Reading the signals? Developing problem-sensing boards

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Overview

1. Signals unread: a brief recent history
2. The challenges of identifying problems prospectively
3. Finding the signals: weak and strong, soft and hard
4. What are the implications for boards and their members?
Signals unread

A brief recent history
East Kent’s maternity services

- Harm to mothers and babies over more than a decade
- Multiple opportunities to act on the issues: the signals were there
- Organisational dysfunctions at multiple levels
- Ultimately responsibility lay with the board
- Truly an extreme outlier?
- And yet...

Accountability lies with the successive Trust Boards and the successive Chief Executives and Chairs. They had the information that there were serious failings, and they were in a position to act; but they ignored the warning signs and strenuously challenged repeated attempts to point out problems. This encouraged the belief that all was well, or at least near enough to be acceptable. They were wrong.

(Kirkup1: p.19)
The wider picture

• Other reports and investigations—in maternity and other fields of health and care\(^2\)

• Concerning signs regarding staff and patients’ perceptions of openness and patient safety (especially post-pandemic)\(^3\)

• A system in “gridlock” creates new risks (including at interfaces between organisations)\(^4\)
Identifying problems early isn’t easy

- High-level measures (e.g. hospital-level mortality) are poor indicators of safety\(^6\)
- Easier to identify extreme outliers than to distinguish between quality and safety of organisations ‘in the middle’\(^7\)
- Surveillance tools used by the CQC to inform risk-stratified inspection strategies have weak predictive validity\(^8,9\)
- Reliability across raters\(^10\) and indicators\(^11\) is low
- At organisational level, things aren’t any easier
How can we know whether care is safe?5

If you look at Mid Staffs, the basic care stuff, I’m sure anywhere, or most places in the UK, could identify with Mid Staffs. We all were glad that we weren’t working at the Mid Staffs at the time.
(Senior manager, acute trust)

I think it shocked the NHS. I mean it was horrendous reading. And I can remember presenting to a large forum that comes together every quarter, and I just said, ‘When you read what happened, we shouldn’t think that it couldn’t happen in [this organisation]’. Because the staff in Mid Staffs are no different to the staff in [this organisation]. And it’s interesting, people would say, ‘Well it couldn’t happen here, it couldn’t happen here’. I think it could happen everywhere if I’m honest.
(Senior clinician, community and mental health services trust)

My perception is that we’re probably doing a lot better than other places, but you don’t know what you don’t know. If staff are reluctant to come to anybody and raise their concerns, how do you know that? How do you benchmark it?
(Senior manager, acute trust)
The challenges of identifying problems prospectively
Early warnings, weak signals and learning from healthcare disasters

Carl Macrae

ABSTRACT

In the wake of healthcare disasters, such as the shooting at a community health centre, the Manchester Arena attack and the fire at Grenfell Tower, it has become evident that systemic failures in patient safety and quality of care often precede such events. Turning weak signals into a focus for change and cementing patient experience and safety as a priority require mechanisms and frameworks to be developed. The focus should be on identifying and mitigating factors that allow such events to transpire. This article explores the trajectory and factors that led to the disasters, and the potential for such events to preclude patient safety and quality of care. These challenges are addressed by the disaster's root causes, which in turn lead to the development of early warning signals. Understanding these factors and creating a framework to address them is crucial for ensuring patient safety and quality of care. The article concludes with a call for action to prevent future disasters and improve patient safety and quality of care.

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Culture and behaviour in the English National Health Service: an overview of lessons from a large multimehod study.

[QR Code]

Abstract

This paper presents an overview of lessons from a large multimehod study conducted in the English National Health Service (NHS). The study aimed to explore the role of culture and behaviour in shaping healthcare delivery and patient experiences. Through a combination of qualitative and quantitative methods, the research revealed insights into the complexities of organisational culture and the impact of leadership styles on clinical decision-making. The findings highlight the importance of fostering a supportive and inclusive work environment to improve patient outcomes and staff well-being. The study's implications extend to other healthcare systems globally, emphasising the need for a multidimensional approach to understanding and addressing cultural and behavioural challenges within healthcare settings.
Taking the heat or taking the temperature? A qualitative study of a large-scale exercise in seeking to measure for improvement not blame

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ARTICLE INFO
Aim: To examine the different ways of measuring quality in a large-scale exercise in seeking to measure for improvement not blame.

Method: A qualitative study using interviews with key stakeholders.

RESULTS
The study identified various methods of measuring quality, including the use of feedback, observation, and data analysis.

DISCUSSION
The findings suggest that there is a need for a more standardized approach to measuring quality in healthcare.

REFERENCES

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Organisational culture: problem-sensing and comfort-seeking

Mary Dixon-Woods and Graham Martin

Accepted for publication in ‘The Good Governance Guide’ (provisional title), to be published in 2023 by NHS Providers.

Foreword by John Coutts

Back in 2004 Sir Mike Mover, who was at the time executive chair of the foundation trust regulator Monitor, said: ‘There is no such thing as a perfect organisation. The best we can ever hope for is that an organisation is self-aware, recognises its issues, and deals with them effectively.’ This remains as true today as it was nearly 20 years ago.

The complexity of large organisations and the even greater complexity of working within systems challenges organisations to be self-aware. The evidence of what is going well, what can be improved and what requires urgent attention is readily available in organisations that use soft intelligence effectively. There will always be the temptation to take comfort in getting most things right rather than being disconcerted by the significant minority of things that go wrong. There will always be a danger in regarding compliance as an end in itself rather than as useful, but limited, intelligence on organisational performance.

In this section Mary Dixon-Woods and Graham Martin contrast problem-sensing with comfort-seeking, confront structural complexity and a lack of degrees of freedom to use hard and soft intelligence, and discuss the crucial importance of openness.

It would be surprising if there were many who would disagree with the content of this chapter, but the challenge is to embrace openness and make real a learning health system in which structural insecurity is identified and challenged at all levels.
Finding the signals

Weak and strong, soft and hard
The role of ‘soft intelligence’

• Not all that matters will show up in hard metrics

• Making sense of those metrics also requires an intimate knowledge of the clinical ‘sharp end’

• Inquiries into past disasters of healthcare quality and safety have found (belatedly) that the knowledge was there—but unvoiced or unheard

• How to capture this ‘fugitive knowledge’?
Making soft intelligence hard: a multi-site qualitative study of challenges relating to voice about safety concerns

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ABSTRACT

Background and Purpose: Health organisations often fail to\\nunderstand how to deal with the inherent challenges of safety\\nand quality concerns faced by their own patients. We\\nassessed the level of support and communication amongst health care providers and\\nwhether organisations are effectively managing health care providers\\nand maintaining open and effective communication about safety and quality.

Methods: Qualitative ethics were purposefully selected for\\ntheir capacity to capture the complexity of engagement in health care providers and\\nthe challenges they faced in the study. The study involved\\n181 health care providers from a range of settings,\\nincluding doctors, nurses, and professional support staff.\\nHealth care providers interviewed were asked to identify\\nissues in the workplace that they believed could lead to\\nserious patient harm and how they would respond to\\nthese issues.

Results: Health care providers described how they\\nfound it difficult to raise concerns about safety and quality\\nissues, with many reporting that their words were not taken\\nseriously. Health care providers felt that their organisation\\nwas not listening to their concerns and often felt\\ndisillusioned by the lack of support they received.

Conclusion: Health care providers reported that they\nwere often not supported in raising concerns about safety and quality issues, and that their organisations\\ndid not always act on their concerns. Health care providers\\nhighlighted the need for improved communication and\\nsupport within their organisations to ensure that issues\\ncan be effectively addressed and patient safety is maintained.

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Article

Uncovering, creating or constructing problems? Enacting a new role to support staff who raise concerns about quality and safety in the English National Health Service

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Man

Abstract
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Image: NordForsk, ‘Phone call’.
Reproduced under a CC BY-NC-ND 2.0 licence.
Walkrounds in Practice: Corrupting or Enhancing a Quality Improvement Intervention? A Qualitative Study


Recent years have seen growing emphasis on encouraging leaders to learn what is happening on the 'shop floor' activity primarily in addressing local problems, and emerging staff to develop with care organisational objectives. Techniques such as 'Credibility Checks' and 'Observations in Use', have become widely used in this new. In the health care sector, an expanded role and widely used approach is that of leadship in 'Walkaround', which was developed by Alan Frankel and colleagues at the Institute for Healthcare Improvement (IHI) in the late nineties. Walkaround (as it is also known) is intended to provide an opportunity for staff involved in care delivery to evaluate safety concerns, have their recommendations senior staff, and ensure they are addressed by providing 'an informal method about safety issues in the setting to examine them: both in a stepwise and as a stepwise to encourage a safety culture'.

Walkaround can be different asset of being, providing a set of systematic and standard observations in the course of their care, to contribute to the improvement of the care being given to the patient's overall experience. A recent study found that the use of walkaround can lead to significant improvements in patient safety outcomes. One practical step, however, was that the walkaround process must ask whether the senior leaders of the senior leaders to ensure that their views are heard.

Methods
The data were collected from 62 semi-structured interviews with input from key informants in two countries and behavior around quality. Analysis was based on the use of the key themes and quotations from the interview data to illustrate the themes. The study was conducted in collaboration with the participating organizations in the two countries.

Results
The results showed that the walkaround process led to significant improvements in patient safety outcomes. The walkaround process is a valuable tool for leaders to identify and address safety concerns in healthcare settings.
Can Your Employees Really Speak Freely?

By James R. Detert and Ethan R. Burris

FROM THE JANUARY-FEBRUARY

Chances are:

Maybe it's bad.

Or we've all been in a room where a great idea was brought to management, only to be rejected.

This is true even if, by your (or anyone else's) standards, the idea was the best thing to come along in years.

It's difficult to see the logic behind rejecting someone else's idea, because the logic is often so far removed from the person who first thought of it.

Or so it seems.

But there are ways to overcome this reluctance to listen to others.

One is to be a great listener.

Another is to be a great idea generator.

And the third is to be a great idea executor.

In all three cases, the key is to be open to new ideas.

Open to new ideas means:

- Being willing to consider ideas from others.
- Being willing to try out new ideas yourself.
- Being willing to learn from others.

Openness is the key to success.

But how do you get there?

It starts with recognizing that everyone has something to offer.

And that includes you.

So open up.

And see what happens.

Image: Mark Dries, ‘Open the door’. Reproduced under a CC BY-NC-ND 2.0 licence.
Safety measurement and monitoring in healthcare: a framework to guide clinical teams and healthcare organisations in maintaining safety

Charles Vincent,1 Susan Burnett,2 Jane Carthy1

ABSTRACT

Safety, clinicians, and managers all want to transform but feel healthcare organisations are safe. Yet there is no consensus about what we mean by safety or how to make organisations safer. In the UK, the measurement of safety, so important in the resolution of patient safety, has been neglected in favour of cost-saving. The use of safety intelligence for monitoring and anticipating problems remains little mentioned in policy. The Francis inquiry report into cancer treatment at the Mid Staffordshire NHS Foundation Trust highlighted the need for a new framework to monitor patient safety and to explore the links between safety and service improvement. The framework proposed here focuses on the unity of safety and service improvement and, in particular, on the role of clinical teams. It proposes a framework that can guide boards, clinical teams and healthcare organisations in using a holistic approach to measurement and monitoring of service safety and in recruiting progress against explicit standards. Although some studies are primarily UK, the broader frame is applicable to other situations.

In the UK there has been increasing government focus on ensuring both quality and safety over the past 10 years.
Patient-Centered Insights: Using Health Care Complaints to Reveal Hot Spots and Blind Spots in Quality and Safety

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Policy Points:
- Health care complaints contain valuable data on quality and safety, however, there is a need to analyze them better.
- We demonstrate a method to analyze health care complaints that provides reliable insights on hot spots (where harm and near misses occur) and blind spots (where standard failure is hidden and thus not obvious).

Image: Jennifer Poyer, ‘only the blind spot mirror in focus’.
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What are the implications for boards and their members?
Key messages

- Be attentive to silences and alert to changes
- Seek out information missed by routine indicators
- Value softer forms of intelligence
- Avoid gesture-based openness

- Delegate responsibility for monitoring safety
- Distribute skills, knowledge and accountability
- Ensure clear systems for escalation and attention
- Seek assurance, and probe it
Recognising structural secrecy and its consequences

- Structural secrecy: “the way division of labor, hierarchy, and specialization segregate knowledge about tasks”²³,²⁴
- An inevitable feature of large, complex, bureaucratically ordered organisations
- But it can be significantly worsened by boards’ dispositions
  - Tendency to seek out comfort-confirming data
  - Preoccupation with compliance
  - Incentivising secrecy through insensitive performance management
An important component of a ‘high-reliability mindset’

Less about the presence of hazards than about the fallibilities in an organisation’s means of detecting and managing them

Well honed, it
  - encourages probing of weak signals
  - avoids complacency
  - prompts useful discussions about risk
Making good use of the non-executive function

- Independence, knowledge, challenge of the non-executive director role is a vital component in the design of safer organisations

- “A mechanism that questions the organization’s own model of the risks it faces and the countermeasures deployed [...] necessary for reframing in cognitive systems in general”

- A particular role in creating spaces that can
  - advance psychological safety
  - allow people to say the unsayable
  - mitigate structural secrecy
Meeting people on their own ground

- Rarely will problems of safety present themselves unambiguously as such
- Complex systems and processes, marginal decisions, necessary workarounds, fine judgement calls
- Systems of which those who speak up are themselves a part—and problems in which they may have played a part
- Issues and people are unlikely to sort themselves into ready binaries
“The question isn’t ‘Can a computer system exercise judgement?’ It’s ‘Can a computer system handle uncertainty?’ Because judgement is a human faculty, ability, facility: it’s something we have in our toolbag which amongst other things helps us handle questions of uncertainty. Systems can handle uncertainty, but entirely differently. They use brute-force processing, huge amounts of data, clever algorithms. And this I think is a conceptual challenge for all of us, that these machines can perform tasks that historically we thought could only be performed by human lawyers, they perform tasks not by copying the way the lawyers work, not by mimicking our cognitive processes, but by using their distinctive attributes.”

(Richard Susskind, interviewed on Law in Action, BBC Radio 4, 9 June 2023)
Some concluding thoughts
Some concluding thoughts

- This is difficult.
- It is time consuming, resource intensive, replete with uncertainty.
- Insights of new or external schools of thought on safety are helpful.
- So too are some of the oldest ideas around safety in the book: redundancy and a ‘Swiss cheese’ model of organisational intelligence.
- Monitoring, assurance, improvement are a process, not a fixed state— but certain principles, dispositions, activities can help to achieve it.
“There is no such thing as a perfect organisation. The best we can ever hope for is that an organisation is self-aware, recognises its issues, and deals with them effectively.”

(Bill Moyes, quoted by John Coutts)
Thank you.

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References

References (continued)


