A National Resource to support the consistent and sustained impact of the Care Aims Intended Outcomes Decision-making Framework

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Session Outline

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<td>Meet and Greet: Overview of HEIW’s offer for Sustainability and Reach</td>
<td>Alex Howells – HEIW Chief Executive</td>
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<td>1:20</td>
<td>Overview of the Core Principles of Care Aims Framework</td>
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<td>1:40</td>
<td>Group Discussion – What struck you? What are the key drivers for the public, the workforce and your Health Board? What questions does this leave you?</td>
<td>Break Out Groups</td>
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<td>2:00</td>
<td>Debrief – Q&amp;A and dialogue around key concerns</td>
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<td>Strategic Intentions and facilitators of the systemic transformation</td>
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<td>Worst fears – What might be lost if these intentions are realised and how might you mitigate these losses?</td>
<td>Break Out Groups</td>
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<td>3:00</td>
<td>Break</td>
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<td>Debrief with Q&amp;A and dialogue around key concerns</td>
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<td>Accountability, line of sight and the issue with looking for Certainty rather than Clarity</td>
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<td>4:00</td>
<td>HEIW Proposal – guidance on how to select key communication links and priority areas for action</td>
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<td>Final Q&amp;A and actions</td>
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Familiarity with Care Aims

How well do you understand the Care Aims framework?

- 1. None of our services use it
- 6. Fully understand it and use it every day

How much impact do you think it's had on the thinking and practice in your Health Board?

- 1. None, only ever heard the name
- 6. Significant impact on practice
Policy Context and Strategic Intentions

- Well-being for all – the public, families, communities, all agencies’ leaders and staff working as equal partners
- Best use of all expertise and resources - acknowledging the unique contribution each person makes to the outcome
- Limited intrusion in people’s lives - supporting resilience and capacity in all service users
- Reduced health and well-being inequalities - proactive, asset-based, community-focussed relationships
- Confident and capable practitioners and leaders - moving to outcomes-driven conversations and decision-making
- A system that makes sound improvement (governance) decisions - continuous reflection on outcome and reasoning, building trust and relationship and facilitating professional autonomy and accountability for improvement

A Learning Health & Care System

The National Clinical Framework ...

- "envisages that health boards and trusts take a population health approach to planning services, grounded in the life course approach.
- Sets out how (they) should adopt service innovations and higher value clinical pathways in a way that fits their local context.
- Emphasises the importance of local organisations applying quality system methodology and the duties of quality and candour. It reinforces the need for clinical teams to embed quality assurance cycles and clinicians to adopt prudent in-practice behaviours.
- ...Highlights the importance of using data on what matters to patients ...

page 11
“Its message is don’t wait to be told. This Framework is your permission to act.”

**Vaughan Gething**

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How hopeful are you that everyone will hear and embrace the permission to act?

- Very pessimistic
- Not hopeful
- Hopeful
- Very hopeful

Adapted from slide by Derek Mowbray 2008

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“There is nothing more difficult to take in hand, more perilous to conduct or more uncertain in its success, than to take the lead in the introduction of a new order of things.”

**Niccolo Machiavelli**
If the answer is 82% ... what is the question??

What proportion of transformational change projects fail?

The TRADITIONAL Language of Systemic Change ...

BEHAVIOUR
TASK
INPUT
WHAT?
ROLE

PROCESS
APPROACH
STRUCTURE
HOW?
OUTPUT

Leads us up the road of certainty

Most people think the doing. This raises anxiety about how?, when?, and what? And how much? everyone should be doing.
Care Aims Framework draws on …

A large body of research that elucidates the factors that support optimal professional practice. In particular:

- The knowledge management literature from other sectors that indicates that tacit rather than explicit research-base knowledge underpins most professional work
- The psychology of human change literature that indicates that collaborative decision-making is at the core of professional effective practice

Professional Decision-making is the Art and Science of Uncertainty

Relies on

- knowledge of interactional & causal relationships (book knowledge)
- competencies acquired through experience coupled with a process of prior learning
- learning acquired through hypothesis-driven decision-making and individual reflections on personal experiences

“More important than the quest for certainty is the quest for clarity.” Francois Gautier

In seeking certainty and pinning it down, in the belief there is a right and wrong way to do things, we depersonalise our decisions and lose reason, autonomy and choice (resilience).
Culture change needed?

- **From:**
  - Explicit knowledge
  - Prescriptive guidelines
  - Generalized "one-size fits all" implementation of practice guidelines
  - Hyper-rational approaches to evidence (scripts and heuristics)

- **To:**
  - Tacit knowledge
  - Knowledge management
  - Collectively constructed personalized "mind-lines"
  - Contextualized communities of practice that support whole systems learning and improvement

Ref: Gabbay and le May, BMJ, 2004;329;1013

What’s the snag??

- Anxiety

"I support you all the way, but I don’t want to mention the elephant in the room." #122300
Containing anxiety in institutions

Isabel Menzies-Lyth (1988)

... the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety (p78)

... the nature of that anxiety is intimately connected to the primary task of the institution.

The primary task being the 'task [the organisation] must perform if it is to survive'. (Miller & Rice, p33)

Functional vs Dysfunctional Learning Cycles

Adapted from: Vince and Martin 1993

The answer?

Move away from role and hierarchy

- Uncertainty cannot be removed; leadership teams need to become more comfortable and skilled at working with the unknown – negative capability
- Find ways to de-personalise conflict - focus conversations on outcomes not on tasks, roles or directives
- Embrace uncertainty, it unlocks autonomy and supports the workforce to co-create their own solutions to complex challenges
- Accept emotions – they are valuable data – listen at a much deeper level to support insight and learning - not knowing can be frightening for everyone!
The Care Aims Framework is a framework for decision-making and evidence-based practice that enhances the negative capability built into the clinical reasoning process, to maximise learning.

- A person-centred approach to collaboration around intended outcome
- A set of principles to guide complex decisions and ensure personal responsibility is retained to promote independence, autonomy and the best possible outcomes

What does it involve?

It represents a significant transformation in culture, mind-set and expectations throughout the system which involves:

- Using knowledge and expertise differently
- Recalibrating the concepts of duty, risk and need
- Repositioning service users (at all levels) from consumers to collaborators
- Changing governance methodology to ensure reflective practice is at its core

How is Care Aims different?

Care Aims focus

- People and their lives
- Impact-based reasoning to guide duty of care
- Person-centred outcomes
- People in control and taking responsibility for outcome, at all levels
- Collaboration/co-production at service boundaries
- Early access to expertise and knowledge

Traditional focus

- Patients/Service Users
- Problem-based reasoning to guide duty of care
- Condition/disease-centred outcomes
- Service responsibility for input and outcome
- Thresholds and referral eligibility criteria
- Delayed access to expert treatment
An outcomes framework helps us tolerate uncertainty

…when we change the order of things!

We need to start with what we can discover not what we can deliver

The Care Aims Framework is not...

- a service delivery model
- an approach to care
- a set of forms/paperwork
- an outcome measure
- a process to be followed

You cannot do Care Aims!

Care Aims
Core Beliefs, Values & Principles
If 82% of transformation fails…

…how can we ensure this is one of the 18%??

Who needs to change and Why?

- Does everyone agree change is needed?
- Has everyone contributed to the Vision and Core Ambitions of this shift in practice?
- Does everyone understand what good would look like?

The natural order of things
Modes of "Leading"

Which is most common in practice?

Ownership and Responsibility

I decide the outcome …

We agree the outcomes together …

I consult you on the outcome …

… and provide some options

Anonymity and Control

Which is most likely to achieve the outcome?

Adapted from a slide by James McTaggart 2018

How would you know you’d arrived?

Public Intended outcomes (in their voice)

1. We (the population of Wales) will be achieving our personal outcomes more frequently
2. We will be feeling confident to self-manage – trusting you and ourselves
3. We will be able to access help when we feel we need it
4. We will be more included in our local communities
5. We will be safer and feel less worried/concerned
6. We will have a better understanding of local resources and be able to access these independently
7. We will have confidence in your services and experience less disappointment
8. We will be treated with respect and dignity by you

How would you know you’d arrived?

Workforce Intended Outcomes (in their voice)

1. We will be happier and confident that reasonable decisions will be supported by the HB/Trust
2. Our patients’ outcomes will be better
3. We will be confident in our own reasoning and ability to learn from our practice
4. There will be collective well-being in the service i.e. we will be valuing, trusting and respecting each other
5. Our job satisfaction will be high and we have pride in our work
6. We will be feeling more committed to the team and the organisation
7. We will be feeling better about managing the demand
8. We will be feeling less stressed
9. We will be feeling safer – not be fearful of being blamed
10. We will be confident in all our strategic decision-makers
11. We would have renewed positivity and energy
**How would you know you’d arrived?**

Directorate/Service Intended Outcomes (in their voice)

1. We will be trusting each other to report issues and learn together
2. People will want to work for us and will be staying with us for longer
3. All staff and leaders will be feeling valued, understood and treated with dignity
4. Higher staff morale – and there will be a no blame culture
5. Our partners will be trusting us to collaborate fully in a common good
6. Our service users will be trusting us to listen and understand
7. Leaders will be feeling more supported in their decision-making (empowered) because they have line of sight to the decisions being made at service level
8. Leaders will be feeling less anxious and therefore more likely to co-create with staff rather than attempt to direct their decisions
9. NHS Wales and WAG will be trusting us and using our intelligence to support strategic decisions
10. We will be financially secure and thriving as an organisation

**Levels of Effectiveness?**

- Low Risk Population
  - Informed Self Help
  - Targeted Public Health programmes
  - Primary care and Universal Offer
  - Individual Intervention

**What works best?**

- Proximity of Intervention
  - Informed Self Help
  - Primary Care
  - Secondary Care – Community
    - Secondary - Hospital
    - Tertiary Care
What works best?
Access to Expertise at every transition

- Informed Self Help
- Targeted Public Health programmes
- Primary care and Universal Offer
- Individual Intervention
- Statutory Intervention

Circles of support and well-being:

- Access technology, opportunity or bespoke solutions
- Understand and make informed decisions
- Live at home
- Be included and loved
- Be understood
- Manage my symptoms
- Diagnostics
- Research
- I need to be able to
- Keep myself safe
- Be nurtured
- Be included and loved
- Be respected
- Have a purpose
- Keep my loved ones safe
- Have equal opportunities to meet my needs
- Make choices
- Bespoke Equipment
- Secure Care
- Be understood
- Licensed treatments
- Intensive intervention

The Village Effect

Picture courtesy of Guardian online

Susan Pinker 2015
What gets in the way of collaborative decisions?

Beliefs and assumptions about NEED!

The effect?

Funneling into “Tiers” of Intervention

Tier 0 - Self Help
Tier 1 – Low level/less specialised
Tier 2 – Moderate/more specialised
Tier 3 – Specialised
Tier 4 - Highly specialised

What stops this working?

ANXIETY and Beliefs about Expertise
The worried well and the hard to reach!!

Problem-based decisions do harm!

Organisational Traps?

Event risks dominate our conversations
Risks, deficits or problems dominate our conversations

- Create beliefs that increase vulnerability and powerlessness – knowledge expertise trumps proximity expertise and reduces resilience and personal responsibility.
- Delay access to more appropriate help.
- Impair communication between everyone around the person with the “problem” – misaligned expectations and dissatisfaction.
- Create incongruous anxiety that restrict autonomy.
- Limit collaboration and stop people adopting self-help strategies that would potentially benefit them.

Risk goes up because learnt helplessness becomes endemic through the entire system!

The effect?

Beliefs about entitlement and resource

- Diagnosis
- Pathways
- Provision

Specialist
Public Health programmes
Informed Self Help

Current Proportion of Overall Budget Spend and Concentration of Expertise for Each Location??

Public Health/Prevention – <5%
Primary/Self Help – <10%
Secondary – Community – <8%
Secondary Care – Hospital – >67%
Specialist Expertise
Tertiary Care – Hospital – 10%?
SECONDARY – HOSPITAL – IN- AND OUTPATIENTS
SECONdary – COMMUNITY – WALK-INS, CLINICS, DOMICILIARY
SECONDARY – HOSPITAL – IN- AND OUTPATIENTS
SECONDARY – HOSPITAL

What works best?
Access to Expertise at every transition
Informed Self Help
Targeted Public Health programmes
Primary care and Universal Offer
Individual Intervention
Statutory Intervention

Natural Collaboration
Engagement of all Partners
Strategic & Operational Elements
Relationship Elements
Shared Outcomes
Communication Infrastructure
How does Care Aims Help?

- All conversations start with impact and intended outcome and lead to reasonable co-created decisions.
- Workload of all services is redistributed to include much more work capacity building across organisations, team and sector boundaries.
- Modes of accessing specialist expertise are changed to support autonomy and collaboration at the point of need.
- Decisions are validated through robust reflective practice forums, peer review and spaces for understanding reasoning across all professions and remits.
- Metrics focus on the impact of the activity and process on well-being outcomes for people.
- Focus is on growing capabilities and nurturing relationships within and across teams.

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From deficits to impacts/outcomes

- **Equality**: The assumption is that everyone benefits from the same supports: this is equal treatment.
- **Equity**: Everyone gets the support they need (this is the concept of “affirmative action”), not producing equity.
- **Justice**: All 3 can see the game without support or mediators because the root(s) of the inequity was addressed. The systemic barrier has been removed.

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What are you counting and why?

“Not everything that can be counted counts, and not everything that counts can be counted.”

Albert Einstein
Provides an Illusion of control

- Most attempts at transformation focus on changing process and task (**what and how we will do things?**) - not on reason and outcome (**why we need to do it and so what we’ve done it?**)
- This focus on changing behaviour often results in a set of rules, guidelines, procedures, pathways and requirements which are then used to direct decisions!
- Applying a **command-and-control paradigm** to **“person-centred decisions”**, reduces decisions to algorithms, stops thinking and breeds apathy.
- Filling in the **paperwork and ticking the boxes** becomes the focus of ‘transformation’ and outcomes are lost in arguments about **task, role, regulations and process.**

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'Companies have no time to tell people what to do in fast-changing markets.
The solution is to train them to think for themselves'

Jack Welch, CEO, General Electric

1985!!!!!!

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Governance

Think about what? How do we know we are thinking the right things?

WHAT EVIDENCE WOULD CONVINCE YOU THAT YOU AND YOUR STAFF WERE DOING YOUR DUTY?

© Kati Malcomess 2010
What gets in the way of reasonable decision-making?

Beliefs and assumptions about what makes a good decision

Where does a good decision start?

PRESCRIBED PDSA?

Frequently results in Buyer's Remorse!

Logic Models – Wrong order of things!

What's missing?
Care Aims is all about the "why" questions, equipping everyone to do the thinking and make decisions that support us to do our Duty not to “perform” a role.

The focus is on conversations about intended outcomes and impacts - i.e. "So What?"

Better Decisions come from a shared understanding of personal impact and aspiration, which comes from better relationships which are build on effective conversations.
So What?

So what we changed the behaviour and processes? Did it result in the intended outcome?

Why?

Reason

Impact

Intended

Outcome

Duty to decide

what would provide the public, their families and those around them with

Reasonable safety

without loss of autonomy

Peace of mind

Clear, wise decisions for my life

Direction for supported self-management

Improved Well-being

Clarity about my options

Evidence-based Assurance

✔ Does your current intelligence help you make effective governance decisions?
✔ What evidence do you have that your interpretation of the data is sound?
✔ What evidence would assure you that everyone was doing their duty?
✔ Who decides what the evidence means?
✔ Whose help do you need to ensure you are learning the right things?
Levels of Effectiveness?

Low Risk Population

Informed Self Help

Targeted Public Health programmes

Primary care and Universal Offer

Individual Intervention

Unplanned/Statutory Intervention

Can we change what we are counting?

Not everything that can be counted counts, and not everything that counts can be counted.

Albert Einstein

Assurance and accountability – the intention is reflection and learning not controlling

INTENDED CLINICAL OUTCOMES (CARE AIM) AND OUTCOME MEASURES

• Care Aims help build an Intelligence Framework
• What data do we need?
• Who’s expertise will help us understand the data?
• What have we learned?
• What do we need to change?

WELL-BEING OUTCOMES FOR ALL (PersonROMS)

PROCESS/EXPERIENCE MEASURES (PersonREMs)

• Data not PERFORMANCE measure
• FACTS not FEAR
• UNDERSTANDING not BLAMING
• DEVELOPING not CHANGING

• NO Targets
• NO League Table
• NO Directives
• NO Zero Tolerance

• NO Targets
• NO League Table
• NO Directives
• NO Zero Tolerance
Outcome Measures – fit for purpose?

✓ Whose outcome is it? Whose formulation?
✓ What are we intending to change?
✓ What is the most valid measure?:
  ✓ Patient-centred well-being outcome measure
  ✓ (Patient) reported outcome measure
  ✓ (Patient) reported experience measure
  ✓ Clinical outcome measure
  ✓ Efficiency/financial outcome measure
  ✓ Productivity measure
  ✓ National compliance measures

Why Care Aims?

✓ clear way of evidencing duty of care through reflection on effectiveness around person-centred aspirations
✓ recognises the need to review plans in a responsive way, when the evidence requires it
✓ helps refine and adapt formulations of need
✓ Helps with open dialogue around reasoning not doing.
The Care Aims Framework enables everyone to show their ethical workings out, so they can account for their decisions and actions in common law.

Did we:
- do the right tasks?
- follow the plan?
- deliver the service competently?
- follow the correct procedure/pathway?
- see the right people? at the right time? in the right place?

Did we:
- Reduce risk and impact? Improve lives?
- Increase well-being?

So what have we learnt and what should we change?

The Fifth Discipline
Peter Senge

Team learning
Teams communicating, shared understanding and shared meaning. There needs to be clear structures in place to facilitate team learning and the sharing of knowledge.
We need to govern reasoning not doing!

Ensure clarity of vision/outcome so everyone knows the reasons for doing things and can change the doing if it's not achieving the shared outcome.

Inspired by Ken Blanchard and Sheldon Bowle's book Gung Ho

Trust is critical to ensure candour

Ensure everyone contributing to the outcome, has autonomy and freedom to act within their scope of practice and can articulate the reasons why the outcome has not been achieved.

Inspired by Ken Blanchard and Sheldon Bowle's book Gung Ho

Assurance not governance – the intention is reflecting and learning not controlling

Ensure everyone gets the recognition and support they need to keep going when the going get tough – open dialogue, shared responsibility and shared learning.

Inspired by Ken Blanchard and Sheldon Bowle's book Gung Ho
HEIW Proposal

**Reach:** Wales-wide, All Health Boards, Entire patient journey, Inter-disciplinary, inter-speciality

**Sustainability:** Grow our own!
4 Regional Leads – 2 year development project to take over training and support for local teams with implementation decisions

**Independence:** Co-creating local offer with key leads and supporting local effectiveness

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HEIW Proposal

**Allocated link person:** Ease of communication and local decision-making

**Identifying teams/service areas/pathways:** Support to identify the teams and local champions to sustain roll-out

**Collaboration and learning:** Co-producing project plans to support accountability and learning from the roll-out