Do OD

ORGANISATIONAL DEVELOPMENT AND CONTINUOUS IMPROVEMENT

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helenckg

Helen Kilgannon

Louise Gelder

lougelder

Louise Gelder

AQUA AT A GLANCE

Our purpose is to
Inspire the best quality health and care for everyone

Our ambition is to
Become the improvement partner of choice for health and care by 2027

We work with systems, organisations, teams and individuals, nationally and internationally

Delivery Expertise

- Safe Care
- Culture & Leadership
- Lived Experience
- Continuous Improvement
- Governance & Regulatory Support

How we work

- **Listen** and **analyse**
- **Co-design** and **co-deliver**
- **Develop people** and **demonstrate impact**
- **Share learning** to inform continuous improvement

Our Values

Excellence	Respect	Integrity	Collaboration

Heading	Timing
Ice breaker/ scene set	10:00
What is Continuous Improvement and where are the synergies with OD	10:10
NHS Impact & Learning from Virginia Mason	10:25
Discussion	10:45
Practice examples	11:00
Plenary	11:20
Close	11:30

A collaborative webinar exploring the relationship between organisational development and continuous improvement in the NHS

- What do you understand by the term “***continuous improvement***”?
- Describe the relationship between OD and CI in one word (slido)

SCIENCE

Art

DEFINING CONTINUOUS IMPROVEMENT

- Improving quality is the outcome, continuous improvement is the way to get there.
- Continuous improvement is applied consistently and produces results over time.
- Continuous improvement is the rigorous application of evidence-based methods.
- To do continuous improvement well people need to learn the skills, yet everyone can do it.
- Continuous improvement happens where the work is done by those doing the work.
- Continuous improvement can be applied to corporate as well as clinical activity

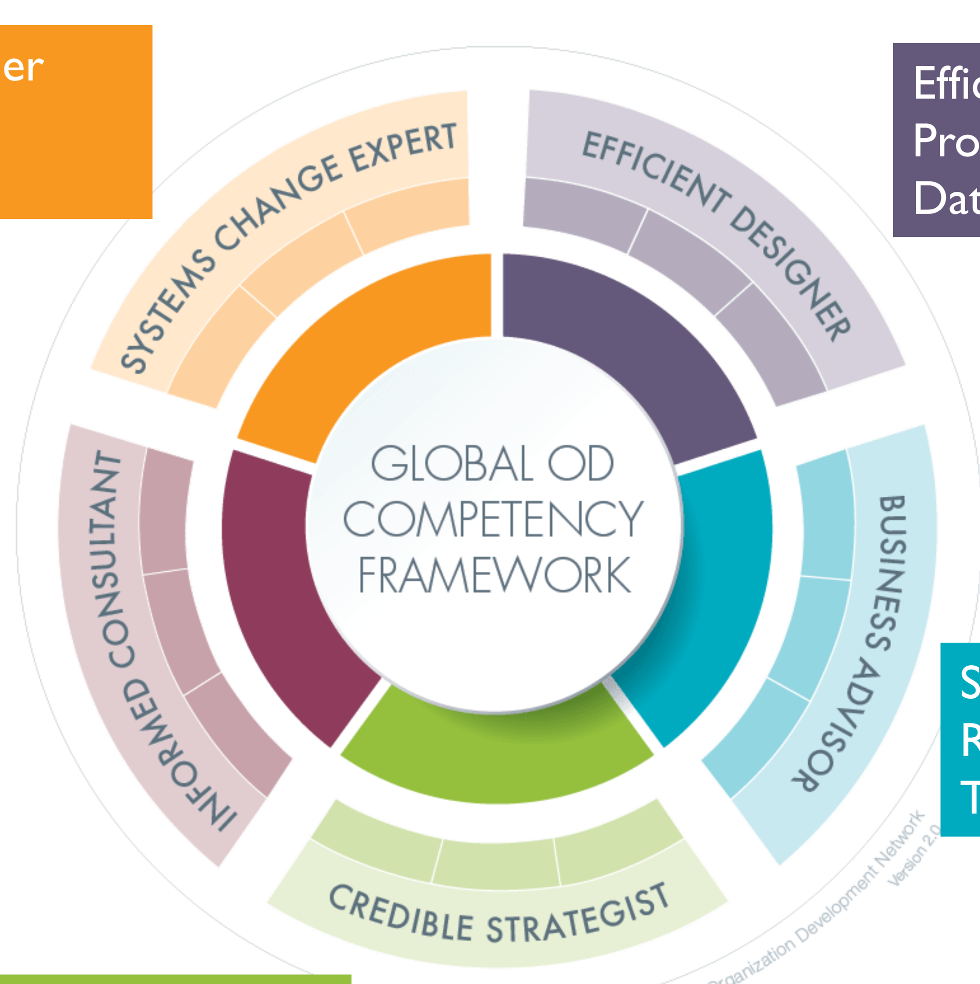
DEFINING OD

- OD is a field of applied behavioural science expanding our understanding of human and group behaviour. Such knowledge also guides and steers our work in developing organisational effectiveness by improving performance as well as internal health, especially during a time of change (Mee-Yan Cheung-Judge)
- OD is all the activities engaged in by managers, employees, and helpers, that are directed towards building and maintaining the health of the organisation as a total system (Schein)
- OD is a long-range effort to improve an organisations problem solving, and renewal process… with the assistance of a change agent, or catalyst, and the use of the theory and technology of applied behavioural science including action research (French and Bell)

aqua
Shape Change Inspire Quality Transform Care

Systems Change Leader
Culture Builder
Innovator

Efficient Designer
Process Consultant
Data Synthesizer



Self-aware Leader
Equity Advocate
Life-long Learner and Practitioner

Strategic Catalyst
Results-Oriented Leader
Trusted Advisor

Credible Influencer
Collaborative Communicator
Cross Cultural Navigator

Global OD Competency Framework - OD Network (2015)

QUESTIONING
PROBLEM FINDING
REFLECTIVE
LEARNING

EMPATHETIC
FACILITATIVE
COMFORTABLE WITH CONFLICT
INFLUENCING

OPTIMISTIC
CALCULATED RISK TAKING
TOLERATING UNCERTAINTY
RESILIENCE

TEAM PLAYING
CRITICAL THINKING
GENERATING IDEAS
CREATIVITY

CONNECTION MAKING
SYNTHESISING
ACCEPTING OF CHANGE
SYSTEMS THINKING

COMMUNICATION
COMMUNICATION
CO-PRODUCING HEALTH AND SOCIAL CARE

THE HABITS OF AN IMPROVER

The habits of an improver - The Health Foundation(2015)

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CRITICAL THINKING
GENERATING IDEAS

Cross Cultural Navigator

Culture Builder

Strategic Catalyst

Innovator

NHS IMPACT (Improving Patient Care Together) was launched to support all NHS organisations, systems and providers to have the skills and techniques to deliver continuous improvement.

NHS IMPACT's five components underpin a systematic approach that includes:

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

PEOPLE PROMISE

Virginia Mason's Improvement System

Virginia Mason Production System® (VMPS)

Respect for People

Safe and Respectful Environment

Engage Individuals and Teams

Patients as Customers and Partners

Improving the Flows of Healthcare

Continuous Improvement

Increase Reliability and Effectiveness

Lead in Quality Care

Accelerate the Impact of Improvement

Build a Strong Foundation

World-Class Management

Strategic Alignment, Cross-Functional Management, Daily Management

VMPS Principles, Tools and Methods

Eliminating Waste, Value Streams, Plan-Do-Study-Act, Innovation, Mistake-Proofing

wbs
WARWICK BUSINESS SCHOOL
THE UNIVERSITY OF WARWICK

How to Foster a Culture of Continuous Improvement

Learning from NHS - Virginia Mason institute Partnership

Nicola Burgess

1. BUILD CULTURAL READINESS as foundation for better QI outcomes

SHARED VALUES

ORGANISATIONS THAT INVESTED IN CULTURAL READINESS BEFORE QI

GOT BETTER OUTCOMES from QI

PRIOR "CULTURAL WORK" ENABLED QI

2. EMBED QI ROUTINES AND PRACTICES into everyday practice

BUILD QI CAPABILITY ACROSS the ORGANISATION

MAKE QI A PART OF EVERONE'S WORK, EVERYDAY

LEARNING IN REAL SITUATIONS → in REAL TIME

3. HAVE LEADERS SHOW THE WAY and light the path for others

LEADERS GO FIRST

MODEL THE IMPORTANCE OF QI

LEADERS AS PROBLEM FRAMERS, NOT PROBLEM SOLVERS

ENABLES PEOPLE TO LEAD IMPROVEMENT FROM THE POINT OF CARE

LEADERSHIP BEHAVIOUR IS A SYSTEM ISSUE

MOVE AWAY FROM "COMMAND AND CONTROL" TO QI AT EVERY LEVEL OF THE SYSTEM

4. RELATIONSHIPS aren't a priority, THEY'RE A PREREQUISITE

SYSTEMATIC QI METHODS WORK BEST where...

SOCIAL CONNECTEDNESS

TECHNICAL CAPABILITY

BUILD IMPROVEMENT EFFORTS

TRUSTING RELATIONSHIPS

SHARED VALUES

5. HOLD EACH OTHER TO ACCOUNT FOR BEHAVIOURS, not just outcomes

AGENDA

REFLECTIONS

LEARNINGS

Set out and role model the behaviours expected for QI

EMBED SPACE FOR REFLECTION and LEARNING IN FORMAL MEETING ROUTINES

6. THE RULE OF THE GOLDEN THREAD: not all improvement matters in the same way

When our improvement priorities and objectives are...

The GOLDEN THREAD

...closely aligned to the highest organisational priorities and objectives

MAKES IT EASIER TO DEMONSTRATE QI OUTCOMES IN WAYS THAT MATTER

LEADING CHANGE ACROSS HEALTHCARE SYSTEM: HOW TO BUILD IMPROVEMENT CAPABILITY AND FOSTER A CULTURE OF CONTINUOUS IMPROVEMENT

SKETCHNOTE BY: TANMAY VORA

#leadingQI

https://warwick.ac.uk/fac/soc/wbs/research/vmi-nhs/

CLEAR, CONCISE AND CONSISTENT SHARED VALUES

'I tell my staff:

"Spend all your time on patient experience, on quality, patient safety and getting the best clinical outcomes"

and that's it…'

(CEO, Hospital A)

© Nicola Burgess 2024

HOW LEADERS LIGHT THE WAY

and show the path for others to improve

- Nicola Burgess -

LEADERSHIP IS A PROCESS... AS MUCH AS A PERSON

Senior leaders ROLE MODELLING THE BEHAVIOURS EXPECTED is an important ENABLING FACTOR

LEADING FOR IMPROVEMENT REQUIRES A COACHING STYLE OF LEADERSHIP

"leaders should be problem framers not problem solvers"

IF LEADERSHIP IS A PROCESS, then leader behaviours can be learned and role modelled

There are elements of leader's work that can be standardised - e.g. GEMBA walks

LEADERS SET ATTENTION - getting organisational participants to focus attention on significant priorities

LEADERS PROMOTE IMPROVEMENT CULTURE through improvement in capability of people

LEADERS ESTABLISH NEW ROUTINES TO FOSTER COACHING BEHAVIOURS and enable a culture of continuous improvement

ACTIONS

ACTION SPEAKS [AT LEAST] AS LOUD AS WORDS

Persuading others to participate in training and engage in improvement requires leaders themselves to have invested their time and attention

CHANGES TO LEADERSHIP STYLE ARE ESSENTIAL FOR DEVELOPING IMPROVEMENT CULTURE WITHIN AND ACROSS AN ORGANISATION

LEADING CHANGE ACROSS HEALTHCARE SYSTEM: HOW TO BUILD IMPROVEMENT CAPABILITY AND FOSTER A CULTURE OF CONTINUOUS IMPROVEMENT

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wbs WARWICK BUSINESS SCHOOL THE UNIVERSITY OF WARWICK

LESSON 3

4. RELATIONSHIPS aren't a priority, THEY'RE A PREREQUISITE

SYSTEMATIC QI METHODS WORK BEST where...

SOCIAL CONNECTEDNESS

TECHNICAL CAPABILITY

BUILD IMPROVEMENT EFFORTS

TRUSTING RELATIONSHIPS

SHARED VALUES

LESSON 4

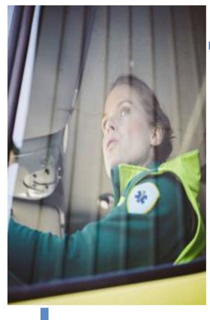
BREAK OUT ROOM DISCUSSION

- Where do you already work closely with improvement teams?
- What are benefits and opportunities of collaborative working?
- Is there anything stopping you working together?

Please take 15 minutes to reflect with peers

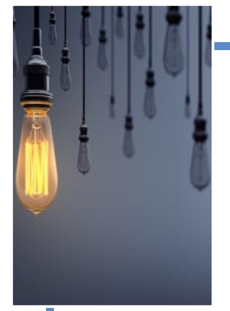
Use the questions to the left to help your discussion if needed

When you return, please can one person from the room share a little in the chat of a theme from your conversation



Acute Foundation Trust Ambulance Handover support

Patient Safety Standards Implementation (PSIRF)

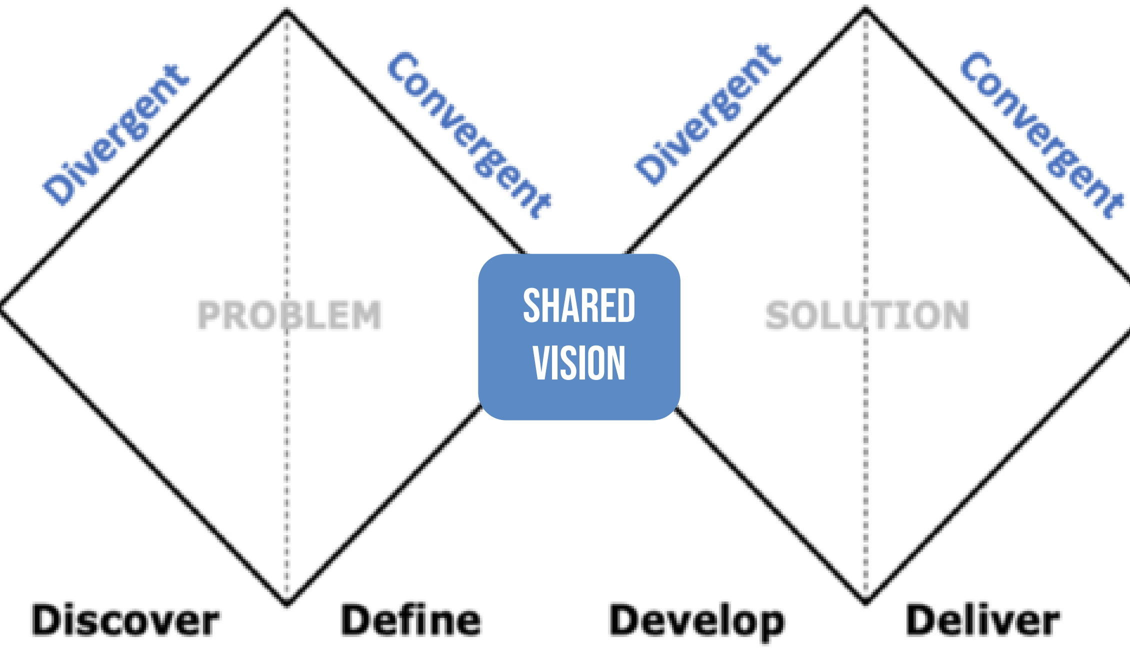


Leadership Development Programme

IMPROVEMENT APPROACH

Problem inputs
- Performance data
- ED team staff insight
- Patient engagement

Problem outputs
- Analysis of 4h performance trends
- COM-B behaviour and culture
- Patient engagement
- Process mapping



Solution inputs
- ED team improvement ideas
- Patient improvement ideas

Solution outputs
- Shared vision
- ED process improvement ideas
- Cross-cutting (cultural and system) improvement ideas
- Driver diagram

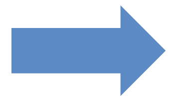
BEHAVIOUR AND CULTURE

The ED teams' insights have been analysed using the COM-B model[1]. The COM-B model describes our everyday actions (behaviour) as being governed by a mixture of our capability, motivation and opportunity.

Capability

Psychological *"I know how to do this"*

Physical *"I can do this"*



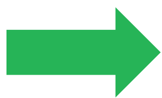
The ED team are almost all aware of the 4h standard, but may not believe in its efficacy. They were unanimous that they prioritise safety and acuity over time to treatment.

The opportunities are in improving **access** to streaming alternatives and minor injury **upskilling**.

Opportunity

Physical *"I have what I need"*

Social *"Others approve of me doing this"*



The ED team all say that owing to ED congestion, there is not enough space to assess and treat patients.

The quickest options for improvement are in opportunity – protecting **space** for doctor/nurse assessment and treatment, better **co-ordinating** See & Treat and more proactive **progress review**.

Motivation

Reflective *"I feel like I want to do this"*

Automatic *"I have the right habits in place"*

The ED team are motivated by providing the best possible care and keeping patients (and each other) safe from harm. The lack of ED flow and its inherent safety risks significantly reduce morale.

There are opportunities to more visibly link 4h performance to **safe care**, improve **accountability** and show **appreciation** of the team.

[1] The COM-B model of behaviour change explained | Together Agency

Aqua role (Feb to May 2024)

- Process map handover pathway; jointly prioritise improvement ideas
- Opportunity audit: Fit2SIt
- System falls mapping & workshop to co-design falls improvement plan

Method

- Triangulate Ambulance data with bottom-up staff and service insights
- Understand the problem and jointly generate change ideas!

Benefits

- **External and impartial**
- **Opportunity**: shone new light on front-door improvement potential
- **Visual** presentation
- **Positivity**: Appreciative approach. re-ignited belief in improvement
- **Partnership:** regular check-ins to jointly shape programme

- **Reduce variation in handover times**
- **Improve consistency of 30m handover performance**
- Improvements to be co-designed and co-delivered by NWAS and WUHT teams (with support from Aqua)

Immediate actions

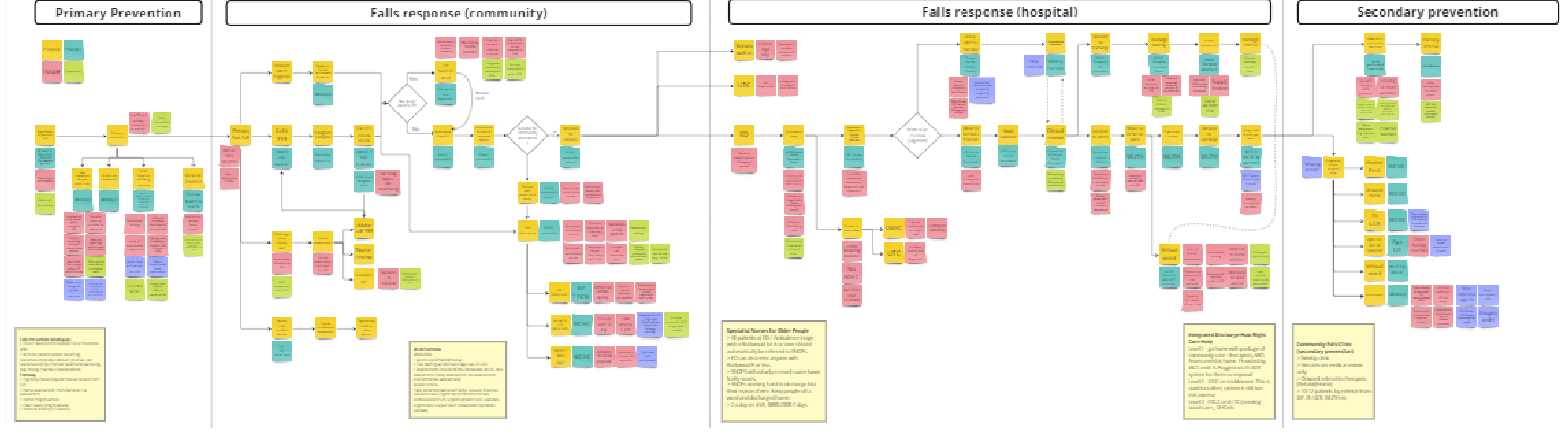
- Rapid co-design to increase:
  - Fit2Sit
  - HAS compliance
  - HALO consistency and usage
  - Bed and wheelchair accessibility
  - Safety checklist - safe and increased usage
- Bed meeting (test of change):
  - Shared design of action-orientated TOR and structure
- Further scoping - senior decision maker at ambulance triage (mirror walk-in benefits)?
- Electronic SBAR?
- Chairs in corridor (patients and paramedics)?

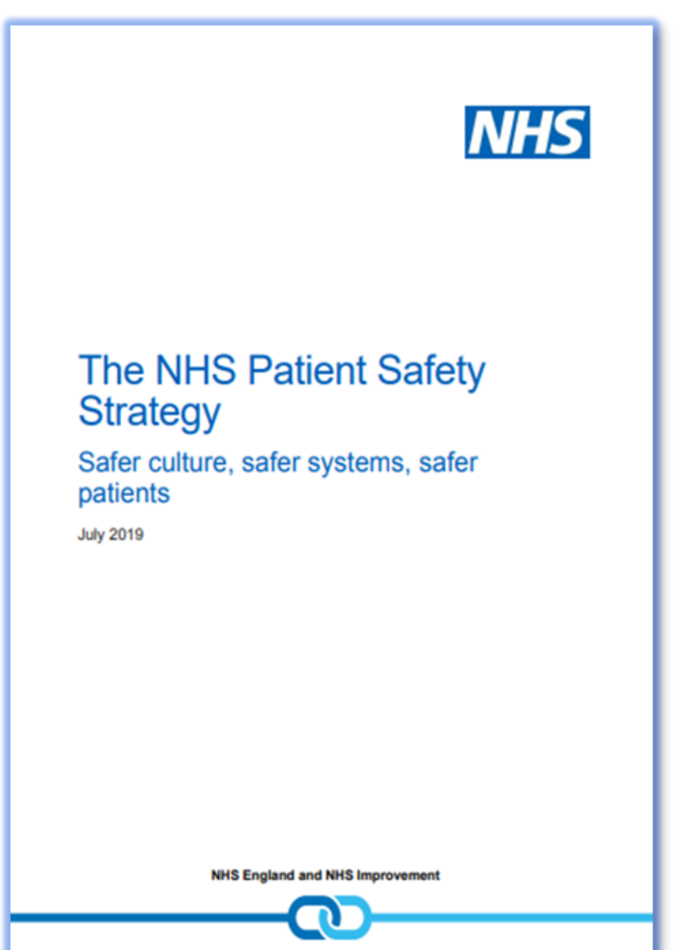
Medium term opportunity

- Direct to non-ED pathways (expedite improvements; prioritise frailty):
  - UTC
  - UMAC (SDEC)
- Bed meeting (tests of change):
  - Visual overview of status & expected discharges in next 72h
- Improved Trust and system visibility of implication of handover and discharge delays on safety, deterioration and deconditioning
- Consider business case for Trust/NWAS joint ALO role?

Next steps

- Jointly agree immediate priority improvements
- SPC charts for 30m and 60m handover times (from 1st Feb; capture impact continuous flow and estate improvements)
- Further data:
  - 24h view of bed transfers and handover times
  - Conveyance numbers: MH and frailty
- Further insight/mapping:
  - ED/UMAC interface
  - Virtual wards
  - Bed meeting (wider scoping)
  - Porter pathways
- Virtual launch – alternatives to ED improvement programme





[Report template - NHSI website (england.nhs.uk)](https://www.england.nhs.uk)

- **Psychological safety for staff:** Psychological safety operates at the level of the group not the individual, with everyone knowing they will be treated fairly and compassionately by the group if things go wrong, or they speak up to stop problems occurring.
- **Diversity:** Team psychological safety is characterized by a climate of inclusivity, trust and respect, where people feel able to thrive as themselves.
- **Compelling Vision:** Before leadership can be practiced well, there needs to be a vision of what we want to achieve. .. the vision needs to be explicit, not reliant on assumption.
- **Leadership & Teamwork:** Compassionate leadership creates psychological safety and encourages team members to pay attention to each other; to develop mutual understanding; to empathise and support each other.
- **Open to Learning:** To develop a culture of learning, the system must focus on what needs to change rather than punitive actions.

SAFETY THE TOUGH NUMBERS

In high income countries, WHO estimates

1 in 10

patients are harmed while receiving hospital care – 50% of which is preventable.

11,000 +

avoidable deaths each year (pre-pandemic).

15%

of healthcare costs are attributable to unsafe care.

Unsafe care is one of the

top 10 causes

of death and disability worldwide.

https://www.who.int/news-room/fact-sheets/detail/patient-safety

CULTURE SHIFT

OLD VIEW	NEW VIEW
Complex system function is safe, unreliable people are the problem.	'Human error' is a symptom of issues with system functioning.
'Human error' causes incidents.	'Human error' is the starting point for a review, not a conclusion.
Compliance with rules ensure safety.	'Human error is systematically linked to tools, tasks, and environments.
People fail to do what they should have done when there is an unwanted outcome.	The decision making made sense to the individual at the time.

Dekker (2014)

Compassionate engagement and involvement

Applying system-based approaches to learning

Considered and proportionate responses

Supportive oversight to strengthen system functioning

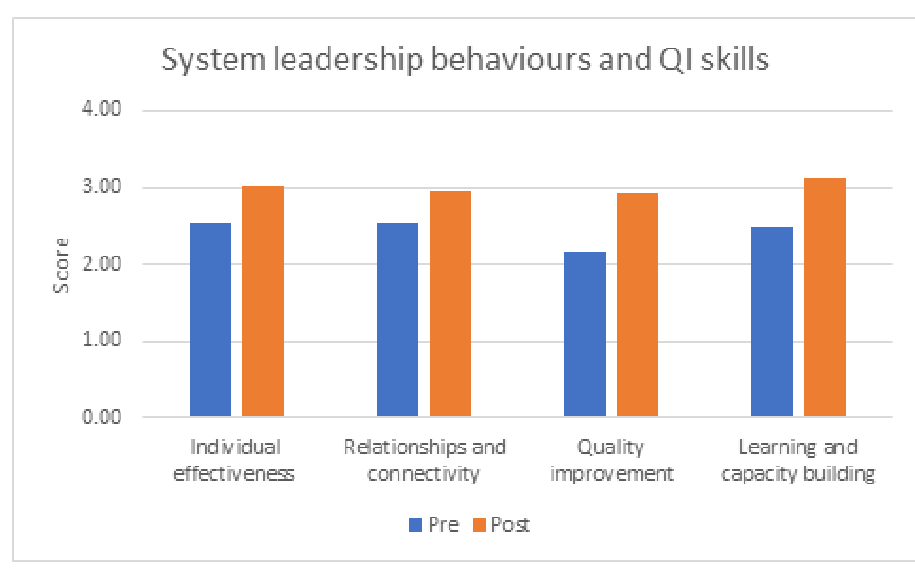
Trust A Haven't changed culture

- Too focused on delivering a ‘plan’ rather than development of psychologically safe cultures
- No commitment to leadership development
- No focus on staff capability and capacity
- Roles seen as add-ons to established duties
- Poor staff and patient engagement
- Limited approach to Thematic Reviews and different data sets to inform learning
- Jumping to solutions as part of the learning processes
- Lack of appreciation of the system and human factors

Trust B Developing the culture

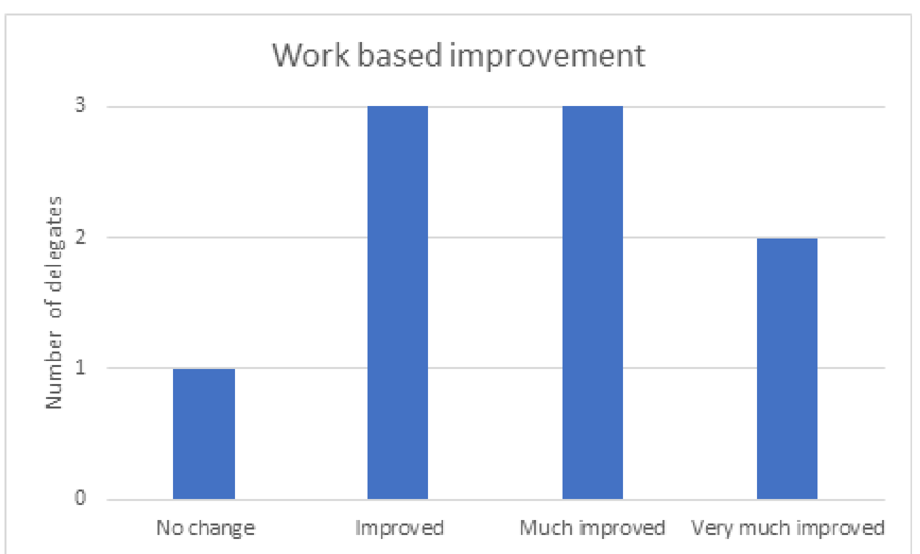
- Have acknowledged it's a long journey and you can't do it all at the start
- Trust board actively committed to culture change
- Continuous improvement activity is central to approach, using multiple sources of data
- Collaboration with patients, service users and their families/support networks
- Training and support to dedicated patient safety investigator roles
- Learning from what goes well

LEADING INTEGRATED TEAMS PROGRAMME



"Patient capacity in my service has increased from 10 to 50 by making minor changes within the team"

"I improved how morning huddles operate, taking a coaching approach and facilitating the team to improve the structure"



THE CI ASK OF SYSTEMS & ORGANISATIONS

Development of Leaders and Culture

Continually Improve Health and Care

Meet regulatory and governance requirements

There is…

…Similarities & complimentary features

…Uniqueness

…Polarities

In relation to CI & OD

- Have we provoked any different thinking around your practice?
- What can you amplify?
- Where can you avoid duplication?
- Where are you considering further alignment between your OD and CI strategy?

CONNECT WITH US

WHAT NEXT...

BITESIZED BOARD

WHAT DOES IT FEEL LIKE TO HAVE THE MIRROR IN THE ROOM?

Join **Sue Holden**, Executive Chair at Aqua, and **Richard Beeken**, Chief Executive at Sandwell and West Birmingham NHS Foundation Trust, and focus on sharing experiences of executive coaching to help enhance team effectiveness and impact.

WEDNESDAY 4 DECEMBER

8:00-9:00AM

VIRTUAL

www.aqua.nhs.uk/bitesized-board

SUE HOLDEN
Executive Chair
Aqua

RICHARD BEEKEN
Chief Executive
Sandwell and West Birmingham NHS Foundation Trust