

# Patient Harm: strategies for solving a wicked problem

## *Exploring patient safety from a complex systems perspective*

The conference began with a welcome and safety briefing from Alastair Mitchell-Baker, Director of Tricordant. Alastair mentioned he was the non-executive “patient safety champion” for his Trust. He hoped the conference would help answer the question – what to do, to make a difference? Participants then considered a patient safety vignette, based on a real life scenario. The conference then proceeded to explore the complex issues behind such scenarios from a variety of organisational and systems perspectives.



The scale of the patient safety challenge facing the NHS was first set out by the CMO’s “Organisation with a Memory” report. Wendy Harris summarised the Department of Health’s recent progress report, “Safety First.” Progress has been made in the apparent growing commitment of leaders, strengthening governance in NHS Trusts, development of NPSA reporting systems, strengthened national safety standards and safety alert bulletin processes. Despite all this, the NHS continues to harm more than 1 in 10 inpatients and waste over several £billion on the consequences of patient harm. “Safety First” emphasises the need to make patient safety a priority through national collaboration, local leadership, effective learning processes and better involvement of local staff and patients.

The challenge of improving patient safety was set within a broader context of the study of disasters and accidents by Marc Gerstein. Why for instance did the US fail to do anything when it was known that Hurricane Katrina was coming, and what the likely impact would be? Over 1000 lives were lost and the area faces a restoration bill of \$200billion. He identified the need for organisations to be able to identify and manage three different regimes to cover high risk potential accidents/disasters, business as usual and innovation. This was challenging and required careful organisational design. In fact Marc’s research indicated that failures in organisation design were a major factor in disasters. However we do know much of what needs to be done to address this. There is much learning for instance from high reliability industries such as nuclear power.

The conundrum – part of the wicked problem – is that despite knowing what to do, we fail to do it. We have become aware of a huge issue but seem unable to really address it. We can “know” what needs to be done and yet the problem appears to persist. It appears to be a “wicked problem, which resists definition and solution. To address it might require much behaviour that runs counter to intuition and political realities.

Robin Youngson developed this further by exploring why given the huge, rapid and varied change in world and indeed in healthcare, the system seems apparently locked in a persistently unsafe mode? From a complex systems perspective there appears to be a safe and an unsafe mode which healthcare systems can operate in. The unsafe mode seems to be driven by the toxic relationships based on the beliefs and consequent behaviours of the main players – patients, clinicians and managers. Robin described how the leadership of his hospital reacted to a horrific accident where a mother was set on fire during a caesarean section and suffered major burns. They used open disclosure, leading to changes in the beliefs and consequent

### ***Locked in an unsafe mode?***

*Between 2002 and 2006 the 35 million passengers flown by US owned airlines saw no accidents. There were 15 million episodes of harm for the 37 million US hospital inpatients in the same period!*

behaviours of clinicians and managers – and subsequently of patients. This has contributed to a “flip” into a safe mode of care in the maternity service – which has amongst the best outcomes for mothers and babies in Australasia. Central to this change in beliefs and behaviours is a reassertion of compassion at the core of healthcare. Robin’s challenge to us all, was do we as leaders give permission to others to care?

Leadership and management can not be divorced and are both needed for effective healthcare systems. As Alistair Mant explained a key aspect of leadership is the exercise of judgement – deciding what to do when it is not clear what should be done. He also outlined a model of ternary leadership whereby leader-follower relationships are governed by reference to an external set of shared values and purposes.

Hugh Ross outlined the practical lessons from the MA and NHSI’s action research programme aimed at reducing hospital standardised mortality rates. They had seen reductions of 10% in mortality – applied across the NHS this would equal 10,000 saved lives. Key lessons were the use of early warning scores, improved staff communication and the need for local ownership and adaptation of improvement approaches. Hugh also emphasised the importance of improving reliability – addressing the high frequency perhaps lower impact events as well as the safety solutions addressing the lower frequency high impact events.

The emphasis on reliability and the link between efficiency gains such as reduced lengths of stay and reduced mortality was echoed by Simon Thane’s reflections on the lessons from the lean manufacturing revolution. He explained how the huge improvements in quality [from 5% scrap to 0.0025%] *and* productivity, came from a whole system approach, changing the strategy, systems, culture and very identity of organisations. UK manufacturing had a “burning platform” – the threat of Japanese competition. Despite the appalling statistics quoted earlier, do we feel we have that same compelling sense of need to change in healthcare?



The issue of patient harm seems analogous to that of manufacturing product quality during the pre-total quality movement of the 1970s and onward. Just as quality needed to be understood as a systems issue, the same is true of patient harm. It has elements at the level of the individual, the group, the organisation and the larger political and social context in which it is embedded. The transformation in manufacturing quality came from a whole system approach that also improved productivity, staff motivation and customer service. Despite the clear differences between healthcare and other industries – there was the same need for a radical whole system change, improving the overall capability and excellence of health services. Furthermore this would improve patient safety, *and* staff motivation *and* patient responsiveness, *and* productivity. This will require courageous leadership from all of us within the healthcare system – placing compassionate and safe care back at the heart of healthcare.

As conference participants reflected together, we identified the opportunity to develop a “community of practice” from the conference to share and learn around patient safety. This could link into the growing interest internationally in the contribution of approaches of systems thinking and organisational learning to patient safety. We also accepted the importance of Board focus and leadership of the transformation needed. Putting compassionate care back at the heart of healthcare is a key part of the transformation needed towards a safer healthcare system. Accepting individual accountability is key. Patient safety is a challenge for each of us – we can and must make a difference. “It’s personal” as one highly experienced participant put it.

The conference was rated as very useful and stimulating by the participants. There was particular praise for the expert facilitation by Valerie Iles and Phil Hadridge.

#### References and resources

1. Copies of all speaker biographies, presentations, papers and web links are available from [www.tricordant.com](http://www.tricordant.com).
2. An organisation with a memory. Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer. DoH 2000.
3. Safety first: a report for patients, clinicians and healthcare managers. DoH 2006.
4. Organisational Bystanders. Marc Gerstein and Robert Shaw. 2006.