

QPS TalkTime

A community of quality and patient safety improvers

Thursday, 5 October from 13.00 - 13.45

IADNAM Conference special

"Creating tomorrow today: how to prepare for a radically different future"



with Dr Helen Bevan

TIT.

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar ^{Oifig an Phríomhoifigigh Cliniciúil}

National Quality and Patient Safety Directorate



 Network of Nursing and Midwifery Leaders established to develop promote and support excellence in health care in partnership with recipients, professional practitioners, regulatory bodies and policy makers.



 A high profile energetic body and a locus of expertise for access by all healthcare professionals which is available to policy leads to seek the advice and participation of Nurse and Midwife Leaders on policy, practice, operational and investigative matters.



An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar ^{Olfig an Phríomhoifigigh Cliniciúil}

áin National Quality and Patient Safety Directorate

Speaker today



Dr Helen Bevan

Professor of Practice in Health and Care Improvement at Warwick Business School, University of Warwick and a Strategic Advisor to the NHS Horizons team

In conversation with



Fiona Hanrahan

Executive Irish Association of Directors of Nursing and Midwifery (IADNAM) Director of Midwifery & Nursing Honorary Clinical Associate Professor (RCSI) The Rotunda Hospital,



Dr. Orla Healy

National Clinical Director, National QPS Directorate

Co-hosted by



Maureen Flynn, Director of Nursing, QPS Connect Lead with the National Quality and Patient Safety Directorate

@QPSTalktime

@NationalQPS #QIreland





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What the session is about?

The speed and complexity of change is increasing exponentially. Yet many of the methods and approaches we use to enable change aren't getting the results we need as quickly or as widely as we need them.

Helen Bevan will help us

- Focus on how we mobilise people around the potential for a radically different future so that we are better prepared for that future.
- · Gain some fresh perspectives on creating and sustaining change
- Give us ideas on how we build capacity for change



How we are running today's session



You will be muted but the chat is open throughout - please post any questions or comments there and we will address them after the presentation.



 If your tech fails, don't worry – we're recording it so you can watch back on the NQPSD YouTube channel and access the slides at your convenience.



Audio is available via your PC or dial in: +353-153-39982 Ireland Toll +353-1526-0058 Ireland Toll 2 Access code: 2734 860 8306



- Please feel free to continue the discussion on Twitter / X: @QPSTALKTIME
 - @NationalQPS | @HelenBevan | @mapflynn | @IADNAM1 | @NurMidONMSD | #QIreland | #patientsafety |



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• You will receive an email from QPS TalkTime confirming your attendance

To get started ... we invite you to

Share using the chat box

• Your name, work and where you are joining us from ...

• Finish this statements:

"The magic ingredient to energizing change is ..."



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IADNAM Conference Thursday 5^a October 2023 Radisson Blu – Co. Sligo

> Healthcare at a Crossroads; Leadership, Integration and Consensus for the future

Creating tomorrow today: how to prepare for a radically different future

Dr Helen Bevan, OBE

@HelenBevan @GoranHenriks

Professor of Practice, Warwick Business School, UK

Strategic Advisor, NHS Horizons, UK

Based on collaborative work with Goran Henriks, Jönköping Region, Sweden

What kind of system do we want for the future?









Our success is measured in lives and health



REGION JÖNKÖPINGS LÄN



Continuosly improve daily work and invest in innovation; Innovate and learn everywhere at the same time – we need simple rules to unite people in systems thinking



If we want to get a large group of people to behave differently, with everyone moving in a coherent direction, there are at least two approaches we can follow

1. Policies, approvals and top-down cascade



Create clear polices and operating systems & hold formal leaders to account

2. Alignment through simple rules



Identify a few simple rules that everyone is accountable for, operating in conditions of greater individual freedom

"A set of several simple rules leads to complex, intelligent behaviour. A set of complex rules often leads to a dumb and primitive behaviour." Michael Dubakov



Oldham's simple rules for managing COγIΠ

Oldham OVID-19 Approach 1. Keep Current with National + NOA* Guideling 2. Defer & experts! 3. Co-ordinate don't confuse 4. Keep Calm 5. Stay Kind i # Coronakindness #Bekind To Each Other

*Note: the NCA is the Northern Care Alliance, the local NHS system of which Oldham is part



https://blogs.bmj.com/bmjleader/2021/02/01/creating-tomorrow-today-seven-simple-rules-for-leaders-by-helen-bevan-and-goran-henriks/







Source: @NHSChangeDay

What is psychological safety?



"A shared belief held by members of a team that the team is safe for interpersonal risk-taking".

"It describes a team climate characterised by interpersonal trust and mutual respect in which people are comfortable being themselves." Amy Edmondson The Fearless Organisation

The psychological safety scan









Willingness to	Inclusivity &	Attitude to risk &	Open
help	diversity	failure	conversation

The degree to which people are willing to help each other.

The degree to which yo can be yourself, and are welcomed for this.

The degree to which it is permissible to make mistakes.

The degree to which difficult and sensitive topics can be discussed openly.

Source: The Fearless Organisation Scan

The hierarchy of capabilities: the further up the pyramid people go, the more we maximise the contribution everyone can make



Source of model: Gary Hamel, Michele Zanini (2020)

Humanocracy: creating organisations as amazing as the people inside them

Embracing failure: "The right kind of wrong"

Right Kind of Wrong Why Learning to Fail Can Teach Us to Thrive



Failure: "an outcome that deviates from desired results"

Basic failure: caused by carelessness or ignorance.

Complex failure: caused by multiple factors, none of which would have caused the failure on its own. Often the result of a complex system that is difficult to understand or manage.

Minimize the chances of both occurring by paying close attention and catching mistakes before they spiral out of control, e.g. checklists, teamwork, applying principles of psychological safety

Intelligent failure: arises from thoughtful actions or experiments and result in useful learning, allowing us to move forward Summary of the book from Harvard Business School Working Knowledge

Criteria for "intelligent failure'



Curiosity in an uncertain territory with no readymade answers





Intelligent failure is a part of meaningful opportunity towards a valued goal



AS SMALL AS POSSIBLE

Design smart pilots to test new ideas before full scale launch

INTELLIGENT FAILURE

one that leads to unexpected discovery, doesn't cause harm and generate useful new learning

Occurs when answers are not knowable in advance

Intelligent failures are not errors



Could we develop a "Trojan mice" strategy?

Having many people across the system who have the skills and agency to test out small, well focussed changes to address complex problems (Trojan mice) nearly always works better than large pilot and roll out projects (Trojan horses).





"Trojan mice... are small, well focused changes, which are introduced on an ongoing basis in an inconspicuous way. They are small enough to be understood and owned by all concerned but their effects can be far-reaching. Collectively a few Trojan mice will change more than one Trojan horse ever could." (Jarche, 2012).

Trojan mice fail often, fail early and learn greatly



https://ssir.org/articles/entry/wheeling in the trojan mice#



https://blogs.bmj.com/bmjleader/2021/02/01/creating-tomorrow-today-seven-simple-rules-for-leaders-by-helen-bevan-and-goran-henriks/



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Connect with us







National Quality and

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Patient Safety Directorate Office of the Chief Clinical Officer An Stiúrthóireacht um Ardchaighdeáin

Dates for your diary....



QPS TalkTime



National Patient Safety Office

A community of quality and patient safety improvers

Thursday, 19 October from 13.00 - 14.00

NPSO Conference special

Live from the Printworks in Dublin Castle



CONNECTING PEOPLE INTERESTED IN QUALITY AND PATIENT SAFETY

#QIreland

Let us know how we did today

Reminder: Short questions (pop up) as you sign off, please help us to improve our QPS TalkTime Webinars by sharing your feedback

We really appreciate your time, thank you.



Contact: <u>Kris.Kavanagh@hse.ie</u> to be included on our mailing list to receive QPS TalkTime invitations