whatever it is you're trying to improve that you can implement. So it takes smaller, more regular meetings that work a bit differently and as I said, are a bit more agile to actually the need of what you're trying to do. So our improvement meetings look completely different now from our kind of executive board meetings to help try and do this type of stuff.

We always ask ourselves these key questions. Do we know how good we are now? Have we got any data? Have we got any patient stories? What are our staff telling us? Who's doing this really well? What's the hospital down the road doing? What's the ward next door doing? How can we understand how we perform or how our quality is in comparison to them? Do we understand where our variation is? There's variation in this room. We're all different heights, ages, sexes. Variation exists, that's normal. Where can you help reduce it where you want to improve quality? So reducing that unwanted variation. So we're always looking for that in the system. And how will we tell our story over time? Because we're going to make all this effort

to be testing, designing, and engaging people and taking things forward. We need to measure as we're going. And that can be really simple, as long as you can capture the right data as you go.

And this is where I am in a new organisation at the minute and this is, they're very similar to you guys, they're just embarking on a quality improvement journey and this is the type of things that they're seeing. So they're so hungry for this but they just need some guidance and understanding of what it's going to look and feel like for them. So this is a whole new system, whole new hospital, different cultures, different peoples, but they've got the same frustrations as the hospitals that I've worked in before. You know, their CEO is desperate for them to just excel and really celebrate the potential that he can see in them. You've got really good clinicians who are saying, I just want to do this better, why is it not working? And the biggest frustration is sustainability. We do this stuff and then we go back and we have a look and it's just not worked. So they've not taken the time to really do the small test of changes. We're going to understand that it is going to work. And I'm sure that's the same in your teams, in your clinics, of people wanting to do the best that they can.

I thought I would share a recent publication from the Chief Executive of the Surrey and Sussex Healthcare Trust. Today we have a CQC, that's one of our regulator bodies, and his organisation was performance management is inadequate, maybe a few years ago, and over the space of about five or seven years, he's taken it to outstanding, which is absolutely phenomenal. The type of quality metrics they've had to change across the organisation must be huge to move from inadequate to outstanding. And this is his statement. He's gone to his people. He said, how can we make this better? You're closest to our patients and our systems. I'm giving you permission. I'm giving you authority to do this. Fail but fail fast. You need to give people the permission to give something a go, expect it not to work, but crack on and move on and learn from that and look after each other. And what he's seen is his patients have had better outcomes and that was recognised from his regulator.

So where to start? There's five P's we talk about a lot. Purpose, processes, patients, professionals, patterns, that's the data. We've touched on this a little. The purpose is so important. I think in healthcare, in our healthcare system, it's really easy to get caught up in efficiency and targets and scrutiny and stuff like that. And that can be totally overwhelming on a day-to-day basis. But the purpose of quality improvement, whatever, no matter how small or how big the project is, it's fundamental to it working. And there's know, kind of key drivers that need to be in position for that to happen. And you know, what is our strategy? What does your boss think? How's this going to work? How's it going to be supported? And who are your workforce are going to help do this? And that means the whole workforce, not just execs, not

just the doctors, not just the surgeons. This means the porters, this means the admin staff, this means the domestic staff. So you're really infiltrating the whole system and trying to understand how you can push quality from every single angle.

So thought I'd share one example. This is old data, but really, really powerful. The theory is exactly the same. Healthcare Improvement Scotland, many years ago, so 2012, you can see the data, ventilator-associated pneumonias had a really, really high death rate. And actually now, in 2019, you can't imagine people dying from just being on a ventilator. And actually, the purple bars are pneumonia, pneumonia, pneumonia, pneumonia, happening over time. So they were measuring it in their intensive care unit, and they were so frustrated around why does this keep happening to our patients? And in Europe, this bundle had been designed, evidence-based, tested, and published. The bundle was so simple. It was putting a checklist at the end of the bed, elevating the bed slightly, adding some humidification to the ventilation, suctioning more regularly, some physiotherapy. So not anything that cost a lot of money, just really simple tweaks. But to do them all together in a bundle took time, and it took working differently, and it took challenging hierarchy.

It took teamwork and people thinking differently. So you can see over time all the wee boxes was then annotating the changes that they were making. The blue dots then getting more reliable at the bundle. So as reliability got better, you can see at the bottom, the days since an actual ventilator acquired pneumonia just got more and more and more. The two blue dots at the far end incidentally were audits that they used to do. So they used to measure, they used to do a point prevalence and measure themselves but they weren't seeing any improvement. So only by small samples and keeping it nice and simple and measuring over time did they start to see the improvement that they wanted.

So why do we need QI? Because we don't know the answers to many, many challenges that we're trying to do. But the staff who are at the front line know that something's not right most of the time. So it's listening to that and picking up on that. Solutions that, you know, we always say in quality improvement, you discover. You just don't know at the time, but you discover what the solution is as you go. It's important to legitimise failing and testing in that culture of give it a go and learn and see how we got on as opposed to keeping things in a box all the time and start small is fundamental to big changes.

So the other wee thing we wanted to talk about today is how do we apply that in a world of safety critical systems like your healthcare systems and ours. And this is a model from the Institute of Healthcare Improvement, IHI. It's a white paper that's been really embraced by senior leaders in the NHS.

And I think it demonstrates brilliantly the two kind of interlinked pieces of the jigsaw that we need to understand how we're going to improve and make our system safer. So you'll see there's different kind of domains within a learning system and hugely encompassed by culture. And culture's not going to be covered in the next 10 minutes by us. We will touch on it. But it's complicated, but it's so powerful to how we do things, how things feel, how we manage things, how we look after each other, how we communicate. And you'll see over in the top left-hand corner that the two where the whole kind jigsaw overlaps is leadership. And as nurses, we've often seen leaders being the senior people and actually through quality improvement, we've grew to understand that leadership is everybody's job, everybody has got responsibility to be leading quality improvement and contributing to the culture and the learning system to help improve.

Because when we don't engage, most quality improvement projects fail because of people. So it's normally not because of budgets. It's not normally because, technically, because of an infrastructure thing. Its permission and its roles and its behaviours, all these things are way more influential. And you can see here 70 % of quality improvement projects fail because of the people involved in the culture aspects.

Part of our work in the past was working alongside UCL's behavioural science unit, UCH's behavioural science unit, and we learnt a lot around how to improve the compliance with our sepsis bundle, capability, motivation, opportunity, three nice simple words that do influence behaviour remarkably. And we, through understanding and studying that alongside Professor Susan Meakey, understood the complexities of what we were trying to do to try and get people to change and come with you can be a really tough nut to crack. And we learned all these sorts of stuff. So we had our sepsis bundle compliance about 40%. So 40 % of our patients who came to ED presenting a sepsis got the bundle and did it well. 60 % weren't. So we started working with Susan to understand how this could be rectified. And this is where it took us. This blew our mind, literally. So we were now talking about how do nurses see doctors? How do doctors see nurses? How do people believe in these things? How do we get them to believe in it? What knowledge have they got? What kind of social beliefs do they have about how all interlinks?

This was absolutely fascinating and a two-year piece of work to understand how we could tackle these type of things to improve. And through doing that, we got the sepsis bundle compliance to 80 % just by working with people's behaviours a wee bit differently.

And it's, you know, most of you have heard of somebody called James Reason. He studied safety systems in depth and he talks about all the influencing things and systems and where it starts and stops. I touched on this earlier. But for us, our micro system, where it all starts and

stops is our patient. And then we're now learning that we need to look after each other, our staff a wee bit better. But when incidents do happen, our patients are involved, our families are involved, our staff are involved. And then we also have our commissioners and our regulators as well. So there's multifactorial things that are happening around us that are contributing to the complexity of it. And reporting is not easy. So another kind of improvement guru, Edward Deming, said, ‘without data, you're just another person with an opinion’, which does make me still giggle. And he's totally right. And I've sat in lots of meetings where they're like, yeah, well, that's not the case. And you're like, well, have you got any data?

We need to report. We don't know how to learn from safety incidents if we're not reporting. We need to understand where they're happening, when they're happening, who they're happening to, why they're happening, etc. So reporting is good. It does strengthen our safety management system. It doesn't mean it's perfect, but it does strengthen it. It helps us raise awareness, identify where our risks are so you can try and proactively mitigate against them. And it just makes the whole thing really rich for learning to try and manage to do your job safely.

But it does bring some problems. People sometimes are still scared to report. There's still a fear of judgment. There's still a fear of the wrong information. We talk about formal and informal culture a lot in the NHS. know, rumours start when things are reported. What does it mean? And people start to kind of add arms and legs onto stories. Some people stop the reporting at a certain level and it doesn't go exactly where it needs to go, potentially. And all that of course limits your ability to tell your story in your picture and understand it and obviously it limits your ability to drive improvement.

So we have learned and seen and witnessed the huge impact that this has on staff and actually nationally through the National Sign Up to Safety campaign. I'm going to share some data with you that they have learned nationally around the impact of people not being nice to each other to put it in a nutshell, particularly when incidents happen because it's devastating.

So this is from the Sign Up to Safety campaign and actually it ran for five years over the whole of England and Wales and in the end, the learning and the publications and the sharing hasn't been around reduction in harm. That has happened a lot in a lot of places which is brilliant. The biggest learning has been if we don't look after ourselves and each other, how can we possibly look after our patients well?

To make our patients safer, we need to look after ourselves and each other. And when you speak to somebody like Susette Woodward who led this programme, she's like, you know, I knew I knew this, but I didn't know it was going to be that powerful by the time we'd studied

this for five years. And it's because of stuff like this. So there's a web page called Civility Saves Lives. And people have produced overwhelming evidence to tell us that incivility, so being rude, being unkind, bullying, harassment, all the type of things that are making a lot of NHS headline news at the minute, have a catastrophic effect on your ability to do your job well.

80% of recipients worry if they've been a victim of rudeness, they worry about it. You go home worrying about it, you worry about it throughout your shift, you worry about it the next day. 38 % have a marked reduction in the quality of the work that they can do. So you can see the facts there for yourself. 75 % of our service users don't want to go back to that hospital. That's it. They've lost trust. They've lost belief in it. And witnesses, we talk a lot around the bystander. So even if you're not directly involved, if you've seen it, cognitively you're changing. Your ability to concentrate and go on and do your job well has already changed. And these are fascinating facts that we are now trying to bring into the way we work and drive quality improvement.

So what do we mean by just culture? So we've kind of had lots of poor examples of people not being able to speak up in the NHS. And actually our focus now is to really try and break those barriers. Remember the complexities I've just described. How do we break down those barriers to allow people to speak up freely without judgment? And there's lots of guidance out there, but there's kind key top tips across five questions, which really are useful to help us ask ourselves as professionals, is this a deliberate harm? 99.9 % of the time the answer is no. So we should be thinking and asking different questions. So was there a health test, i.e. was that person fit to be at work or that team, whoever was involved, you know, were they unwell? Have they just had their 10th night shift in a row? All these type of health questions that are really relevant to when errors and lapses happen.

The foresight test is if we knew that there was health problems or health potential health problems, et cetera. What did we do about it? Did we know about it and did nothing or how were we proactively trying to mitigate against that? Yeah, so these questions take us through just understanding, in the wider system, how have we looked after each other and mitigated against things that that's happening as opposed to blame. So it's some guidance there and it's easily available online.

What Just Culture asks us to do is to try and learn a bit differently. It tries to encourage us to learn from a restorative point of view. And what that really means is instead of saying, what policy wasn't adhered to, and how are we going to reprimand them, and what consequences are we going to embed, we really need to understand who's been hurt. Our first and foremost priority is always our patient, but very close to that is a member of staff and a member of

family. So who is that person and what are their needs? So we've really changed the way we look at account... we're trying to change the way we look at accountability from who's to blame in the past and how can we reprimand them to whose job is it now to make this better? Whose job is it now to take this learning forward? And how are we going to do that? And this is really, there's loads of really good books from Sydney Decker, again, another kind of guru who's studied safety systems and other industries as well as healthcare.

What does it mean to start thinking differently about this? Well, it means that staff are in a better space to proactively give an account of what's happened. They're then in a space where they can be really authentic and really honest about what's happened without the fear of judgment and reprobation. They're repaying the organisation because they can tell their story. They can say sorry. That's really important to staff when things like this happen. To colleagues, to patients, to families. It's a way of really acknowledging responsibility and it really helps them be in a place where they can look forward to trying to make it better. The organisation gets phenomenal learning by just understanding if they can empower and embed a learning culture like this. They build trust with staff and they get phenomenal learning to help them try and prevent stuff like this happening in the future.

So that's whistle-stop of headline messages from me. I'm going to hand over to lovely Anita, who's going to share her quite sensitive but amazing story around an era that she was involved in in theatres, which I think might resonate with a few of you guys today.

Anita Malana

Good morning, my name is Anita. I wanted to tell you my story. This happened last year, 5th of January. So I was on a night shift, 8 o'clock in the evening. As soon as I come in, I have the consultant surgeon, liver surgeon saying, can we sign for patient? Then at the same time, handover happening, there's emergency theatres open, there's this liver transplant. There's vascular theatre and there's labour ward theatre happening with four regular staff at that time. And we asked the on-call to stay, so that's five. So on the daytime, we will have at least three staffs in a room. So just imagine these four theatres happening at the same time, so we need 12 and there's only five of us. So that's that. And I started that shift as a coordinator, meaning I'm in charge of the department.

But because my colleague does not work with the surgeon because she finds that surgeon...probably prior to that day that he's very rude. She then said to me, Anita, I don't want to scrub. If he's scrubbing, I'm not scrubbing, then you scrub. And then Anita said, okay, I will do that. At the same time, when you're the room manager or when you're running the department, your head is to...my mindset at that time is that I'm running the department. So

then to switch into being a scrub nurse is obviously totally different. Anyhow, at eight o'clock I went into the liver transplant theatres. The consultant surgeon started looking at the liver. We did the bench work. The specimen, the liver itself is not very good.

We have the patient at that time, said hello to the patient. She's really, really, really lovely, lovely patient. And I'm going to apologize now, because whenever I tell this story, my voice shakes. I think it's just, the event for me is really still embedded. But before, I cry. I promise you, I'm not going to cry this time. It's just that it's so, to talk about it, it's therapeutic for me. But to go through that, obviously it's hard. I don't know guys if you can relate with that. Anyhow, I'll just carry on. So...

At that time, so from eight o'clock till 10 o'clock, the surgeons doing their bench work. We have a patient at that time as well, but it's not appropriate for a patient to be obviously seeing the liver. So we took her to recovery. At 10 o'clock, two consultants said to us, so two consultants, two registrars said to us, okay, we will carry on, we will do the surgery. At 10 o'clock, from recovery patient back into the liver theatre. Started the procedure. We have two consultants, I don't know who's operating, so your preference is different from his preference. It's like that. So I don't know which one to prepare for the surgeon. Then eventually we found out who's operating. We started the surgery at 10 o'clock in the evening. Did a transplant until five o'clock. No break. So around five o'clock I was so tired and I asked my colleague if somebody can relieve me. But at the same time, it's appropriate to have a handover at that time because we finished the transplant, we're just closing. And at the beginning, we're missing two swabs, two small swabs. And I said to the surgeon, I'm missing two swabs, two small swabs. He lifted the liver, he found two swabs. So that's that. Then counted the needles. I'm supposed to have 151 needles, then I can only, I counted 149. Counted it again until three times. I said, my gosh, I'm going to faint soon. I feel like 5 % battery and that's it. I'm going to faint soon. So I said, I need somebody to take over for me because I just feel really dizzy. And then at that time, another colleague of mine was really nice. She took over. So I counted, we found a needle under my trolley. So that's all correct. And she took over for 10 minutes. And then I came back after 10 minutes and the surgery's finished. So that's that. So that's what happened at Thursday evening. Then Sunday the patient came back for evacuation of hematoma. And that's when they found out there's a craniotomy swab or a medium swab just underneath the fascia. Just when they were closing, normally the practice is for them to put the swabs for the, what do call this, the guts? What's the professional term for...the colon. For the colon to be out of the way so that we don't perforate it.

So anyhow, for the coordinator at that time telling me, the patient that you scrubbed for, she came back with a swab. So at that time, my gosh, I said, what happened? Because I don't know.

Then obviously talking about just culture, Sunday, all this gossip basically, they created stories after stories from what they think happened at that time. And as a senior member of the team, it's kind of when you see people talking about it. And you know, I do feel it that they're talking about this swab. So it's a big, it's quantified as a never event. Investigation happened. What happened to me at that time? I did not sleep for three days, and I had blisters and rashes everywhere from head to toe. My colleague is my witness. And it's not nice actually, but having that experience...What matters to me is to be asked, how are you, Anita? It matters to everyone who's been involved in this situation is to know how is that person. We need to know is that person is, I work for two weeks, I work like a zombie for two weeks. And MM (Margaret Mary) would come to me, how are you, Anita? I would just say, I'm fine. And I just said to MM this morning, whenever I see, at that time, whenever I see her email, I could not open it without crying because it's that sensitive for me and it's really heartbreaking for me to be, I did not want it to happen, but it happened, you know.

Well, the learning from that never events, going through so many interviews and investigation and all that, I knew that we needed to improve our communication. Our department, between eight till six, is 130 staff, and 21 theatres, on a good day can be 19, but it's a lot. A lot of people to communicate to, and a lot of people to explain what's happening.

So I just want to tackle four things with the learning from that never event. Improve communication, situational awareness, psychological safety, and culture. Hence, last year we did this QI work. I know that we really needed it in the department. We needed to improve this. So we started this theatre safety huddle. So last year September, our aim, having to target the four things that I know that we needed to improve. So, to have 19 theatres, we wanted to improve communication. So we have this 10 minutes meeting. And as you said this morning, it's always difficult to find the right time. We start at eight o'clock, we finish at six, and there's no way that we're going to be quiet. We're always busy.

8:20, we start at 8:20. It's a 10 minute meeting where the whole, the theatre team would come and attend the meeting and say, I am good to go. I have a problem with my theatre. I have a skill mix issue. I have equipment issue. And to tackle psychological safety for a staff to say, I am not happy. I have a skill mix issue. I am not happy with my colleague. Let's just say that the knowledge with the surgery, let's say, is limited. Can I please have somebody? Or I haven't done this procedure. Prior to this, it's difficult to say that I haven't done an external split. This is their platform to speak up. And as managers, we need to attend to that.

In terms of culture, we have, it is a multidisciplinary attendees. We have anaesthetists, have surgeons attending. We even have the procurement, because we don't have supplies. And we

realize by gathering data, we realize that our main problem at that time from September up until now, but it's going down...It's procurement. We had at least 80 safety issues coming from procurement because there's no sutures, there's no swab. And when you go in the theatre, you explain to the surgeon, they will say like, well, I need to have it. And then you end up being the middle person saying like, how am I going to produce a suture that you want when we have a supply issue? It's so difficult. But then again, we tell in that meeting, please include in your briefing, the surgeon does not have a suture. Can we use another? When they know it, prior to surgery, there's flexibility. There's no incivility.

The buy-in at the very beginning...What we're measuring here, the time in minutes, attendees, and the safety issue they raise. So with the time in minutes, we know that our target is 10 minutes. Whenever it goes up to 15 minutes, we know that there's more issues raised. Attendees, the main target at the very beginning of this planning is for the scrub nurses only. But then again, we have the ODPs, have anaesthetists, we have surgeons attending, and mostly the emergency theatre surgeons who come like, need another theatre, can you please help? And it does help because there's one day that there's 15 cases that needs to be done in an emergency theatre at eight o'clock. But because of the situational awareness and improved communication, we have two cases left at six o'clock which is very, very good for us because it's been disseminated in other theatres.

As a human whenever we make mistake, it's really, really, really important to say, are you okay? We're all going to make mistakes. I don't know the background here, but we know that when we make mistake, it's not the mistake, but it's the learning from that mistake. And whenever there's a mistake, look at the person behind that mistake and say, how are you? It matters a lot.

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