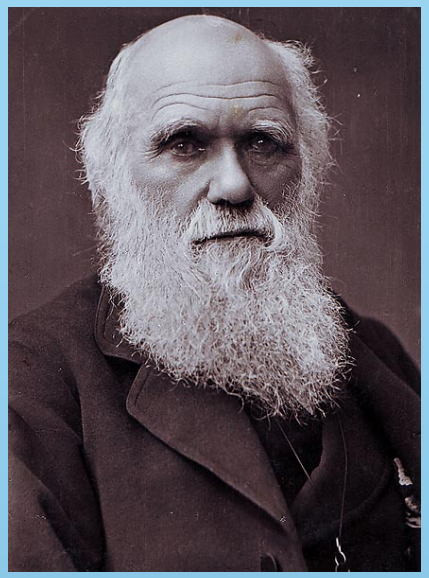
Sir David Nicholson

Making Change Happen

THE IMPORTANCE OF CHANGE

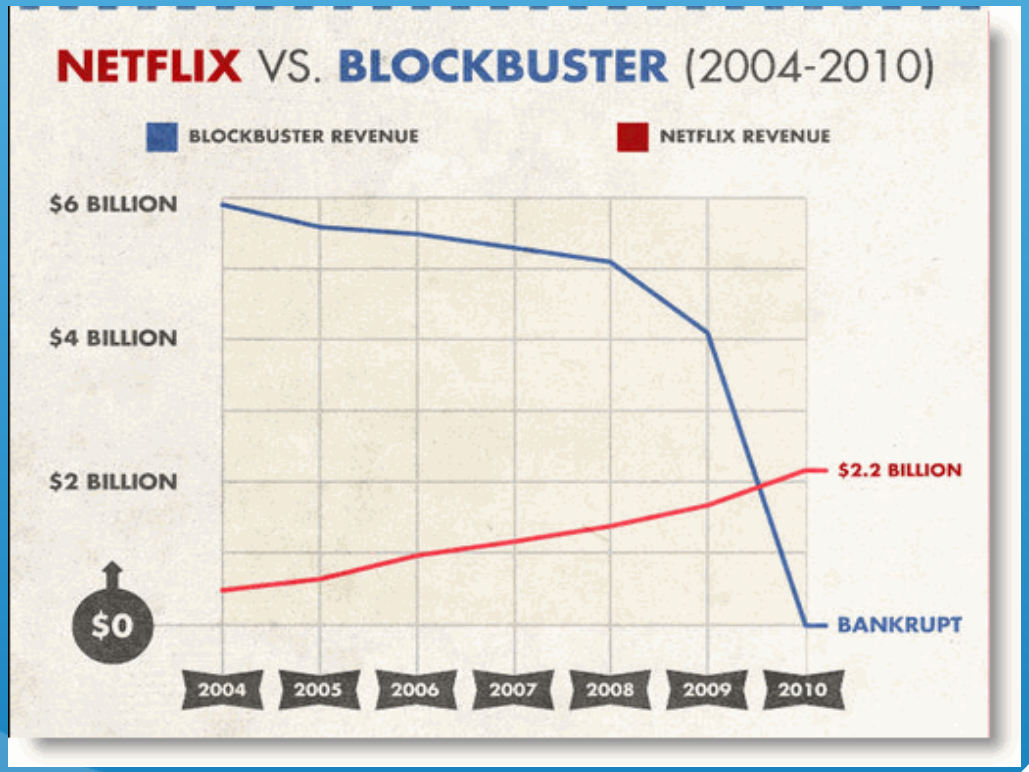


"It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change."
— Charles Darwin

Blockbuster remained rooted in an outdated business model and weighed down with fixed costs of buildings

Netflix adapted their model from postal service to online anticipating behaviour changes from technology

Blockbuster passed up the purchase of Netflix for $50m and is now bankrupt. In 2016 Netflix is estimated to be worth around $30bn



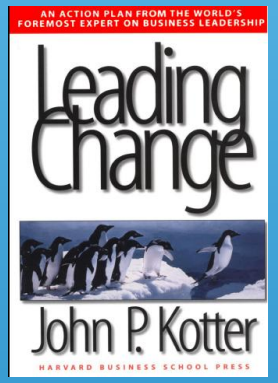
ADOPTING A CHANGE MODEL

Having a way of talking about and implementing change is important to undertaking it successfully.

A range of change models exist to support organisations to make change happen……..

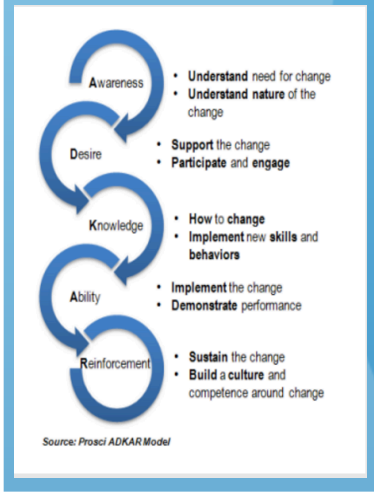
McKinsey&Company

The McKinsey 7s Model



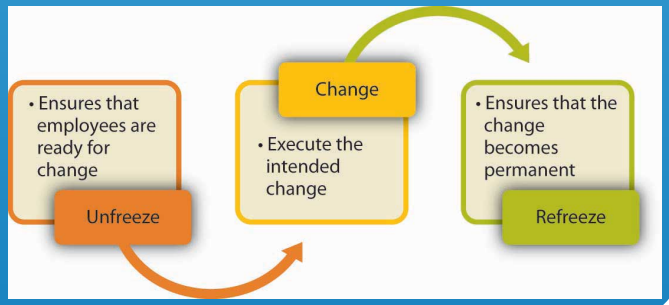
John Kotter's 8 steps to change

"All models are wrong but some are useful"
George E Box, British Statistician



Prosci's Adkar Model

Lewin's 3 stage model



WHY A CHANGE MODEL IS NEEDED IN HEALTHCARE

Global Drivers

Massive changes required to deliver improvements in quality within resources

A Change Model

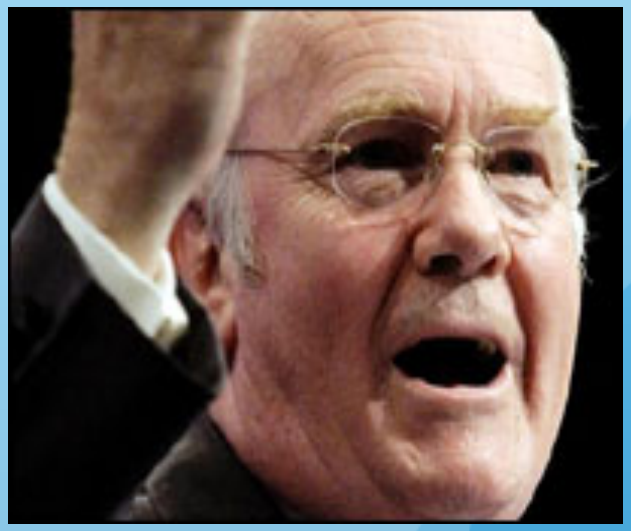
- Creates a common language of change
- Able to build on best evidence and support rapid spread and adoption
- Can build change capacity
- Provides a tool for people to structure local work around
- Allows better integration of change efforts
- Can build a coherent approach to learning and development

THE NHS CHANGE MODEL

The NHS Change Model was developed with hundreds of NHS staff at all levels who wanted to build energy for change across the NHS by using an approach based on solid research

The model brings together collective improvement knowledge and experience from across health and care into eight components

A SHARED PURPOSE – REDUCING MRSA



In 2004 MRSA was seeing year on year increases and had become a top public concern and political priority

The then Health Secretary John Reid announced an ambitious target to halve MRSA in four years and *".. ensure that the whole NHS gives this issue the same high priority that the public does."*

"Halving a problem, when you don't really know the scale of the problem, is an extraordinary feat."
Lib Dem Shadow Health Sec. Paul Burstow

"I think it would be very difficult to predict on the evidence so far."
Dr Paul Grime from the BMA

"This target is nothing but all talk and it will achieve little to combat the wider issue of hospital acquired infections."
Cons. Shadow Health Sec. Andrew Lansley

LEADERSHIP FOR CHANGE – *do all our leaders have the skills to create transformation*

MRSA EXAMPLE

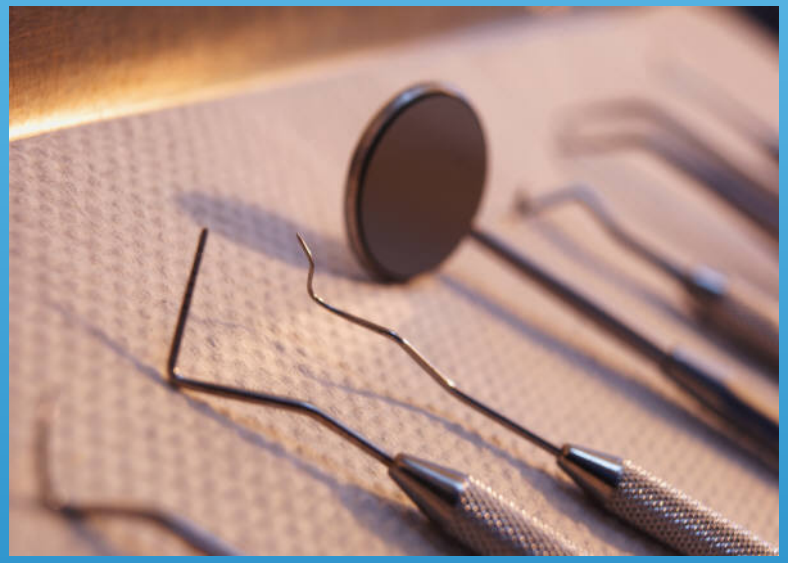
New CNO Christine Beasley galvanised the profession and new Infection Prevention and Control leads were required in every hospital

SPREAD OF INNOVATION - *are we designing for the active spread of innovation from the start?*

MRSA EXAMPLE

Improvement teams were established who visited NHS hospitals to review practices and advise on improvements and implementation.

IMPROVEMENT METHODOLOGY – *are we using an evidence - based improvement methodology ?*



MRSA EXAMPLE

A series of high-impact interventions in the form of care bundles were rolled out. Use of root cause analysis became commonplace in the NHS and a culture of facilitated learning developed

RIGOROUS DELIVERY – ***do we have an effective approach for delivery of change and monitoring of progress towards our planned objectives?***

MRSA EXAMPLE

MRSA was made a top priority for every hospital in the country, giving it equal status to waiting times and was robustly performance managed

SYSTEM DRIVERS – ***are our processes, incentives and systems aligned to enable change?***

MRSA EXAMPLE

Legislation was introduced in 2006, a statutory Code of Practice on HCAI for all healthcare providers. The Care Quality Commission began annual IPC inspections of hospitals. Commissioner fines introduced.

ENGAGEMENT TO MOBILISE - *are we engaging and mobilising the right people?*

MRSA EXAMPLE

In 2004, the NPSA launced a "cleanyourhands" campaign launched to improve hand hygiene in NHS hospital. This engage staff, public and patients in a common cause and introduced a culture of healthy challenge.

TRANSPARENT MEASUREMENT – ***are we measuring the outcome of the change continuously and transparently?***

MRSA EXAMPLE

The new Health Protection Agency introduced the mandatory surveillance and public reporting of MRSA. Chief Executives had to sign off data returns.

CASE STUDY– MRSA: OVERVIEW

Leadership for change:
New CNO Christine Beasley galvanised the profession and new Infection Prevention and Control leads were required in every hospital

Innovation spread:
"improvement teams" (ITs),visited NHS hospitals to review practices and advise on improvements and implementation.

Improvement methodology:
A series of high-impact interventions in the form of care bundles were rolled out. Use of root cause analysis became commonplace in the NHS.

Engagement to mobilise:
In 2004, the NPSA launched a "cleanyourhands" campaign to improve hand hygiene in NHS hospitals

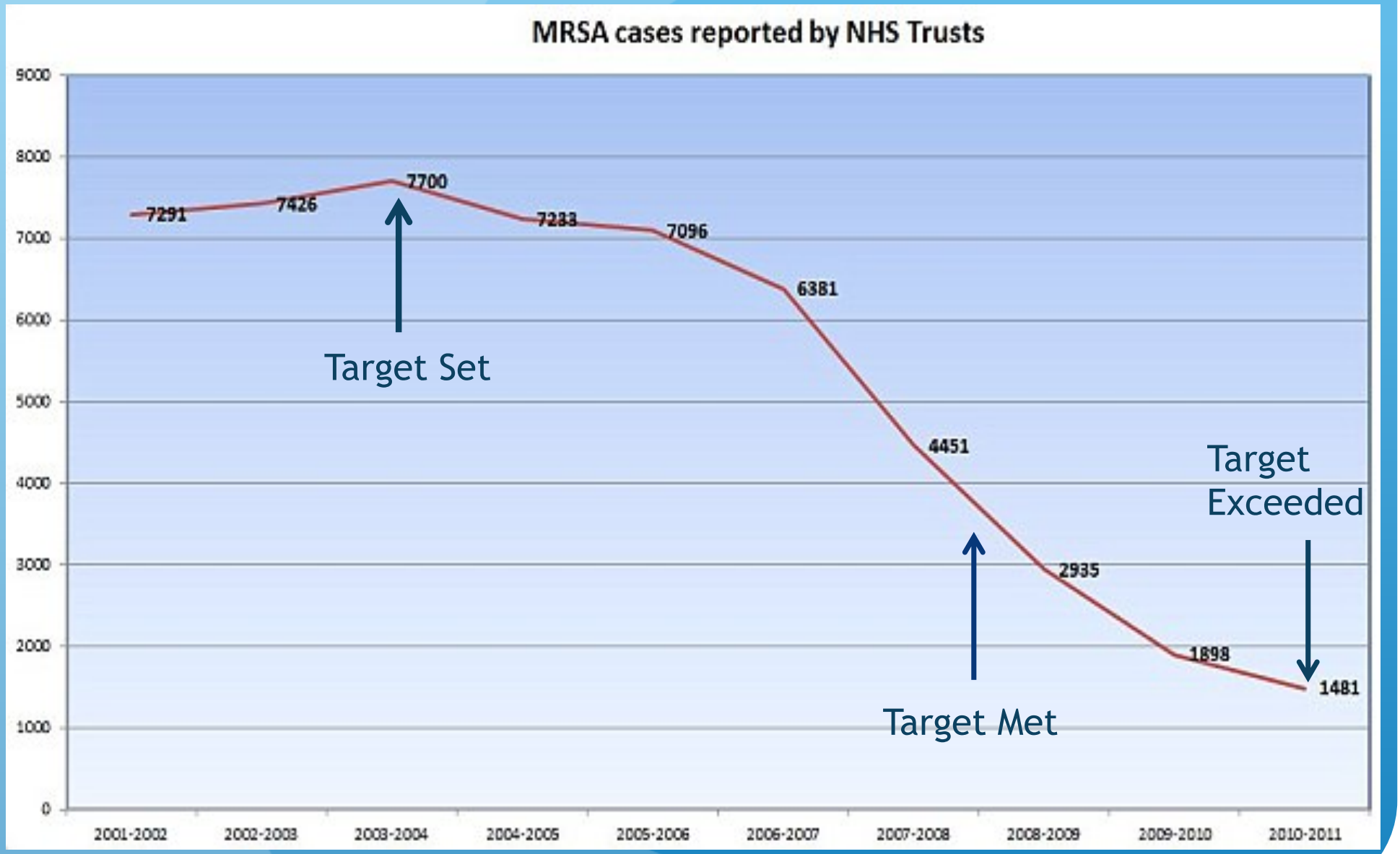
Shared purpose:
Cutting rates of MRSA was a clear and consistent purpose that all the staff and – importantly – patients and the public could support and help deliver

Rigorous Delivery:
MRSA was made a top priority for every hospital in the country, giving it equal status to waiting times and was robustly performance managed

System Drivers
Legislation was introduced in 2006, which implemented a statutory Code of Practice on HCAI that applied to all healthcare providers. The Care Quality Commission was given new powers, including annual IPC inspections of all hospitals.

Transparent Measurement:
The new Health Protection Agency introduced the mandatory surveillance and public reporting of MRSA

CASE STUDY MRSA: THE RESULTS



HIGH QUALITY CARE FOR ALL

High Quality Care for All, published in 2008, provided a framework for improving quality

This laid the foundation for radical change in the delivery of stroke services in London

THE SEVEN STEPS TO QUALITY

Bringing Clarity

- A clear definition of quality – safety, experience, effectiveness
- NICE Quality Standards for service pathways/conditions

Measure

- The system can only improve what it measures – a range of quality measures covering safety, clinical outcomes and patient experience

Publish

- All measures of quality at every level of the system, must be made transparently available to support accountability, patient choice and prioritisation

Reward

- Payments and incentives structured to drive quality improvement
- Commissioning for Quality (CQUIN) and the Quality and Outcomes Framework (QOF)

THE SEVEN STEPS TO QUALITY

Leadership

- The National Quality Board brings together the system leadership for quality
- Clinical Senates and Clinical Networks will provide leadership locally and regionally for quality improvement

Innovate

- Academic Health Science Centres who seek out new and innovative ways of caring for people
- NICE's technology appraisals will ensure innovation reaches front line

Safeguard

- Essential standards of safety and quality must be maintained
- Each part of the system must fulfill their responsibilities in relation to quality, as well as working together in the interests of patients

CASE STUDY – TRANSFORMING STROKE CARE IN LONDON

Care was centralised into a hub and spoke model with designated HASUs operating 24/7 with stroke units attached providing rehabilitation services

X 30
Receiving Hospitals

TO

X 8
Hyper Acute Stroke Units

The locations chosen ensured no-one was more than 30 minutes by ambulance from a HASU

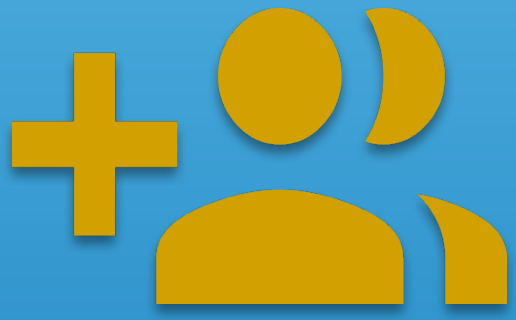
Consultation with 37 roadshows and 5,000 responses with evidence to explain and engage partners, staff and the public in the case for change

CASE STUDY – TRANSFORMING STROKE CARE IN LONDON

The results have been a transformation in services……

Faster access to clot busting drugs and brain scans through HASUs accepting all stroke patients

Improved mortality rates – estimated to save around 96 additional stroke patients every year who would likely have died under a non-centralised system



Reduction in length of hospital stay of around 7%, equivalent to over 12,000 days a year London wide

CASE STUDY – A COMPARISON OF STROKE CHANGES

LONDON

- Hyperacute stroke care provided to all patients in a HASU.
- A significant reduction in mortality over and above the reduction seen in the rest of England.
- Reduction in length of stay of 1.4 days.

MANCHESTER

- Hyperacute stroke care only to patients presenting within four hours of developing symptoms. No hospitals lost services.
- No impact on mortality over and above reduction in England.
- Reduction in length of stay of 2 days.

In London the changes were overseen by the Strategic Health Authority. This 'system leadership' provided a structure to make difficult choices.

In Manchester the changes were planned by agreement among the local organisations involved, with leaders less able to resist parochial challenges.