Improvement Leaders' Programme

Participant Manual

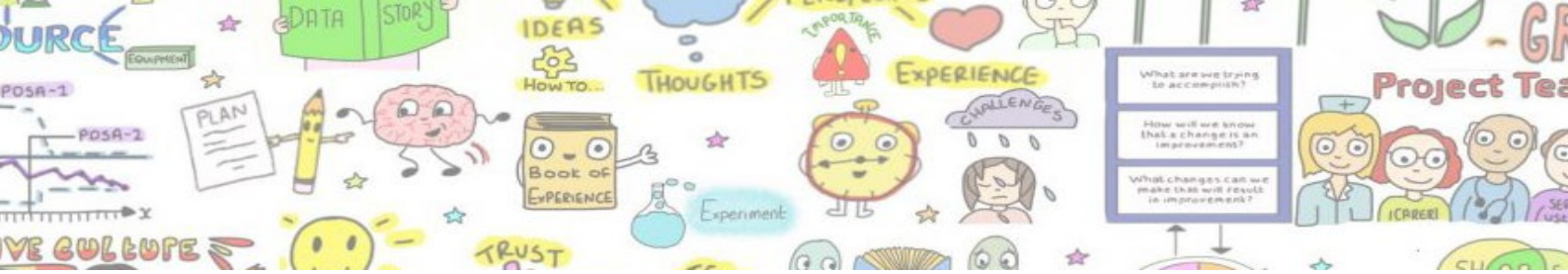
EAST LONDON NHS FOUNDATION TRUST

QUALITY IMPROVEMENT DEPARTMENT
9 Alie St, London, E1 8DE

RESOURCE
DATA
STORY
IDEAS
How to...
THOUGHTS
PERSPECTIVE
EXPERIENCE
POSA-1
people saw the apple fall but only Newton asked WHY?
CURIOSITY
EMPOWER
INTERVIEWS:
PROJECT CHARTER
AT LEAST WE KNOW FOR NEXT TIME
FAILURE
ONE TEAM
LEARNING
CONTINUE to GROW OVER TIME
Facts TELL Stories SELL
we connect, grow, learn + remember stories and feelings
ENGAGE

Day 3

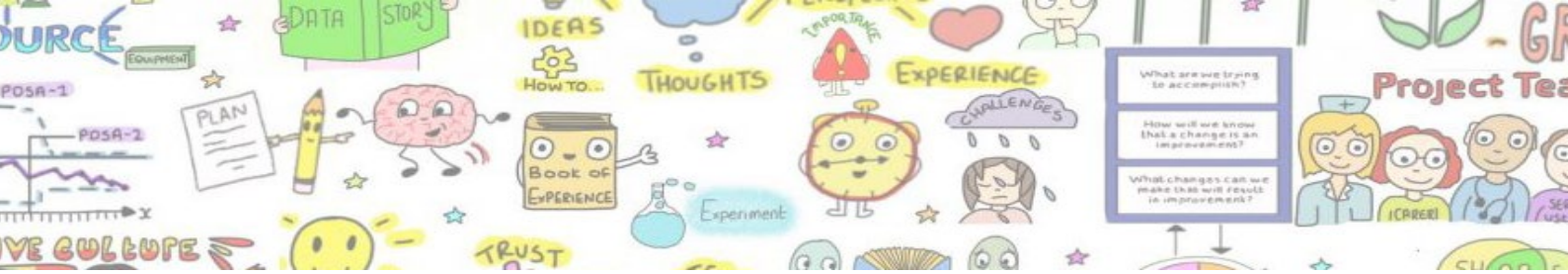
people saw the apple fall but only Newton asked WHY?
CURIOSITY
EMPOWER
INTERVIEWS:
ONE TEAM
CONTINUE to GROW OVER TIME
Facts TELL Stories SELL
we connect, grow, learn + remember stories and feelings
ENGAGE
WHY?
WHY?
WHY?
start small
WATCH it GROW
DATA
STORY
IDEAS
PERSPECTIVE



Participant Manual

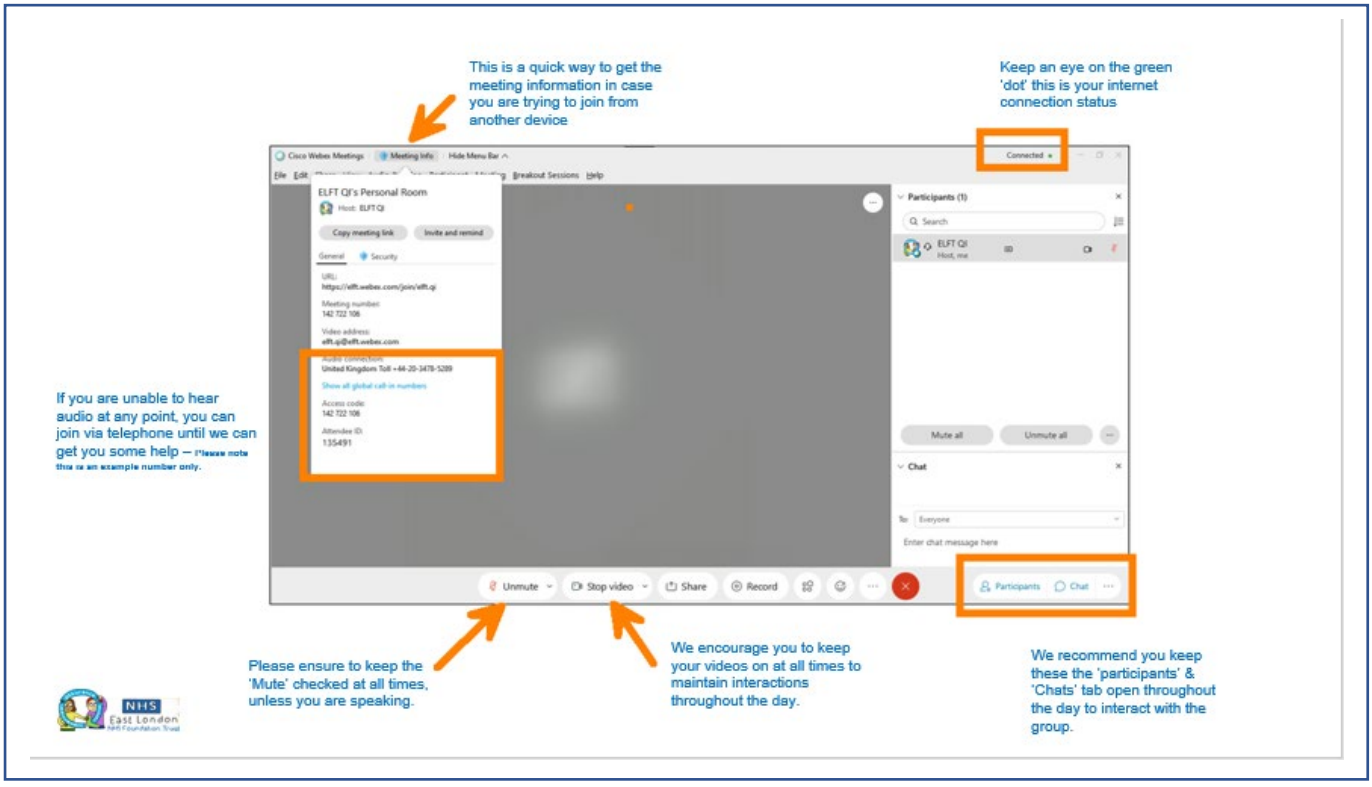
Each module of the Participant Manual contains the following information:

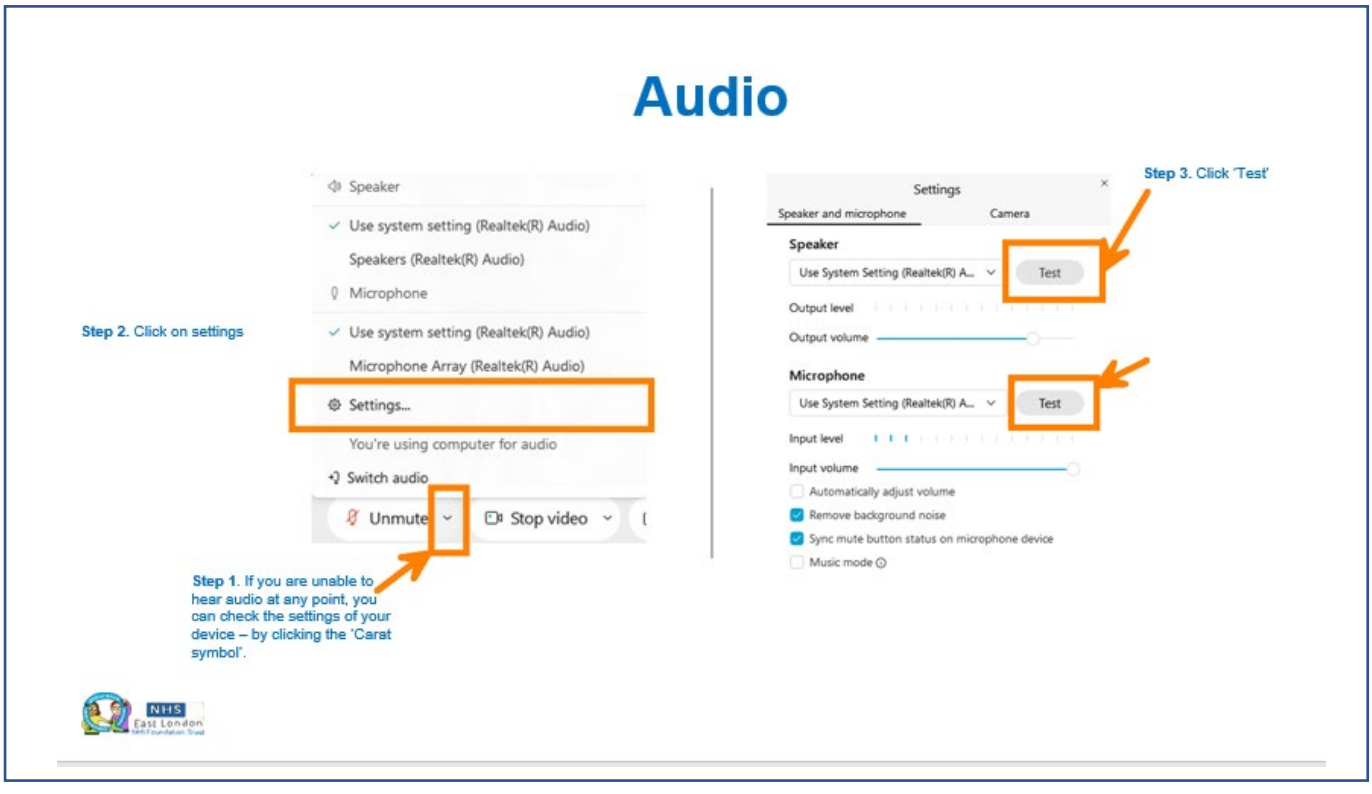
	**LEARNING OBJECTIVES** The expected knowledge and skills participants will gain by the end of each module.
	**KEY CONTENT** Key content covered during each module.
	**RESOURCES** A list of resources used during each module.
	**TRAINING ACTIVITIES** A list of exercises done by participant's during each module.
	**ASSESSMENT AND TAKE AWAY WORK** An assessment of key information covered during each module.

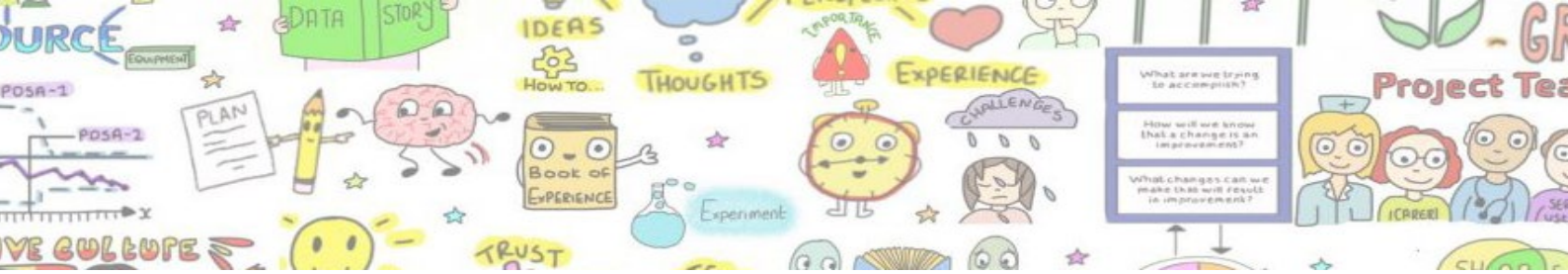


Day 3

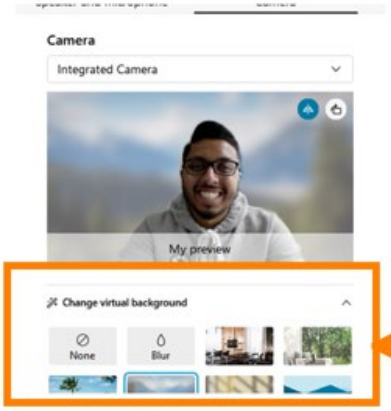
Welcome and Introductions





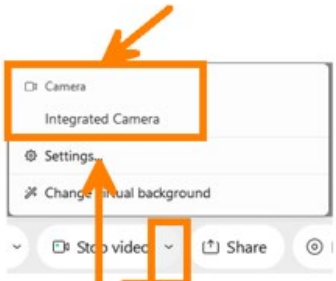


Video/Background

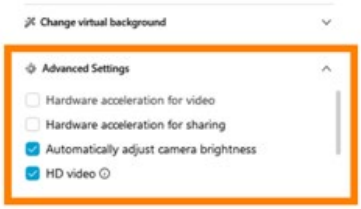


Step 2. Select your background of choice.

If you want to remove the background then repeat the process and select 'None'



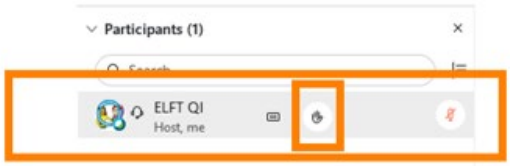
Step 1. If you would like to change your background, you can do so by clicking the 'Carat' symbol and selecting settings or change virtual background.



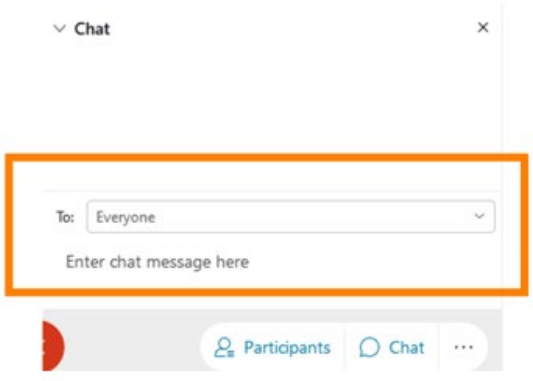
Troubleshooting

If you are losing connection or your system is slowing down, then please 'de-select' all available options.

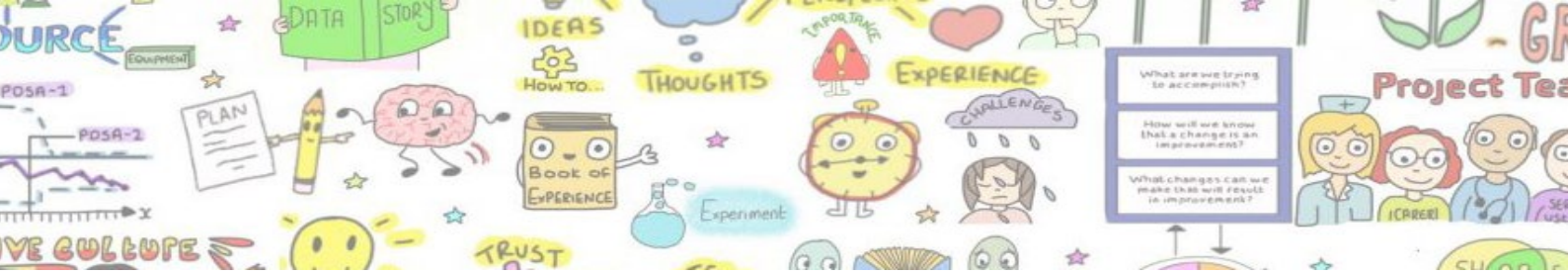
Participants/Chat



In the 'Participants' tab you can see a few options available. You can 'raise your hand' & you can see your 'mute status'

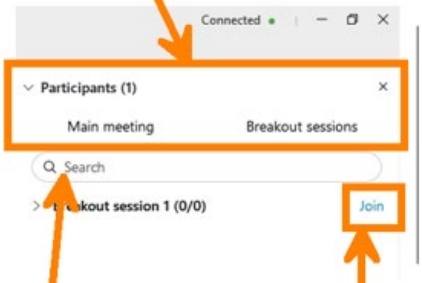


Please ensure that when you are sending messages in the 'Chat', you select the option 'Everyone'. Unless you intend to send a message 'Privately' then ensure that you have selected the person correctly.



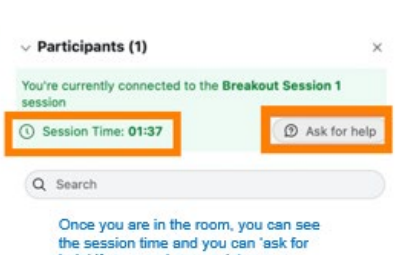
Breakout Room

When we open up the breakout rooms, you will notice that the 'Participants' section now contains the 'Breakout Sessions' feature.



You can quickly search which breakout rooms you are looking for here.

Click here to 'join' the room



Once you are in the room, you can see the session time and you can 'ask for help' if you need any assistance.

If you want to leave the breakout session, then select then click 'Leave session' – You will then go back to the main room.

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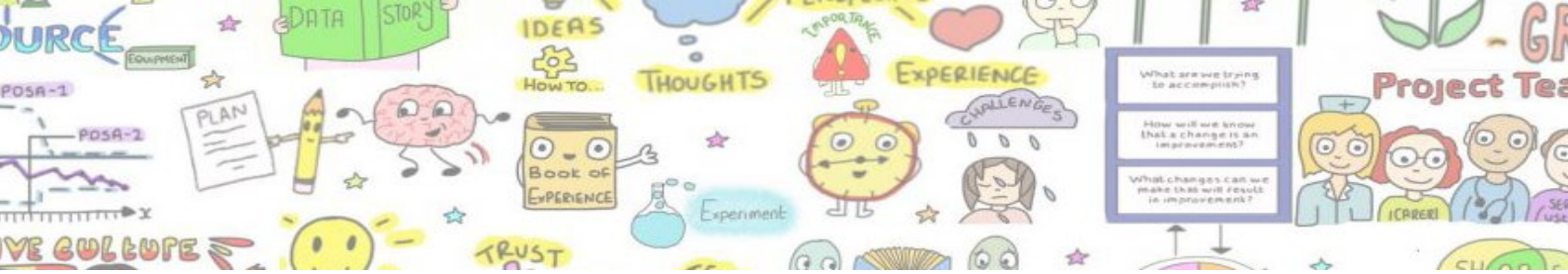
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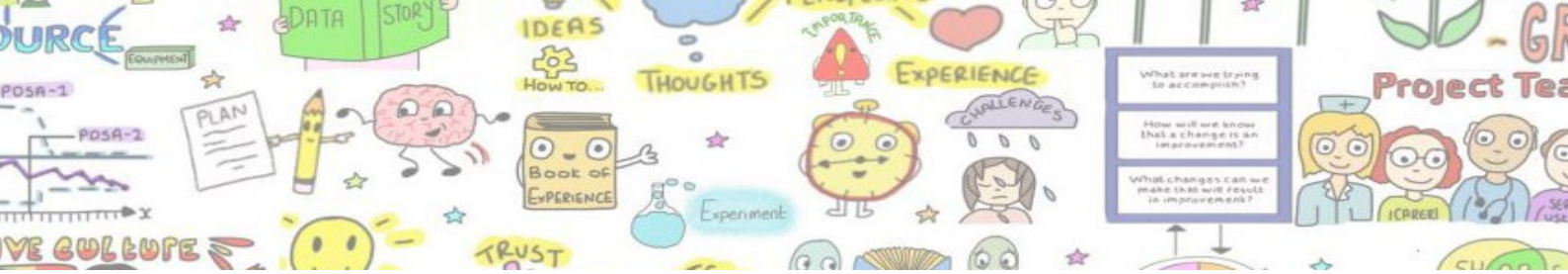
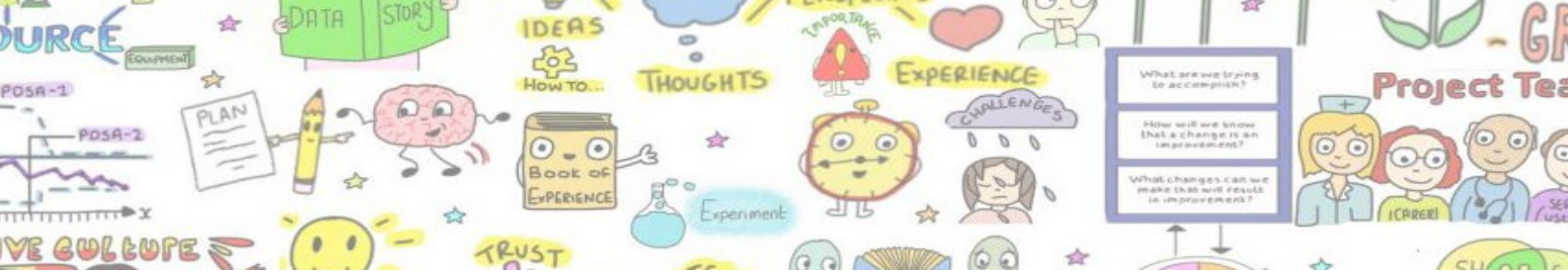
My Notes



Module 3.1

Understanding Variation and Run Charts

	**LEARNING OBJECTIVES** • Understanding of the two different types of variation in a system • Understand what a run chart is, how to use it • Understand how to interpret a run chart to understand variation in a system and react appropriately
	**KEY CONTENT** • Different types of variations • Interpreting run charts
	**RESOURCES** • Power Point Presentation
	**TRAINING ACTIVITIES** • Run Charts
	**ASSESSMENT** • N/A



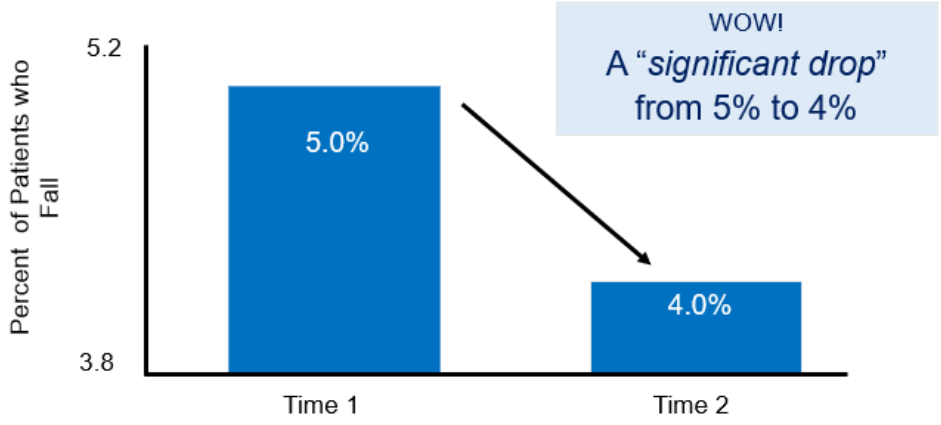
The Quality Measurement Journey

AIM (Why are you measuring?)
Concept
Measure
Operational Definitions
Data Collection Plan
Data Collection
Analysis → ACTION

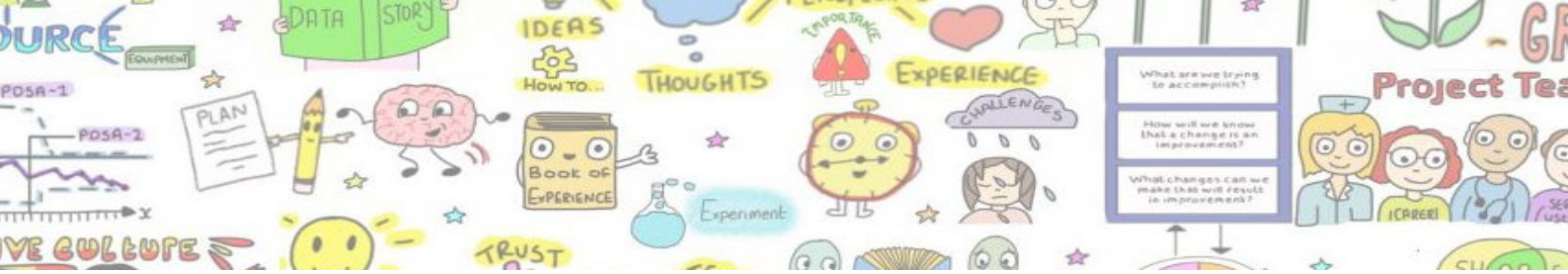
Source: R. Lloyd. *Quality Health Care: A Guide to Developing and Using Indicators.* Jones and Bartlett Publishers, 2004.

Average percentage of Patients who Fall

Before and after the implementation of a new protocol



Conclusion - The protocol was a success!



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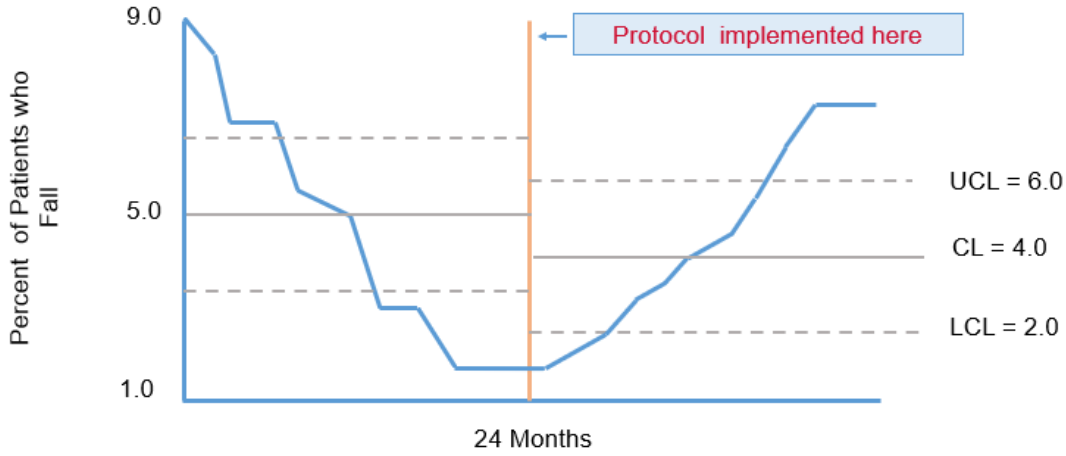
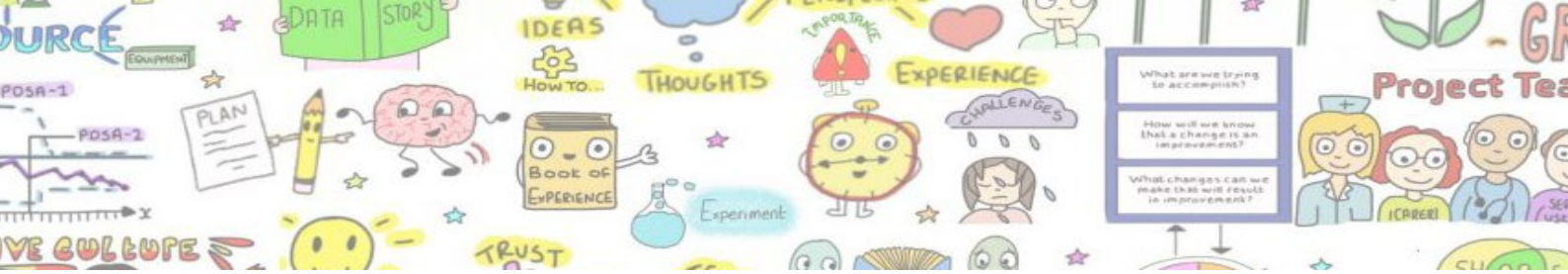


Now what do you conclude about the impact of the protocol?

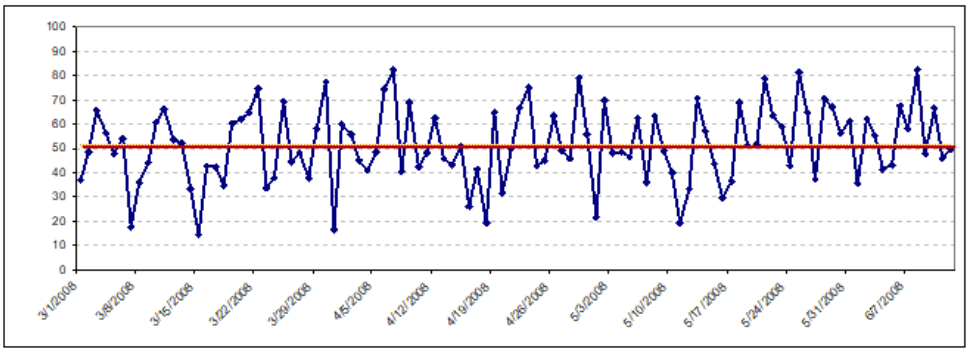
If you don't understand the variation that *lives in your data*, you will be tempted to ...

- Deny the data (It doesn't fit my view of reality!)
- See trends where there are no trends
- Try to explain natural variation as special events
- Blame and give credit to people for things over which they have no control
- Distort the process that produced the data
- Shoot the messenger!



Common Cause or Random Variation

- Points equally likely above or below center line
- There will be a high data point and a low, but this is expected
- No trends or shifts or other patterns



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Special cause or non-random variation

Unintentional

Unplanned, often unknown, cause of the system becoming unstable

Intentional

When we're trying to change the system

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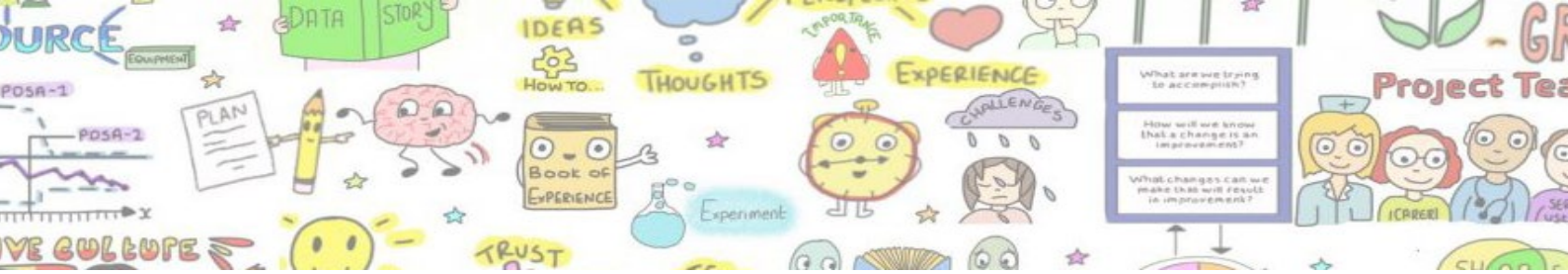
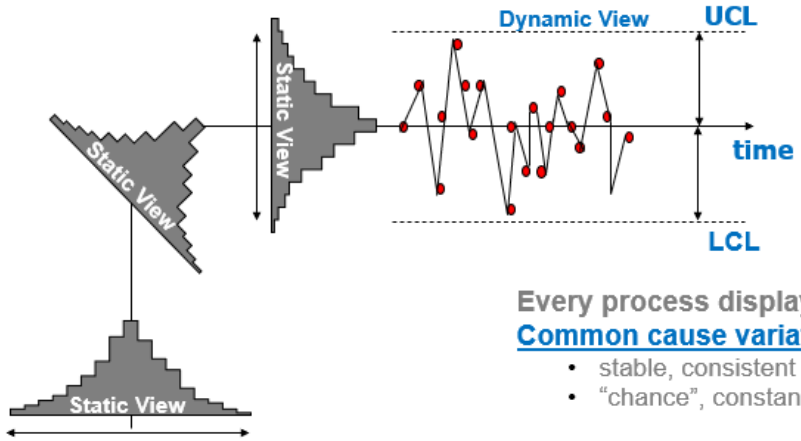


"What is the variation in one system over time?" Walter A. Shewhart - early 1920's, Bell Laboratories



Every process displays variation:

Common cause variation

- stable, consistent pattern of variation
- "chance", constant causes

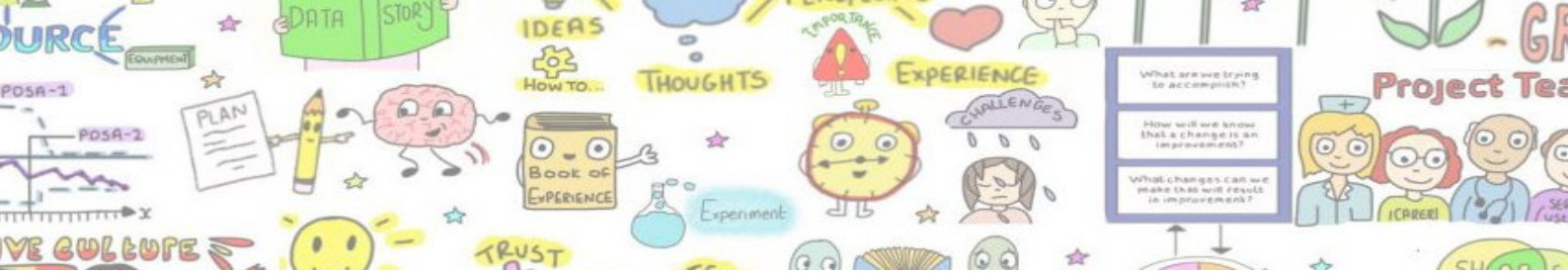
Special cause variation

- "assignable"
- pattern changes over time

How do we analyse variation for quality improvement?

Run and ***Control Charts*** are the best tools to determine:

1. *The variation that lives in the process*
2. *If our improvement strategies have had the desired effect.*
3. *Determine if an improvement strategy has sustained the gains*



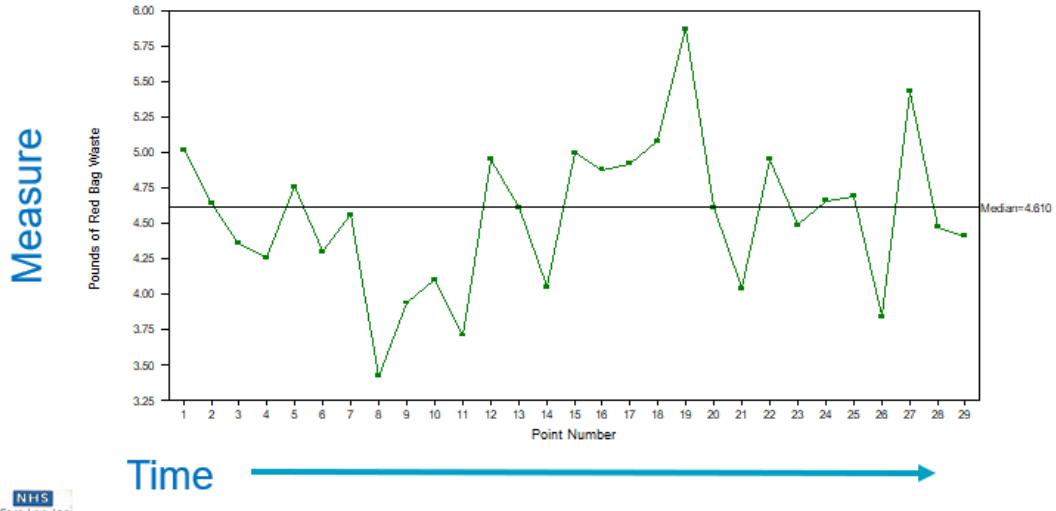
How many data points do I need?

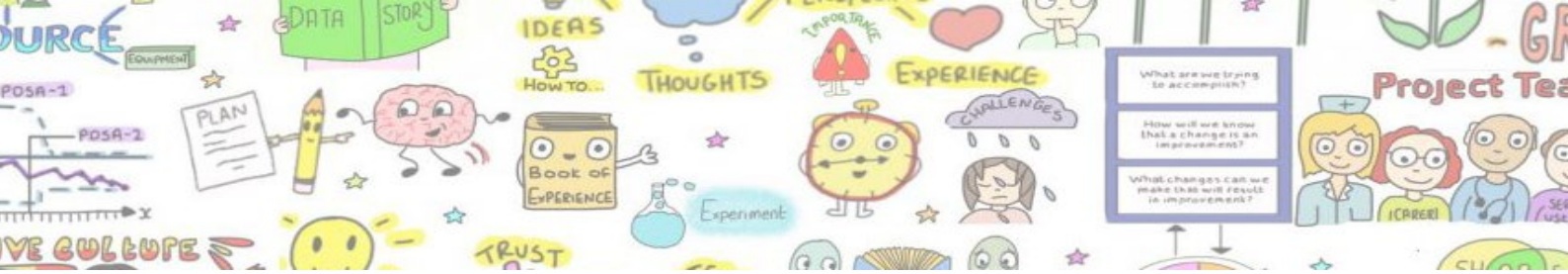
Ideally you should have between
10 – 15 data points before constructing a run chart

10 – 15 patients
10 – 15 days
10 – 15 weeks
10 – 15 months
10 – 15 quarters…?

- *If you are just starting to measure, plot the dots and make a line graph.*
- *Once you have 10-15 data points make a run chart.*

Anatomy of a run chart





How to analyse a run chart…

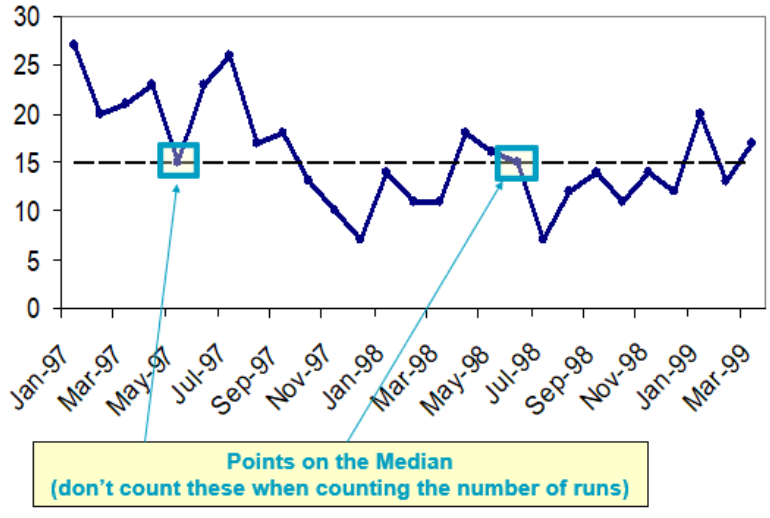
"How will I know what the Run Chart is trying to tell me?"

It is quite easy:

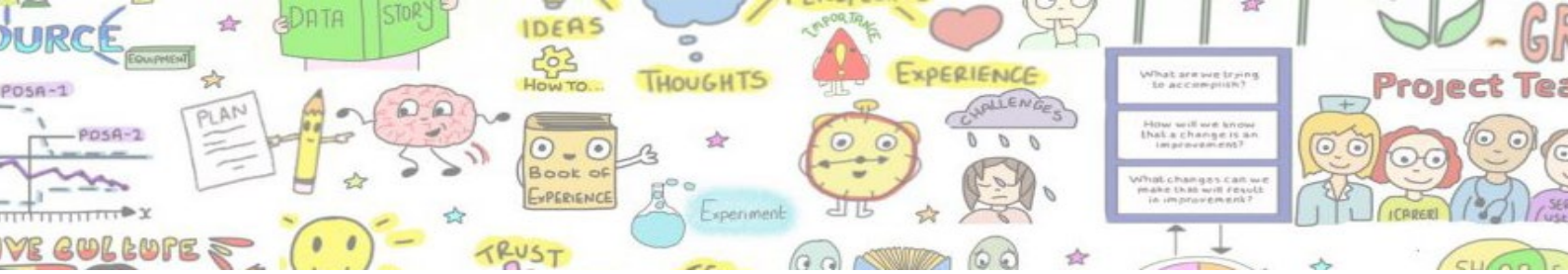
1. Determine the number of runs.
2. Then apply the 4 basic run chart rules decide if your data reflect random or non-random variation.

How many Runs?

Run = series consecutive points above or below the median, ignore points equal to median

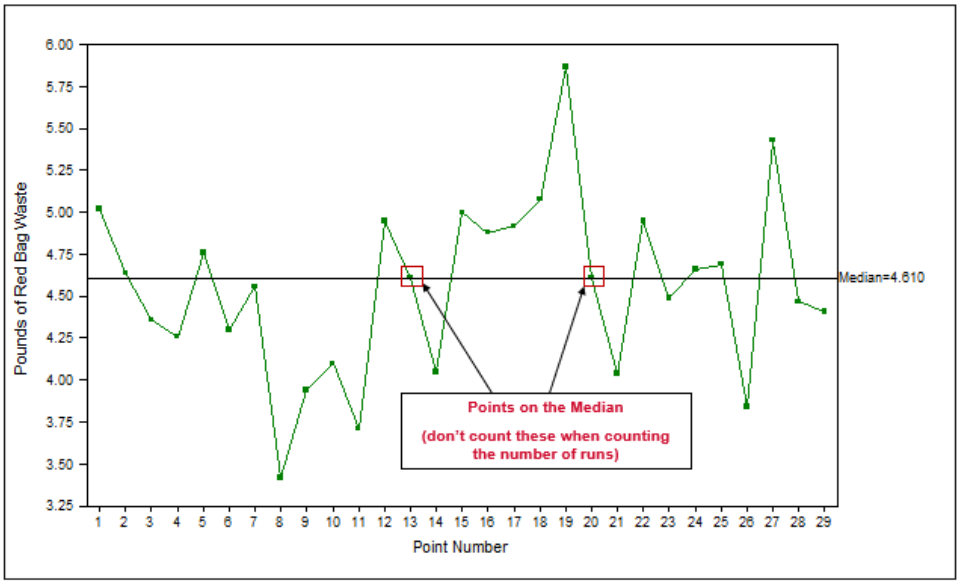


Points on the Median
(don't count these when counting the number of runs)



Run Chart: Medical Waste

Determine the number of runs on this chart

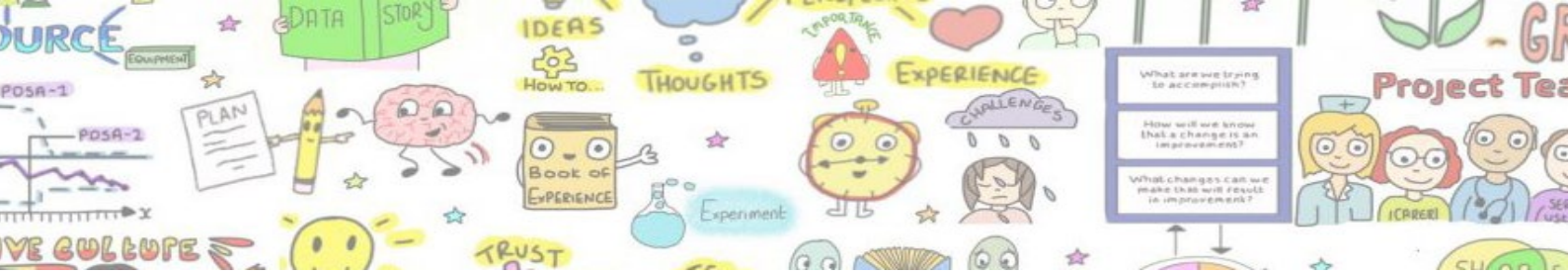


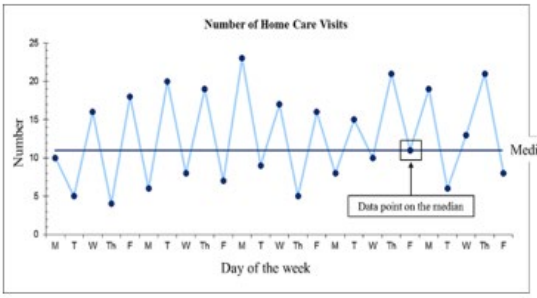
Too few or too many runs

Use this table by first calculating the number of ***useful observations*** in your data set. This is done by subtracting the number of data points on the Median from the total number of data points. Then, find this number in the first column. The ***lower number of runs*** is found in the second column.
The ***upper number of runs*** can be found in the third column. If the number of runs in your data falls below the lower limit or above the upper limit, then this is a signal of a special cause.

# of Useful Observations	Lower # of Runs	Upper # of Runs	# of Useful Observations	Lower # of Runs	Upper # of Runs
10	3	9	21	7	16
11	3	10	22	7	17
12	3	11	23	7	17
13	4	11	24	8	18
14	4	12	25	8	18
15	5	12	26	9	19
16	5	13	27	10	19
17	5	13	28	10	20
18	6	14	29	10	20
19	6	15	30	11	21
20	6	16	31	11	22

Source: Swed, F. and Eisenhart, C. (1943) "Tables for Testing Randomness of Grouping in a Sequence of Alternatives." *Annals of Mathematical Statistics*. Vol. XIV, pp. 66-87, Tables II and III.





An example of too many runs on a run chart.

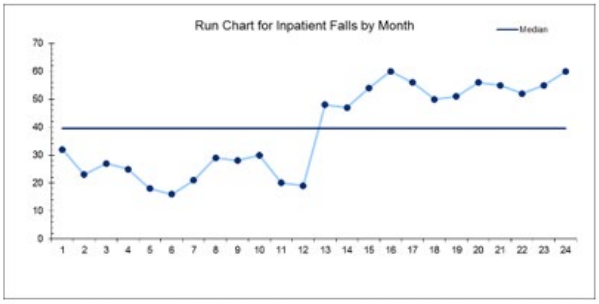
25 data points -1 on the Median = 24 useful observations.

(8 to 18 runs)

An example of too few runs on a run chart.

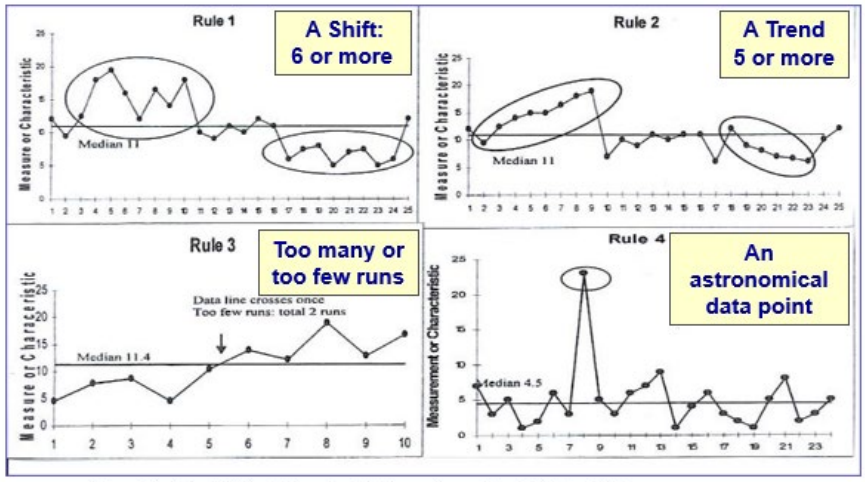
24 data points with none on the Median = 24 useful observations.

(8 to 18 runs)

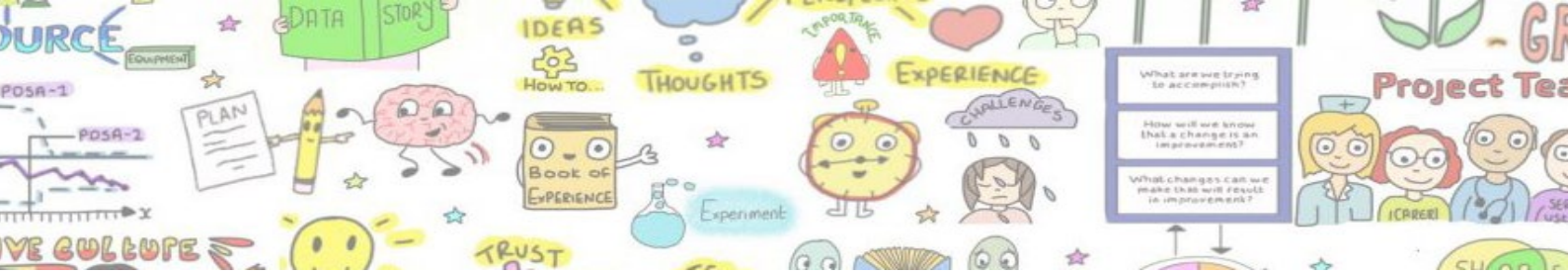


Sometimes you have too much variation and at other times too little variation!

Non-Random Rules for Run Charts

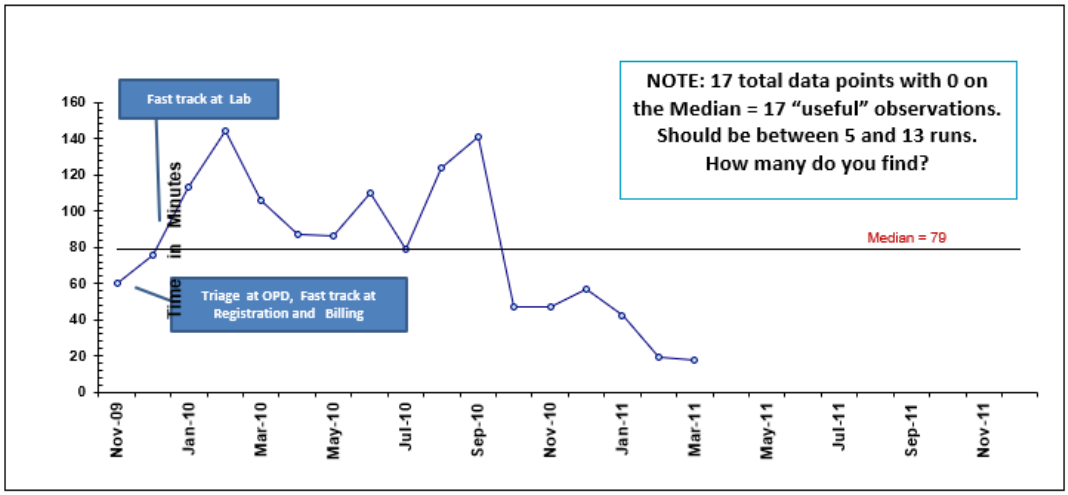


Source: The Data Guide by L. Provost and S. Murray, Jossey-Bass Publishers, 2011.



Determine the number of runs on this chart and then apply the 4 Run Chart Rules

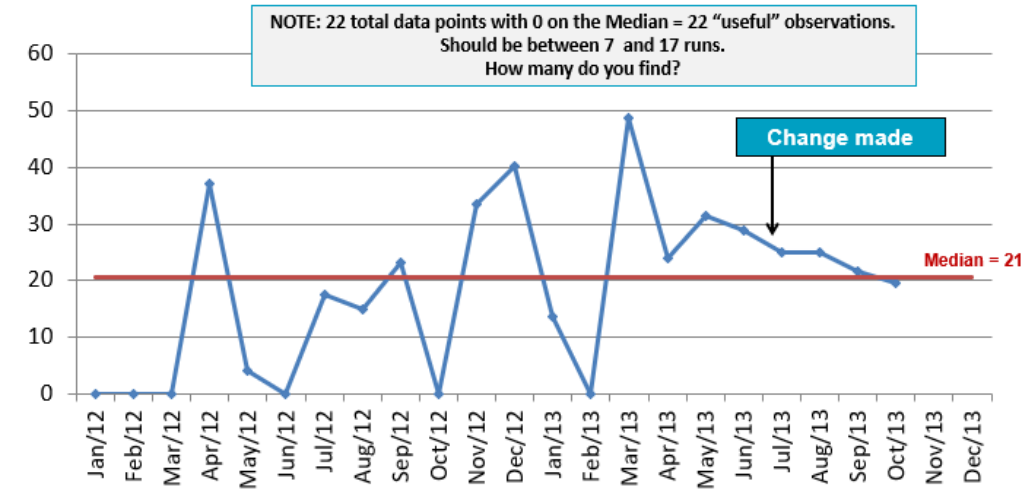
Time of Registration of Critically Ill Under 5 children to Initiation of Treatment in the Ward

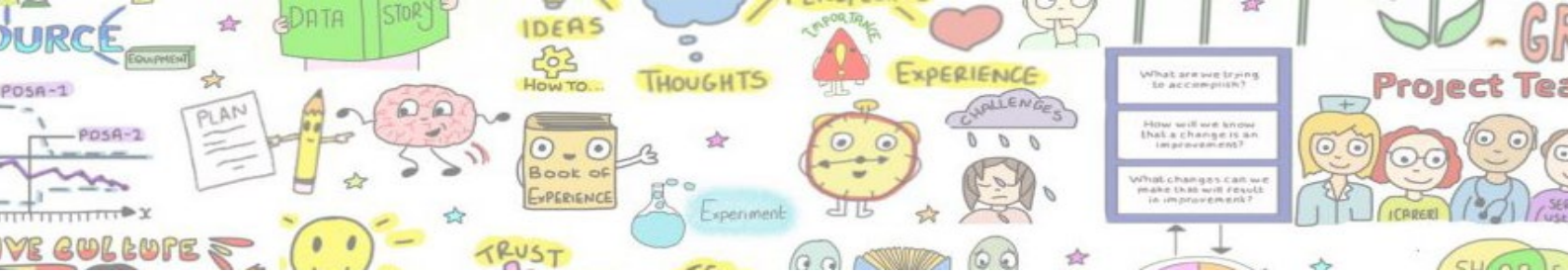


Neonatal Deaths

Neonatal deaths per 1000 live births

How many runs on this chart? Apply the Run Chart rules.

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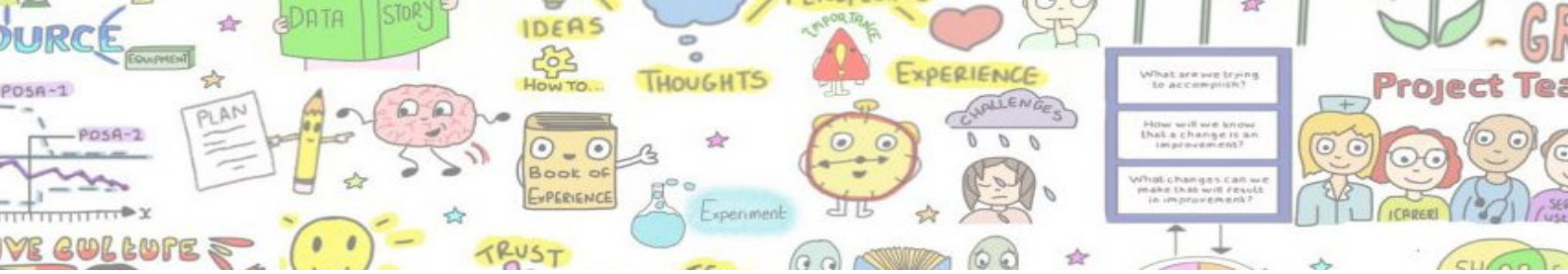
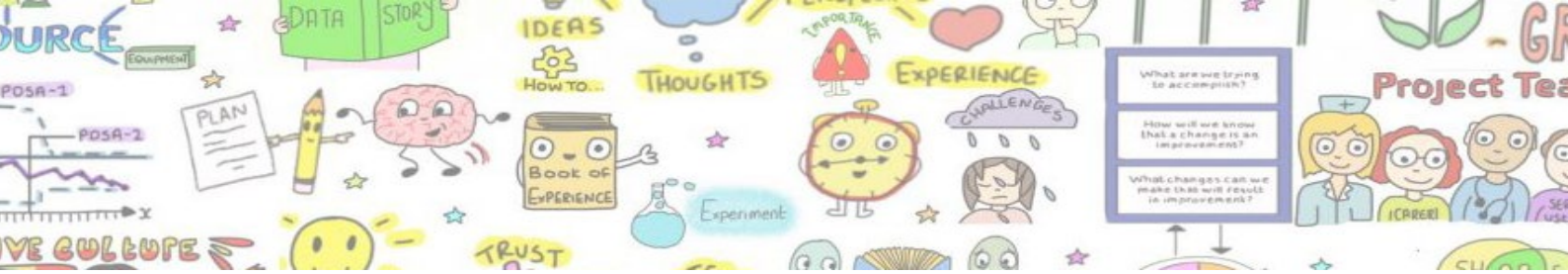


Module 3.2

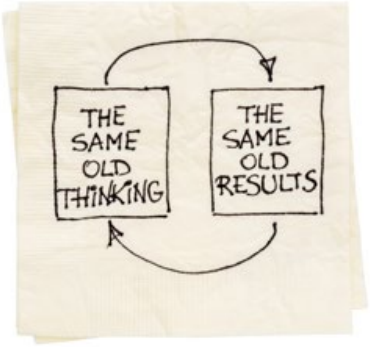
Developing Change Ideas

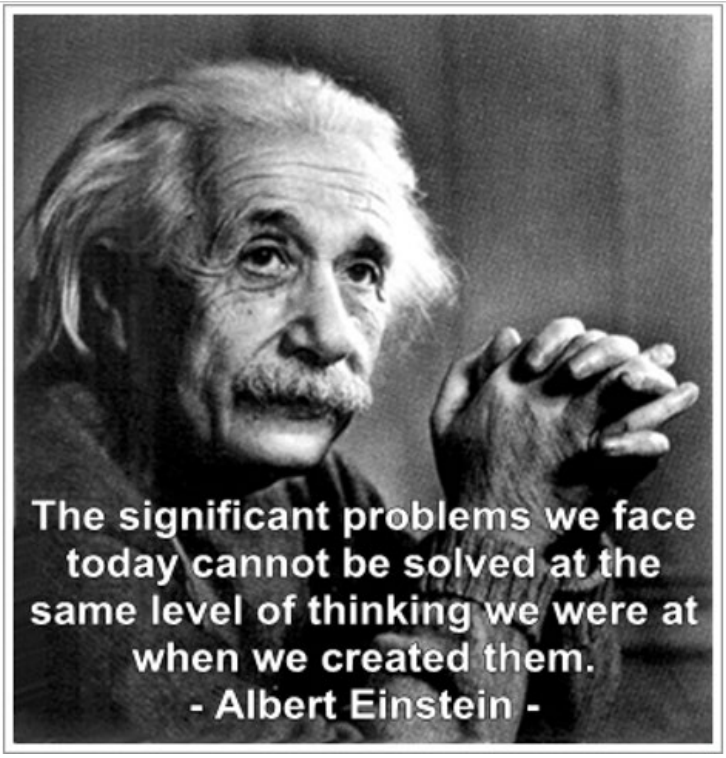
	**LEARNING OBJECTIVES** • Understand the different ways people can generate ideas for change, including the importance of creative thinking. • Understand some useful tools to generate ideas, including creativity methods. Practice using some tools
	**KEY CONTENT** • Creative thinking • Idea generation
	**RESOURCES** • PowerPoint Presentation
	**TRAINING ACTIVITIES** • Small group activity
	**ASSESSMENT** • N/A

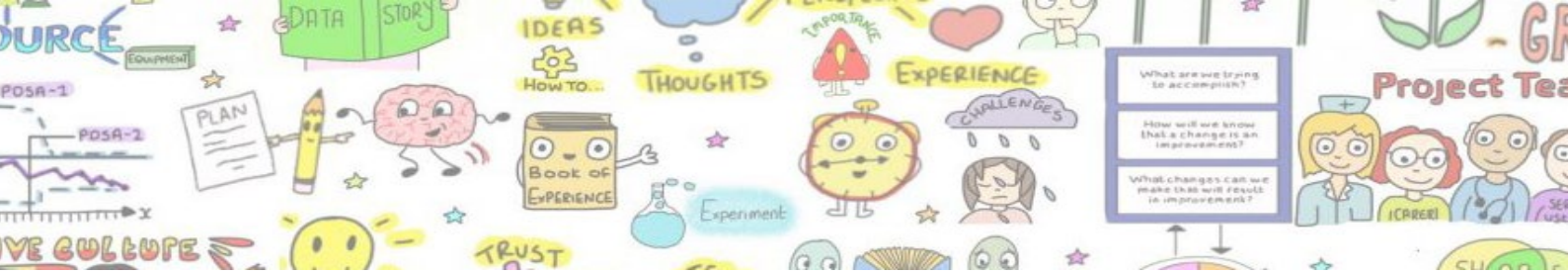


Early in the life of an improvement effort, there are two possible obstacles…

MORE OF THE SAME







First order or second order change?

Reactive Changes (First Order Changes)

- Keep the system running!
- Solve problems or react
- Return the system to prior condition
- Short term impact

e.g. more flyers, more training, more resources, more rules

Fundamental Changes (Second Order Changes)

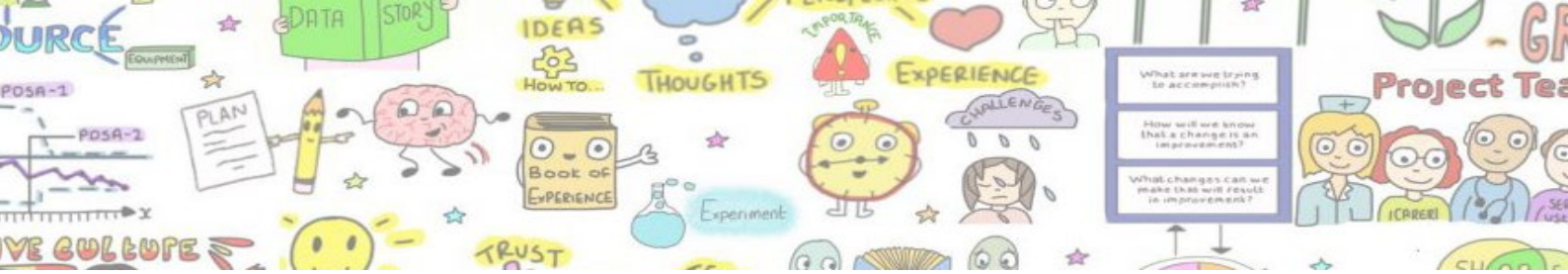
- Create a new system of performance
- Design/redesign aspect of the system
- Necessary for improvement beyond problems
- Fundamentally alters the system
- Long term impact

e.g. process redesign, person centered approach, standardizations, changing system boundaries

Developing second order changes

Benchmarking or learning from others	Creative Thinking	Change concepts
Change packages	Logical Thinking about current system	Using technology

The Improvement Guide, Chapter 6, p. 120



Learning from others to develop second order ideas

Spend a few minutes on your own working through this grid.

You will find it in your participants guide

	For the topic are tackling who is already doing this well?	How could we learn from them?
Within ELFT		
Other healthcare providers		
Other industries		

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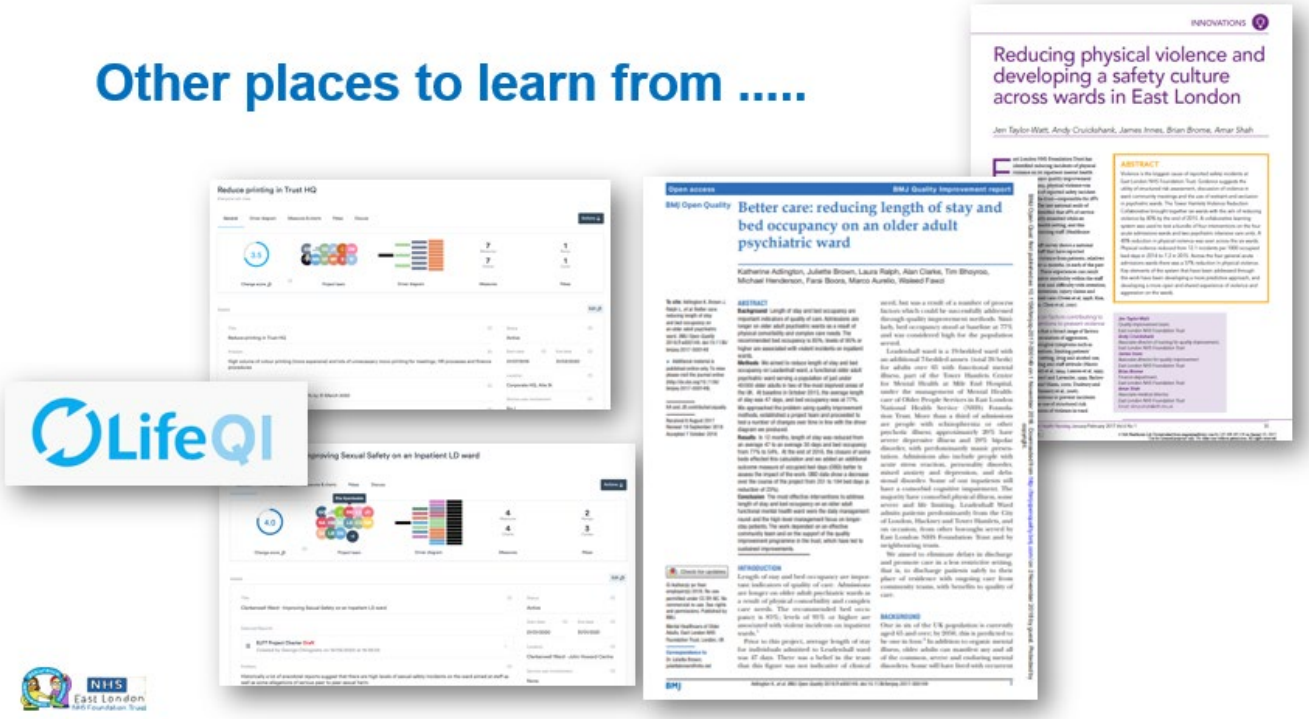
Other places to learn from .....



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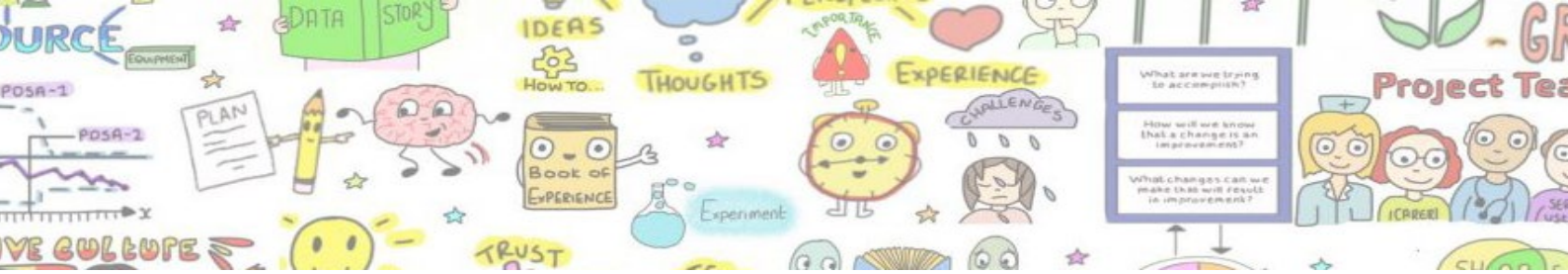
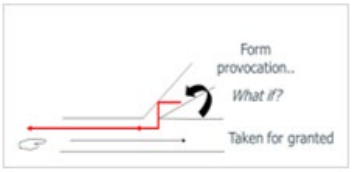


Provocation Tools



Reversal

Exaggeration

Distortion

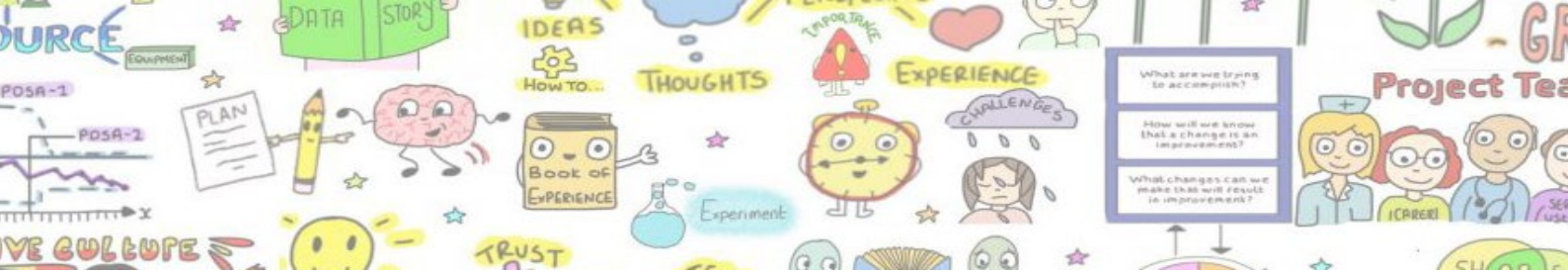
Wishful thinking

Escape

ELFT Safety Culture Bundle

- **Broset Violence Checklist**
- **Safety Cross**
- **Safety Huddles**
- **Safety discussion in community meetings**

Taylor-Watt et al (2017) Reducing physical violence and developing a safety culture across wards in East London. *British Journal of Mental Health Nursing. 6:1 , 35-43*



The Sepsis Six

UK SEPSIS GROUP

1. Give high-flow oxygen — via non-rebreathe bag
2. Take blood cultures — and consider source control
3. Give IV antibiotics — according to local protocol
4. Start IV fluid resuscitation — Hartmann's or equivalent
5. Check lactate
6. Monitor hourly urine output — consider catheterisation

within one hour

...plus Critical Care support

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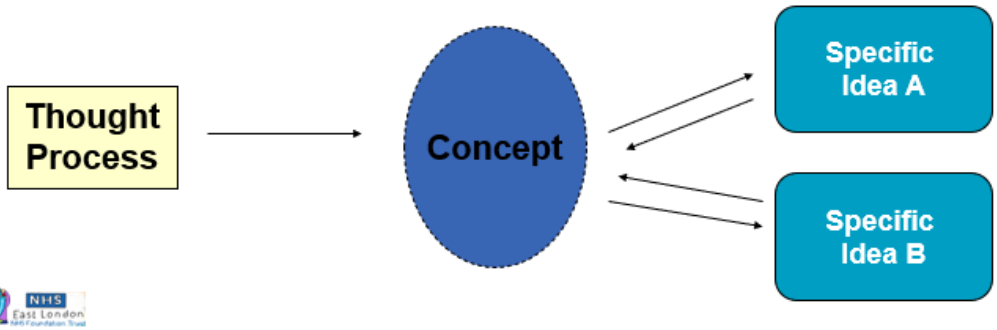
Using Change Concepts

Change Concept: a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement.

Concept
An opportunity to create a new connection



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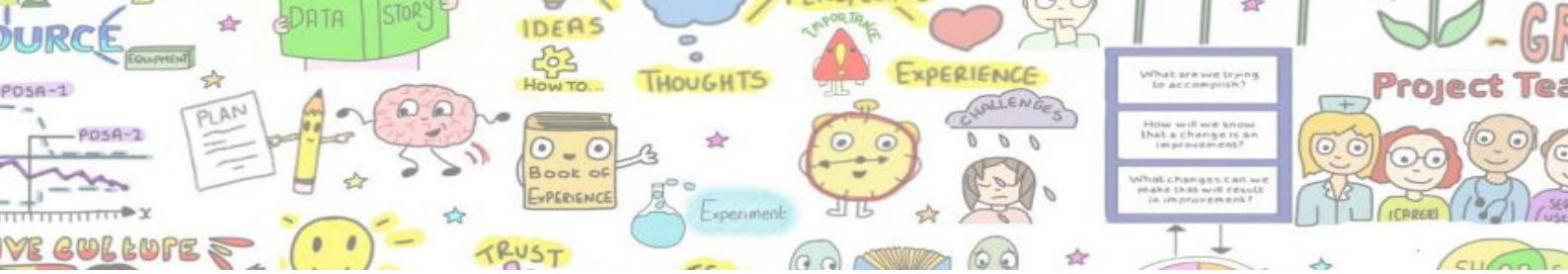


Change Concepts – here are a few

Improve workflow

Enhance relationships

Manage time

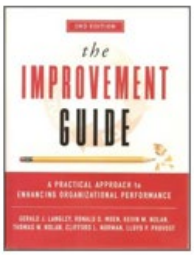
Manage variation

Design the system to avoid mistakes

The Improvement Guide, Chapter 6, p. 120

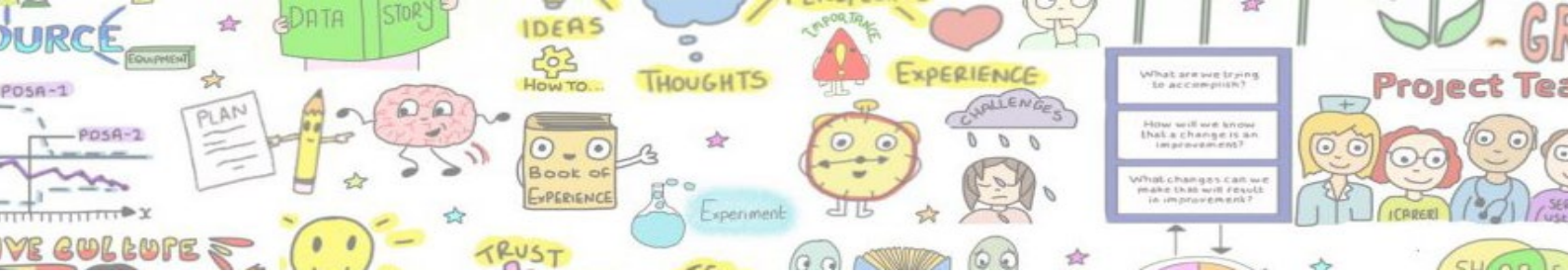
Change Concepts

The *Improvement Guide* contains 72 change concepts can be used to create ideas for testing.



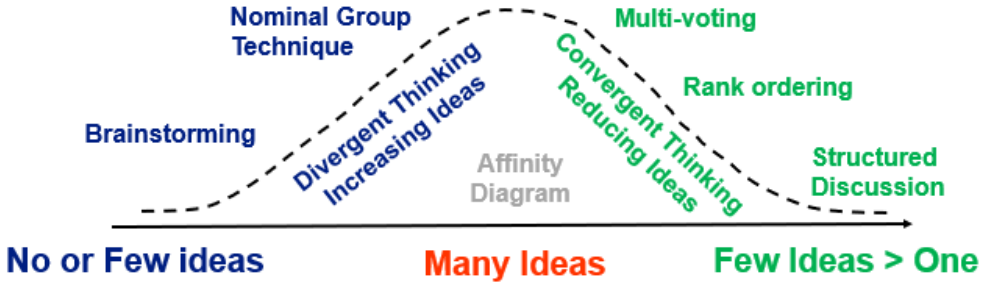
Appendix A 359

1. Eliminate things that are not used
2. Eliminate multiple entry
3. Reduce or eliminate overkill
4. Reduce controls on the system
5. Recycle or reuse
6. Use substitution
7. Reduce classifications
8. Remove intermediaries
9. Match the amount to the need
10. Use sampling
11. Change targets or set points
12. Synchronize
13. Schedule into multiple processes
14. Minimize handoffs
15. Move steps in the process close together
16. Find and remove bottlenecks
17. Use automation
18. Smooth workflow
19. Do tasks in parallel
20. Consider people as in the same system
21. Use multiple processing units
22. Adjust to peak demand
23. Match inventory to predicted demand
24. Use pull systems
25. Reduce choice of features
26. Reduce multiple brands of the same item
27. Give people access to information
28. Use proper measurements
29. Take care of basics
30. Reduce demotivating aspects of the pay system
31. Conduct training
32. Implement cross-training
33. Invest more resources in improvement
34. Focus on core process and purpose
35. Share risks
36. Emphasize natural and logical consequences
37. Develop alliances and cooperative relationships
38. Listen to customers
39. Coach the customer to use a product/service
40. Focus on the outcome to a customer
41. Use a coordinator
42. Reach agreement on expectations
43. Outsource for "free"
44. Optimize level of inspection
45. Work with suppliers
46. Reduce setup or startup time
47. Set up timing to use discounts
48. Optimize maintenance
49. Extend specialist's time
50. Reduce wait time
51. Standardization (create a formal process)
52. Stop tampering
53. Develop operation definitions
54. Improve predictions
55. Develop contingency plans
56. Sort product into grades
57. Desensitize
58. Exploit variation
59. Use reminders
60. Use differentiation
61. Use constraints
62. Use affordances
63. Mass customize
64. Offer product/service anytime
65. Offer product/service anyplace
66. Emphasize intangibles
67. Influence or take advantage of fashion trends
68. Reduce the number of components
69. Disguise defects or problems
70. Differentiate product using quality dimensions
71. Change the order of process steps
72. Manage uncertainty, not tasks



Divergent and Convergent Thinking

Adapted from Executive Learning Inc. Team Training Materials.



Provocation Exercise – Part 1

Select one of the provocations below and develop a what if statement around an issue you face
E.G "what if, patients did their own dialysis

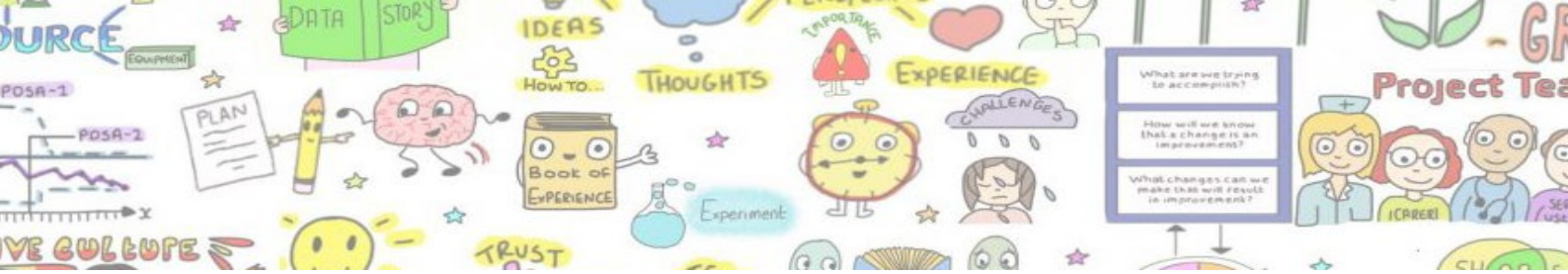
Reversal – going in the reverse or opposite direction from the normal direction or order (get admitted after person is in a bed)

Exaggeration – suggesting a measurement that lies outside the normal range (TFG: Placement into foster care takes over 6 months to accomplish / Provocation: Placement takes less than 1 day

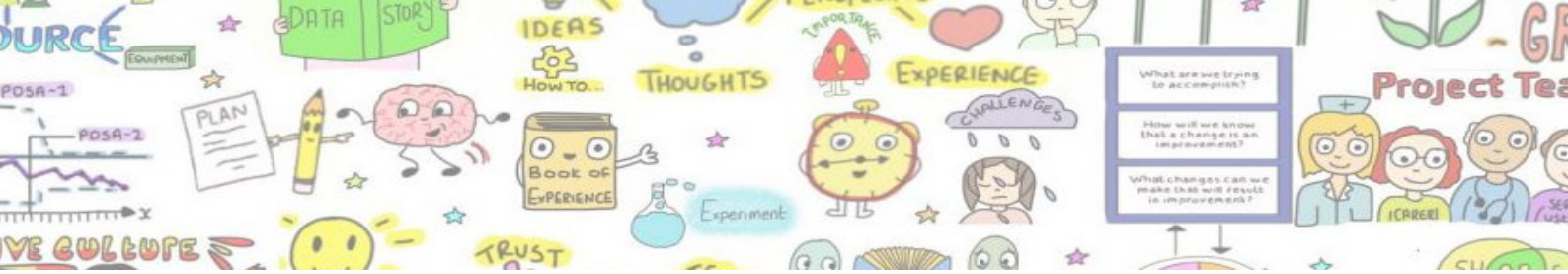
Distortion – Take normal arrangements (relationships and time sequences) and mix-up the normal to create the provocation (students give tests to teachers, TV selects what you watch)

Wishful thinking – stating an "impossible" fantasy (it is easy to park at the hospital, pencil writes by itself

Escape – list things that are taken for granted about the situation or process, then drop/cancel/do away with it (GP surgeries have waiting rooms)


DATA
STORY
IDEAS
HOW TO...
THOUGHTS
EXPERIENCE
CHALLENGES
PLAN
Book of Experience
Experiment
TRUST
Project Tea

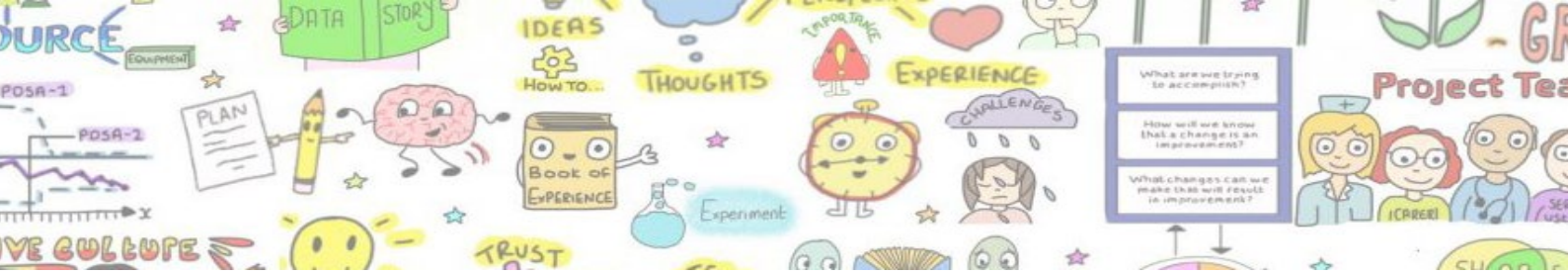
My Notes



Module 3.3

Testing Change Ideas using PDSA

	LEARNING OBJECTIVES • Understand what a PDSA is and what the core components are • Understand how to use them in a project setting to learn over time what works and doesn't • Understand some of the challenges in using them effectively
	KEY CONTENT • PDSA
	RESOURCES • PowerPoint Presentation
	TRAINING ACTIVITIES • N/A
	ASSESSMENT • N/A



The Typical Approach…

In the conference room

Views of the world: Theories

DESIGN → DESIGN → DESIGN → DESIGN → APPROVE

…..and in the real world.

IMPLEMENT

The actual world: "Moment of Truth"

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The Quality Improvement Approach

In the conference room

Views of the world: Theories

DESIGN

APPROVE IF NECESSARY

…..and in the real world.

TEST & MODIFY → TEST & MODIFY → TEST & MODIFY

START TO IMPLEMENT

The actual world: "Multiple Moments of Truth"

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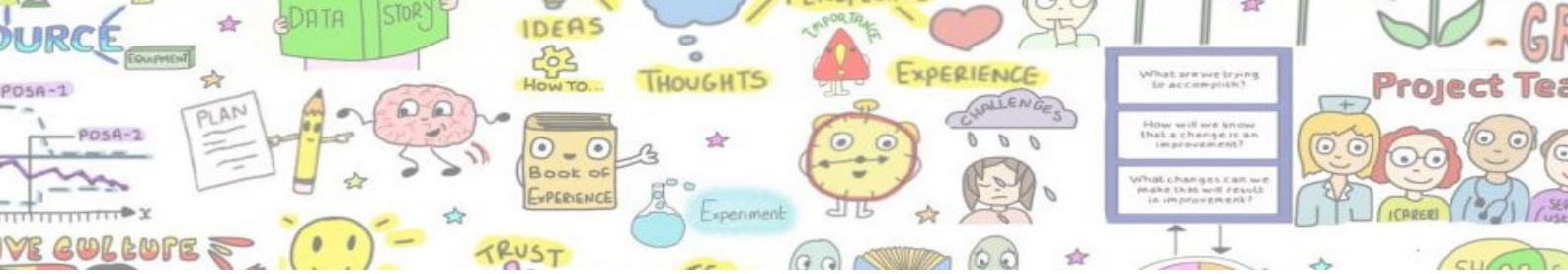
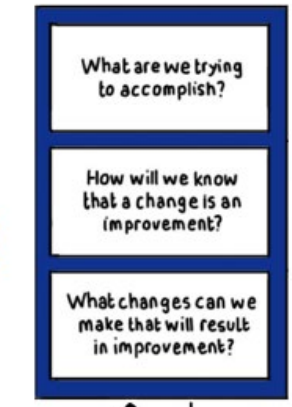


A model for *accelerating* learning and *developing* change



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What's next and where's next?

What will happen if we try something different?

What's our Theory?

Did it work? (did it match predications, expectations, hopes?)

Let's try it!

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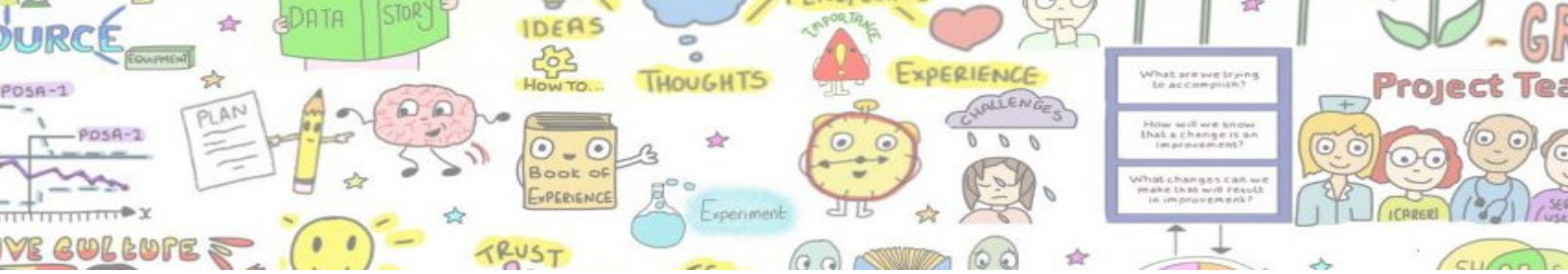


PDSAs cycles are conceptually simple but quite sophisticated in their delivery

- System understanding and appreciation – it is not a standalone approach
- Quick (but not dirty) tests
  - Clearly define the problem and causes first
  - Must have a theory/prediction
  - Key stakeholders involved (Service users, staff, others)
  - Need clear plan of "what, who, how, when"
  - Collect data and communicate what has been learned!
  - Don't move too quickly to full scale!
- *Can* be used at larger scale

THE PROBLEM WITH...

OPEN ACCESS

The problem with Plan-Do-Study-Act cycles

Julie E Reed,[1] Alan J Card[2,3]

INTRODUCTION

Quality improvement (QI) methods have been introduced to healthcare to support the delivery of care that is safe, timely, effective, efficient, equitable and cost effective. Of the many QI tools and methods, the Plan-Do-Study-Act (PDSA) cycle is one of the few that focuses on the crux of change, the translation of ideas and intentions into action. As such, the PDSA cycle and the concept of iterative tests of change are central to many QI approaches, including the model for improvement,[1] Lean,[2] six sigma[3] and total quality management.[4]

PDSA provides a structured experimental learning approach to testing changes. Previously, concerns have been raised regarding the fidelity of application of PDSA method, which may undermine learning efforts,[5] the complexity of its use in practice[6 7] and as to the appropriateness of the PDSA method to address the significant challenges of healthcare improvement.[8]

This article presents our reflections on the full potential of using PDSA in healthcare, but in doing so we explore the inherent complexity and multiple challenges of executing PDSA well. Ultimately, we argue that the problem with PDSA is the oversimplification of the method as it has been translated into healthcare and the failure to invest in a rigorous and tailored application of the approach.

THE VALUE OF PDSA IN HEALTHCARE IMPROVEMENT

The purpose of the PDSA method lies in learning as quickly as possible whether an intervention works in a particular setting and to making adjustments accordingly to increase the chances of delivering and sustaining the desired improvement. In contrast to controlled trials, PDSAs allow new learning to be built in to this experimental process. If problems are identified with the original plan, then the theory can be revised to build on this learning and a subsequent experiment conducted to see if it has resolved the problem, and to identify if any further problems also need to be addressed. In the complex social systems of healthcare, this flexibility and adaptability of PDSA are important features that support the adoption of interventions to work in local settings.

A successful PDSA process does not equal a successful QI project or programme. The intended output of PDSA is learning and informed action. Successful application of the PDSA methodology may enable users to achieve their QI goals more efficiently or to reach QI goals they would otherwise not have achieved. But it is also successful if it saves wasted effort by revealing QI goals that cannot be achieved under realistic constraints or if it identifies new problems to tackle instead of the originally identified issue. A well-conducted PDSA promises learning. But it does not, and cannot, promise that users will achieve their desired outcomes.

As PDSA has been translated into healthcare from industrial settings, an emphasis has been placed on rapid small-scale tests of change, often on one, three and then five patients in 'ramps' of increasing scale, and responsibility delegated to frontline staff and improvement or quality managers. This pragmatic approach has been embraced and has been seen as providing a new freedom for healthcare staff to lead change and improvement in local care settings.

However, the process of change rarely progresses in simple linear ramps.[5 7] The conduct of PDSAs can reveal other related issues that need to be addressed in order to achieve the improvement goal. Such issues may relate to minor changes to current practices or processes of care, but can often reveal larger cultural or organisational issues that need to be addressed and overcome.

BMJ Qual Saf 2016;25:147–152. doi:10.1136/bmjqs-2015-005076

147

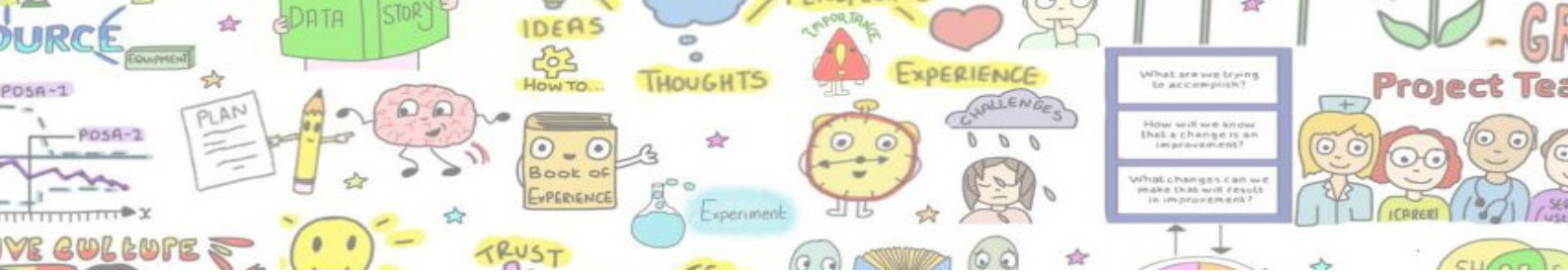
Reed, J, and Card, A, J. (2016). The problem with the Plan-Do-Study Cycles. BMJ Qual Saf, 25, p147-152

Summary of Key Principles in the application of PDSAs

Scientific tool to help build learning quickly

Requires rigour and an understanding of context and process

Is rarely a one shot solution and might require multiple small cycles

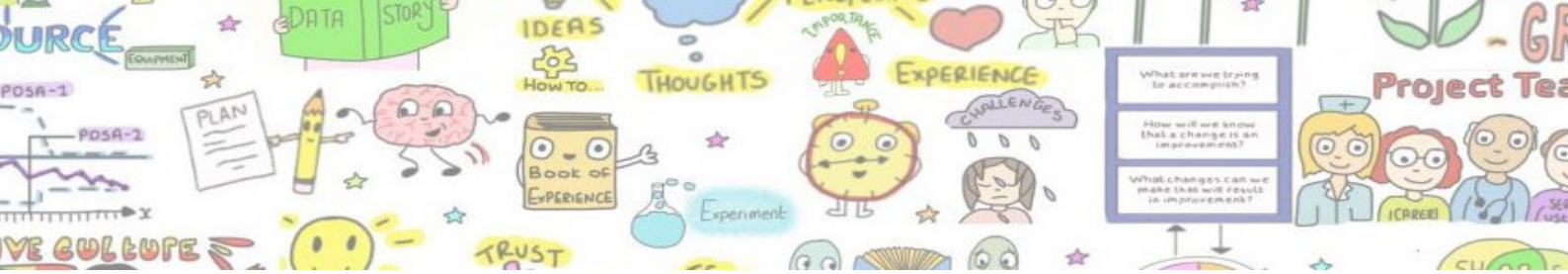


General considerations: What's the objective of this cycle? What do we want to learn? What's the size for this test?	
PLAN	What's your theory? • **Questions**: what do you want to answer through this test? • **A prediction:** for each question • **Data**: what do I need to measure and collect to understand if the prediction held true? • **Allocation of activities**: Who needs to do what, when, where, how – to run this test?
DO	• Run the test and record Did you stick to the plan, or do anything differently?
STUDY	• Make time to learn by looking at your data, stories, experiences. Compare your data with the predictions. Were your predictions correct?
ACT	What should we do next? Adopt, adapt, abandon…

Lets PDSA!: A scenario…

- A clinic is experiencing long waits before someone is seen for assessment. We're using QI to help us improve this.
- The team are keen to address this as waits for assessment are impacting on capacity to deliver appropriate and timely care.
- One change idea is the use of text messages **to help remind people** about their appointments, so we have fewer non-attendances.
  - Not everyone is sure about this test
  - People are aware of the time it may take to do this and the potential costs involved.
  - Not everyone thinks this is a key determinant of people attending

Let's plan how we might use a series of tests for this change idea



Objective of the cycle: Linking to Driver Diagram and Aim

To increase the number of service users attending their assessment appointments by 30% by May 2022

- Motivation
  - Appropriate referrals
    - Develop referral forms to clarify provision of care with service users and referrers
  - Appropriate messaging
    - Text reminders via nokia phone
- Communication
  - Follow up
    - Pre-Call: Check with Service user if appointment is wanted/useful
- Resources
  - Assessment Rooms
    - Develop room rota for scheduling
    - Evening or out of hours assessments
  - Staff Capacity

But what about the size of the test?

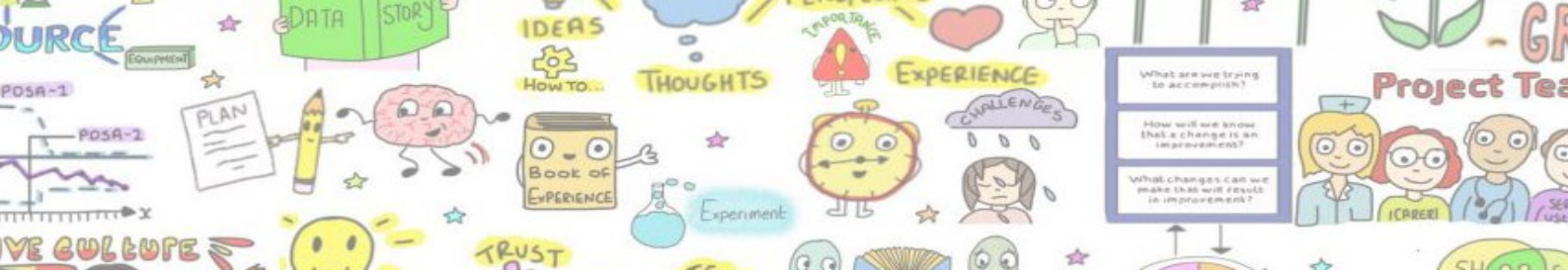
Start as small as possible for the given context!

Start as small as possible to develop confidence in whether the idea will work before spreading further

Why?

- Minimises time and resources going into ideas that don't work
- Minimises unnecessary upheaval to working practices before knowing something works
- Minimises other types of risk, which come with change

- 1 service user
- 1 day
- 1 admission
- 1 clinician



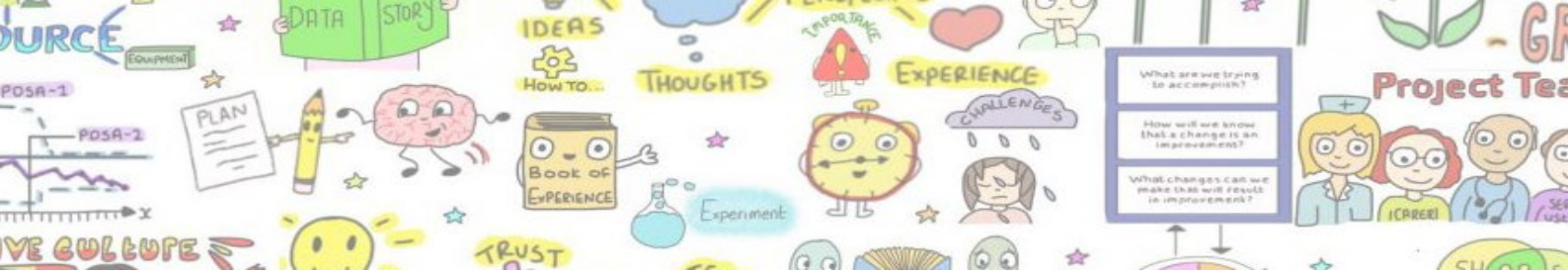
Tips for minimising risks and designing tests on a small scale

- Conduct the test in with one service user or one staff memeber
- Conduct the test over a short period of time (1 hr or 1 shift)
- Simulate the change
- Test the change with one member of the team that developed it
- Test on a small group of volunteers

PLAN	**Questions**: what do you want to answer through this test? • **A prediction**: for each question • **Data**: what do I need to measure and collect to understand if the prediction held true? • **Allocation of activities**: Who needs to do what, when, where, how – to run this test?

Check:

Can someone **not involved in this project** repeat this change idea based on what we have written



Let's create a Plan for the first PDSA…

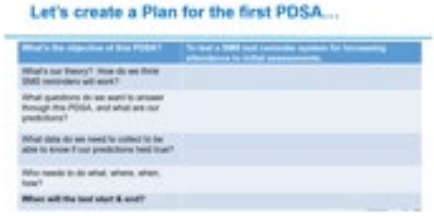
What's the objective of this PDSA?	To test a SMS text reminder system for increasing attendance to initial assessments.
What's our theory? How do we think SMS reminders will work?	People can forget appointments, especially if the letter was sent a few weeks ago. A 48-hour reminder text could help prompt people to attend.
What questions do we want to answer through this PDSA, and what are our predictions?	How viable is it to send each person an assessment text 48 hours before their appointment? …any more?
Who needs to do what, where, when & how? (team has admin staff, therapists, managers, assistant psychologists)	
What data do we need to collect to be able to know if our predictions held true?	
When will the test start & end?	

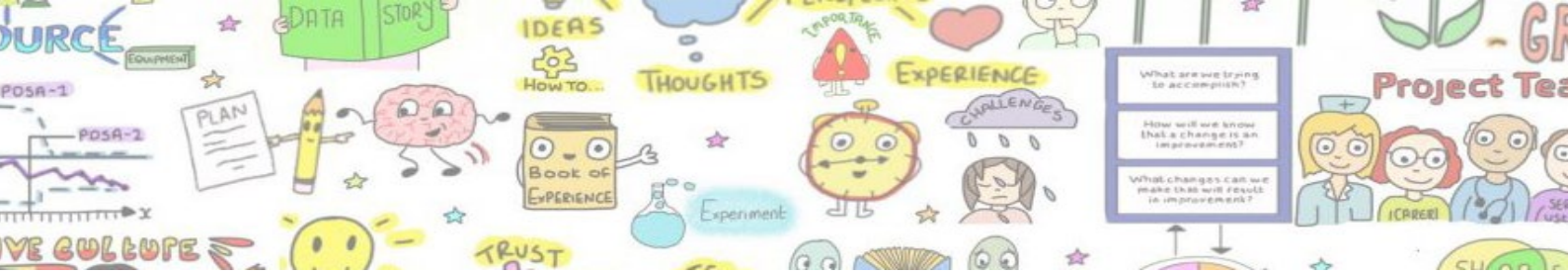
Exercise

- In breakout rooms lets have a go at working through the PDSA template provided

We will ask one or two groups to feedback

- 15 mins to use the template provided
- 2 mins for each section





Building evidence in testing changes: Building degree of belief

Gold Standard:

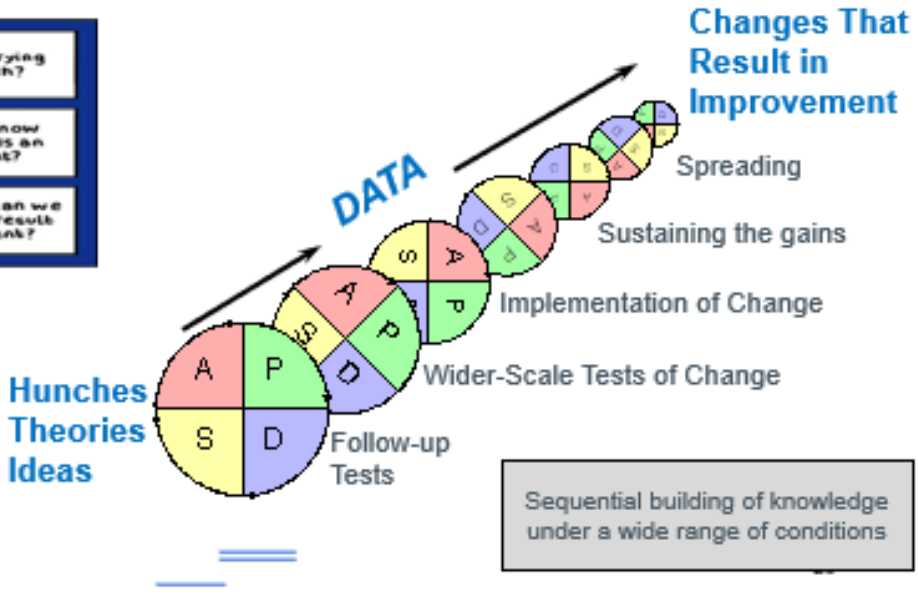
"Satisfactory prediction of the results of tests conducted over a wide range of conditions is the means to increase **the degree of belief** that the change will result in improvement."

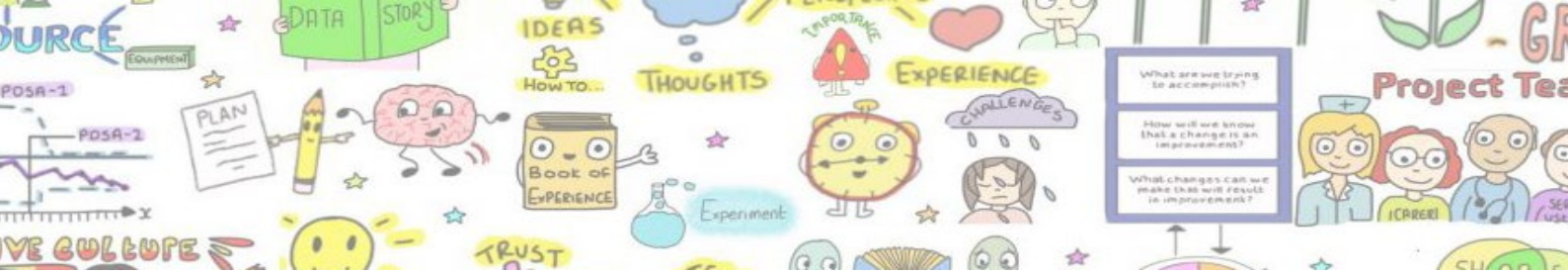
The extent to which prediction can be supported by evidence

- Similarity in conditions/contexts where evidence came from and where we are going to use the idea
- Test under other conditions:
  - Different days
  - Different tools
  - Different times
  - Different people

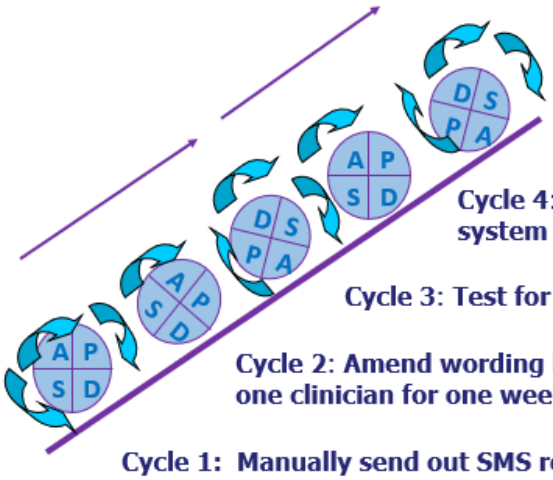
Multiple cycles to build knowledge?

Repeated Use of the PDSA Cycle for Testing





PDSA Ramp… Change Idea = SMS reminders



Cycle 5: Implement

Cycle 4: Test an automated messaging system for one week

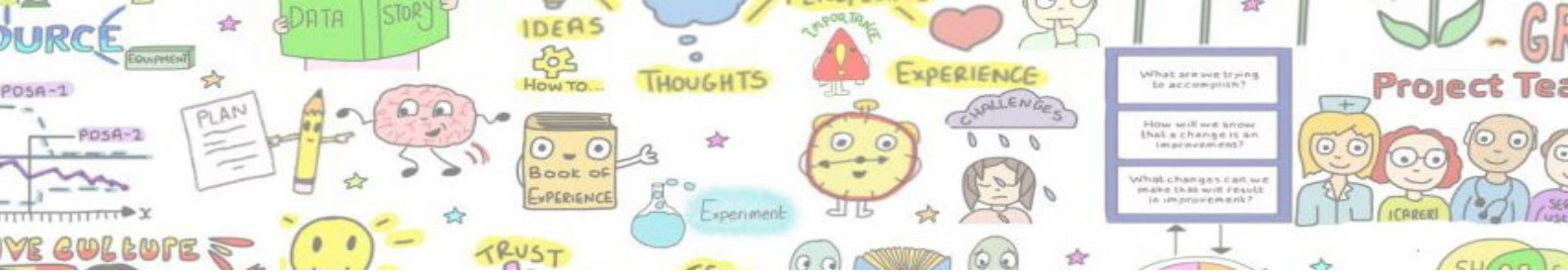
Cycle 3: Test for all clinicians for one week

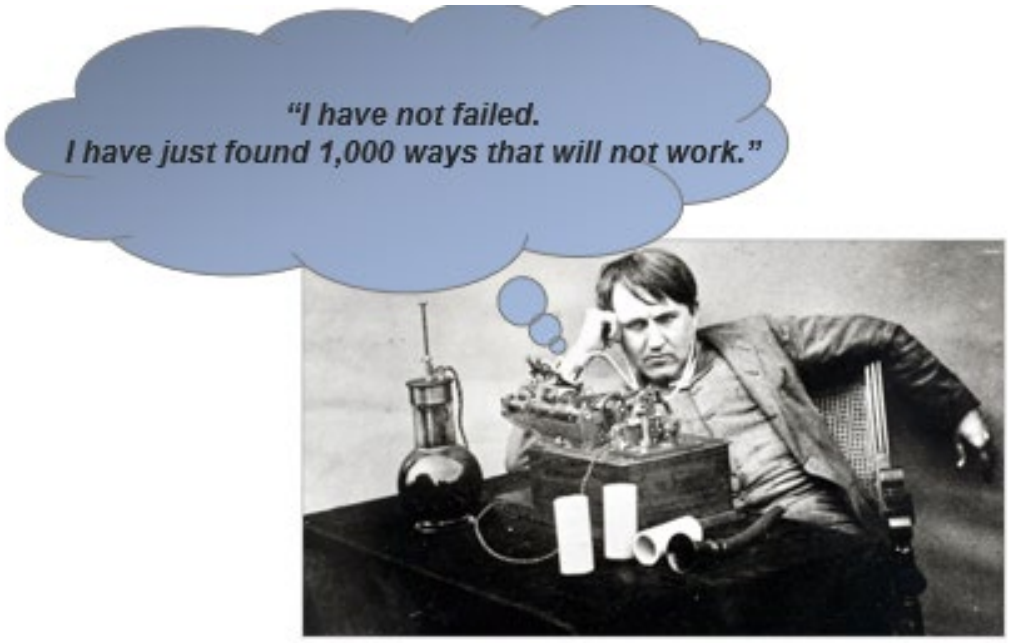
Cycle 2: Amend wording based on feedback and test for one clinician for one week

Cycle 1: Manually send out SMS reminders 2 days prior to one clinic

"Failed" test

"Drive out fear: so that everyone may work effectively for the company. *Where there is fear of asking questions*, critical questions will never be surfaced and hence never addressed" - Deming



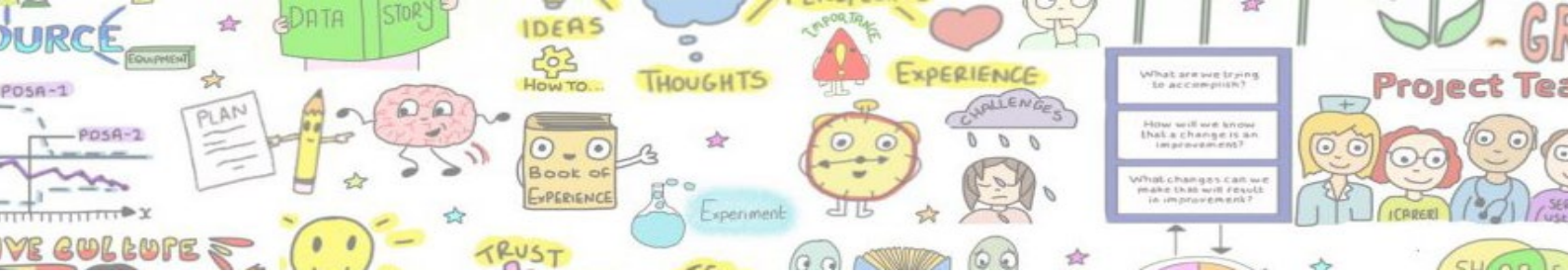


Edison in his lab in 1888, after working long hours on his phonograph.

Over to you

Visit Menti and let's have a go at some questions

Menti Code - 49439172


DATA
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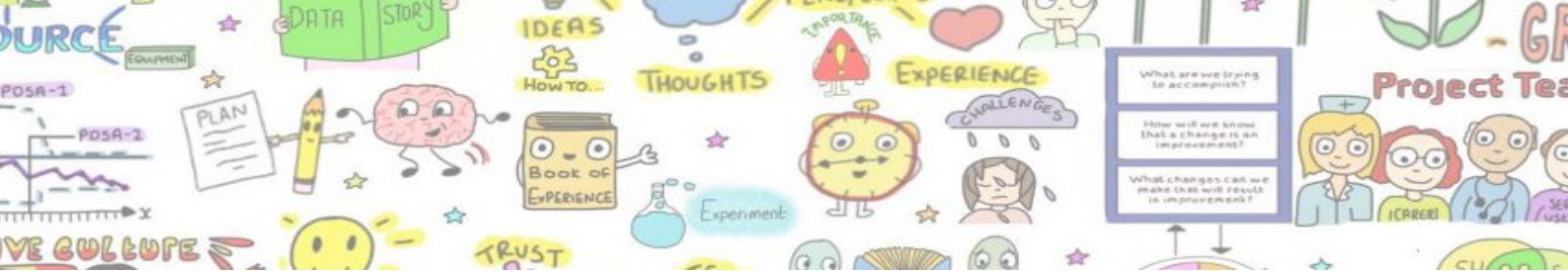
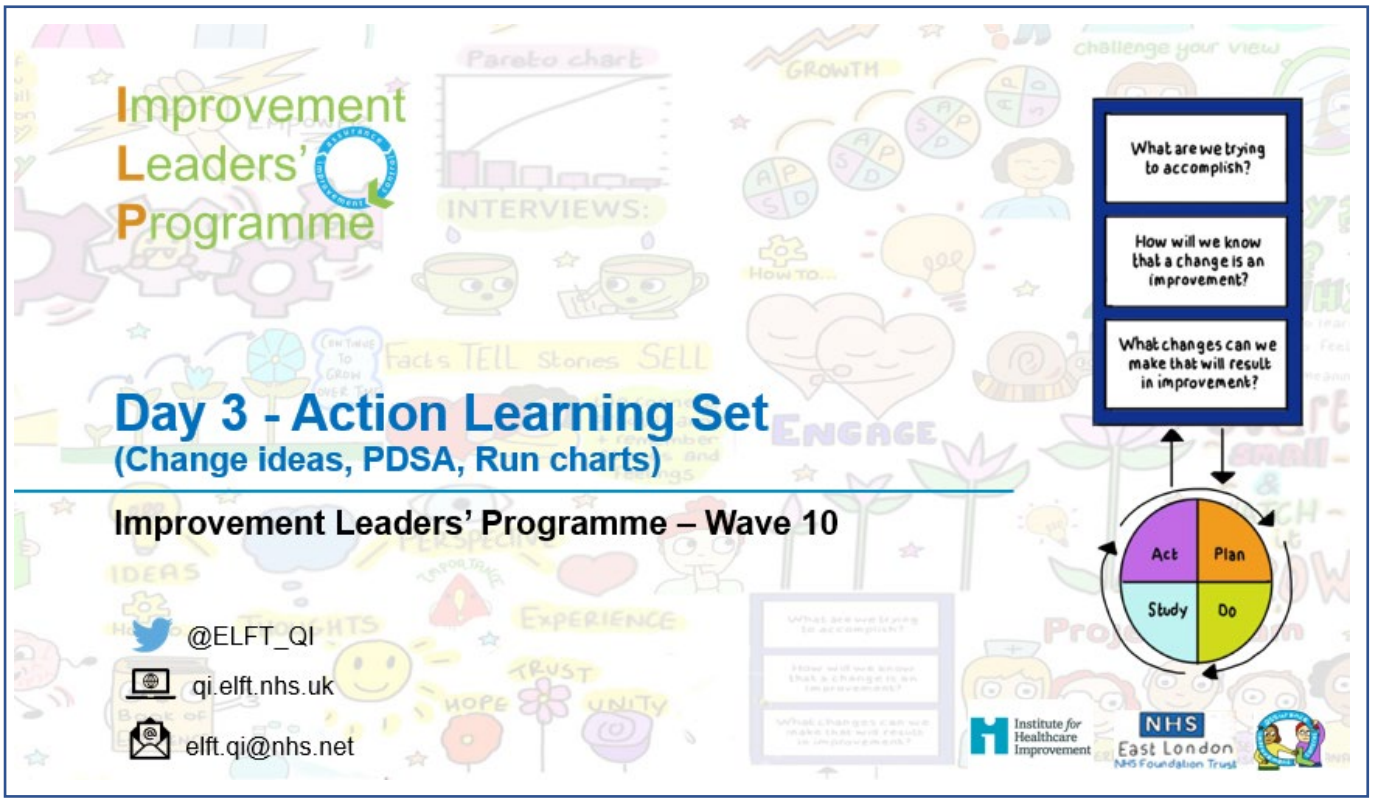
THOUGHTS
EXPERIENCE
CHALLENGES
PLAN
Book of Experience
Experiment
TRUST
Project Tea

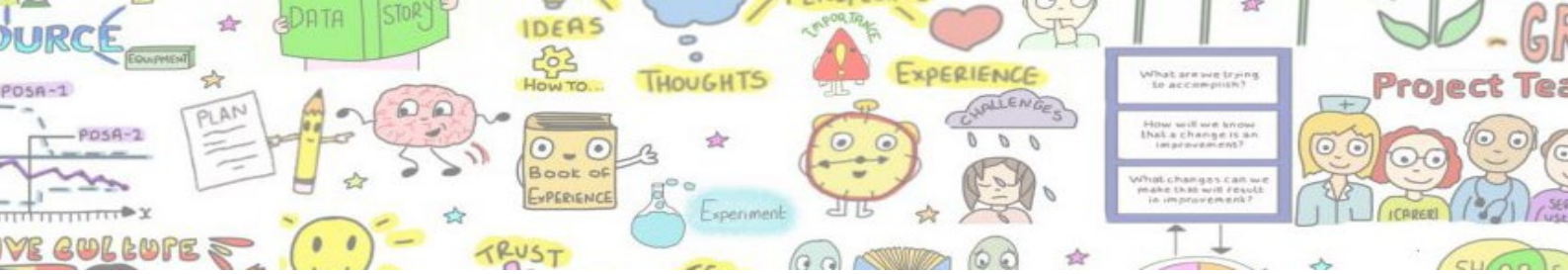
My Notes



Module 3.4

Action Learning Set - 3

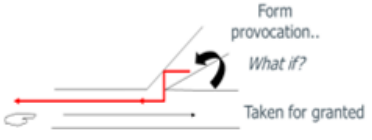




Activity	Description	Time
	Arrival Buffer	5 mins
Provocation Tools	Group discussion on the potential benefits of the provocation tools and how they can help reveal creative change ideas. (distortion, reversal, wishful thinking)	10 mins
PDSA Planning	Individually practice preparing a plan for a PDSA and discuss plans created by 2 ALS members.	30 mins
BREAK		10 mins
Run charts	Individual time to practice interpriting Run Charts – Run Chart Quiz. Followed by group discussion and agrrement on corrent answer. Followed by discussion and Q&A with facilitator.	40 mins

Idea Generation Exercise - Provocation Tools (15min)

Familiarise yourselves with using provocation tools to get out of normal thought patterns and make new patterns.



- **Have a group discussion about what might emerge if you applied any of these provocation tools to generate unique ideas for you project.**
  - **Focus solely on the positives and potential benefits.**
  - **Make a personal note of which tool you will try when you next meet with your project team.**

Provocation Tools:

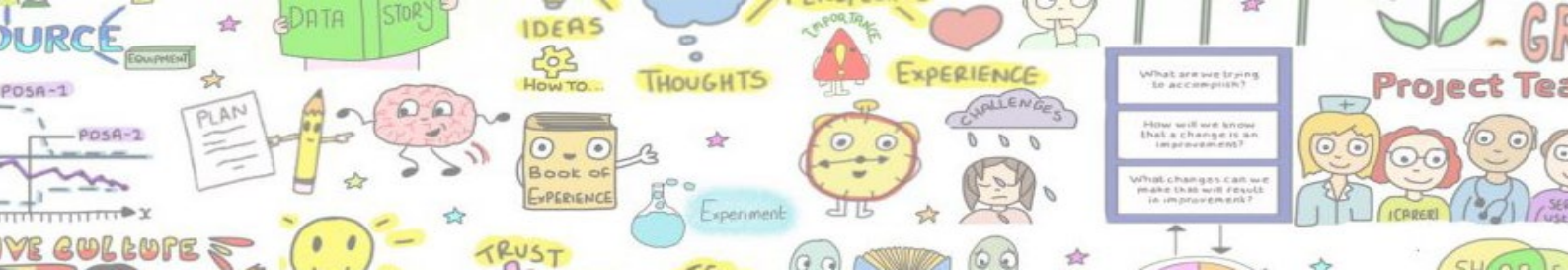
Reversal – going in the reverse or opposite direction from the normal direction or order *(e.g., get admitted after person is in a bed)*

Exaggeration – suggesting a measurement that lies outside the normal range *(e.g., Placement into foster care takes over 6 months to accomplish / Provocation: Placement takes less than 1 day)*

Distortion – Take normal arrangements (relationships and time sequences) and mix-up the normal to create the provocation *(e.g., students give tests to teachers, TV selects what you watch)*

Wishful thinking – stating an "impossible" fantasy *(it is easy to park at the hospital, pencil writes by itself)*

Escape – list things that are taken for granted about the situation or process, then drop/cancel/do away with it *(e.g., GP surgeries have waiting rooms)*



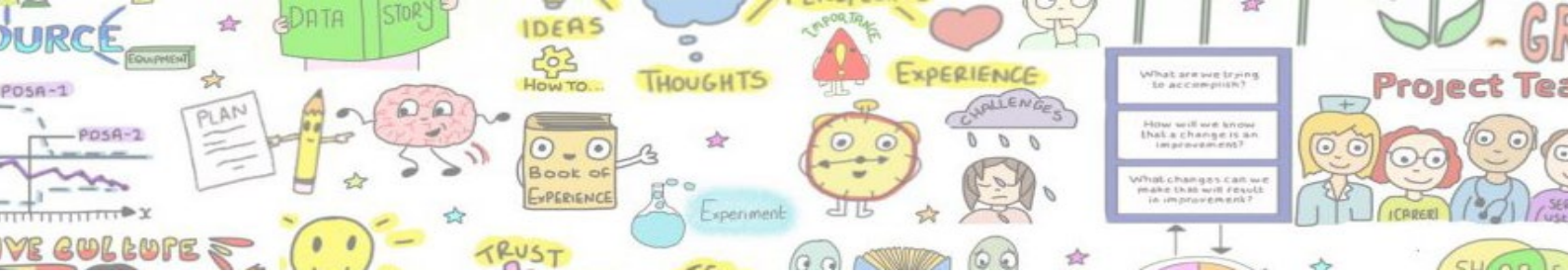
PDSA – Planning a first test of change (30min)

Practice constructing the 'plan' section of a PDSA cycle.

1) Pick a change idea for your project that you can test by next Tuesday and spend some time planning this alone. Use the grid in your Participants Guide **(10 mins)**
2) Pick two people to share their PDSA plan back to the group **(20 mins).** Listen out for, and discuss:
   - Are the questions being asked by this PDSA cycle clear?
   - Will the measure help them understand this?
   - Is it clear what is happening, when and who is doing what?

PLAN	
PDSA Title Change Idea	
Objective of the test Theory	
Prediction (What do you predict will happen when your run the test?)	
When will you do the test? Where are you going to do the test? Who is going to be involved in running the test?	
How will you evaluate the success of the test? How will you know whether your predictions are supported or not? (how will you get this data)	
What do you need to do to set up the test? (Note tasks and by who, by when)	

Continue on back if more space needed

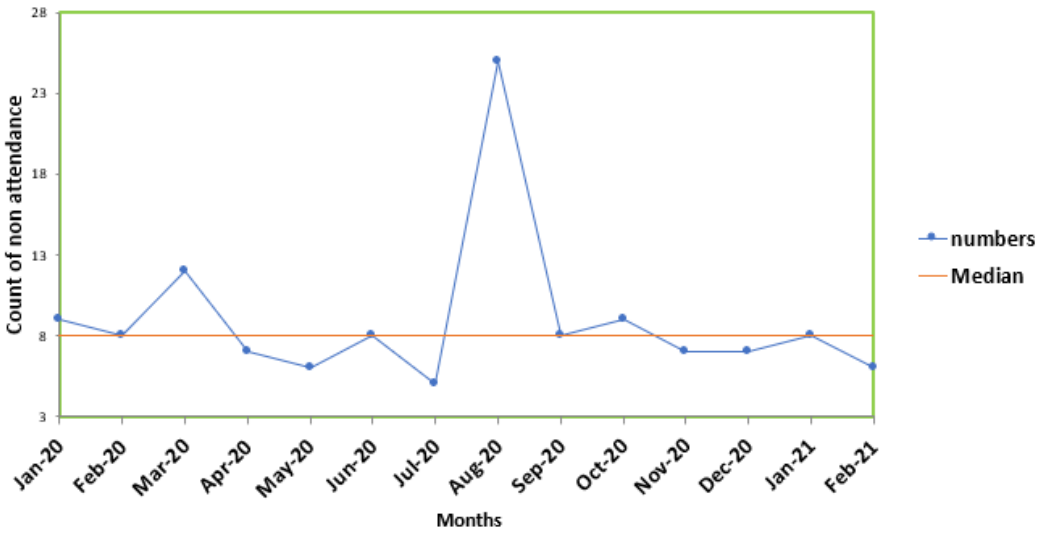


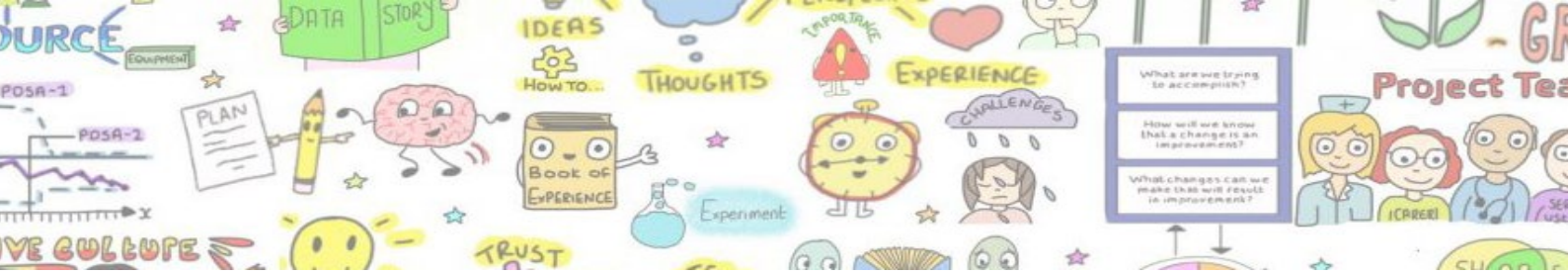
Interpreting Run Charts (40 min)

Test your knowledge and build understanding around interpreting Run Charts

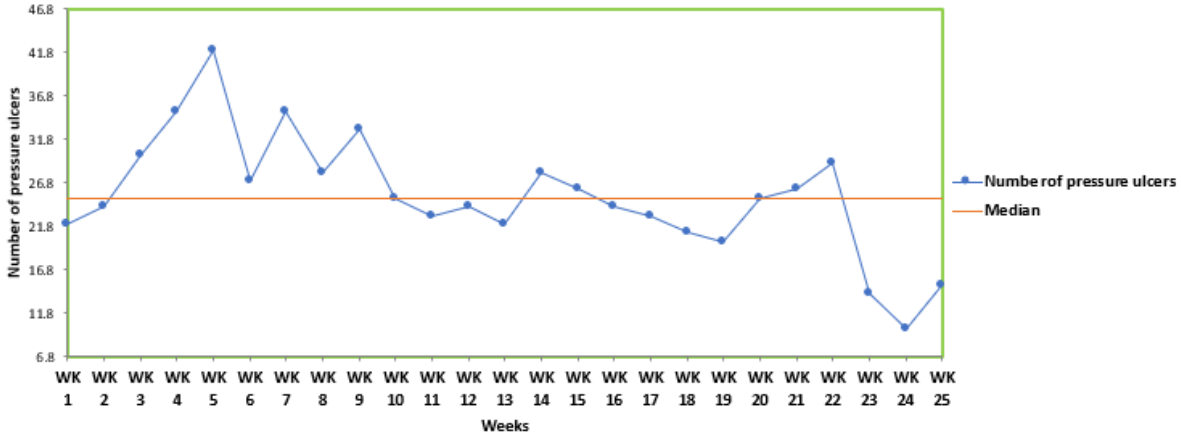
1) Find the Run Chart rules on the QI website https://qi.elft.nhs.uk/resource/run-charts/
2) On your own, use the Participants Guide to interpret the 4 run charts. For each chart, work through all 4 run chart rules to identify non-random variation. Annotate the chart before moving to the next chart. **(15 mins)**
3) As a group, discuss each chart and agree on which rules are met on each. **(10 mins)**
4) Report your final answers to your facilitator. Discussion and Q&A **(15 mins)**

Non attendance at Adolescent Outpatient Clinic - Run Chart

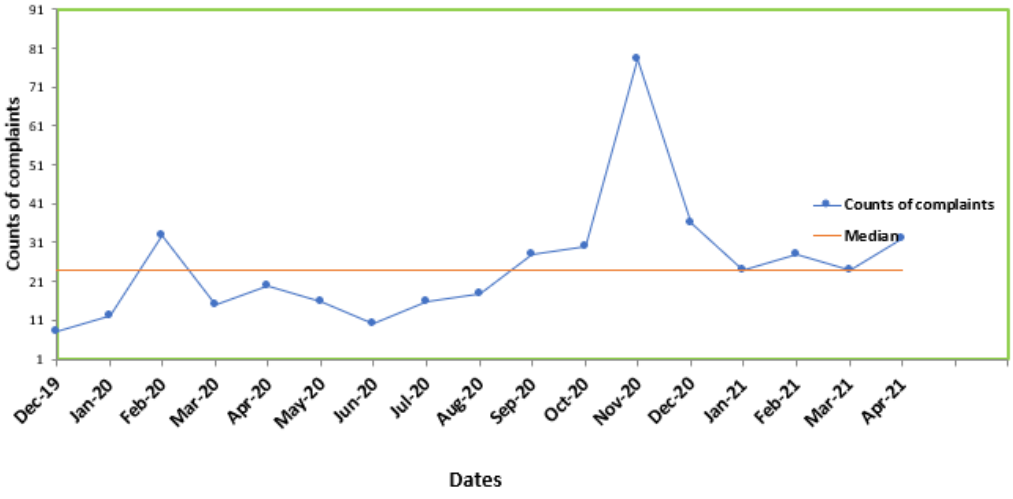


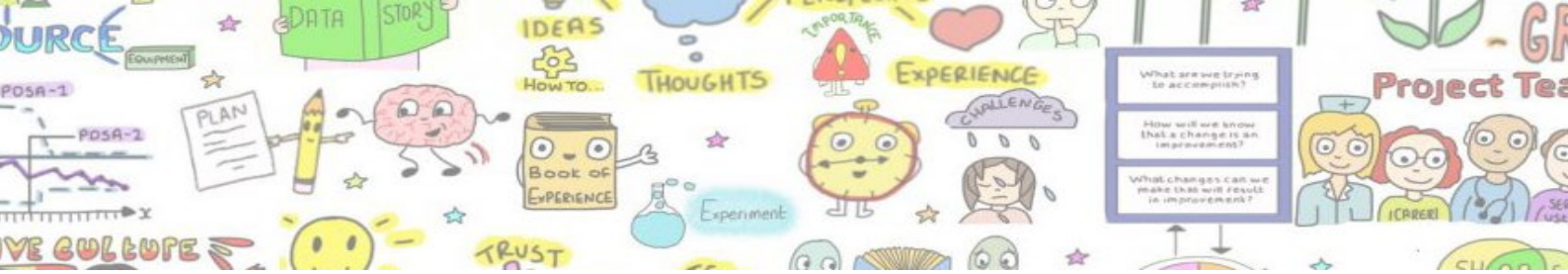


Number of grade 2 pressure ulcers in the Extended Primary Care Team – Run Chart

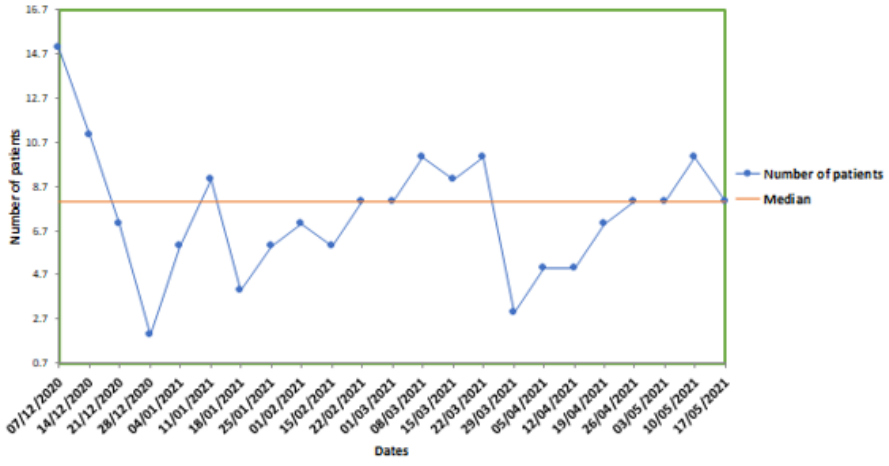


No. of complaints received in the community health service

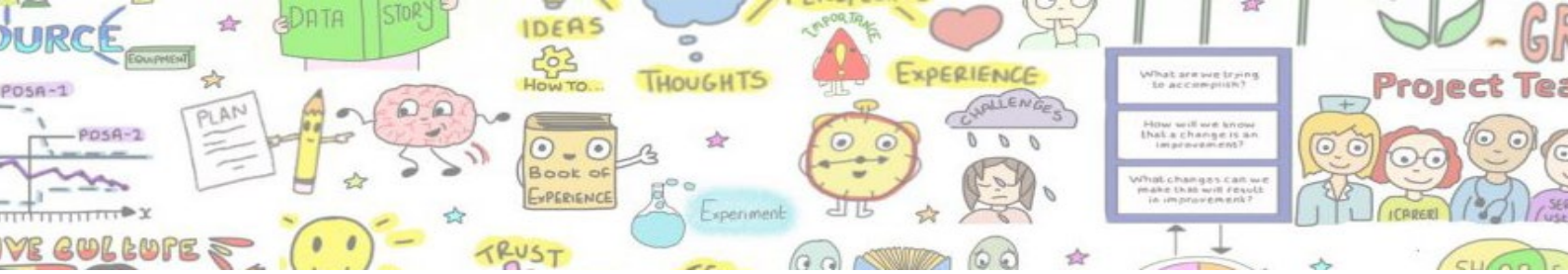




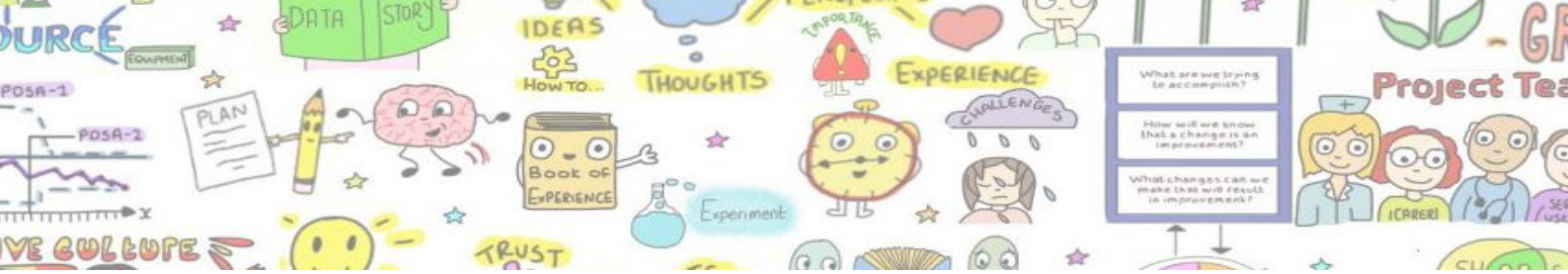
No. of patients starting therapy in Bedfordshire Wellbeing Service – Run Chart



NHS East London NHS Foundation Trust


DATA
STORY
IDEAS
HOW TO...
THOUGHTS
EXPERIENCE
CHALLENGES
PLAN
Book of Experience
Experiment
TRUST
Project Tea

My Notes



Activity

Spiral Journaling

One thing I learned from the teaching this morning…	One thing I learned about myself today…
What one tool I will use to understand the problem…	What will help me to succeed in completing the action period work?