

## Lynne Maher

I: Well, I'm very lucky today to have with me Dr Lynne Maher who is head of innovation practice at the UK's National Health Service Institute for Innovation and Improvement. Lynne, thanks very much for coming. I wonder if we could, perhaps, start, with you telling us a little bit about the role of the institute for innovation and improvement. We've got this huge health service in the UK, lots of challenges. How does the institute contribute?

LM: Well, the institute's main focus is on helping the NHS overcome some of its greatest challenges. That might take the form of: looking for new ideas to help get over the challenges that we don't seem to have got over in the past or not working as well as we might; helping the workforce in terms of building their skills and capability; and developing products such as manuals or case studies or toolkits that people in the NHS can use to help them with innovation and improvement.

I: So, it's very much a support for the practitioners in the very large and very widely distributed health service, but it's providing them with tools and resources, but you're feeding that, also, with your own research so that you're generating new tools, new techniques, new approaches.

LM: Yes, we like to consider ourselves as 'thought leaders'. So, we are absolutely searching for new approaches as well as supporting staff, in terms of helping them to understand what these new approaches are, how they can use them, how they can benefit from them. And it is practitioners, but I'd also say we work with senior leaders as well. So, for example, helping chief executives to understand the benefits of working with other companies outside the health arena, for example, to inspire them with new ideas, learning from how the other companies do things, for example, their own customer service work or access or systems. So we work with leadership teams right through the whole gamut of health service staff to junior frontline practitioners and we've done some fantastic work with portering staff, to help them develop their roles to provide a service and to help them develop a mechanism where they can be accredited for competencies that they learn. So, really turning portering services on their head, because they've never before had competencies or career aspirations. They tend to be a group of staff who stay in the same place for 30 years.

I: So, very much the work is around how to manage innovation more effectively and how to engage all the players in that very big system.

LM: And how to make a practical difference.

I: Absolutely. Within that context, I know one of the things you've been working on is what you've called 'experience-based design'. I wonder if you could tell us a little bit about that and perhaps give us a couple of examples

LM: Yes, this came across because the NHS does have an aspiration to work with patients and we had a policy directive even called a 'patient-led NHS'. But, when it was examined how that translated practically in the NHS, it was discovered by the healthcare commission that being an NHS patient was still very frustrating and it certainly wasn't patient-led. Now, it got us to think about, well, how do other industries approach their relationships with their customers, because, if we're putting ourselves in that situation with patients, we could see them as our customers?

So, we started to look outside the health service and said, 'What do others do?' In our research, we came across some fantastic work that had been done by design agencies. Design agencies, they might design products, but there are design agencies who design services: the way we go into a shop, the way we check in and out of hotels, the way we go into airports and everything we do. Design agencies work very closely with the end consumer to design a service that gives that consumer a good experience, because, if the consumer's had a good experience, they want to go back.

Now, even though that's set in a commercial world, we realised that there were big gains from learning and taking some of their practices into healthcare, because what we want is, not only for patients to have effective, safe, timely treatment, but we want them to have a good experience. What we were finding was, even if the process of care was seemingly very slick, very efficient, very safe, it could be that the patient's experience of that care was diabolical, in some respects. Alternatively, we spoke to patients who had probably not had the best clinical care that we would wish, but, actually, because their relationship and their experience had been good, they would rate that care very highly.

So, I think that led us to understand the importance of understanding the experience of patients as they go through their healthcare process. In addition, we expanded that a little bit, because we also looked at the experience of staff delivering the service. So, we looked at the experience of staff delivering the service and the experience of patients receiving the service. Both together are so powerful. People come from different mindsets, but, when you get them together, we can very clearly highlight the areas in the process of care that provide a poor experience. There is a good correlation between poor experience of staff delivering, because they feel that they're not delivering it well, and the experience of patients receiving care.

Then, rather than what we might have traditionally done as professionals and said, 'OK, we've got this information and now we are going to work out the actions that will improve this,' we worked very closely with patients and we call it 'co-design'. So, we are co-designing with the end users to say, 'How do you think this should be made into a better experience? How can we put this right?' So, we were getting their ideas. Some patients were leading project groups themselves. They were willing and able and they actually led project groups. So, that was kind of interesting in terms of typical patient/staff role.

But we've got absolutely tangible improvements from that and they range from issues around dignity. So, for example, some patients were in a clinic and they were called into the clinic and taken around a corner and then asked to step on a pair of weighing scales. When they looked up they realised that they were standing right back in front of the whole clinic and everybody was looking at them in the waiting area. They found that very embarrassing. While nobody could see exactly what they weighed, the nurses were asking them to take their shoes off and their coats off and the men were mainly worried about their socks, but the women were mainly worried about how much they weighed. It was just uncomfortable and something that was very easily, in five minutes, put right.

There were other issues around information, which we get so wrong, because we always write it from a professional perspective. When we'd identified, together with patients, the issues around information, rather than us going and writing it or the professionals, the patients took it away, they rewrote it and then they gave it back to the professionals and said, 'Put your official bits in.' So, it completely flipped it on its head and changed the focus from staff who were worried this was going to create more work, because they had no more work; the patients were doing the work. Actually, we later found out that one of the patients had professional writing skills, so was probably more able to do that than any of the staff.

There are lots of other examples. A particularly hospital, who were working with patients who'd had a stroke, through experienced stories, patients talking about what worried them, what caused them anxiety, they discovered a link between patients going to the toilet with a stroke that affected one side in particular, because the toilet roll holder was on the other side. When they reached over, they had more of a tendency of falling off the toilet or falling into the wall and causing distress. There was a correlation between the number of accidents – people falling and hurting themselves – and the side of the stroke. Again, immediately, when that came to light, this particular organisation put toilet roll holders on both sides. Very simple, easy things that, actually, benefit the patients – the patients now feel safer, they're not going to fall – benefit the organisation, because we don't want to be filling in accident forms, staff don't want to do that, and, often, if the patient had fallen, they could've hurt themselves and it would've prolonged the length of stay. So, for the patient, for the staff and for the organisation, there has been quite massive benefits.

I: This is fascinating stuff and, clearly, it has a link to some of the innovation theories around bringing users into the innovation process right at the front end. You've given some great examples. I guess the other question that begs is what are the difficulties in actually making this kind of thing happen? It seems to me almost a no-brainer that we want to have a better quality experience all round. What are the difficulties in actually making that happen?

LM: I think some of it is about mindset. So, we tend to do the things that we've always done and then we get surprised when it turns out the same. Every

organisation would say it does engage patients and we do an annual satisfaction survey where they tick the boxes and organisations will have patient forums. But still, with all of those, there is a barrier and there is a stopping point. So, the patients are over there in the forum or writing their patient satisfaction survey and the staff are still behind their barriers, if you like.

What we found is it's quite a difficult transition for staff to relate to patients in a different way. They're slightly fearful, because we always talk from our professional perspective and now we're talking, using a slightly different language. We're not sure as professionals, we're a bit under confident, we think we should be taking charge. It was quite an effort when a patient wanted to run one of the project teams, because we think we should do that; that's our role, we're the professionals. So I think there's quite a lot of anxiety about who's in what role and what does that mean?

The other thing is, this, undoubtedly, needs a lot of leadership support, because if staff are unsure, a typical response is, 'Oh well, we'll default back to our old way and we'll just have a forum.' If there is strong leadership, which we have found has made a big difference in some of our pilots, to give staff confidence and time, that makes a big difference. Telling stories, listening to stories, working with patients to identify what the key touch points are where emotions and a certain part of the process come out as really important is not a five minute job. You ask any staff member in the National Health Service in the UK, 'What's the most precious commodity?' and they'll say it's time, 'We haven't got time.'

So, we need to find time, because, actually, if we can find time, we can save time. So, for example, the stroke case study I told you, means that staff haven't got to write out accident forms or incident forms, staff don't have to look after patients for extra time in bed, staff didn't have to rewrite the information, but patients had a much better idea of what was happening. There is another example of where a patient was telling a story which was a safety incident – they needed a nurse to come and look at a drip – the nurse couldn't find the equipment, it took her ages, the patient was getting anxious, the staff member was getting anxious and there could have been a safety incident. Because that story came out and we were able to work together with the staff member and the rest of the ward staff and the patient to relocate the equipment and put it all together, the staff member had to go to three different cupboards to find the right equipment. It used to take about eight or nine minutes to find the equipment, now it takes two. You need one or two things like that, that can easily release an hour a day. So, time, but I think some of that is a mental block.

I: One last question prompted by this discussion of the user's experience, the patient's experience: many of the examples you've given are around improving the quality of what's actually happening for everybody concerned and that's, as we know from so many sectors, hugely important. Are there examples where that process

also generates a completely new way of thinking, perhaps opens up completely new innovations?

LM: Well, I think yes and there are some examples around looking at how to provide emergency services. There is a hospital in the United Kingdom who have joined up with a hospital in Australia, interestingly, who are also looking at their emergency services. Typically, in England, we would do a business case, we would work with architects, we'd design a new emergency room based on our understanding of how emergency rooms work. But, rather than going straight down that route, these hospitals identified a three month window where they would gather experiences of patients and of staff to say, 'Why are they really coming in here? What do they really need and what are some of the underlying problems?' Because some patients do come into emergency services because of just not being able to get access to the care they need elsewhere.

What some of that work has done has, not only changed what would have been the floor plan, but actually changed the system. So, what that prompted was more work with general practitioners, social workers and the local walk-in clinic about how we can help patients, particularly, to understand how to access services and how to get prompt services.

So, it's fundamentally changed the thinking about accessing emergency services. I think there is more and more of that to come, really based on relationships where, in other services, patients will take more responsibility for their own care, like they'll go home and fill in their own observations, because we're all intelligent people. There are some people who it's absolutely not suitable for, but I think we do patients a disservice by assuming they're not competent. Well, that's rubbish. Lots of patients can do more for themselves and want to. They want to be more involved, but, typically, as professionals, we've held that back.

I: That's absolutely fascinating. Thank you very much indeed, Lynne.

LM: Thank you.