Culture issues in another complex industry.....

Martin Bromiley
Chair, CHFG

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The challenge of culture change in one of the largest and most complex organisations in the world. Where multiple tribes and hierarchical organisations work in close proximity in a safety critical environment, yet at the same time attempt to resolve conflicting approaches between regulators, policy makers and the frontline……

……..the NHS

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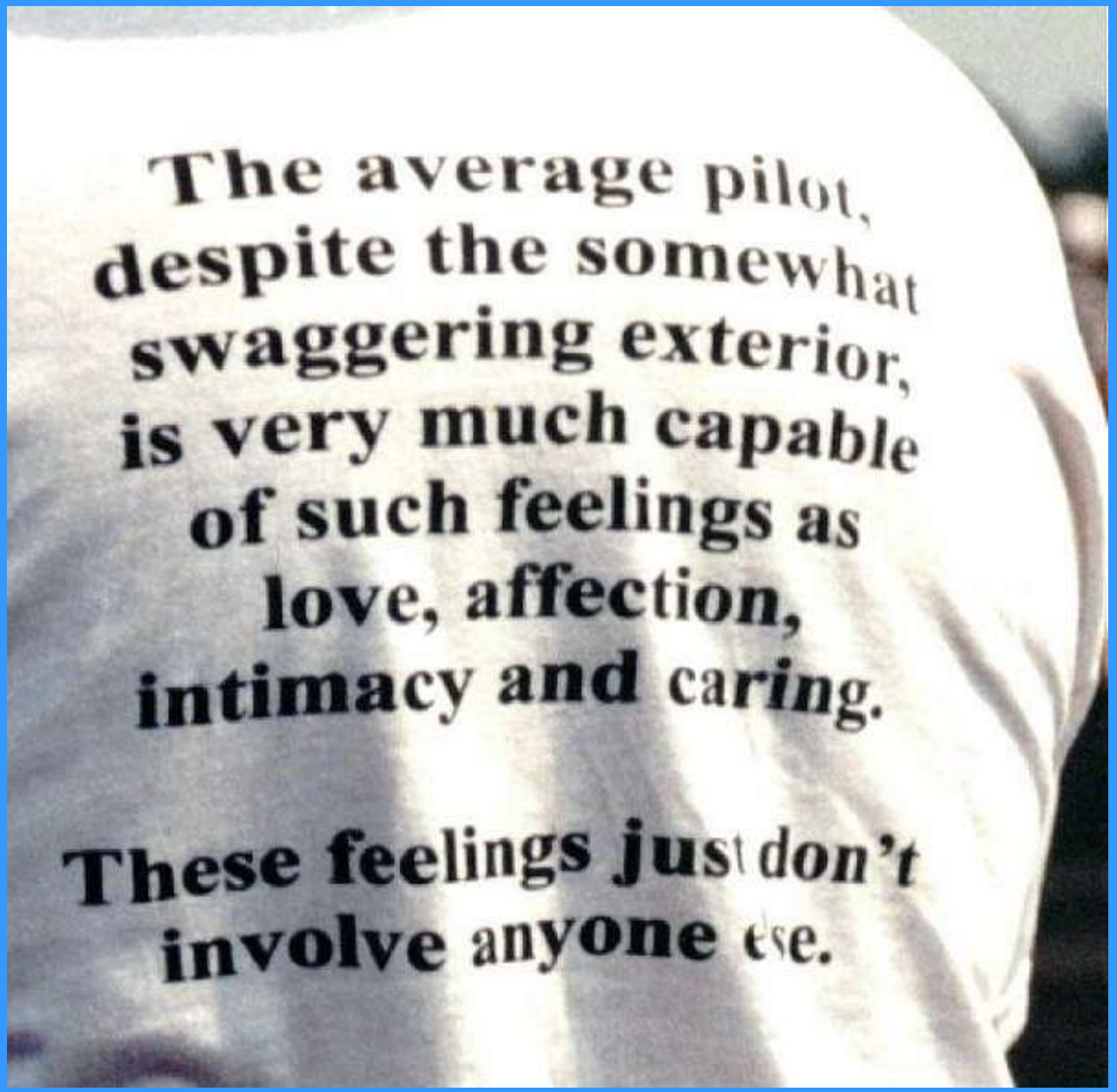
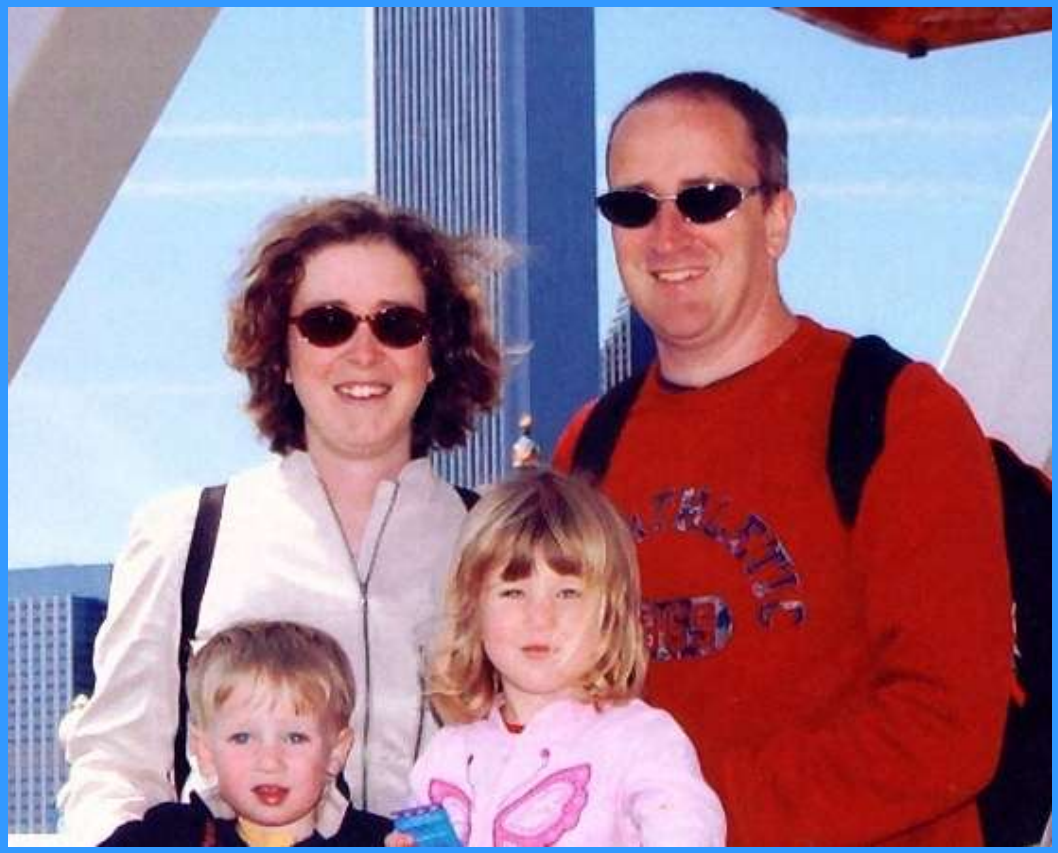

The average pilot,
despite the somewhat
swaggering exterior,
is very much capable
of such feelings as
love, affection,
intimacy and caring.
These feelings just don't
involve anyone else.



Healthcare 2005 – A production line mentality

- Productivity was everything
- Human error due to poor performance and weakness, technical perfection is the cure
- Safety usually down to luck, no real concept of what safety is anyway.....

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“As a Junior Doctor with no special interest in patient safety…”

Healthcare 2005 – what we now know

- In one year 3,283 patients dead through preventable error – in England alone
- ~1 in 10 patients suffer some form of unintended harm
- ~1 in 300 will die as a direct result of error

(Data from Parliamentary Inquiry into Patient Safety, 2009 and DH/NAO publications 2005-2009)

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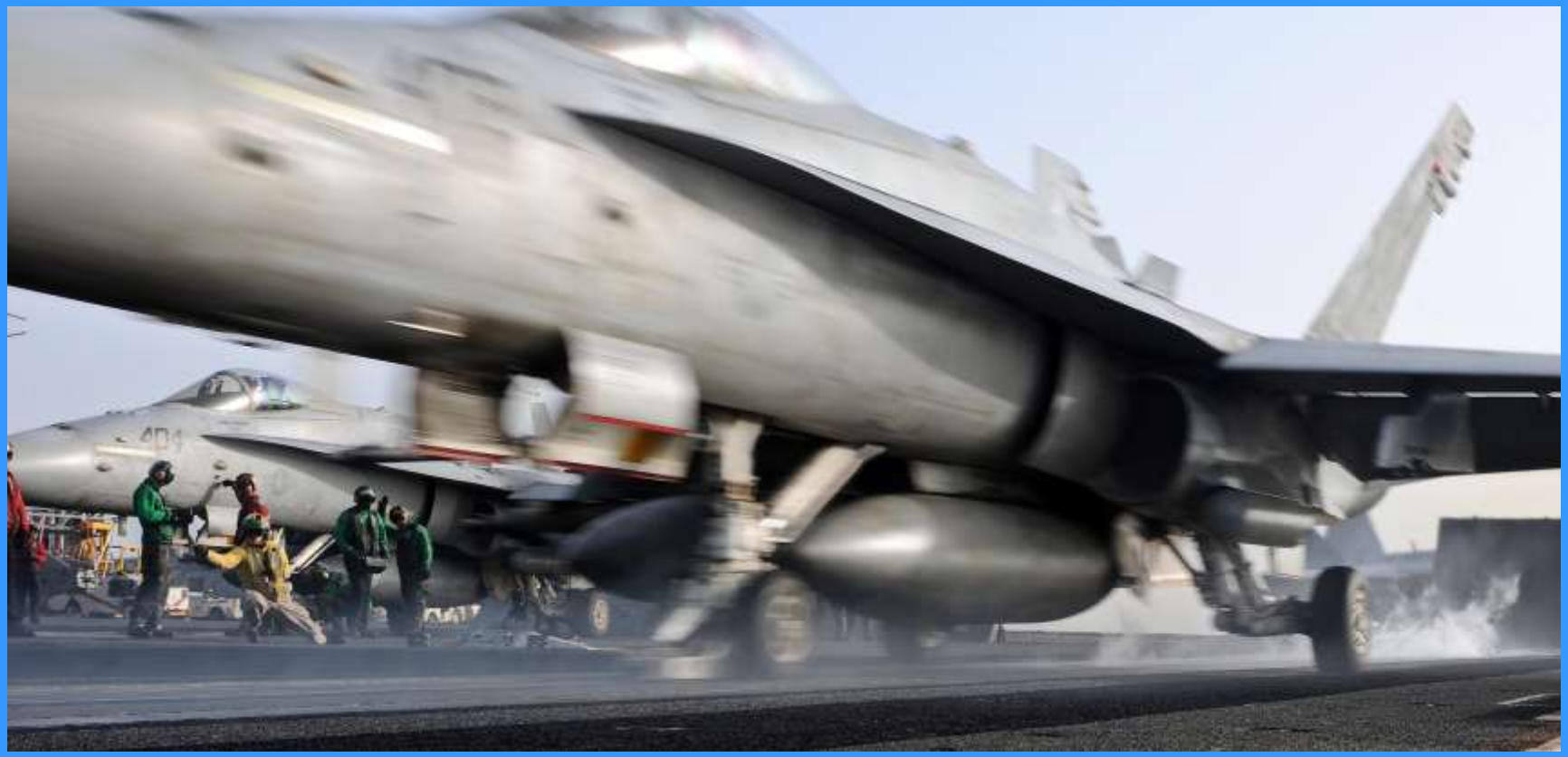
WELCOME !
SCHOOL


TOWNSEND THORESEN
TACA



2007, the goal – to shift the culture of healthcare….

- **Dr Jane Carthey** – HF Specialist
- **Tony Giddings -** Former member of the Council of the Royal College of Surgeons Eng
- **Jane Reid –** President, International Federation of Perioperative Nurses
- **The late Prof Helen Muir -** Cranfield
- **Prof Jim Reason –** Univ of Manchester
- **Matthew Sargeant –** Hywel Dda Health Board, Consultant Psychiatrist
- **Cate Quinn** – Care Quality Commission
- **Prof Charles Vincent** – Imperial
- **Sir Ian Kennedy** – Chair HCC
- **Carey Edwards** – RAeS
- **Prof Sydney Dekker** – Lund University
- **Nikki Maran** – Scottish Clinical Simulation Centre
- **Prof Rhona Flin –** Univ of Aberdeen
- **Linda Watterson –** Royal College of Nursing
- **Allan Goldman** – Consultant Intensivist
- **Mark Emerton** – Orthopedic Surgeon
- **Stephen Ramsden** – Chief Executive L&D NHS Trust
- **Dr Melinda Lyons & Bev Norris –** HF Specialists representing the NPSA
- **Hugh Rogers & Nikki Davey –** representing the NHS Institute
- **Prof Nick Barber** – Prof of the Practice of Pharmacy, Univ of London
- **Paddy Carver** – Ex CAA

Clinical Human Factors Group
www.chfg.org

We are independent, impartial, and work in a voluntary capacity…

Our vision is to engender human factors thinking in the hearts and minds of all healthcare staff and stakeholders.
From board to ward and beyond…

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Our strategy – to shift the culture of healthcare….

....but command & control and regulation struggle to work in the healthcare community

Our strategy – to shift the culture of healthcare….

- "Targeting" specific individuals to engage with and involve
- Building a website with resources as a focal point for creating a "community"
- Being aware of organisational politics, but not being constrained by the politics
- Recognising that you can't understand culture if you don't understand why people behave like they do
- Building relationships with journalists and using the national press to engage those within the system
- Creating opportunities for frontline operators, academics, researchers, enthusiasts, policy makers, and managers to mix, across organisational boundaries

Healthcare today – the story so far – our contribution?

Political & Policy level recognise that:

Error is normal and the system is usually the cause

A need for cultural shift to “high reliability”/aviation model

Standardised practices give reliable outcomes

HF critical & a national strategy is under development

Frontline level:

HF & Safety much more widely discussed & now part of some medical training

The human “condition” better understood

CRM, notechs & simulation more common

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Lessons? – Understand the culture

- Frontline people are your source of information, they are the REALITY of your operation – understand the real impact of the rules you create
- Talk through your observations with outsiders

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The lessons of Mid-Staffs
Between 400 & 1200 preventable deaths can occur and not be noticed

Production targets, organisational insularity and tick box regulation create conditions ripe for disaster - "whistle blowers become a nuisance"

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Lessons? – Levers/Influencers for change

- Regulator?
- Boss?
- Public & Politicians?
- Charities, Think-tanks & Researchers?
- Press/Journals?
- Victims & Relatives?

.....or peers?

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Lessons? - Strategy

- Top down and bottom up, multiple sources – multiple messages – same themes
- Narrative and story better than data; but personal data more powerful than organisational data
- At senior levels the business case for safety is interesting, but the story is still more engaging

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Thank you……want to learn more about HF in healthcare?

- Have a look at www.chfg.org & register to stay in touch
- Pick up free resources on the website inc those below
- In the next couple of weeks our “Human Factors How to Guide” will be joined by Volume 2
- Strategic guide for Boards about culture and HF due 22 May
- Watch out for our next free seminar due autumn 2013

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