QUALITY IMPROVEMENT PROGRAMME

East London NHS Foundation Trust NHS

Mixed method evaluation of ELFT's Quality Improvement Programme

October 2016

Foreword

Providing high quality care for our service users is the reason why most of us work in the NHS, and why we often go far beyond the limits of our job descriptions in our efforts to ensure every service user receives care that we are proud of. At East London NHS Foundation Trust (ELFT), we have been working hard to provide an environment where all our staff feel that they have the skills and the support to be able to continually improve their service, in order to better serve our communities.

Our Quality Improvement (QI) Programme, launched in February 2014, is designed to shift the power balance to our staff and service users, supporting them to work together to tackle some of our most complex quality issues and unleash their creativity and innovation. Increasingly, this is being recognised outside of ELFT as best practice and the route to transforming care delivery at the scale and pace needed to ensure the NHS survives and flourishes.

We have seen some amazing improvements in outcomes and experience already, through the wonderful dedication, passion and innovation of our staff and service users. It is a true privilege to be able to support this work across the organisation.

Just as we ask our teams to continuously reflect on the quality of care being provided and make iterative adjustments, so too is the QI Programme continuously adapting to changing needs and environments. This annual evaluation, following the second year of the programme, is part of an annual process of reflecting and adjusting, in order to help us learn and improve as an organisation.

We would like to thank the service users, staff and senior team who have contributed to this evaluation, and who are embracing the philosophy of continuous improvement within their daily working lives. We would also like to thank members of the evaluation team for drawing together the quantitative and qualitative information in this report:

- Sarah Stilwell – Quality Outcomes & Experience coordinator
- Philip Thompson – Quality Outcomes & Experience coordinator

- Ferdous Ali – Trainee data analyst
- People participation team

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1 Introduction

East London NHS Foundation Trust provides mental health and community health services to a population of approximately 1.5 million people, mainly in East London, Bedfordshire and Luton, with some specialised services in other parts of London, Hertfordshire, Essex and Bedfordshire. The Trust operates from more than 100 community and inpatient sites and employs almost 5,000 permanent staff.

The Trust's mission is to 'provide the highest quality mental health and community care in England' and the quality improvement (QI) programme was designed as a key vehicle to help achieve this. Underpinning principles of the QI programme are:

- to support frontline staff to work in partnership with service users and carers, providing teams with the skills and freedom to innovate and test out ideas which could make a real difference;
- to support hundreds of quality improvement projects at the frontline, measuring their impact and spreading those ideas that have been shown to improve the quality of care;
- to help teams focus on the aspects of care that are of most importance to service users and stop activity that is of less value;
- to embed a culture of listening to staff, service users and their families in efforts to continuously improve our services;
- to measure the impact of making changes over time;
- build improvement teams involving a range of staff and service users that work together to flatten hierarchies, capture diversity of opinion and ideas, and engage everyone to be part of improvement work.

Within the QI programme, two broad system-level stretch aims were set to provide alignment and direction for QI projects:

- Reducing harm by 30% each year;
- Providing the right care in the right place at the right time.

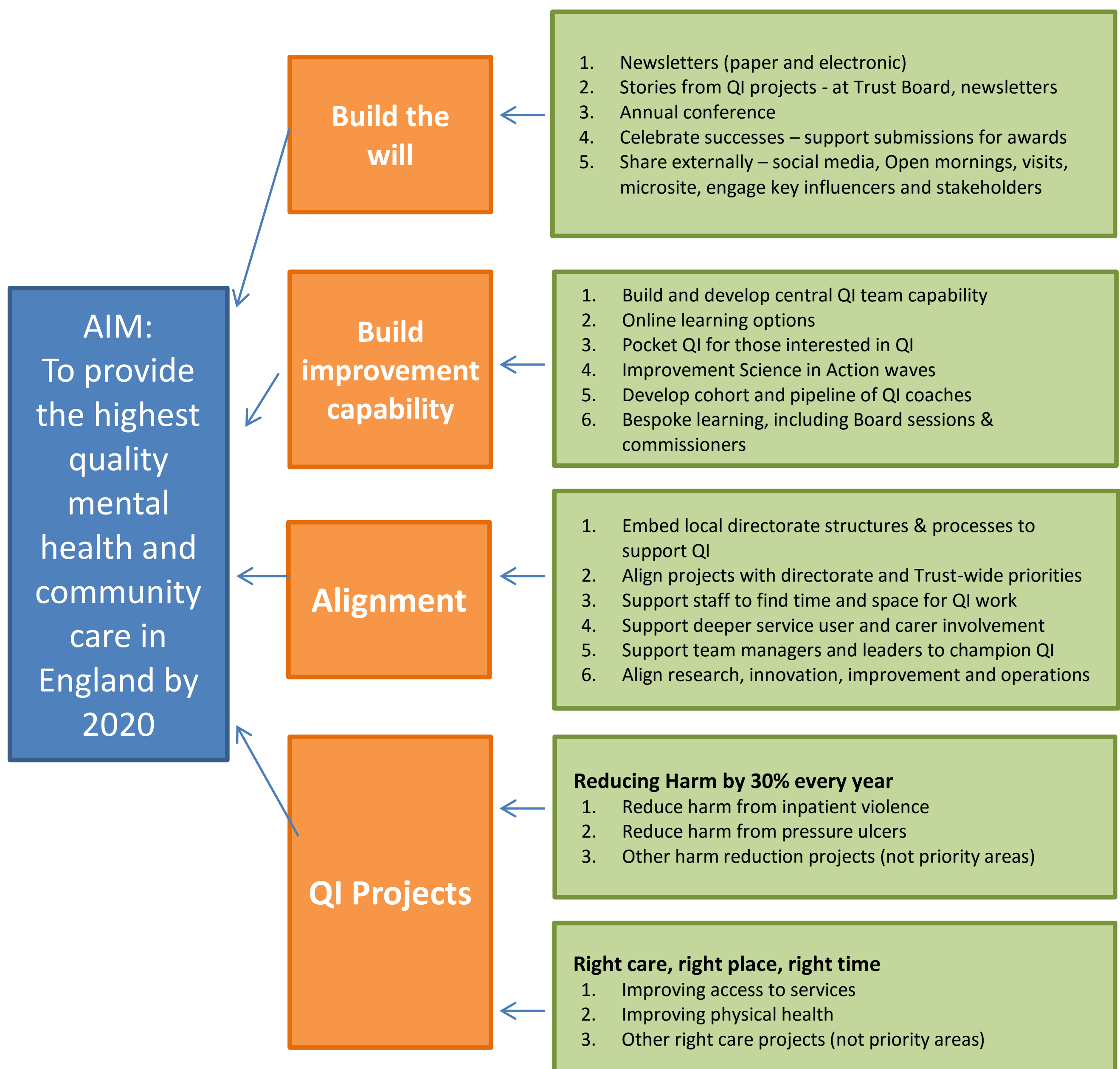
This report describes the progress that the Trust is making with quality improvement, following the end of the second full year of the programme. The purpose is to summarise activity, celebrate successes, identify challenges and to

provide a platform to continue learning and adapting in order to embed a culture of continuous improvement within the organisation.

Components of the QI Programme

The theory of change underpinning the QI Programme is visualised in figure 1 below, the driver diagram for the organisation-wide approach. This describes four primary drivers: building will, building capability, alignment and projects. The evaluation is structured in order to assess progress on each of these four primary drivers.

Figure 1. Driver diagram visualising the organisation-wide approach to QI



2.1 Progress with building will

The QI programme continues to test ideas and new ways to engage people, both internally at ELFT and the wider healthcare community with the quality improvement work taking place.
This includes a range of activities including:

- Bespoke Pocket QI sessions for particular services keen to engage staff in QI
- A series of roadshows in Bedfordshire and Luton to begin engaging staff and service users with the QI approach
- A publicly available microsite as the central resource for all things ELFT QI
- Newsletters (paper and electronic) to both internal and external stakeholders
- Sharing stories from QI projects at every Trust Board meeting and within the newsletters
- An annual conference to celebrate QI work
- Supporting award submissions by project teams
- Sharing the ELFT QI work with an external audience, through social media, quarterly open mornings, monthly newsletters and visits by key external influencers and the microsite

Microsite

As at August 2016, there had been 130,000 views of the QI microsite. The frequency of visits to the microsite has increased over the year (figure 2), and it is also being used as a global resource for QI (figure 3). During evaluation interviews with senior staff and staff directly involved in QI projects, people said they valued the microsite as a useful tool in their QI work.

Figure 2: Monthly Number of Visits to the QI microsite.

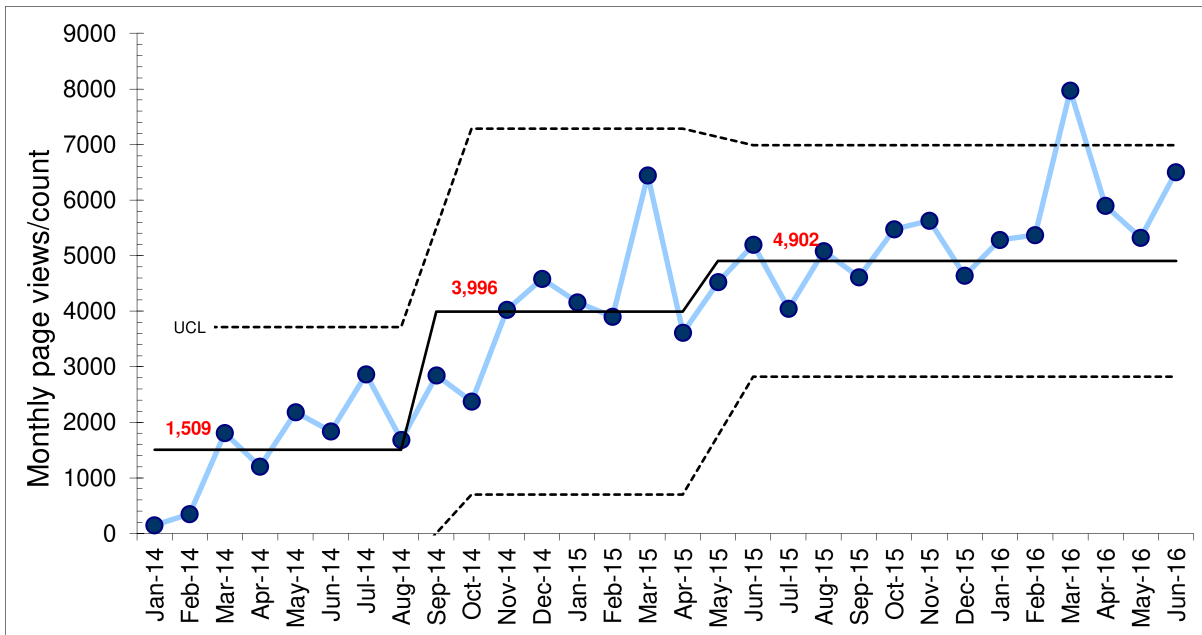


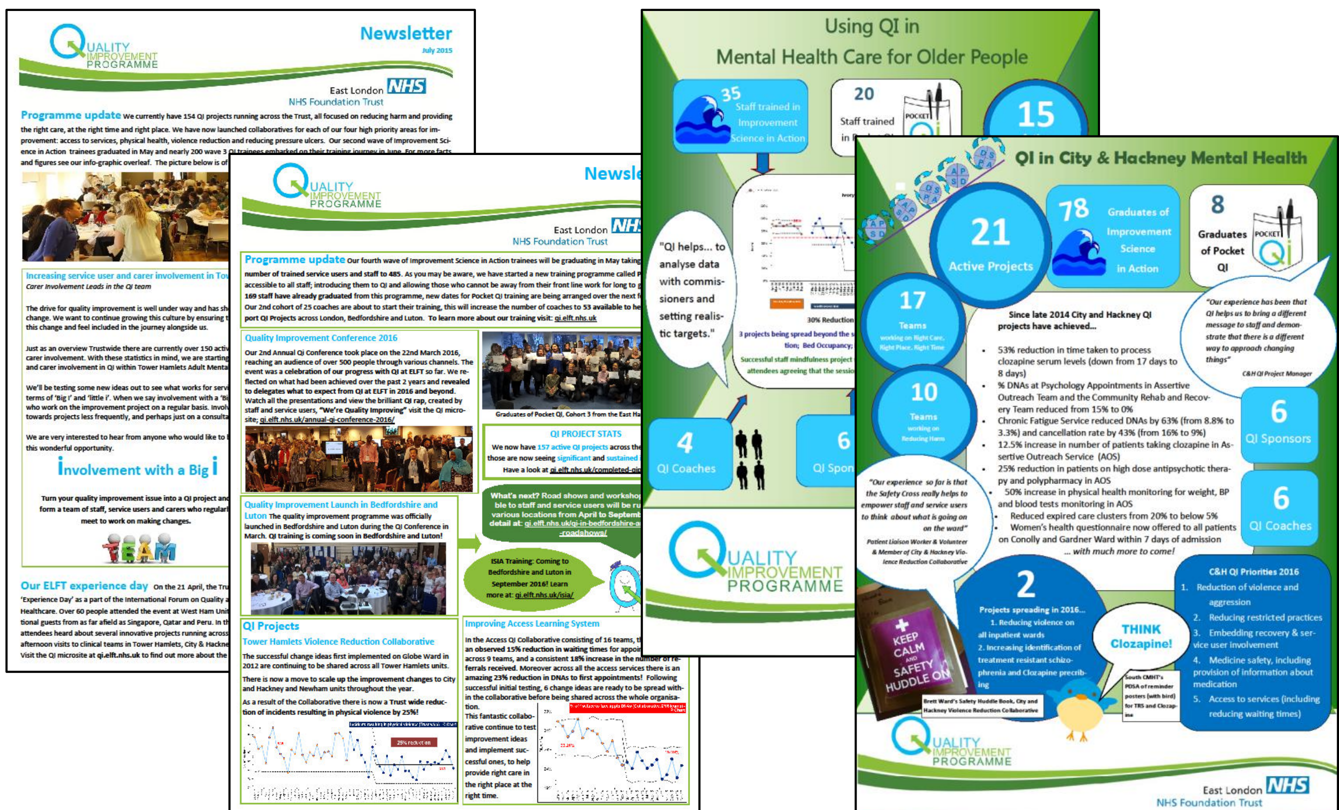
Figure 3: Global views of microsite visits in 2015/16

Newsletter

A key aspect of building the will is communications. The QI Programme releases monthly internal and external e-newsletters and a quarterly paper newsletter. The purpose of these communications is to create an awareness and understanding of quality improvement and increase staff engagement through sharing latest QI news and learning resources. More importantly it is a platform to directly share learning and improvement stories from the many different QI projects taking place across the Trust. There are also weekly updates on events and upcoming QI training through the Trust's internal "News from around the Trust" bulletin.

Our internal e-newsletters reach approximately 5000 staff across the Trust. A further 750 external stakeholders are reached through the external e-newsletter. The quarterly paper newsletter is sent out to Trust sites, GP practices, external community groups and other partners. Examples of these newsletters are below, in figure 4.

Figure 4. Examples of QI newsletters issued in 2016



Sharing QI stories at the Trust Board

Every Trust Board meeting includes a lunchtime discussion led by a project team using QI to tackle a complex issue. This is key to helping the Board understand how teams across the organisation are using QI, and better understanding the improvements in outcomes and challenges being faced by our teams. In 2015/16, the following project teams have presented their work at the Trust Board:

- Improving access to occupational therapy assessments at Newham centre for mental health
- Reducing restraints on Westferry ward (John Howard Centre)
- Reducing waiting times in the Newham psychological therapies service
- Improving the disciplinary process (HR team)
- Reducing missed doses of medication across older adult wards
- Improving access at the Newham Child & Family Consultation Service
- Improving access to clozapine for people with treatment resistant schizophrenia

Annual conference 2016

On Tuesday 22 March 2016, the QI programme held its 2nd annual conference which was attended simultaneously by 350 people at the East London venue, 110 people at the Bedfordshire venue and a few hundred more watching online via the live webstream. The half-day event was successful in celebrating our progress, showcasing excellent work by project teams and bringing people together in an energising and innovative way.

Videos of the 2016 conference are available at - https://qi.elft.nhs.uk/annual-qi-conference-2016/

Award nominations

The QI programme supports teams to celebrate their work nationally through submission for various awards. Since launching in 2014, the QI programme has been shortlisted for over fifteen awards, and has won the following in 2015/16:

1. **HE NCEL (2016)**
   In February 2016 the Trust's QI capability building won first prize at the Health Education North Central and East London (HE NCEL) awards.

2. **BMJ Award (2016) –** The QI programme at ELFT won the 2016 Education Team of the year Award.

3. **Nursing Times Awards (2015) -** The Trust won a Nursing Times award for the Care of Older People, in recognition of the work led by the teams on Sally Sherman ward and the Lodges to reduce levels of physical violence.

4. **Patient Safety Awards (2015) -** The Trust was recognised as Trust of the Year at the Patient Safety awards in July 2015.

Publishing projects

The QI team supports projects to publish their work in BMJ Quality Improvement Reports, a peer-review open access publication, as part of our efforts to share QI work with the global audience. Below are some of the projects published since the launch of the QI programme.

1. **Low stimulus environments: reducing noise levels in continuing care**
   Abstract: In the low stimulus environment project, we aimed to reduce the levels of intrusive background noise on an older adult mental health ward, combining a very straightforward measure on decibel levels with a downstream measure of reduced distress and agitation as expressed in incidents of violence. This project on reducing background noise levels on older adult wards stemmed from work the team had done on reducing levels of violence and aggression.

   Authors: Juliette Brown, Waleed Fawzi, Amar Shah, Margaret Joyce, Genevieve Holt, Cathy McCarthy, Carmel Stevenson, Rosca Marange, Joy Shakes, Kwesi Solomon-Ayeh

2. **Developing psychological services following facial trauma**
   Abstract: Adults presenting to oral and maxillofacial surgery services are at high risk of psychological morbidity. Research by the Institute of Psychotrauma and the centre for oral and maxillofacial surgery trauma clinic at the Royal London hospital (2015) demonstrated nearly 40% of patients met diagnostic criteria for either depression, post traumatic stress disorder (PTSD), anxiety, alcohol misuse, or substance misuse, or were presenting with facial appearance distress. Most facial injury patients were not receiving mental health assessment or treatment, and the maxillofacial team did not have direct access to psychological services. Based on these research findings, an innovative one-year pilot psychology service was designed and implemented within the facial trauma clinic.

   Authors: Deba Choudhury-Peters, Vicky Dain

3. **Improving physical health for people taking antipsychotic medication in the Community Learning Disabilities Service**
   Abstract: Adherence with antipsychotic monitoring guidelines is notoriously low nationally. Without active monitoring and measures to improve metabolic abnormalities, more patients may develop related morbidity and mortality. An audit highlighted antipsychotic monitoring in this learning disability service in London did not match guideline recommendations. People with intellectual disability also experience health inequalities. Psychiatrists are well placed to provide advice and

assistance that is suitable for those with complex communication, behaviour, and social needs.

Authors: Helen Thompson, Ian Hall, Amar Shah

4. Using league tables to reduce missed dose medication errors on mental healthcare of older people wards

Abstract: The unintentional omission of medication is one of the most commonly-reported administration errors on hospital wards throughout the world. The omission of a dose of medication can severely harm the patient affected, but to date there is limited evidence about cost-effective means for reducing the incidence of such errors. The current report describes a quality improvement project, conducted on the mental healthcare of older people (MHCOP) wards in East London NHS Foundation Trust, which led to a greater than 90% reduction in the rate of unintentionally omitted doses of medication. The project involved the publication of a fortnightly league table which ranked each of the wards by how many doses they had missed, with the ward missing the fewest doses receiving a prize. PDSA cycles were used to refine the concept, with the final incarnation of the fortnightly league table also incorporating the publication of a poster for each ward which showed how many weeks it had been since the ward missed a dose, and the ward's overall trend in missed doses. The project has resulted in the average missed dose rate on the MCHOP wards decreasing from 1.07% to 0.07%. In real terms, this represents a reduction from an estimated 2878 to 188 missed doses per year on the six MHCOP wards. By greatly reducing the risk of patients experiencing adverse drug events as a result of missed doses, this project has given rise to a potential cost-saving of around £34,000 per year across the wards studied. The use of league tables represents a simple, cost-effective means of tackling the problem of doses of medication being unintentionally omitted on hospital wards.

Author: Alan Cottney

5. Safer Wards: reducing violence on older people's mental health wards

Abstract: Through the Safer Wards project we aimed to reduce the number of incidents of physical violence on older people's mental health wards. This was done using quality improvement methods and supported by the Trust's extensive programme of quality improvement, including training provided by the Institute for Healthcare Improvement. Violence can be an indicator of unmet needs in this patient population, with a negative effect on patient care and staff morale. Reducing harm to patients and staff is a strategic aim of our Trust.

Author(s): Juliette Brown, Waleed Fawzi, Cathy McCarthy, Carmel Stevenson,

Solomon Kwesi, Maggie Joyce, Jenny Dusoye, Yasin Mohamudbucus, Amar Shah

6. **Psychological Medicine in Bart's: improving access and awareness**
   Abstract: Providing good quality psychiatric services to patients who attend general hospital has been an area that has attracted a lot of interest.(1)(2) We know that more than one quarter of general hospital patients have a mental disorder, mental ill health impedes recovery from physical illness, and mental disorders are often unrecognised in patients with physical illness. By improving the quality of our service we hope that we can achieve better integration with the medical teams and thus tackle the aforementioned problems.(3)(4) In our trust, relevant work has been completed by the clinical health psychology team in Cardiac Rehabilitation wards.

   Author: Areti Pavlidou

7. **Improving access to competitive employment for service users in forensic psychiatric units**
   Abstract: Employment has been proven to be an effective recovery tool and therapeutic intervention for those with severe and enduring mental health conditions. Aside from monetary reward, employment is a means of structuring time and provides a sense of worth and achievement, which enhances self-esteem and confidence. A social identity is developed through employment, encouraging social support and increasing social networks. Securing employment can bring about improved quality of life and positive change in one's social circumstances; therefore it can reduce symptoms associated with mental illness and potentially prevent re-offending, as the individual develops a sense of independence, self-efficacy, and value.

   Authors: Charlotte Beck, Connie Wernham

Below are projects that have been submitted for publication and are awaiting a decision:

- **Richmond Wellbeing Service Access Strategy for Older Adults**
  Authors: Clare Bate, Sarah Gowling, Jennie Persson, Genevieve Holt, Sue Ashbourne, James Bloomfield, Hannah Shortland, Clare Bate
- **Improving ward environments and developing skills for discharge with the implementation of self-catering on a low secure forensic unit.**
  Author: Alison O'Reilly
- **Role of peer support workers in improving patient experience in Tower Hamlets Specialist Addiction Unit**
  Authors: Wiktor Kulik, Amar Shah

Engaging with ELFT staff face-to-face

In 2014, the QI programme used a series of roadshows following a launch event to meet with approximately 1000 of the then workforce of 3500 face-to-face within four months. This helped raise awareness of QI across the Trust and engage people in the run-up to the first wave of training. In 2016, the QI programme is using a similar approach to engaging with staff in Bedfordshire and Luton, with the 2016 conference in Bedfordshire acting as a launch event, followed by a series of roadshows and away days with teams. In total, this has allowed face-to-face engagement with approximately 280 people over a three month period. In Bedfordshire and Luton services, these initial awareness-raising events have transitioned into preparation for the first wave of Improvement Science in Action training, with over 150 staff designing projects with coaching and consultation support.

In East London services, engagement efforts have transitioned from generic awareness raising, to more tailored learning events:

- Bespoke Pocket QI offerings for groups of staff within particular services. Over the last year, this has taken place in East Ham Care Centre, Newham community health services, Richmond IAPT services and the forensic service. These bespoke sessions have been popular, have received good feedback and seem to be an effective day for busy clinical staff to learn QI skills and gain awareness of the broader QI programme
- Economic evaluation workshop with LSE for the finance team
- Data masterclass planned for informatics, performance and corporate teams with the IHI in October 2016

The induction for all new staff has included a section on quality and quality improvement since 2013.

2.2 Progress with capability building

A key aspect of the QI Programme involves helping staff develop knowledge and skills in quality improvement. In 2015/2016, this included the following:

- Build and develop central QI team capability
- Online learning options
- Pocket QI for those interested in QI
- Improvement Science in Action waves
- Develop cohort and pipeline of QI coaches
- Bespoke learning, including Board sessions & commissioner workshops

Figure 5: Capability building plan for ELFT QI

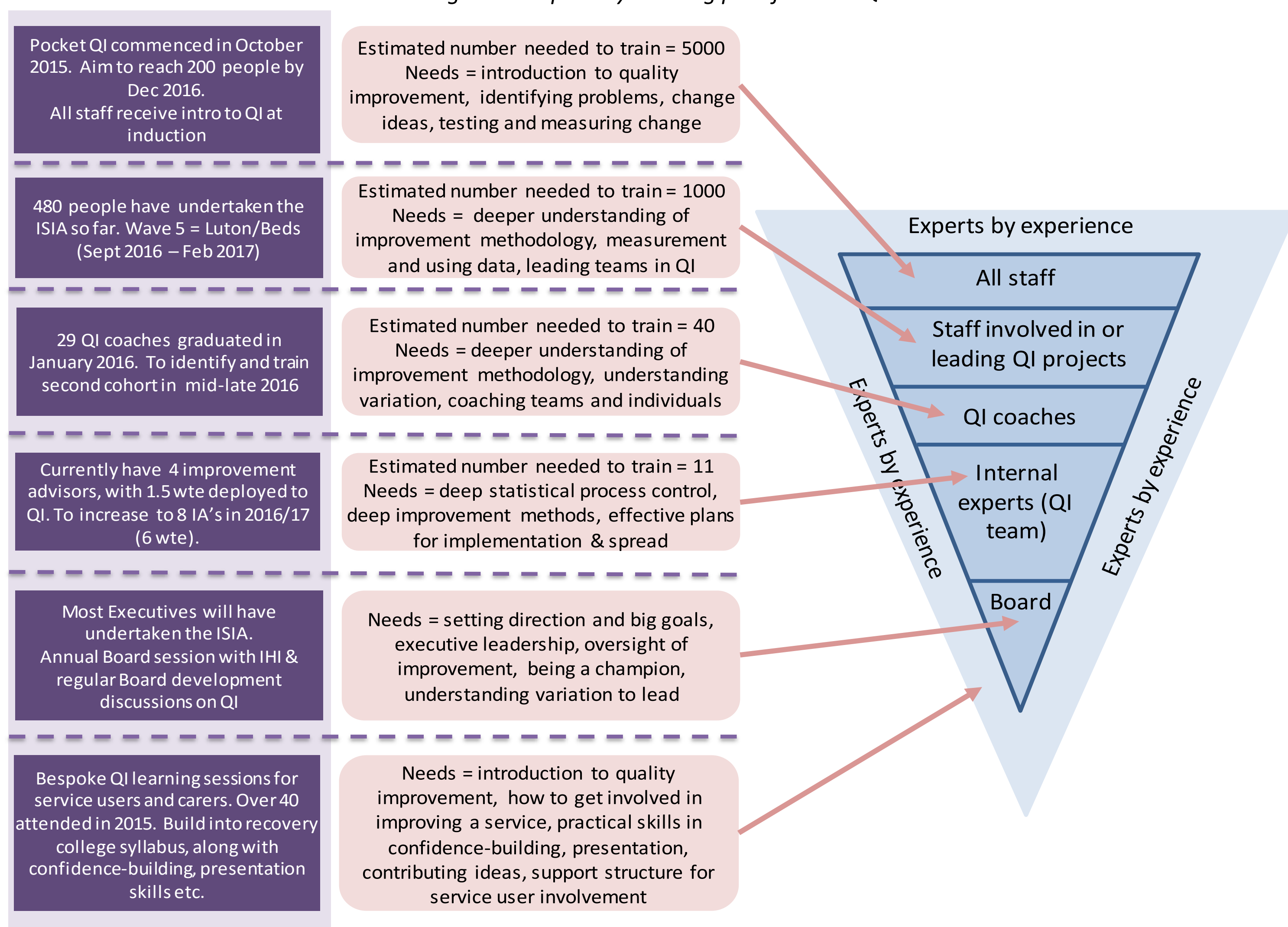


Figure 5 above illustrates the strategic plan at ELFT for building capability and capacity for quality improvement.

QI Training Analysis

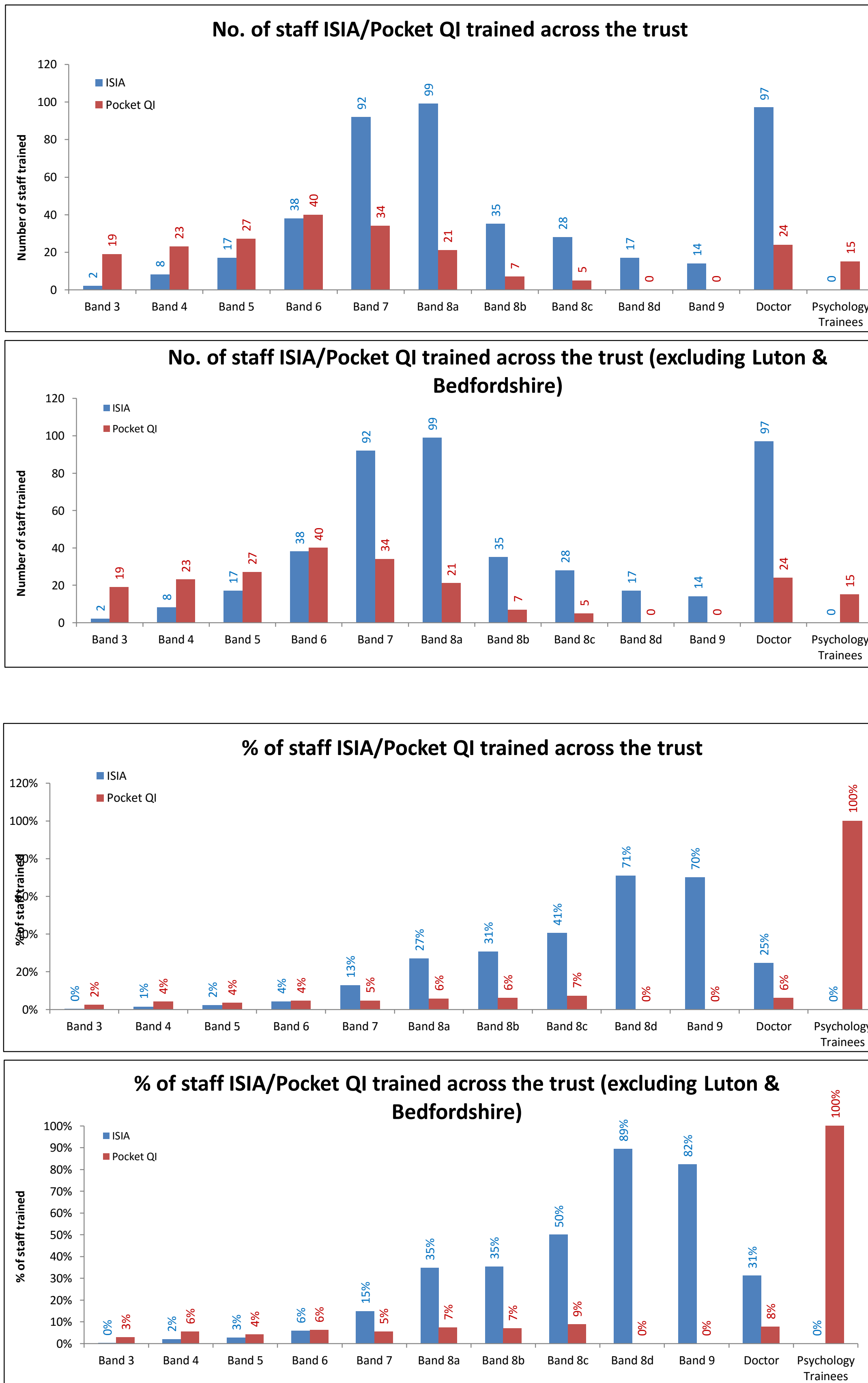
To date, there have been two main vehicles for staff to build improvement skills.

1. Improvement Science in Action is a 6 month course that revolves around real life QI projects and has now seen 480 delegates trained through a series of 4 waves.
2. Pocket QI started in October 2015 and is a 2 month course that rotates through different areas of the Trust to increase accessibility for front line staff. A total of 237 delegates have now graduated from this offering.

Figure 6 below indicates the number and percentage of staff, at various bands, who have undertaken these two training programmes. Compared to the picture a year ago, it is evident that Pocket QI is helping build improvement capability within the more junior bands of staff. Numbers of staff at band 3-6 trained through Pocket QI within the last 9 months already outstrip the number trained through Improvement Science in Action over the last two years.

The comparison of percentages shows just how far the programme has to go to build improvement capability across the entire workforce, particularly amongst bands 3-7 staff. Pocket QI has been designed as the key vehicle for addressing this.

Figure 6: ISIA/Pocket QI trained across Trust by banding

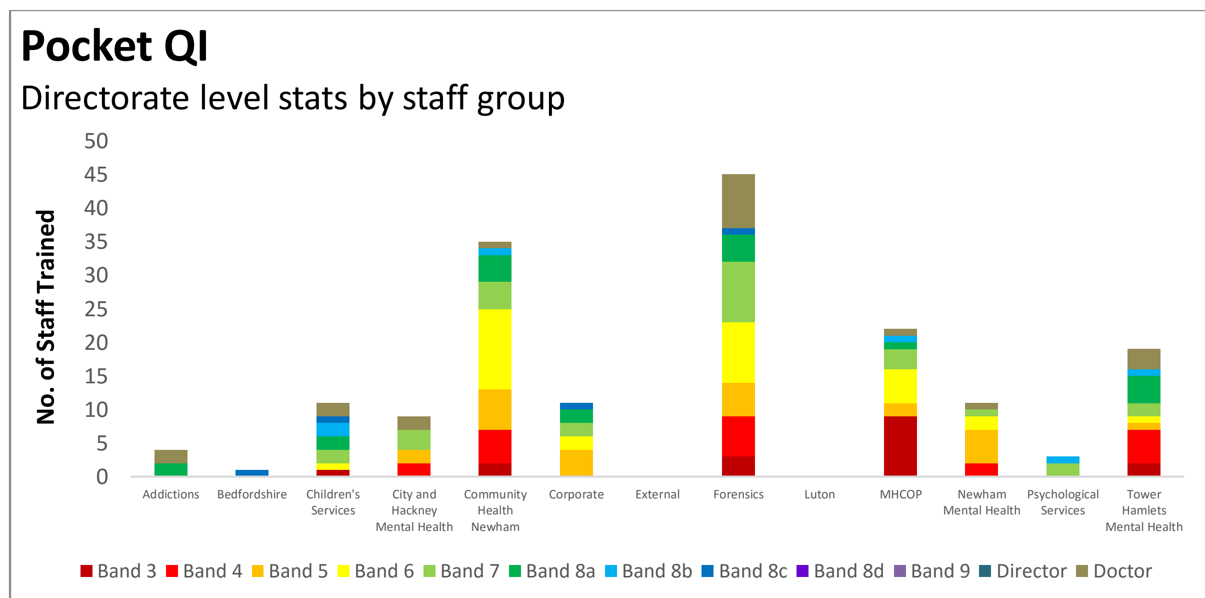


Pocket QI

Since Pocket QI was introduced in October 2015, 237 people have graduated from this course. Five cohorts have graduated through a two-month course split into four modules. There have also been a number of bespoke sessions run in services, either as one-day events or two half-days. Figure 7 below shows the number trained by directorate.

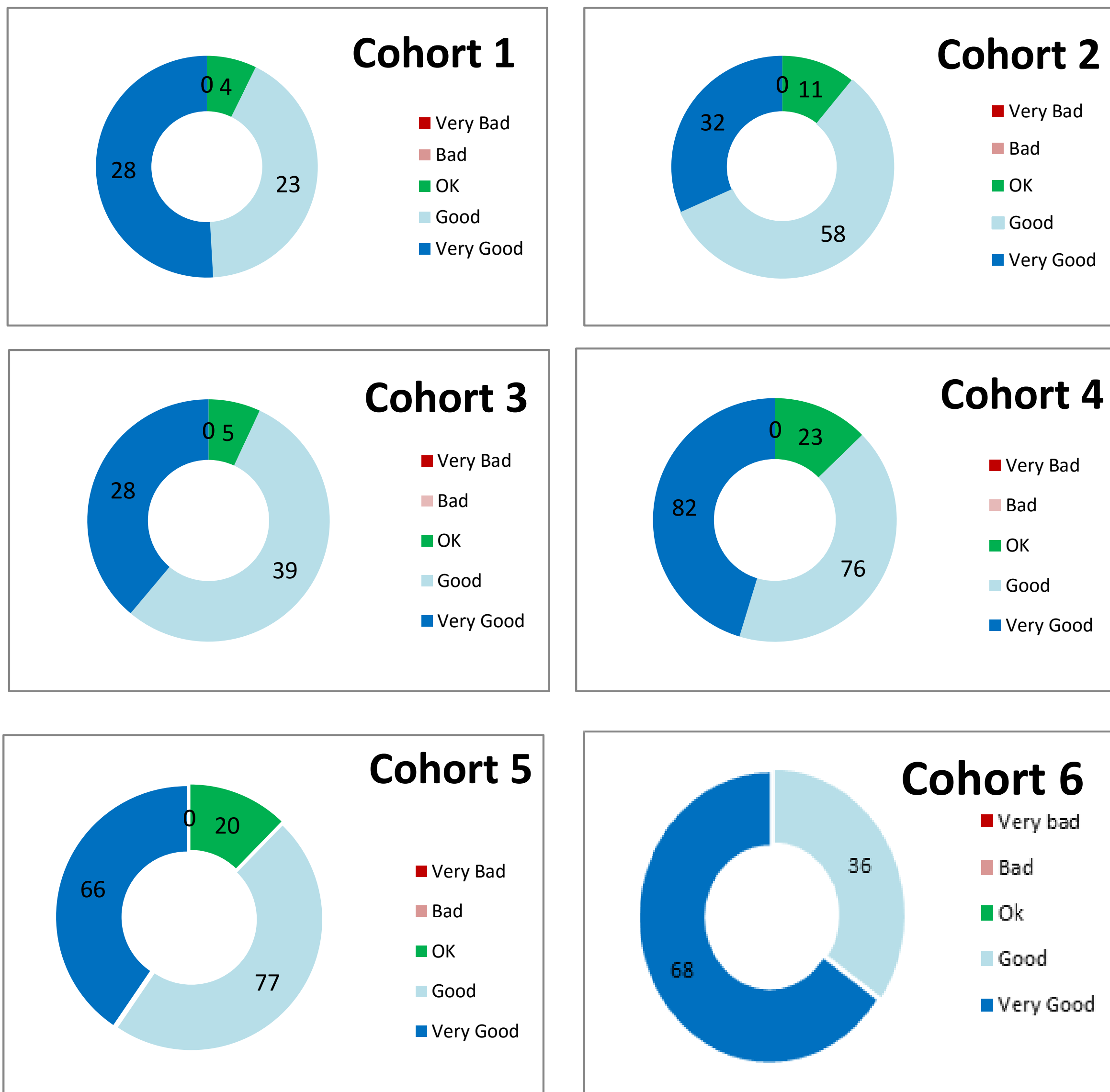
Demand for Pocket QI has been consistent over the past 9 months since it commenced. Training capacity for Pocket QI was doubled from April 2016 to meet this demand, and currently demand and capacity are evenly matched. A cohort of 30 staff are predicted to graduate from Pocket QI every month on a continuous basis. From September 2016, the format will be switched to two half-days based on feedback from attendees. There is also now a standard 'Pocket-size' handout for each module, following feedback.

Figure 7: Staff trained in Pocket QI by directorate



Each module for each cohort is evaluated, and adaptations to content and delivery are made in response. Figure 8 summarises the quantitative feedback from attendees for each cohort on their overall experience of the modules.

Figure 8: Aggregated responses by Pocket QI attendees to the question 'How would you describe the module overall?'



Across all cohorts, 41% of attendees described their module to be very good and 48% described theirs to be good. Below is some of the qualitative feedback from attendees:

Positives:

"Good balance of didactic and experimental learning"

"I feel more confident in the QI projects I am a part of having learnt more about the theory and tips."

"The different teaching methods kept me engaged throughout the session"

“Excellent mix of group work, videos, games, and PowerPoint presentations.”

“Very good, it stimulated thought through active participation.”

“Very knowledgeable trainer, engaging and friendly.”

“Excellent range of training methods, very interactive enjoyed the games!”

Points for improvements:

“Course was very short/fast paced. Hand-outs weren’t available during the lecture.”

“Would have liked more time to move about, there was too much sitting”

“More exercises would be good especially if the sessions are at the end of the day”

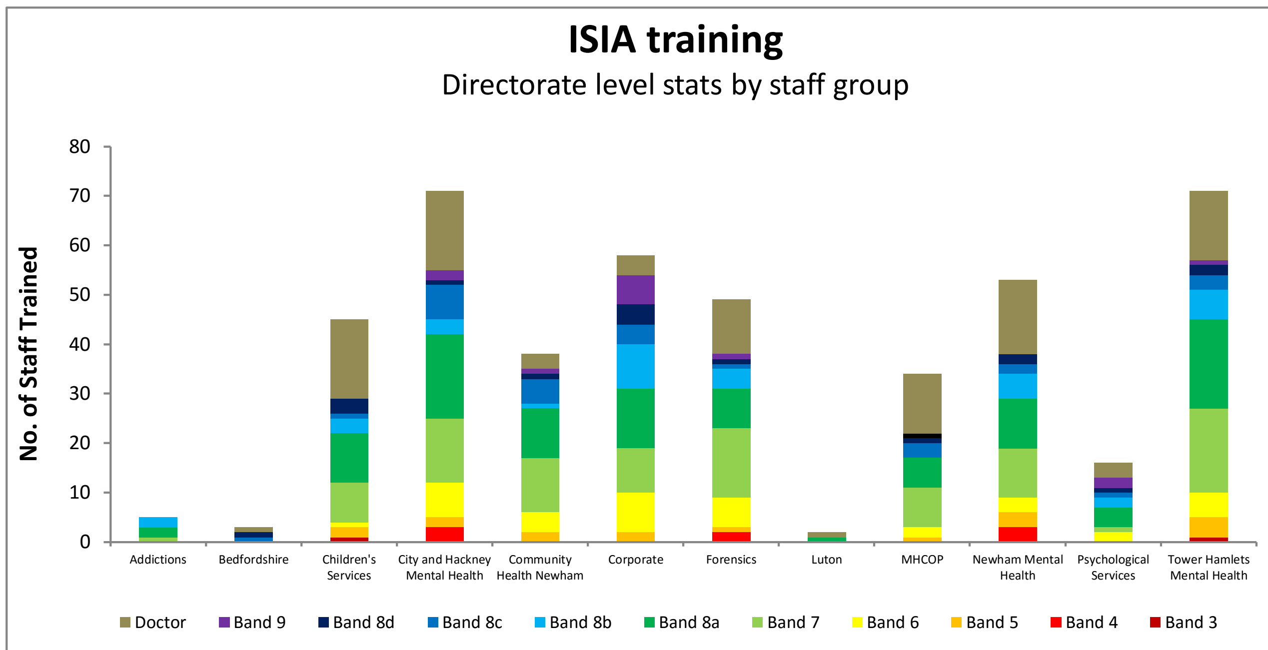
“Venue was not great, too hot and presentation slides need to be more clearer”

Improvement Science in Action training (ISIA)

Improvement Science in Action will continue to focus on training those leading QI project work or in leadership / management roles within the organisation. Pocket QI should increase access to QI training for those delivering care on the frontline, where time to access training may be more of an issue.

Figure 9 below shows the variation in numbers trained through the first four waves of the ISIA programme across the various directorates in the Trust. Wave 5 of the ISIA will be specifically for staff in Bedfordshire and Luton, and is due to run from September 2016 to March 2017. Wave 6 of the ISIA will run from October 2016 to April 2017 for London-based staff.

Figure 9: ISIA training data by directorate

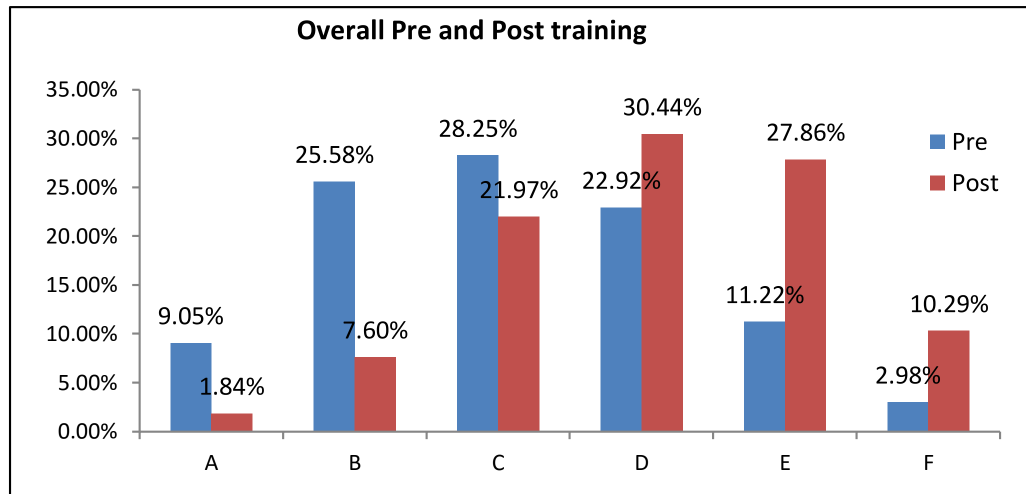


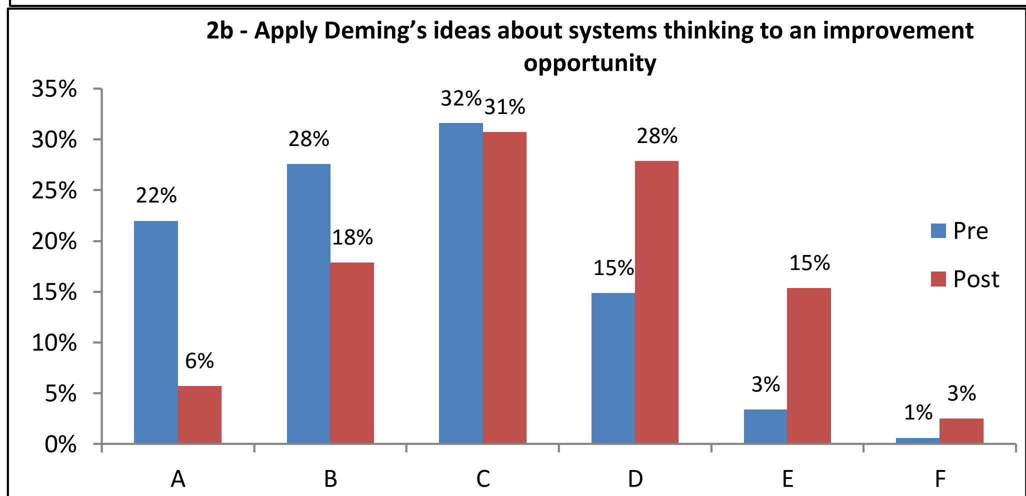
Each of the waves in ISIA training are evaluated with detailed questions answered by participants, both pre-training and post-training, to understand the impact the training has on their skills, knowledge and confidence. The feedback also helps adapt the content and delivery of the course with each offering. Figure 10shows pre- and post-training evaluation of all the ISIA waves to date, for all questions combined, and two key questions from the survey. The data shows an increased confidence in understanding and applying the concepts of QI following the ISIA.

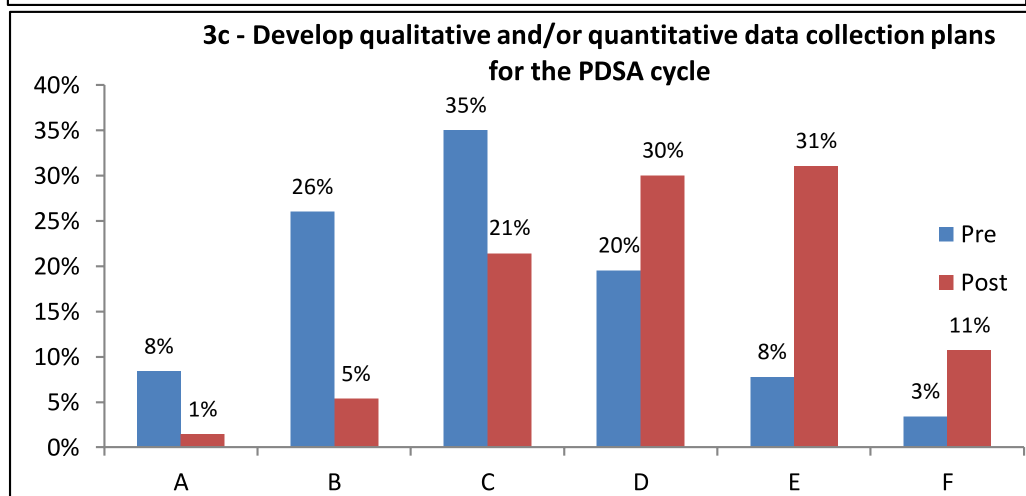
Figure 10: ISIA training evaluation data, pre and post training

Key

A. I have no knowledge of this concept/tool.
B. I have heard of this concept/tool but could not explain it or apply it.
C. I have a working knowledge of this concept/tool and could at least explain what it is.
D. I have a working knowledge of this concept/tool and could explain how to apply it if there was someone with deeper knowledge in the room to back me up.
E. I have a solid working knowledge of this concept/tool and could demonstrate how to apply it to daily work.
F. I am confident and comfortable in explaining, applying, and teaching this concept/tool.



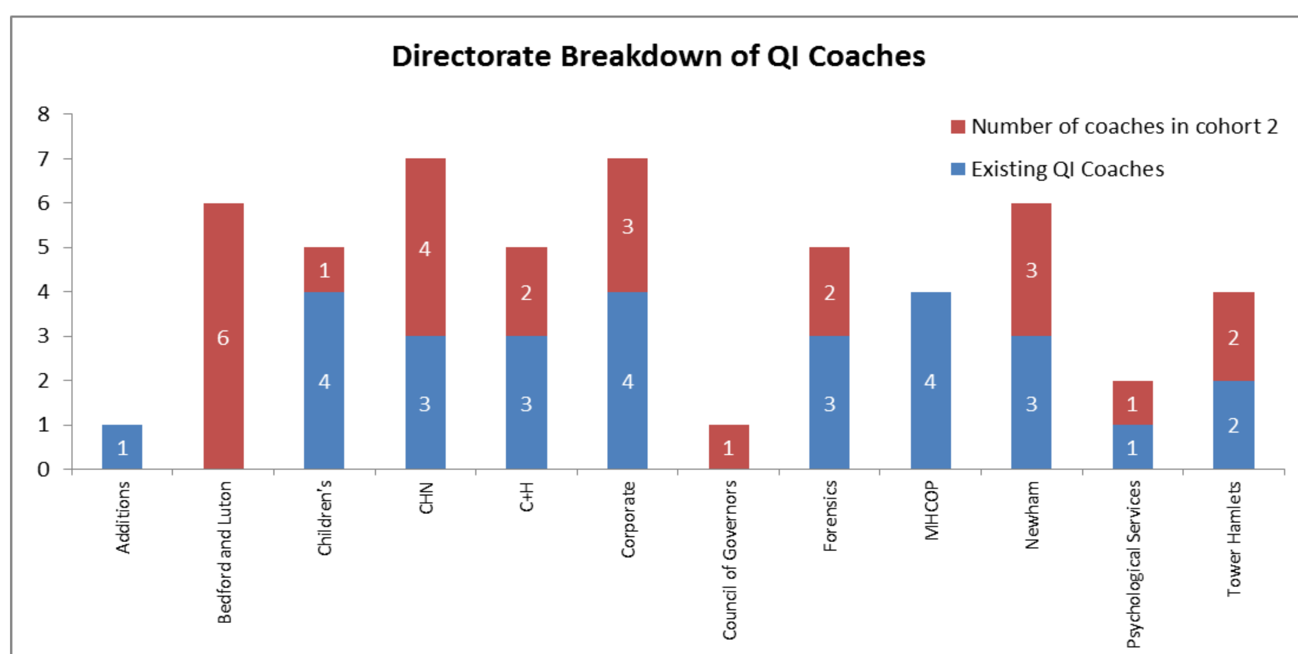




Developing improvement coaches

The first cohort of 30 QI coaches was trained in 2015. A second cohort of 25 QI coaches is being trained from July to November 2016. Current coaching capacity, per directorate, is depicted in figure 11 below.

Figure 11. QI coaching capacity across the Trust directorates



QI Coaches - Cohort 1

The first cohort of QI coaches was trained from September to January 2016, in a new course co-designed by the Institute for Healthcare Improvement and ELFT. Their training was evaluated to understand the impact of the training and how it can be improved (see figure 12).

The evaluation shows an increase in confidence with developing driver diagrams, aims, measures, using PDSA cycles, charts and tools following the training. Some areas show little change, such as implementation, organising effective meetings and influencing and engaging people. These aspects have already been addressed in the design of the programme for cohort 2.

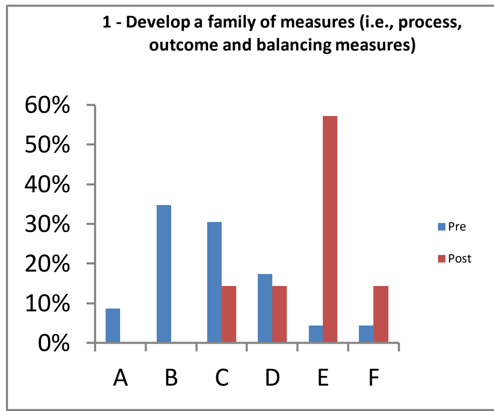
Figure 12: Evaluation of cohort 1 QI coaching training

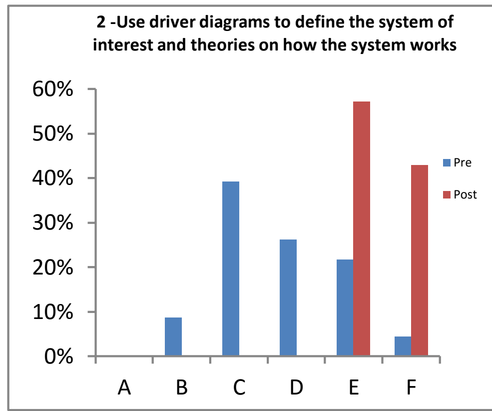
Answer Key for questions 1 -11 & 13 – 20

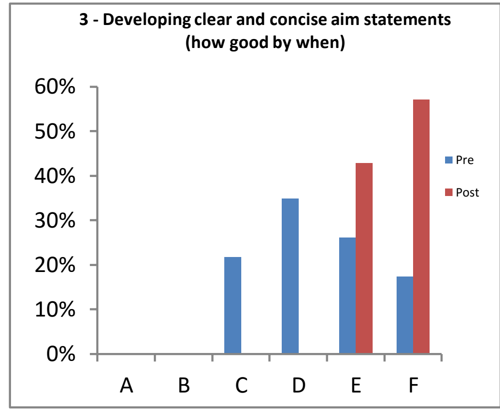
A. I have no knowledge of this concept/tool.
B. I have heard of this concept/tool but could not explain it or apply it.
C. I have a working knowledge of this concept/tool and could at least explain what it is.
D. I have a working knowledge of this concept/tool and could explain how to apply it if there was someone with deeper knowledge in the room to back me up.
E. I have a solid working knowledge of this concept/tool and could demonstrate how to apply it to daily work.
F. I am confident and comfortable in explaining, applying, and teaching this concept/tool.

Answer Key for questions 12 and 21-24

A. Not confident
B. Partially confident
C. Quite confident
D. Very confident


1 - Develop a family of measures (i.e., process, outcome and balancing measures)
60%
50%
40%
30%
20%
10%
0%
A
B
C
D
E
F
Pre
Post


2 -Use driver diagrams to define the system of interest and theories on how the system works
60%
50%
40%
30%
20%
10%
0%
A
B
C
D
E
F
Pre
Post


3 - Developing clear and concise aim statements (how good by when)
60%
50%
40%
30%
20%
10%
0%
A
B
C
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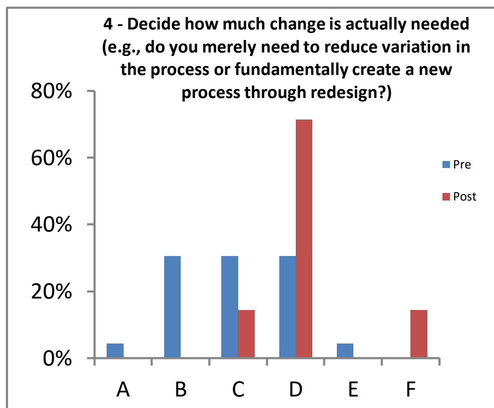
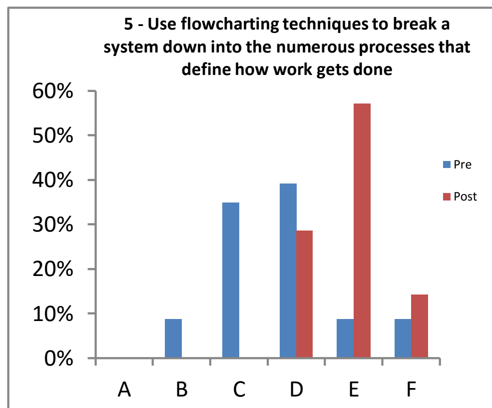
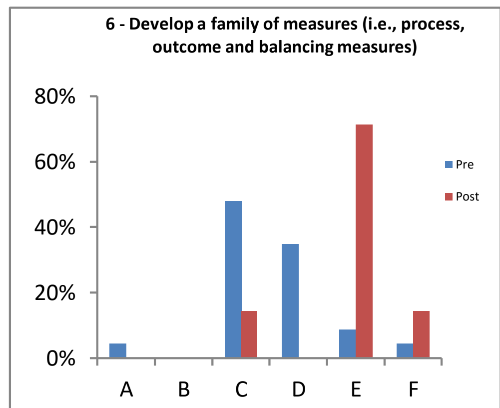
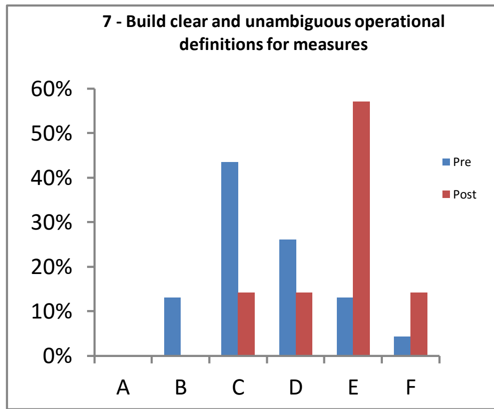
F
Pre
Post


4 - Decide how much change is actually needed (e.g., do you merely need to reduce variation in the process or fundamentally create a new process through redesign?)
80%
60%
40%
20%
0%
A
B
C
D
E
F
Pre
Post


5 - Use flowcharting techniques to break a system down into the numerous processes that define how work gets done
60%
50%
40%
30%
20%
10%
0%
A
B
C
D
E
F
Pre
Post


6 - Develop a family of measures (i.e., process, outcome and balancing measures)
80%
60%
40%
20%
0%
A
B
C
D
E
F
Pre
Post


7 - Build clear and unambiguous operational definitions for measures
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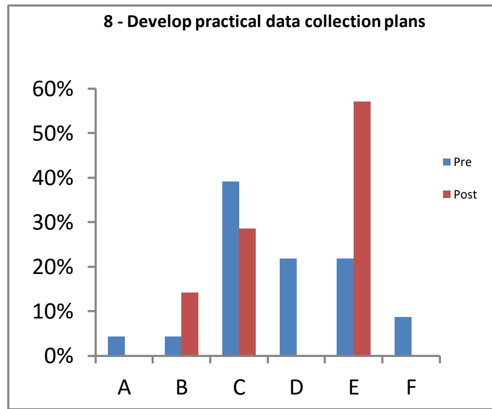
8 - Develop practical data collection plans
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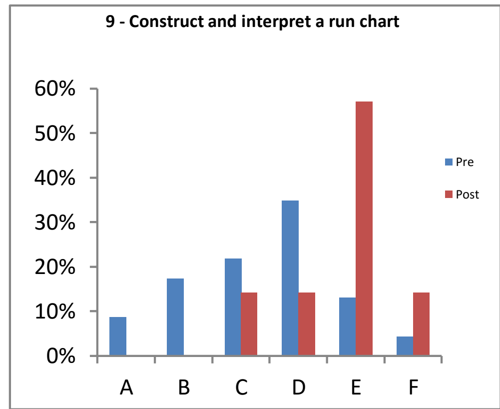
9 - Construct and interpret a run chart
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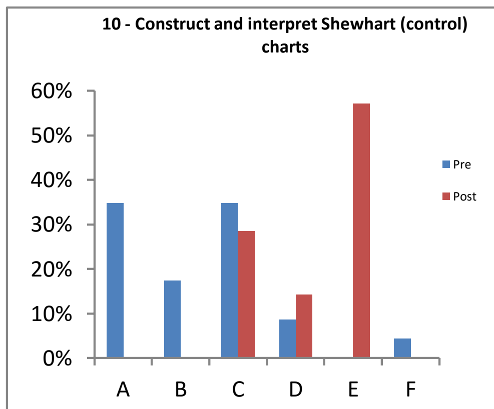
10 - Construct and interpret Shewhart (control) charts
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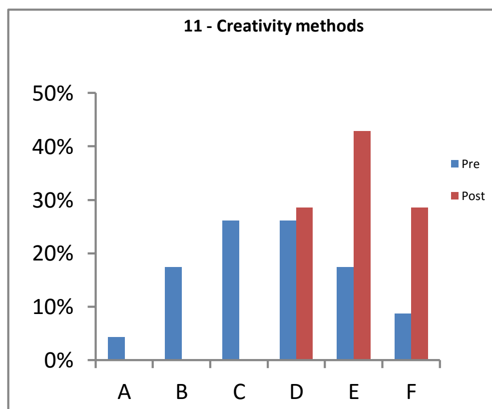
11 - Creativity methods
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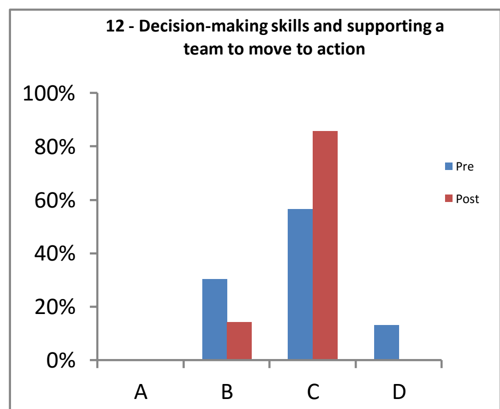
12 - Decision-making skills and supporting a team to move to action
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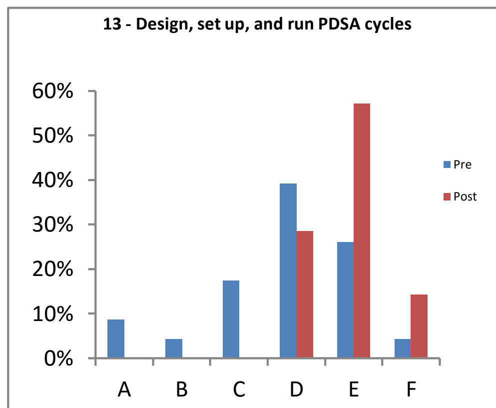
13 - Design, set up, and run PDSA cycles
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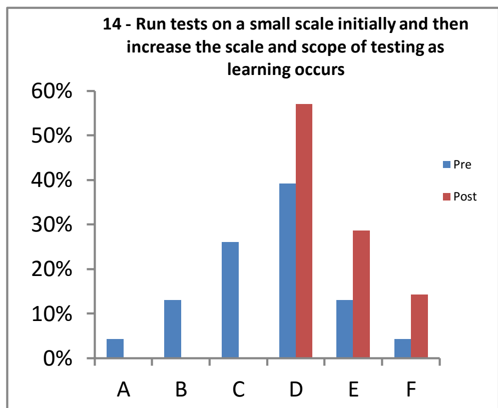
14 - Run tests on a small scale initially and then increase the scale and scope of testing as learning occurs
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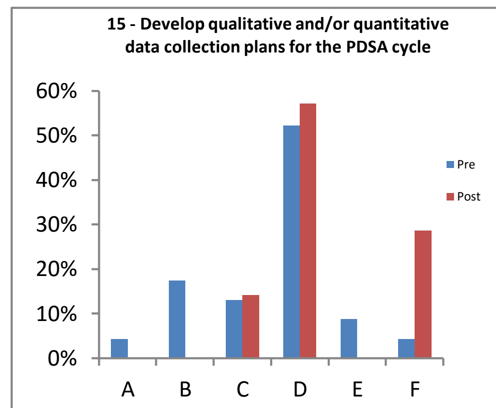
15 - Develop qualitative and/or quantitative data collection plans for the PDSA cycle
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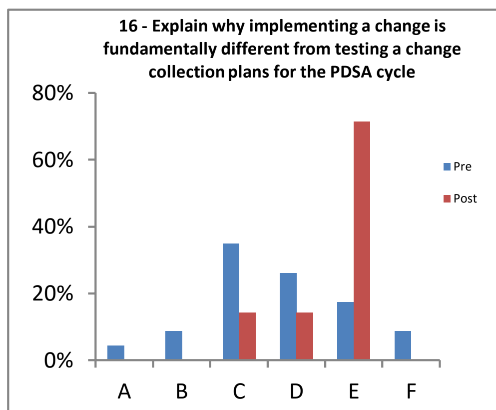
16 - Explain why implementing a change is fundamentally different from testing a change collection plans for the PDSA cycle
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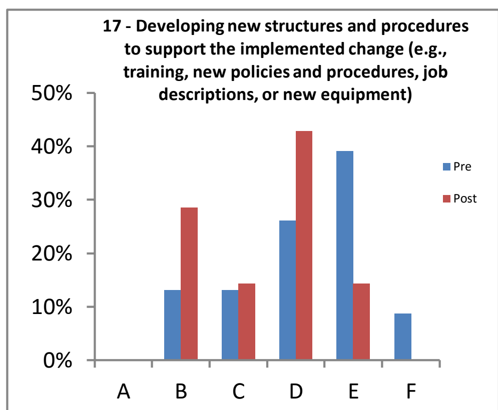
17 - Developing new structures and procedures to support the implemented change (e.g., training, new policies and procedures, job descriptions, or new equipment)
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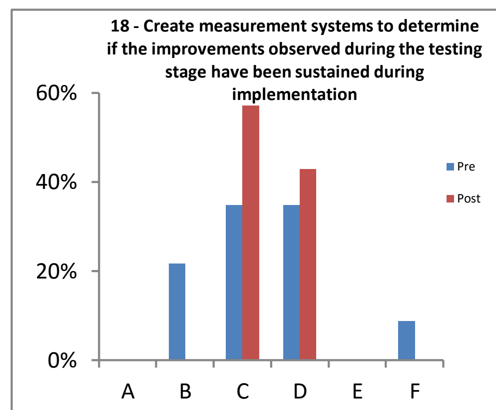
18 - Create measurement systems to determine if the improvements observed during the testing stage have been sustained during implementation
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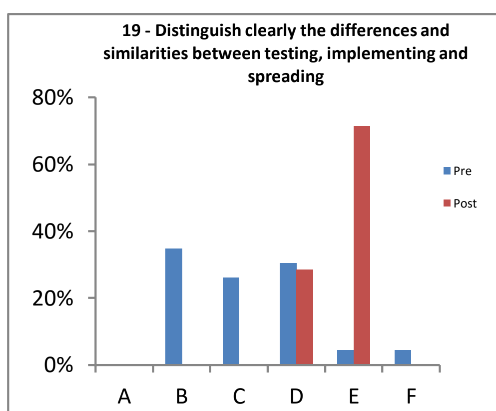
19 - Distinguish clearly the differences and similarities between testing, implementing and spreading
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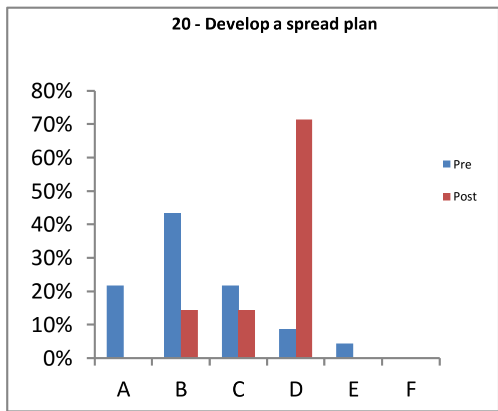
20 - Develop a spread plan
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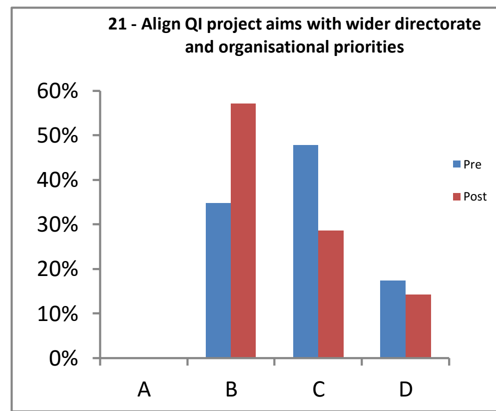
21 - Align QI project aims with wider directorate and organisational priorities
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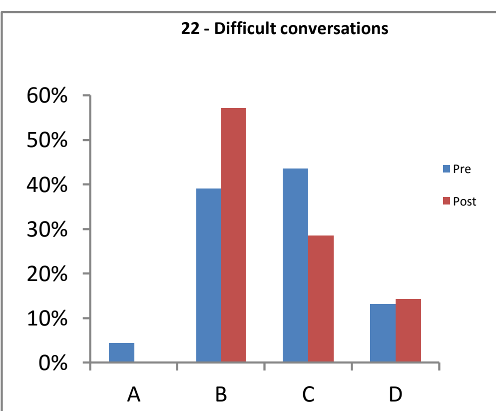
22 - Difficult conversations
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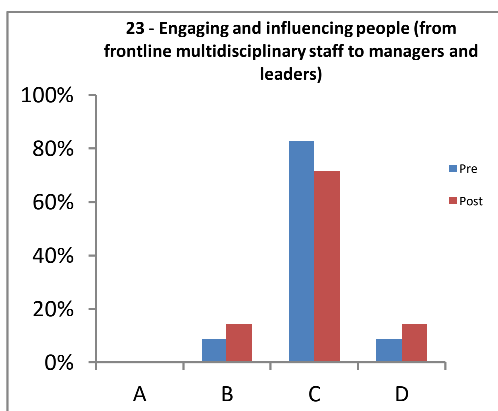
23 - Engaging and influencing people (from frontline multidisciplinary staff to managers and leaders)
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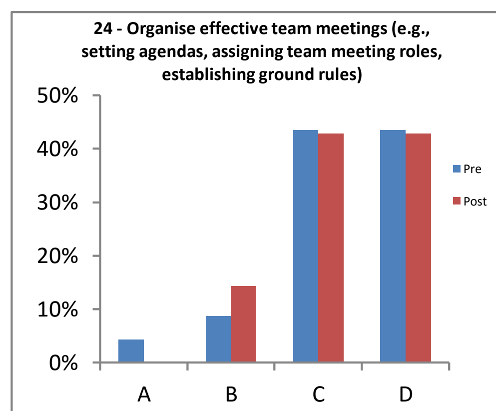
24 - Organise effective team meetings (e.g., setting agendas, assigning team meeting roles, establishing ground rules)
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Feedback from cohort 1 QI coaches

In June 2016, the QI team interviewed 24 of the 28 cohort 1 QI coaches across the Trust using individual structured interviews. The purpose was to understand their experience in the role, the challenges they are facing and their ideas on how we might solve these. All coaches were aware that their feedback would be shared, unless they specifically requested it not to be. This section highlights the key themes that have emerged from all of the interviews. Each directorate has already reviewed the feedback from their coaches, put in place interventions to address the issues raised.

Engagement:

"I've been really pleased to be able to be a coach and to have the opportunity. I really appreciate the investment that has been put into me and the other coaches. I really think the way the Trust is investing in this is really good."

"Enjoyed learning with coaching colleagues and the way we are moving to a different kind of management. Think the directorate has been supportive, but challenges in the reality of trying to do this on a day to day basis."

"An interesting role with the potential to be fun."

"Mixed, in large part because I didn't feel very confident in the methodology, but when I have actually done the coaching and working with team I feel much better."

"Projects were not working therefore I couldn't apply the learning. Found it more useful attending projects other coaches or QI leads were leading on to learn how to do it"

"I enjoyed training, the ideas and learning new skills."

"Really positive experience"

"In summary, a mixture of rewarding, enjoyable, but also quite frustrating, time-consuming, demanding and challenging."

"Being a coach has been a wonderful experience. It has helped me develop as a person and professional, learning and using new skills over the past several months. It has helped me get to know the organisation better and to link with staff I would not otherwise have worked with."

"When I meet with people it is quite rewarding, although I don't feel I've been able to get my teeth into anything and in terms of actioning coaching skills…it's been more about encouraging and talking about driver diagrams and PDSAs at the moment."

Application of role:
"Used to have a designated day when doing the coaching training but now fit it into day to day work."

"Day set aside initially and asked teams to meet on this day but not always possible."

"Maybe 3-4 hours per week"

"It feels like both me and projects have less time to spend on QI work now compared with 6 months ago."

"One day a week, meeting regularly with teams and supporting them outside of team meetings with data and teaching."

Support structure:

"I think QI Leads need to have capacity to support coaches more directly. They need to have the time to spend with coaches to enable them to reflect and progress in their role."

"I think the idea of QI lead coming and supporting would be really helpful"

"Need more coaches and more people coming into the QI Forum"

"For my 2 projects on waiting times, xxx is QI lead. I am learning a lot from him. It really helps for coaches to shadow QI leads. He has really helped to do this together on these waiting times projects as they are so challenging. It does really help for learning. I wouldn't say don't put coaches in big projects. Think there is value in it. It's good for the project. It's good for the coach to learn."

"very responsive to ideas, doing a brillliant job. Has helped to move Corporate on so much."

"Delays in getting data in time for meeting - e.g. psychotherapies, although in the end xxx (QI lead) managed to get this sorted out, but we shouldn't have to go centrally to sort everything out"

"QI charts - having to recreate charts every time is really frustrating!"

"More project representatives to attend the QI forums."

"Need more coaches - aim for 10: range of different grades"

Priorities
"Could we have protected time for QI - even if you don't have a project you could be thinking about safety incidents, audits, complaints, service user feedback, team data, etc that feed into QI"

"We need to go back to saying QI is a priority. I think this needs to come from DMT. Senior

managers are not saying this at the moment, but instead that QI is not a priority. We need the same push we used to have."

"People need to see and be interested in the things they discuss in that time and feel involved and that they can make ideas and changes"

"Leadership was slow to get involved in QI, this was a huge problem, no forum and no sponsors."

"Leadership has been better since QI has been made a priority."

Overall, the majority of coaches were positive about their experience and felt motivated in this new role. The general consensus for greater link and support with QI leads from the central team has already been actioned with a designated QI lead assigned to each directorate, supporting the forums more actively and meeting with directorate coaches every month. The issue of protecting time for this role is a complex and delicate one, as directorates and individuals need to balance multiple demands. The QI team discuss individual difficulties on an ongoing basis with service and clinical directors, and are now more flexible about allocating spare QI coach capacity to other directorates where this makes sense.

2.3 Progress with alignment

The work on aligning the organisation around improvement goals has encompassed the following elements in 2015/16:

- Embedding local directorate structures and processes to support QI
- Aligning projects with directorate and Trust-wide priorities
- Supporting staff to find time and space for QI work
- Supporting deeper service user and carer involvement
- Supporting team members and leaders to champion QI
- Aligning research, innovation, improvement and operations

Local structures and processes to support QI

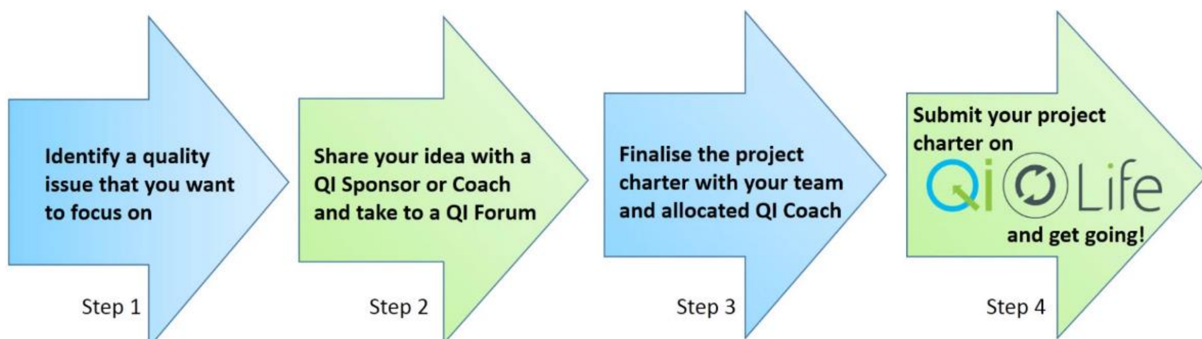
As most improvement work occurs within individual teams, we have built a support system to reflect this, allowing projects to be 'sponsored' within the local Directorates. Each project has a QI coach and a senior sponsor from within the directorate, with a monthly forum bringing together sponsors, coaches and project leads in each directorate (see figure 13). This direct line of sight from directorate leadership teams to frontline projects is key.

Each directorate now has a clear process that describes how a team can get approval for a project, from developing an idea, pitching the case to the local QI forum and obtaining the support structure to progress.

Over the past year, the local directorate QI forums have matured and evolved. Chaired by clinical directors or sponsors, these groups now approve project initiation, review progress across the portfolio of directorate projects, try to understand challenges faced by teams in order to unblock barriers, and consider when projects are ready to close. Example processes for starting and closing a project are published on the QI microsite, and a high-level example can be seen in figure 14 below. Each directorate has a more detailed flow-chart to clarify the local decision-making and involvement process.

Figure 13. Support structure around each project

Figure 14. Process for starting a QI project at ELFT



For topics where multiple teams are working together towards a shared aim (usually on one of the Trust's four priority areas of QI work), the support structure also includes a learning system across all the project teams. As an example, the sixteen teams working to improve access to services have a learning system which consists of a bi-monthly face-to-face or virtual learning set, a shared measurement system with a dashboard distributed monthly, an executive-level sponsor and an electronic newsletter sharing stories of each team's work.

Over the past year, the Trust has also become clearer about the roles and responsibilities for the various types of people involved in quality improvement work. This is captured in figure 15 below.

Figure 15. Description of the various roles within the QI support structure at ELFT, with the responsibilities for each role.

Aligning projects with directorate and Trust-wide priorities

Whilst at the start of the QI programme, teams were encouraged to identify an issue to work on that mattered to them and their service users, and only ensure that they aligned with one of the high-level Trust aims (reducing harm or right care, right place, right time), over the past year, the directorates have been gradually working towards projects aligning with directorate priorities. This remains an area of continued work, both in terms of involving everyone in defining strategic improvement priorities at directorate level, and in terms of engaging teams in dialogue to understand their data and help them define the issue to work on that both matters to the team and their service users, but also aligns to the directorate's improvement priorities.

Supporting teams to find time and space

A big focus of the QI programme is to make QI work as easy as possible for teams. Finding space and time for QI project work is difficult for most. While the Trust has undertaken many changes to reduce burden on teams to find more space for QI work, the last year has focused on making QI work as easy as possible. This has involved two major workstreams, detailed below.

New web platform for all QI project work (QI Life)

The QI Life web platform provides a centralised location for all QI project work. It will lead to us moving away from the Access database to manage the project portfolio, Excel for data work, Word for charter documents, Powerpoint for driver diagrams, storage on network drives and countless paper-based forms. Along with streamlining the project sign up process, the platform also helps store core information, allows users to create driver diagrams in a very simplistic fashion, log PDSA data and most importantly chart their data using SPC charts. Interpreting SPC charts has always been a difficult task when training staff. The platform's ability to identify special causes automatically will help staff focus on learning from their data as opposed to spending their time charting their data.

The platform has been customised to meet ELFT's needs in a two-stage design process. These improvements are being tested and implemented gradually from June to October 2016. Figure 16 shows some screenshots from the platform.

Figure 16: Screen shots of QI Life Web platform

QI Life
Projects | Connect | Resources | Analytics
amar.shah@elft.nhs.uk | Log Out
Settings

Advance Care Planning in Dementia

PDF

General | Drivers | Measures | Change Ideas | PDSAs | SPC Charts | Documents

General Information
Project ID: 101026

Edit | Close Project | Submit Monthly Report

This project is now being promoted as a "Success Project". Click the button below to view the promotion tracker form.

Success Project

Title: Advance Care Planning in Dementia

Status: Active

Aim: To increase numbers of people with new dementia diagnosis offered discussion on ACP.

Location: Memory Services - TH, Newham and C&H

Start: 10/07/2014

End: 03/07/2016

Rationale:

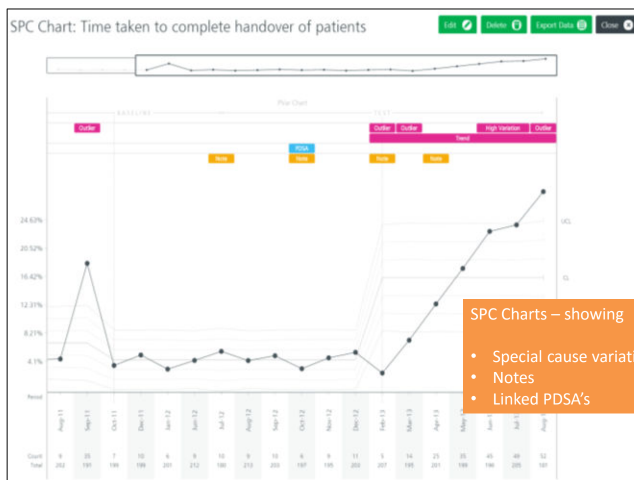
Tags: (A few key words that relate to this project)

QI Code: QI0033

Approved?: Yes

Directorate: Mental Health Care for Older People (MHCOP)

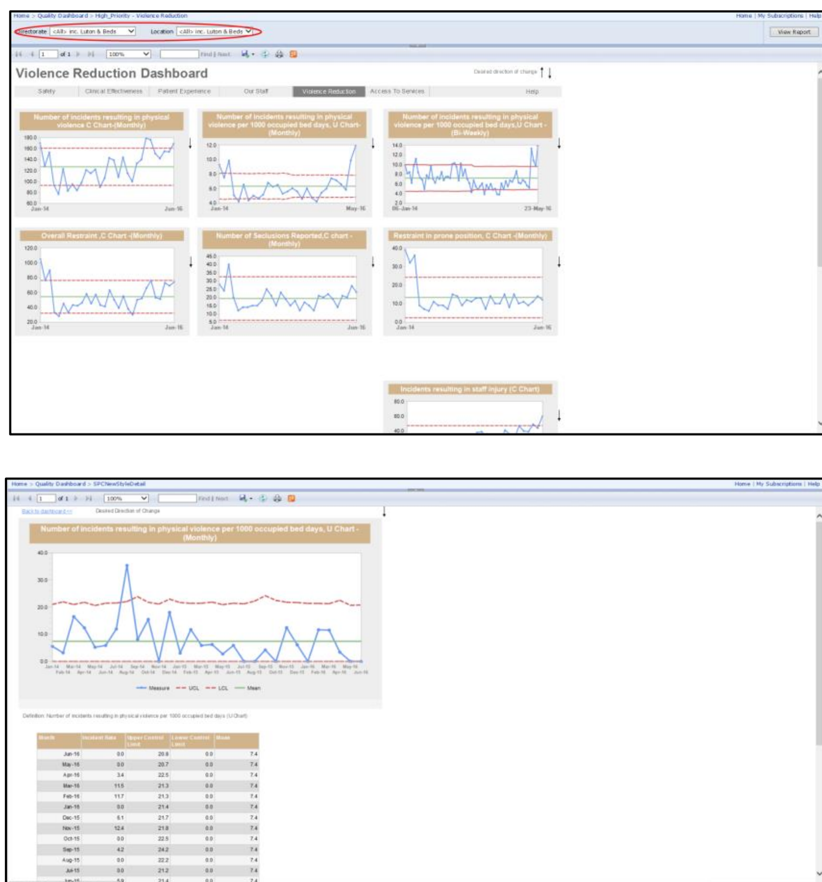
Progress Score: 4.0



Making data more accessible

Over the past year the QI team and the informatics department have been working together to make more data from the central data warehouse available to teams at directorate and team-level. The whole system measures viewed at the Board are now available at directorate and team-level as statistical process control charts. Both qualitative and quantitative data collected from real-time patient experience surveys across the Trust are now accessible at team-level. Dashboards at team level for those teams working on violence reduction and access to services are now live, and refreshed in real-time. This allows teams and sponsors working on these areas to view their data at their convenience, without extra effort.

Figure 17: Screenshots from the Quality and Performance Dashboard



Further developments are in the pipeline, including physical health measures, contract performance indicators and more bespoke views by service type. However, one key challenge is that the current reporting platform has a poor user interface, which makes it clunky to use, and any development work requires high level of people-time to write individual code for each chart.

Service User, Carer or Customer Involvement

As at August 2016, a total of 60 QI projects at ELFT (38% of active QI projects in the Trust) feature service user, carer or customer involvement. Of these 32 include involvement with a 'Big I' – i.e. where the service user, carer or customer acts a full member of the project team, involved in all aspects of design, development of ideas, testing. A further 28 projects include involvement with a 'small i' – i.e. where service users, carers or customers are regularly consulted during the lifetime of the project through activities like surveys, focus groups, consultation etc. This compares with a total of 30% of projects having service user, carer or customer involvement in August 2015, of which 21 involved big I and 33 involved little i. Service user, carer and customer involvement per directorate and over time is displayed in figure 18 below.

Figure 18: Service user, carer or customer involvement in QI projects, by directorate

	Big I	Little i
Bedfordshire	1	1
Children's Services	1	3
City and Hackney Mental Health	11	2
Community Health Newham	3	3
Corporate	1	3
Forensics	5	3
Mental Health Care for Older People (MHCOP)	3	2
Newham Mental Health	6	3
Tower Hamlets Mental Health	1	4
Primary Care and Specialist Psychological Services	0	4
Luton	0	0
Z. N/A	0	0
Total	32	28

Feedback from service users at Working Together Groups

The evaluation team invited service users and carers to contribute their opinions on how to support greater involvement in QI projects. Participants were asked a series of questions. Below is a summary of their feedback:

1. *The Trust has been trying to make some changes recently to improve care. Have you noticed anything different? If so what do you think of it?*

Service users have seen a visible improvement in the quality of services they use. They mentioned individual recovery planning with occupational therapists that take into consideration the 'whole person', benefit advisors helping patients overcome financial issues, improved meals on wards and an increase in service users getting involved in the trust by working and volunteering, voicing their opinions on quality improvement and staff recognising concerns they have raised.

"Having a Benefits Advisor on board helped to quickly sort out lack of finance for basics such as food."

"With some of the changes, I can see more service users really getting involved in the trust by working, volunteering , training etc. etc."

"The quality of the Meals at Newham Centre for MH"

2. *Have you been involved in making any changes within the service? If yes, how did you get involved?*

From those participants that have been involved in influencing change in services, the most common suggestions have been regarding inpatient care, with suggestions raised through forums, complaints and general feedback to ward staff. One service user was invited back onto the ward to see the changes, and they saw better privacy curtains for beds, better activities and new security arrangements.

3. *In your opinion, are there any factors that would restrict or prevent QI within the Trust?*

The most common factors raised which were felt to be a barrier were around the issue of support for projects. Service users felt they need to see more support to put test ideas into practice quicker. Other concerns raised were about the shortage of staff and complacency of staff to change ideas.

4. *Are there any particular benefits of quality improvement in the Trust in your view?*

The overall involvement of service users in QI projects has made service users feel valued and an integral part of quality improvement for the trust. They spoke about feeling more empowered through opportunities for employment and

training. Carers feel they are seen by the trust as experts by experience. As well as this they have seen the growth in awareness about quality improvement on wards and visible improvement.

"Love how service users accepted in getting job in the trust, giving them empowerment to lead to independence"

"Love how Carers are seen by the trust as Expert by experience"

"the induction of new staff benefit from service users and carers telling their story"

"the recognition of awards…make us feel appreciated and belonging and accepted"

5. *What can the trust do to support and encourage service user involvement in quality improvement?*

Service users feel that there should be more communication between the trust and GP's as they are first point of contact for a lot of patients. This can be an opportunity to build awareness to service users about quality improvement early on. Most of the responses were around providing service users more support throughout the life of projects and in particular around technical issues such as analysing data.

"The trust can help us by supporting all the way through from start to finish with a project"

"Assign a mentor to help us with the project"

"Have adequate meetings to explain any issues arises"

6. *Do you have any ideas about how to make the Trust's services safer, more efficient and more relevant to you?*

Ideas raised included:

- All staff in contact with service users to have greater awareness and understanding of mental health issues, to reduce stigma and provide more compassionate care
- More early intervention services
- Reduced waiting times for priority services such as psychological therapies

- More information on how to recognise deterioration in mental health and how to seek help

Ongoing work in this area

Although the number of projects involving service users, carers or customers represents a slight increase overall since 2015, this remains far beneath our ambitions and is hence an area of ongoing high priority for the Trust. Over the past year, a service user and carer QI steering group has been established, reporting to the QI programme board. The group meet on a monthly basis, it is chaired by a Service User and attended by Service Users and Carers involved in or interested in QI at ELFT, the People Participation Team and representatives from the QI team.

This working group aims to shape Service User and Carer involvement in QI across the Trust, building will, building capability through QI training, ensuring our systems for Service User/Carer involvement are standardised and that people involved in QI projects are well supported. The monthly meeting also serves as a QI Forum for Service Users and Carers, open to all and there to provide support to those already involved in QI or looking to be.

The driver diagram for this aspect of the QI programme includes 4 primary drivers; **Communication** (in and out); **Big I** (SU/C in QI project teams); **Little i** (providing feedback to QI projects); and **Monitoring & Evaluation** of how projects involve service users. A People Participation Lead supported by Service Users and Carers in group is responsible for leading on each of these primary drivers.

Change ideas tested and implemented so far include pooling contact lists of those interested in QI, developing role descriptions for service user and carer involvement in QI projects, clarifying the process for reimbursing service user and carer time for involvement in QI projects, and continuing the half-day introduction to QI training for service users and carers.

2.4 Projects

As at August 2016, there are currently 156 active QI projects, with a total of 24 have been successfully completed.

Figure 19: Active and completed projects by directorate

	Active	Completed
Bedfordshire	5	0
Children's Services	17	1
City and Hackney Mental Health	17	9
Community Health Newham	14	0
Corporate	9	4
Forensics	18	4
Luton	5	0
Mental Health Care for Older People (MHCOP)	14	2
Newham Mental Health	15	0
Primary Care and Specialist Psychological Services	7	2
Tower Hamlets Mental Health	32	2
Z. N/A	3	0
Addictions	0	0
Total	156	24

Completed projects

There have been 24 successfully completed projects since the initiation of the QI Programme. A selection of these are listed below:

- *Chronic Fatigue MDT Therapies Referral Pathway:* This Project was carried out by the City and Hackney Mental Health directorate which had multiple aims that they successfully met, this included improving access to evidence-based therapy in the Chronic Fatigue service and to reduce DNA rate to 6% for all appointments within 6 months.

- *Improving the QI microsite and increasing its usage:* To improve the quality and usefulness of the QI microsite with a view to increasing its usage by staff, service users, carers and the general public; to increase awareness, knowledge and involvement of the QI programme.

- *Reducing bed occupancy on an older adult mental health ward in Newham*

- *Improving recovery rates in Richmond Wellbeing Service*

- *Improving reliability of physical health monitoring within City & Hackney community mental health teams*

Closed projects

There are many reasons why QI projects are closed without having been successfully completed. Project closure forms capture the reasons and learning from these projects. Below are some of the main factors identified from the projects closed in the past year without having met their aim:

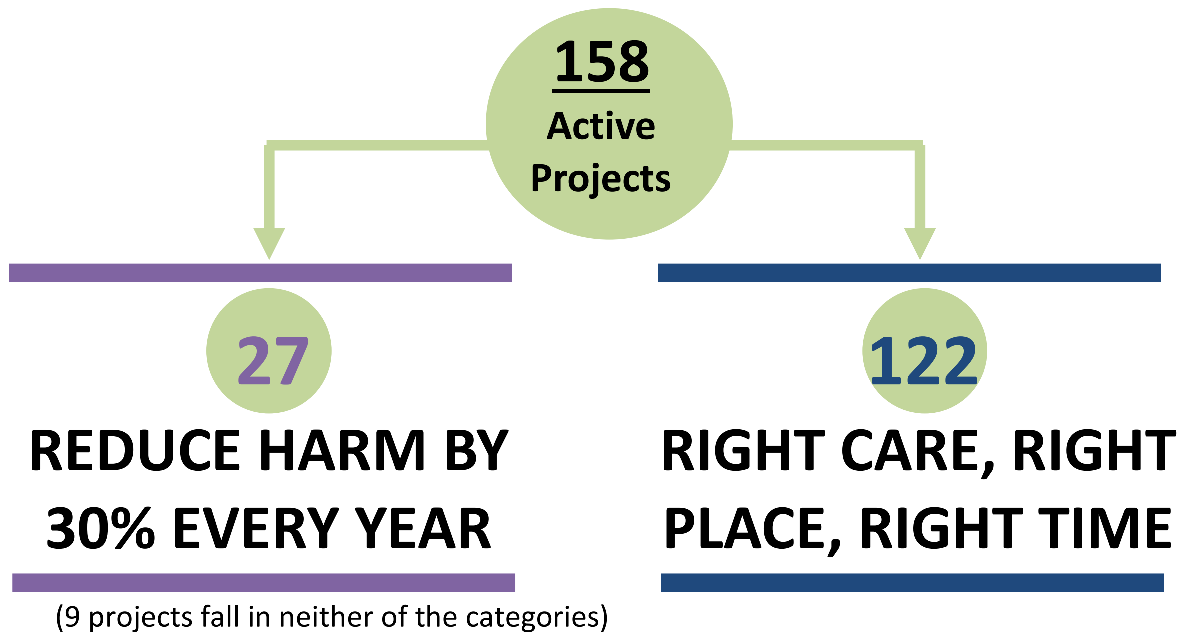
- "The continued measurement of the quality of supervision is being undertaken effectively in different forums so there is duplication of effort."
- "Lack of team capacity, No longer a priority for team/directorate"
- "Problem not suited to QI"
- "This is an IT based project around building a piece of improvement software. It is not suited for PDSA's and improvement methodology."
- "Key Staff have left the trust or moved on to new teams."
- "Difficulty in engaging primary care staff."

Aligning projects to high level aims

The Trust initially set two stretch aims at the start of the QI programme in 2014, to help align project work to: reducing harm by 30% every year and

delivering the right care, at the right place, at the right time. Figure 20 shows the breakdown of projects focusing on each aim.

Figure 20: Distribution of QI projects across Trust stretch aims



(9 projects fall in neither of the categories)

2.5 Reducing harm

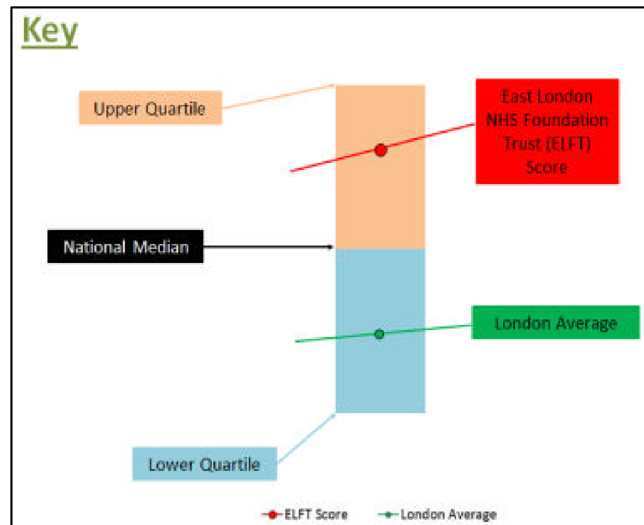
Under the umbrella of reducing harm by 30% every year, there were 2 key focus areas:

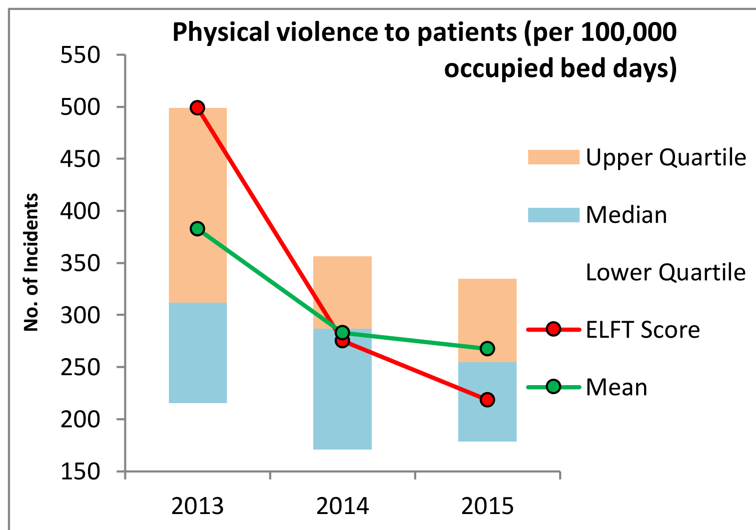
- Reducing harm from inpatient violence (the most reported safety incident at ELFT)
- Reducing harm from pressure ulcers (the most frequent cause of serious incidents at ELFT)

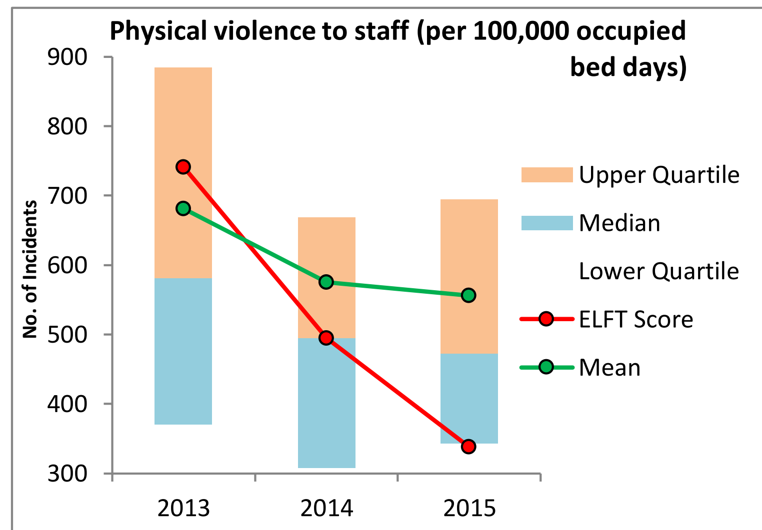
Violence reduction

Findings from the NHS Mental Health Benchmarking Framework suggest that violence towards service users and towards staff at ELFT has improved compared to other mental health providers, moving from being above the upper quartile to being below the national median in 2015 (see figure 21).

Figure 21: Data from the NHS Mental Health Benchmarking Framework



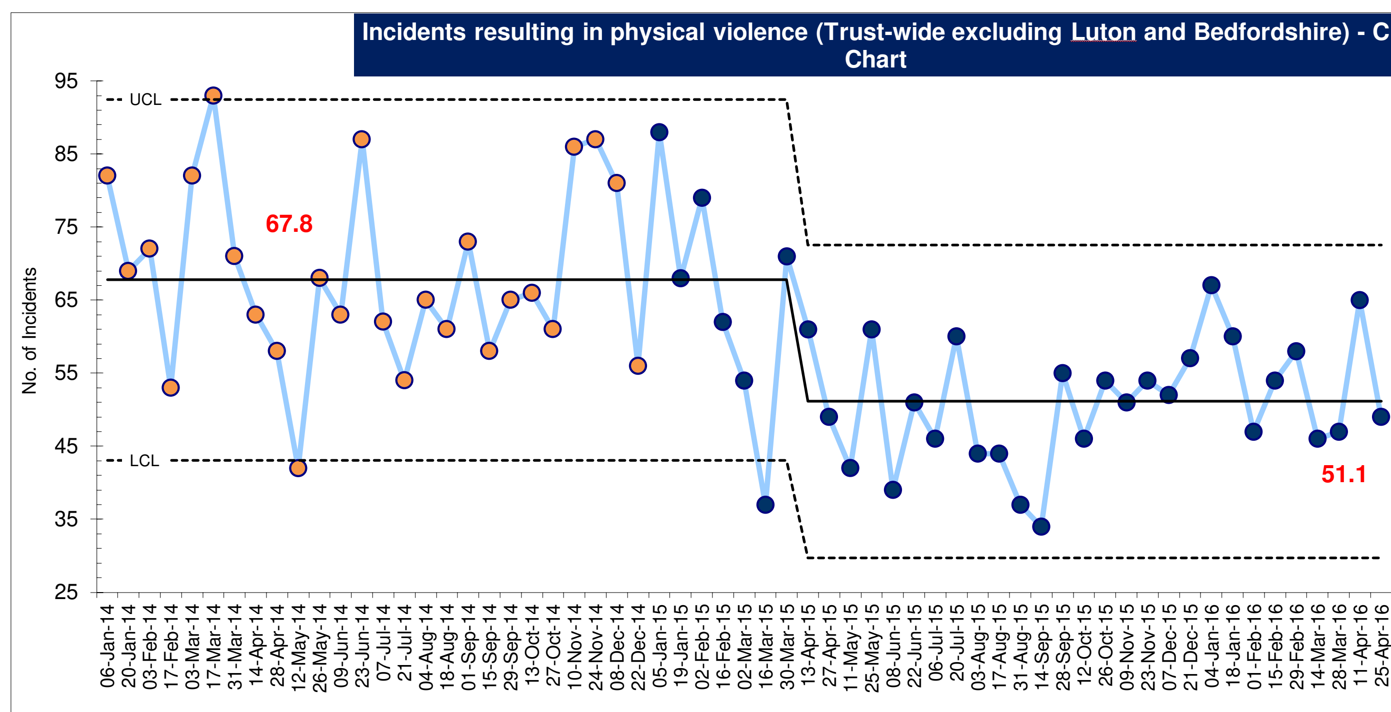




Trust-wide impact

Since the introduction of the QI Programme there has been a significant reduction in the number of incidents resulting in physical violence reported within the Trust (excluding Bedfordshire and Luton wards where the QI work is only just beginning), from an average of 68 per month to 51 per month (figure 22). This reduction in violence is due to projects in many different areas of the Trust, and in different types of services.

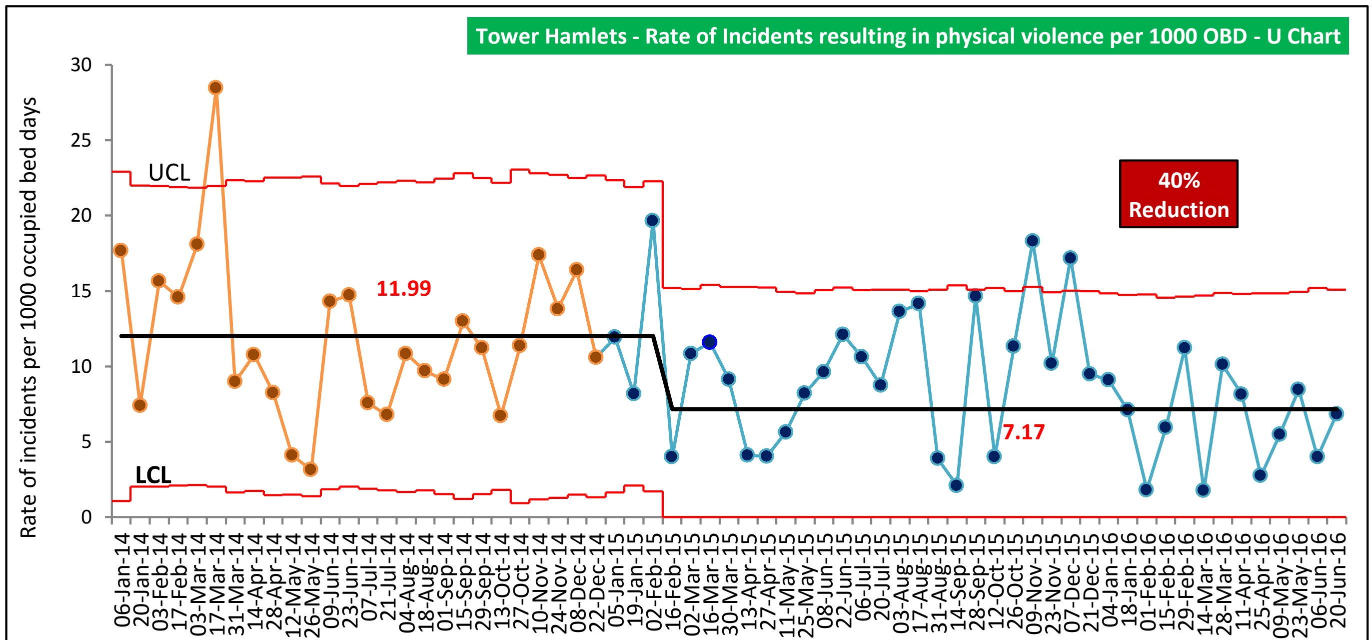
Figure 22: Trust-wide physical violence incidents per 1000 occupied bed days



Tower Hamlets

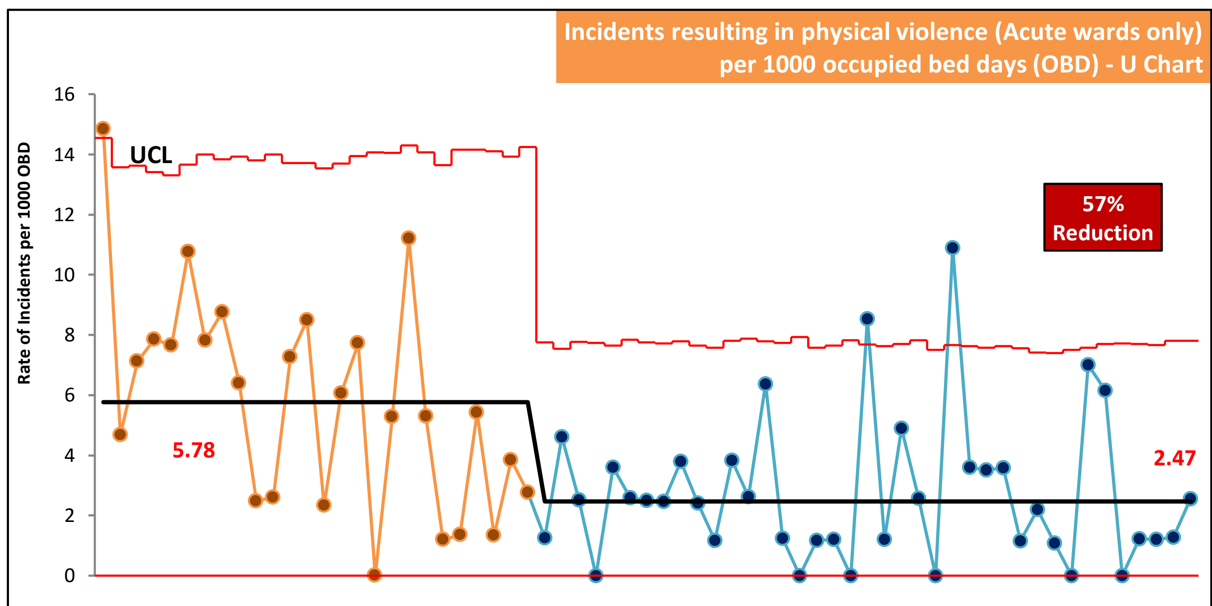
Tower Hamlet's Globe Ward began their work on violence reduction in 2012, through testing four interventions. Over two years, the average time between incidents increased from 5 days to 11 days. The learning from this ward was scaled up to the other five inpatient wards in the Tower Hamlets directorate using a collaborative learning approach. The teams taking part in the violence collaborative met every six weeks to share their testing, data and learning. Since the beginning of the project, Tower Hamlets has seen a 40% decrease in incidents of physical violence (see figure 23).

Figure 23: Physical violence incidents in Tower Hamlets directorate



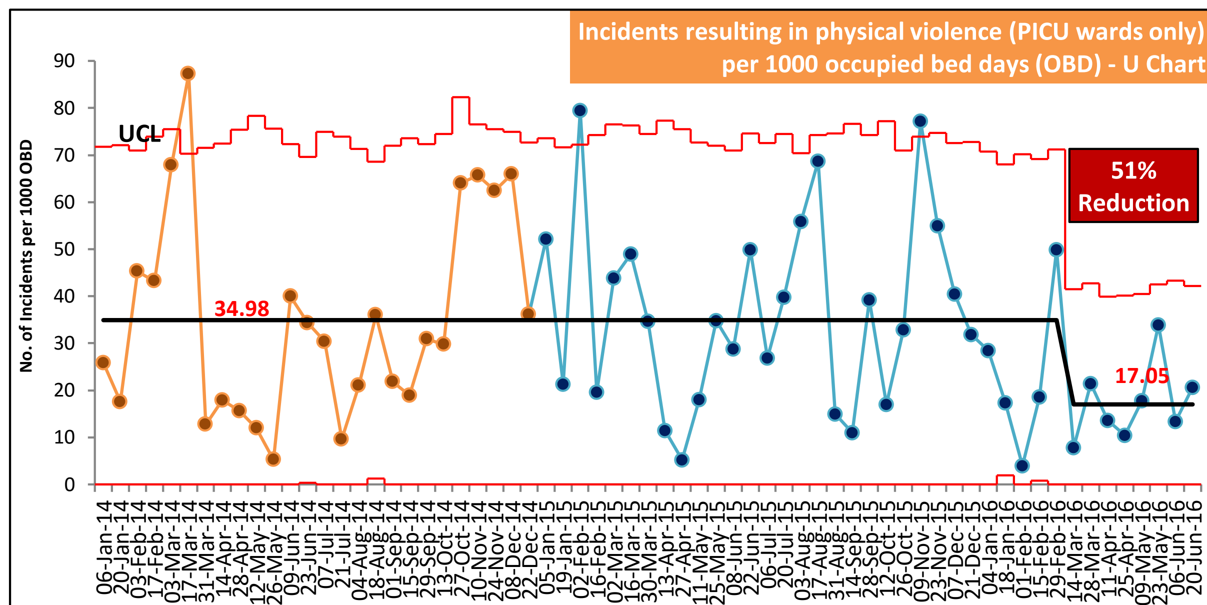
Stratifying the data by ward type shows that the four acute wards at Tower Hamlets have seen a 57% reduction in the average number of physical violence incidents (figure 24).

Figure 24: Tower Hamlets Physical violence Incidents Acute wards



Between March 2016 and June 2016 the two Psychiatric Intensive Care Unit wards at Tower hamlets have experienced a decrease in incidents of physical violence by 51%.

Figure 25: Rate of incidents of physical violence on psychiatric intensive care units

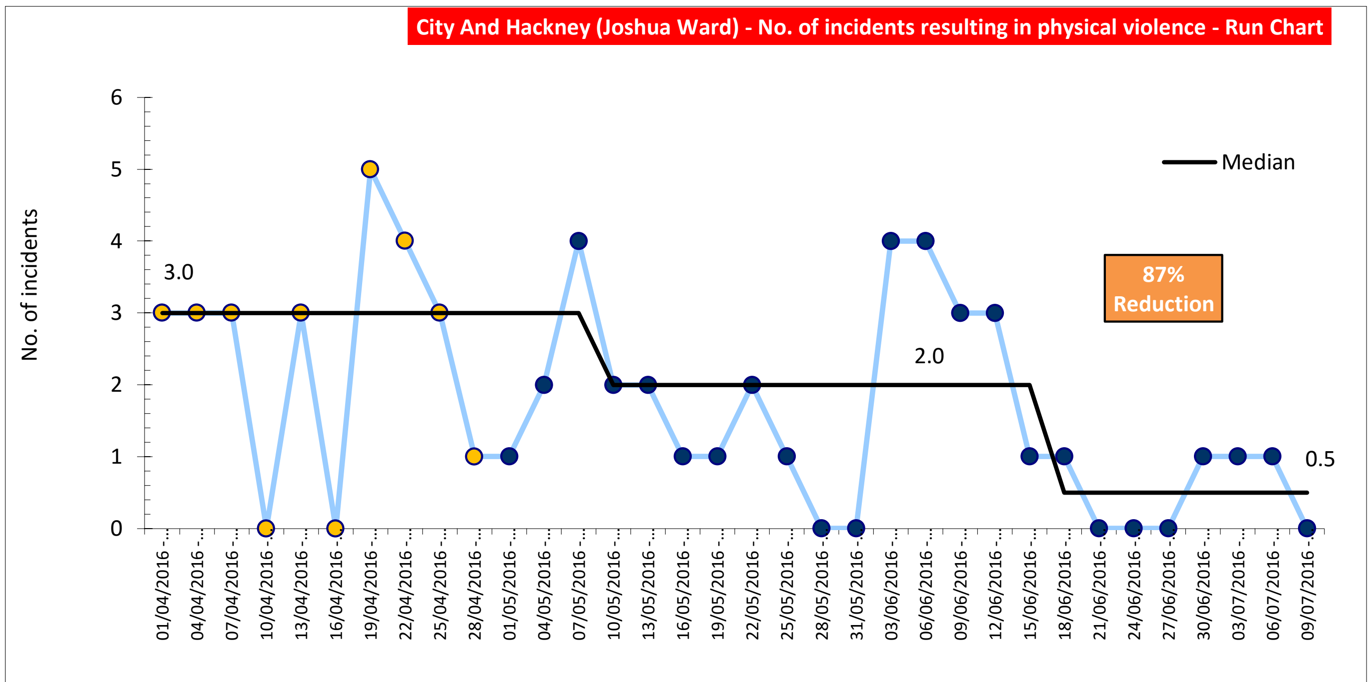


Scale up to City & Hackney and Newham centres for mental health

All inpatient adult wards in City & Hackney and Newham have started systematic scale-up work to reduce violence and develop a safety culture using a QI approach since the start of 2016.

The project is building on the work in Tower Hamlets with wards testing the package of four change ideas in different combinations using a planned experimentation approach. Currently, data is being collected over time and being compared to baseline data. Positive results are emerging, for example Joshua Ward has been recording the number of violent incidents every 3 days and has seen an 87 % reduction in the number of violent incident since the introduction of change ideas at the end of April 2016 (figure 26).

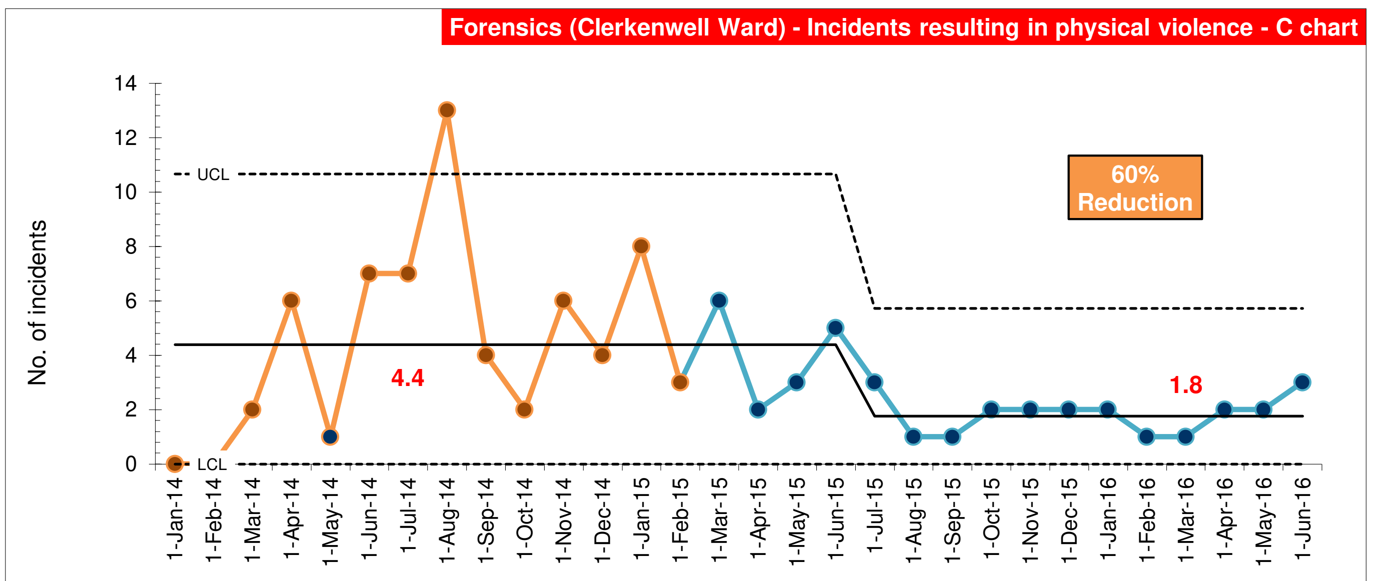
Figure 26: Joshua Ward, number of violent incidents.



Forensics

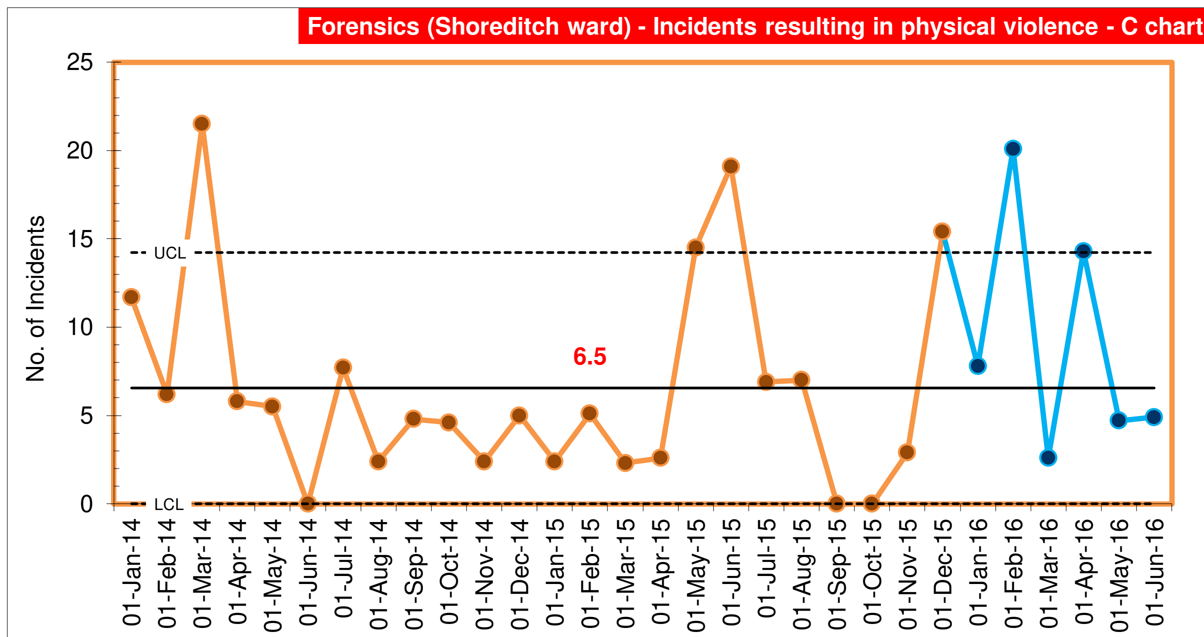
Analysis of violence in our forensic services showed that 23% of all violent incidents were occurring on Clerkenwell ward. A project on this ward has now seen significant sustained reductions in incidences of violence, use of restraint and staff sickness rate since July 2015 (figure 27).

Figure 27: Clerkenwell ward number of incidents per 1000 occupied bed days



In February 2016, work began to scale this project up to Shoreditch ward. Meetings with ward staff have taken place to generate change ideas, some of which have been tested but not in a robust manner as yet. There have been no noted improvements in their data yet (figure 28).

Figure 28: Shoreditch Ward number of incidents of physical violence

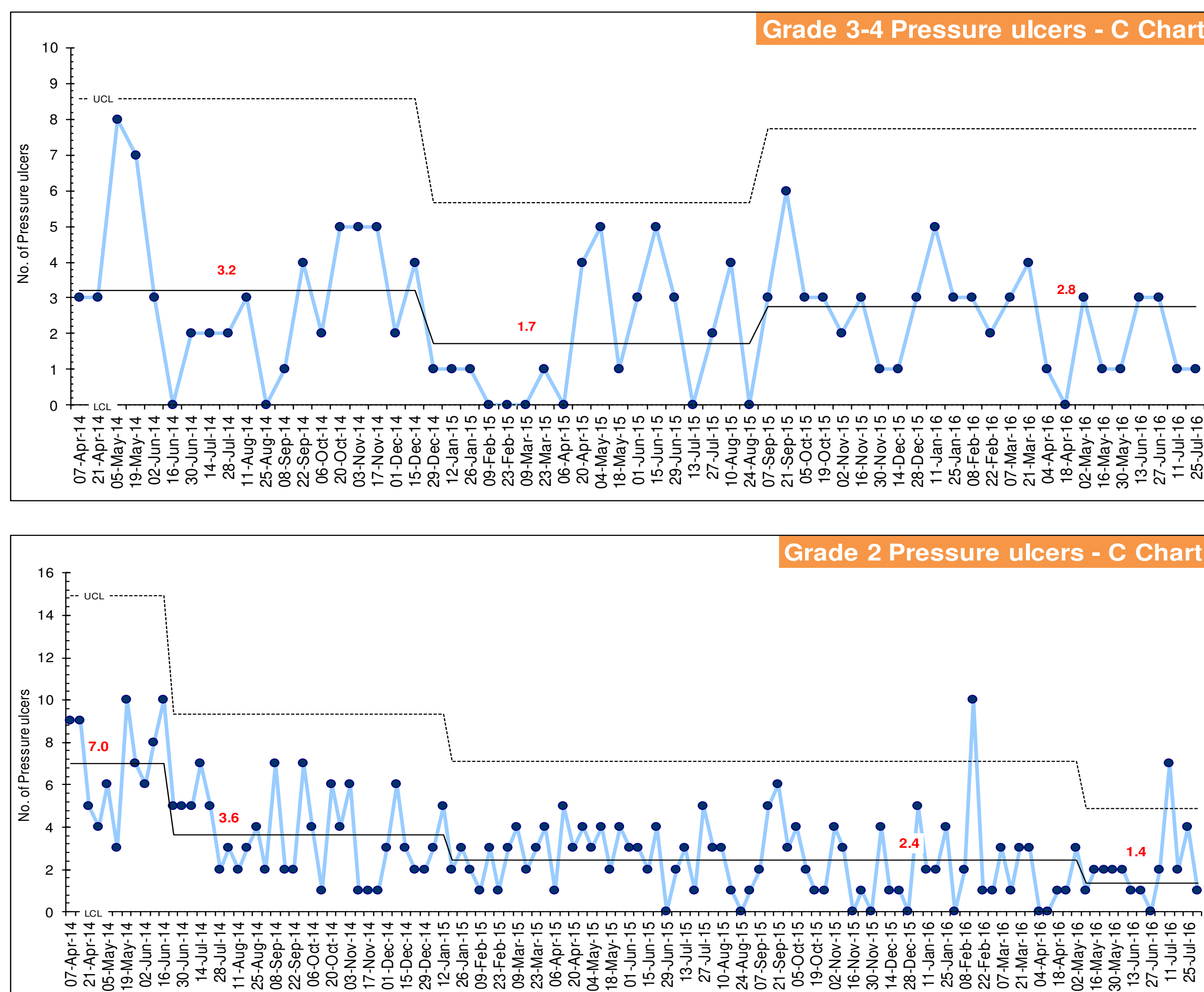


Community acquired Pressure Ulcers

In 2014, the Extended Primary Care Service (EPCS) identified a number of patients in Newham who were acquiring Pressure Ulcers whilst receiving care and also seeing a large number of patients referred in with existing Pressure Ulcers. The service began using the QI approach to tackle this complex issue, with the aim of reducing the number of pressure ulcers acquired in the EPCS.

The service has improved reliability of the evidence-based Waterlow risk assessment and SSKIN bundle care planning tools in order to support better prevention and management of acquired Pressure Ulcers. This has resulted in an 80% reduction in the number of Grade 2 Pressure Ulcers acquired in the service (figure 29). The frequency of grade 3 and 4 pressure ulcers remains unchanged, and ideas continue to be tested within the teams.

Figure 29: Community acquired pressure ulcers in the Newham extended primary care team



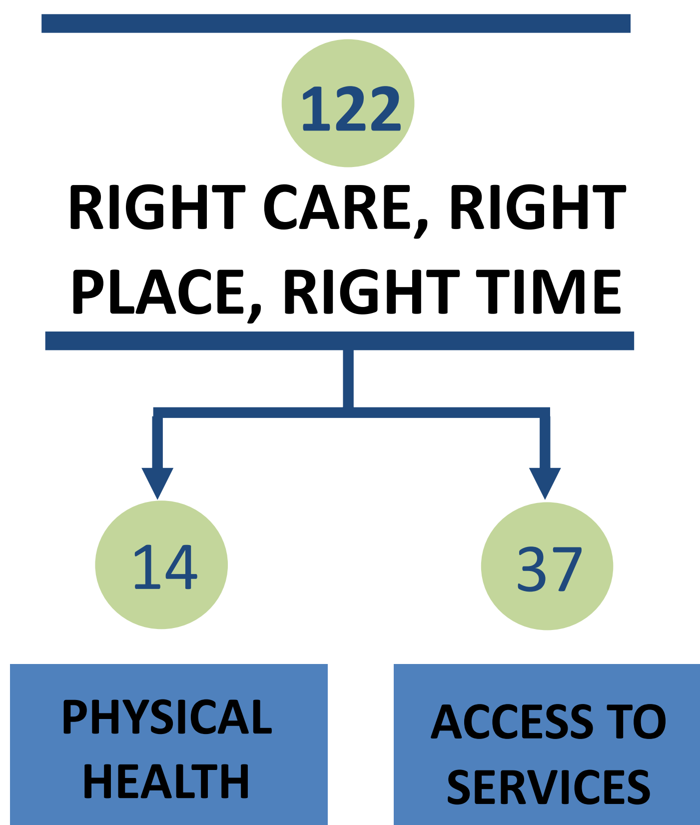
Staff within the service have reported benefiting greatly from having two Specialist Tissue Viability nurses based at EHCC and Vicarage Lane at a recent engagement event and specialist training has also been provided to local authority funded formal carers. Front-line teams are working closely with informal carers and families and focusing on specific patient groups, such as those who are non-compliant (i.e. do not use the equipment provided), end of life care patients and those with neurological problems. There is great complexity in managing Pressure Ulcers in the community, particularly for these patient groups and the service is committed to identifying and testing out new approaches to address these challenges and better prevent and manage Pressure Ulcers in the community.

2.6 Right care, right place, right time

Of the 158 QI projects currently active, the majority are working towards the 'Right care, right place, right time' aim. At the start of the QI Programme in 2014, most projects were working towards reducing harm but there has been a significant shift over time. Currently, there are 122 projects aligned with the 'Right care, right place, right time' aim. Within this area of work, the Trust has identified two priority topics which are both of strategic importance for the organisation and where many teams have elected to work. These are:

- Physical Health
- Access to services

Figure 30: Number of active projects and teams testing changes within the 'Right Care, Right Place, Right Time' strategic aim



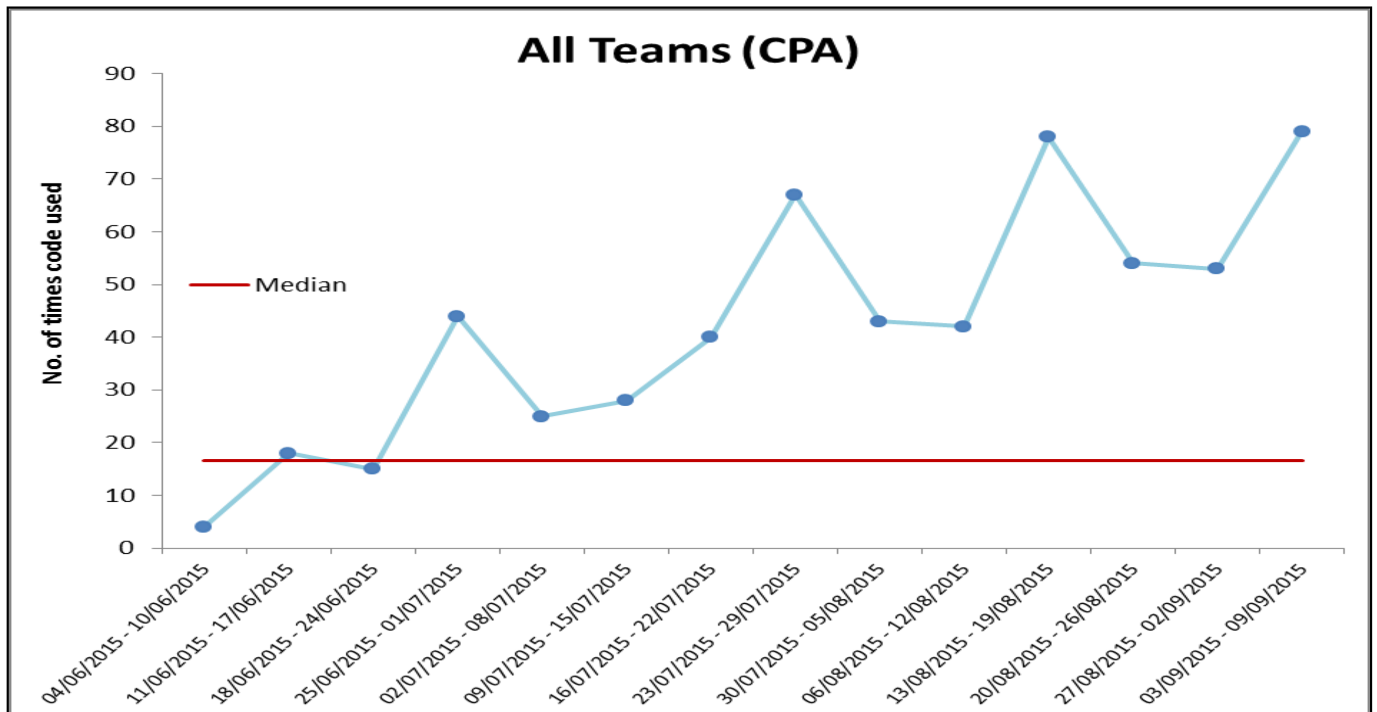
Physical health

Severe mental disorders are associated with poor physical health, increased rates of metabolic syndrome abnormalities and as a consequence, premature mortality. Improving physical healthcare to reduce premature mortality in people with severe mental illness is a priority for ELFT and NHS England. Some psychotropic medications contribute to physical issues and need regular monitoring.

In 2014 the physical health quality improvement projects mainly focused on physical health assessments and monitoring. In 2015 this work continued, the trust identified physical health as a priority area and staff from a range of professional backgrounds and levels came together with service users to form a collaborative learning system.

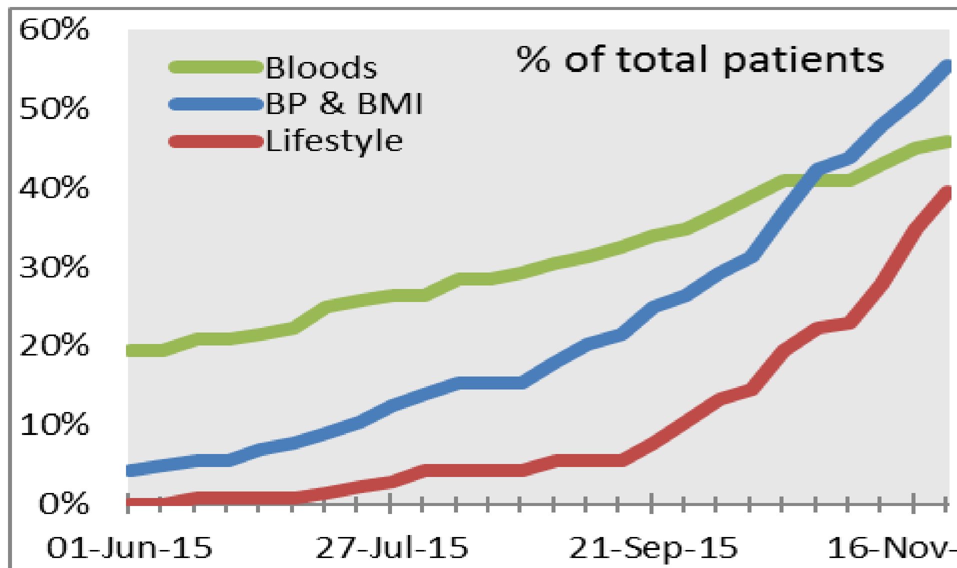
The physical health collaborative included six weekly learning sets, with the aim to reduce the cardiovascular risk of service user's prescribed psychotropic medication. A driver diagram was created focusing on four main primary drivers; equipment, assessment and monitoring, interventions and service user/carer involvement. QI projects focusing on assessment and monitoring involved the introduction of physical health monitoring pods to community mental health service waiting areas. This initially started as a single project in City and Hackney's Assertive Outreach service and over time monitoring pods were introduced to all community services. The teams focused on identifying ways to increase the number of service users having their physical health assessed and monitored (see figure 31). This chart illustrates an increase in the use of the physical health RiO codes for service users on CPA, a proxy measure for the recording of physical health measures. This has now been superceded by the testing and implementation of an electronic physical health monitoring form across all services.

Figure 31: Physical health monitoring in City & Hackney community mental health for service users on the Care Program Approach (CPA)



Newham's Assertive Outreach team focused on increasing the percentage of service users having physical health checks. They measured three different parameters; blood, blood pressure (BP) and body mass index (BMI) and lifestyle factors. They tested ways to improve the percentage of service users having their physical health regularly assessed. The data on reliability of physical health checks for this team is shown in figure 32.

Figure 32: Newham Assertive Outreach Service – reliability of physical heath monitoring



As the national and local CQUINs focused on assessment and monitoring of physical health from April 2015, the focus of QI work in this field switched to testing interventions aimed at health promotion, a complex adaptive problem suitable for the QI method.

The work on interventions has mainly focused on health promotion and this involved projects working on weight reduction, physical activity levels, promoting self-catering within inpatient settings and smoking cessation. Three different project teams across different inpatient units are currently testing interventions aimed at improving service user's levels of physical activity.

Access to services

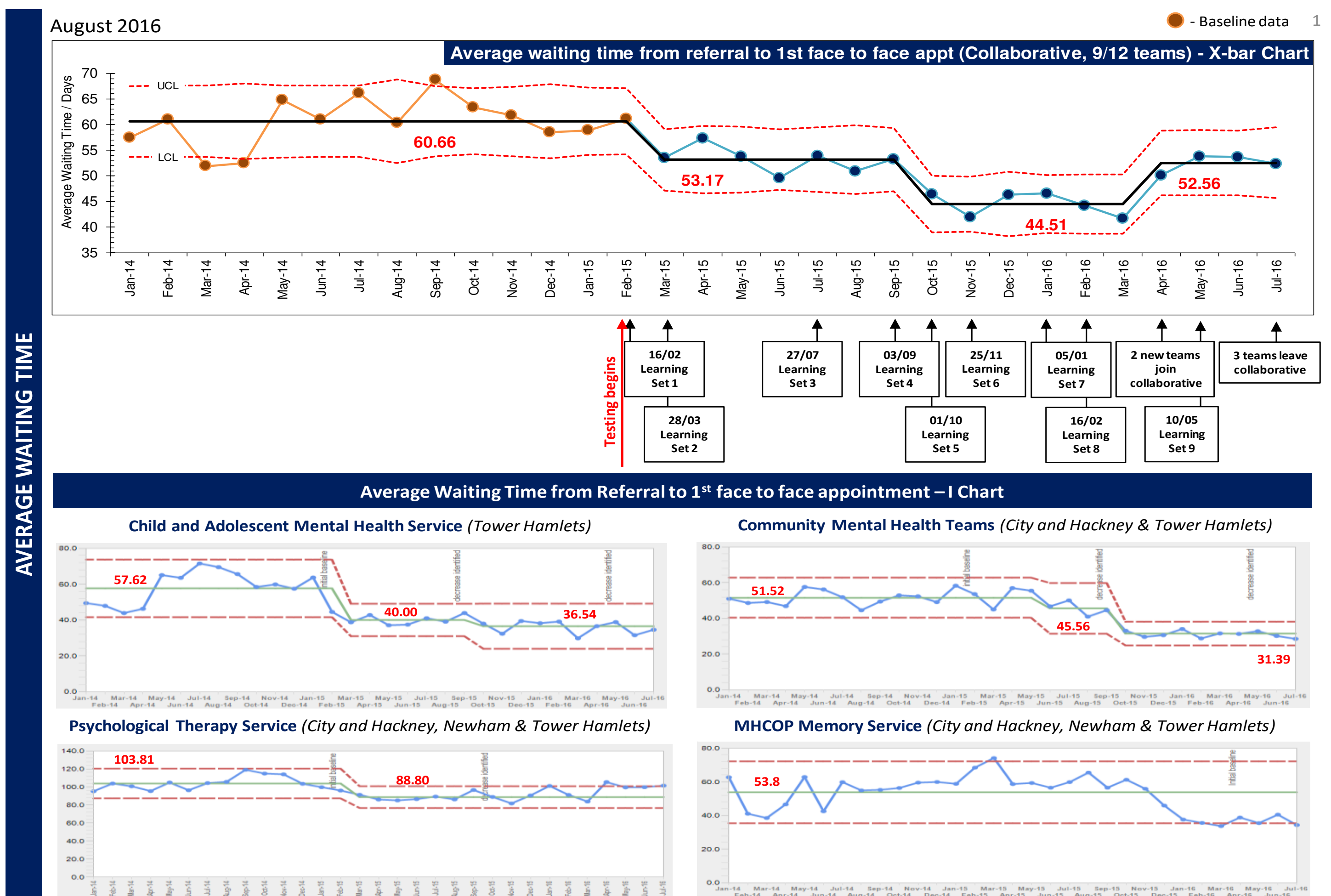
Improving access to services projects account for 27% of all trust priority projects in 2016. Currently there are 3 key areas of work within improving access to services, these are:

- Reducing waiting times from referral to assessment
- Increasing number of appropriate referrals
- Reducing the proportion of service users who do not attend appointments

Between eleven and sixteen teams have been working on this area over the past year. These teams have been brought together in a collaborative learning system, in order to actively learn from each other, share data and be more tactical about prototyping and scale-up.

Overall the services that are running QI projects to reduce waiting times have seen a 14% reduction in average waiting times overall since February 2015 (see figure 33).

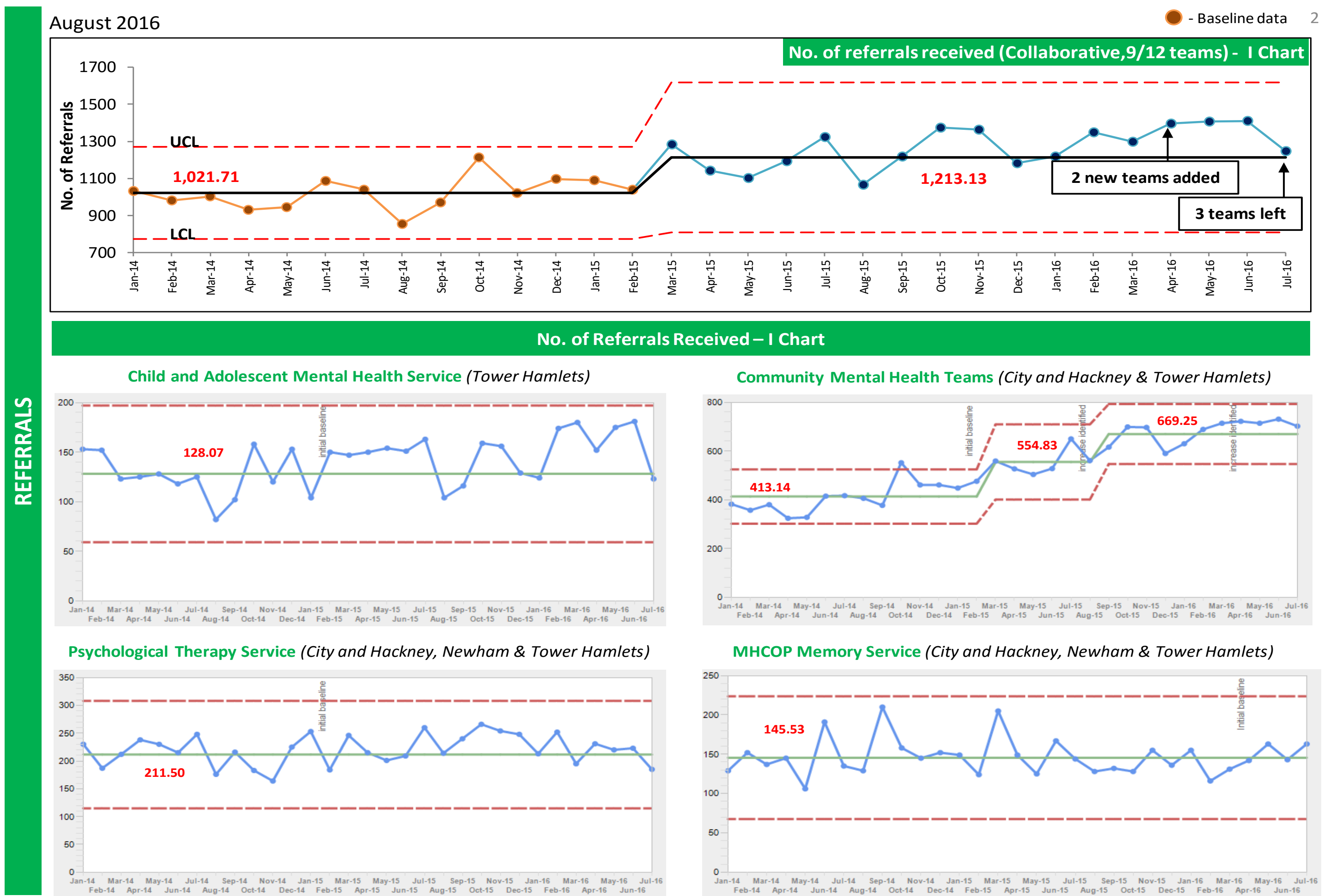
Figure 33: Referral to assessment waiting times for the collaborative learning system for improving access



The chart above also shows stratification of this data by service line, with community mental health teams, CAMHS teams, psychological therapy services and memory services all working on this topic together and seeing improvement.

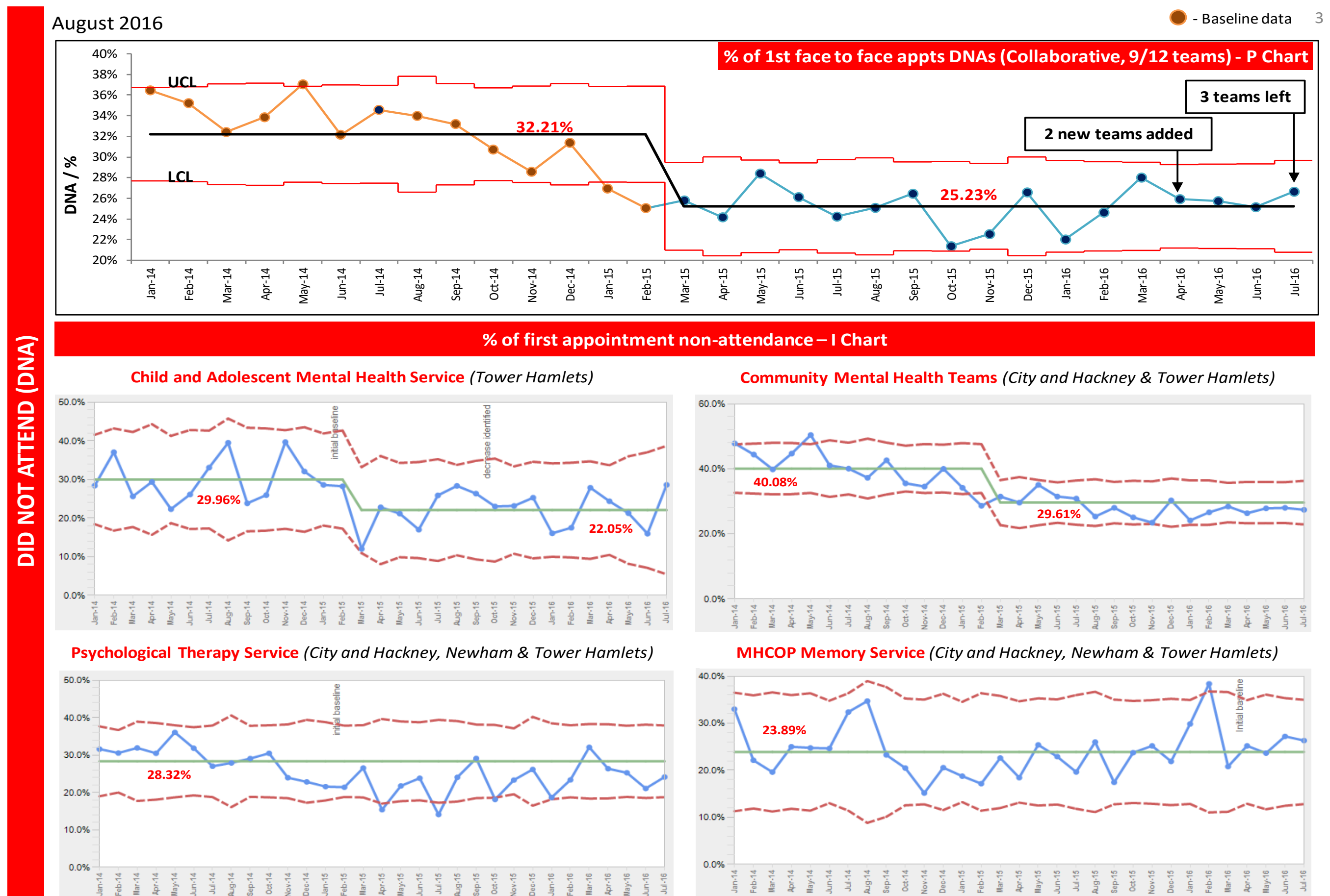
This reduction in waiting times across all types of community services has been witnessed despite an increase in referral volume (see figure 34). A small number of teams are working towards this as their primary aim, but most have seen this as an unintended consequence of their work on the initial pathway into their service.

Figure 34: Number of referrals across the improving access collaborative learning system teams



Several teams within the collaborative learning system are working on non-attendance at first appointment, others are working on both waiting times and non-attendance. The improvement in this outcome measure is seen in figure 35 below.

Figure 35: Proportion of service users not attending their first appointment, across the improving access collaborative learning system teams



The learning system data contains many stories of testing and learning within individual teams. A summary of the change ideas currently being tested across the teams is outlined in figure 36.

Figure 36. Table summarising change ideas and change concepts currently being tested within the improving access collaborative learning system at ELFT

Change Concept	Change Idea	Teams Testing
17 – Use automation 59 – Use reminders	iPLATO **text messaging system** (automated system). Task to gather views on how to achieve consistency in processes	MSK Physio; Newham EPCL; Specialist Health Visiting; NH Psychological Therapies; TH CAMHS; TH Psychological Therapies
59 – Use reminders	EE **text message reminders** (manual Microsoft Outlook system).	Community Sexual Health and Reproductive health; CH Wait Times
27 – Give people access to information	**Introductory leaflet** for service users and GPs	TH Adult Mental Health
39 – Coach customers to use products/service	**Assessment leaflet** to provide information about the process of assessment, therapy choice etc	NH Psychological Therapies
51 - Standardization	**Referral form** that was developed and tested by the NH Psychological Therapies wait times project	TH Psychological Therapies, CH Psychological Therapies
15 - Move steps in the process closer together	**Daily referrals meetings** instead of weekly meetings	NH CAMHS Front Door Service / CH Wait Times
16 – Find and remove bottlenecks 71 – Change the order of process steps	**Telephone triage**	TH CAMHS Community; CH Wait Times
34 – Focus on the core process and purpose 68 – Reduce the number of components	**Stopping groups** for patients awaiting individual psychotherapy	CH Psychological Therapies
21 – Use multiple processing units 55 – Develop contingency plans	**Emergency clinic slot**	Specialist health visiting
41 – Use a coordinator	**Referrals coordinator screens** and either accepts or sign-posts new referrals	CH Psychological Therapies
14 – Minimize hand-offs	**Post appointment letters** directly from team	CH Wait Times

3 Data from surveys and interviews

The Quality Improvement Programme has now been running for over two years, with over 150 teams using QI to tackle a complex quality issue. The aim is to support the teams to work together with service users and carers to lead improvement in every area of the Trust's work. While we can be proud of the innovative and sustained improvements that we are seeing already across some complex quality issues, we always want to aim higher.

Integral to a culture of continuous improvement is curiosity. This means listening, reflecting, learning from our successes - and our failures - and adapting and testing changes all the time. A key part of this is the annual QI evaluation, which includes face-to-face interviews with teams, as well as service user consultations and Board-level feedback. Individual feedback from staff is also vital to inform the on-going development and approach to QI at ELFT.

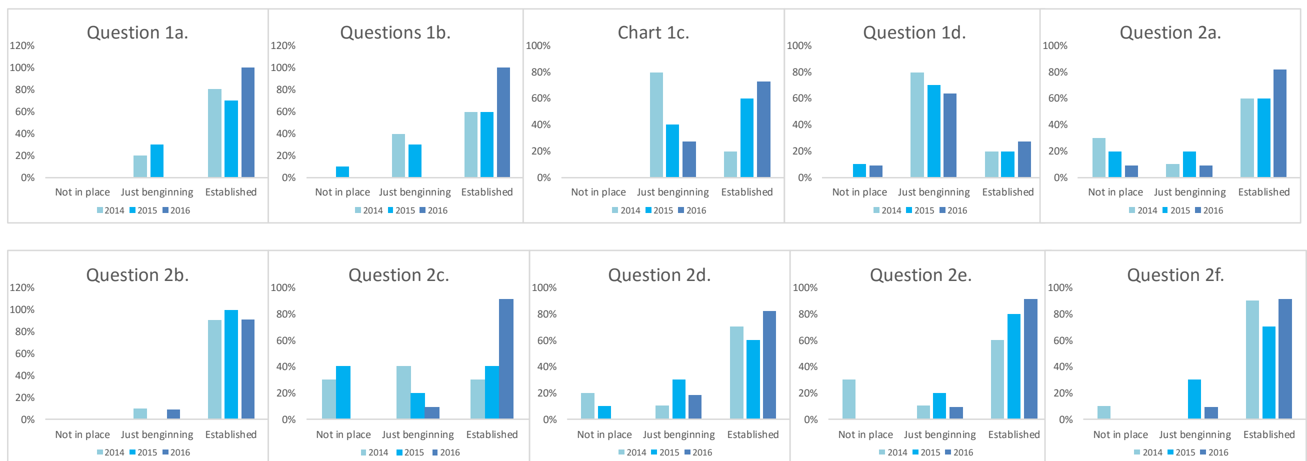
In June 2016 we asked all staff at ELFT to participate in a survey to provide feedback on how we can improve quality for our service users. In order to gather feedback from all levels of staff at the trust, three surveys were designed using the online survey tool 'Snapp Survey' and sent out via email for staff to complete; the surveys were sent out to Board staff, all members of directorate management teams and all members of staff. In this section you can find a summary of the feedback from the surveys.

Board Survey

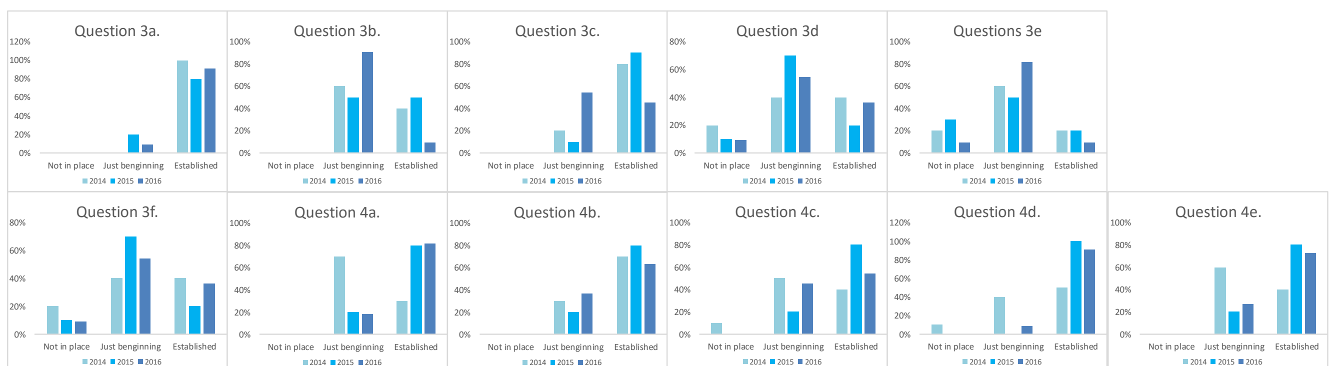
The Board survey has now been repeated every year since 2014. The data over the three years can be viewed below, together with the individual questions asked.

Figure 37. Board survey results (questions and responses viewed over three years)

1a.	My organisation has an explicit Aim Statement related to reducing harm this year
1b.	We have publicly declared this Aim Statement
1c.	We have established specific measures related to this Aim Statement
1d.	Each directorate or service has established their own Aim Statements designed to reduce harm this year in their area in support of our organisation-wide aim
2a.	The topic of reducing harm and improving quality is the first item on the Board's agenda
2b.	We review measures related to patient safety and harm at every Board meeting
2c.	At every Board meeting we hear the story of at least one incident that caused harm to a patient
2d.	The Board has viewed recent data to determine the extent of harm in our care delivery system
2e.	When a patient safety event has occurred, the Chief executive or Medical Director take the lead in conducting an in-depth and thorough root cause analysis of the incident
2f.	The Chief executive or Medical Director personally present the results of the in-depth root cause analysis on a patient safety event to the Board



3a.	Our organisation has identified a small set of key "high level" quality and safety measures
3b.	The measures on our dashboard are well-understood by the whole Board
3c.	The measures on our quality and safety dashboard are timely (no more than a month old) when presented to the Board
3d.	The same dashboard presented to the Board is regularly shared with all staff
3e.	The same dashboard presented to the Board is regularly shared with patients, families and the public
4a.	The Board asks as many hard questions about the quality and safety dashboard as it asks about the financial reports
4b.	This organisation aggressively works to maintain an environment that is just and fair for all those who experience pain, harm or loss as a result of avoidable harm
4c.	The Board has approved policies that protect staff members from retribution and punishment when they report an error or patient safety incident
4d.	The Board has regular conversations with clinical leaders to ask how they are helping achieve the organisation's quality goals
4e.	The Board has sent a clear signal to management, nursing, and medical leaders that it is serious about safety policies, and expects them to be followed



5a. The Board has sent a clear signal that all staff who are working to uphold our safety policies will be supported, all the way to the Board.

5b. We have a good system for educating all Board members so that they clearly understand their responsibilities and accountabilities for quality

5c. All Board members are expected to attend at least basic training in concepts and principles of quality improvement

5d. All Board members can describe the current levels of quality and safety within this organisation (i.e., they have reviewed the high level measures and can at least describe our baseline performance)

5e. All Board members can explain or describe the model or framework used at this organisation to drive quality

5f. The Board is regularly exposed to learning from organisations (inside or outside of healthcare) that are viewed as benchmarks in the area of quality

6a. The Board has approved and resourced a strong plan to build the knowledge and skills of staff (both clinical and non-clinical) in the area of quality

6b. The Board has made it very clear to the senior management team that they are expected to achieve results: (i.e. reducing harm and right care, right place, right time)

6c. Executive performance reviews are directly tied to the achievement of measured quality and safety results

6d. There is as much weight assigned in performance evaluation of executive directors to quality as there is to financial performance

Qualitative comments from Board members

What ideas do you have that could help the Board in leading a continually improving organisation?

Board members felt that there needs to be more discussion around the trust on certain topics under leadership such as, accountability in quality and performance and having a focus for continuous improvement. The board expressed they would like to take more of a role in sustained messaging and role modelling to continuously improve their organisations.

"Board members more active involvement in identified QI projects. Members have clear quality improvement objectives"

"Pleased to see new quality strategy which aligns QI with QA and other change management approaches. Need to be clear and honest about the things that still aren't perfect, and drill down into services and localities as this is where variation exists...are we always aware of this clinical variation? Clinical variation also exists in 'models of care'.... we need to ensure we are sharing best practice and using evidence base."

What are the main factors that have supported the Trust's progress so far on quality improvement?

When asked about things which have supported QI progress in 2016, board members acknowledged the dedicated efforts of the QI team and its leadership, as well as commitment from the board, senior executives and patient engagement.

"Systematic, resourced, high profile programme Board leadership Clinical leadership Patient engagement - this needs to be improved"

"IHI support, our QI leadership and passion. Great QI team Investment and support in the QI resource Success breeds success...people want to be part of something so positive. Patient involvement"

"Commitment to the Programme from across all levels in the organization. Continuous efforts and raising awareness and communication of success Bringing QI into as many conversations about service delivery as possible"

What are the main factors that have hindered the Trust's progress so far on quality improvement?

Some of the key factors raised regarding hindering factors to QI work have been the issue of competing demands on time and capacity, staff feel QI needs to be promoted more in the context of other quality improvement methods and a greater focus should be put on clinical staff.

"Time. Sharing good practice across teams localities etc. Now happening and being reported at Board level. But could it be faster? (Bearing in mind the need to take staff with us and make them the change agents. Luton and Beds needed special help on 'hygiene factors' before approaching QI"

"Capacity - lack of benchmarks - some lack of understanding"

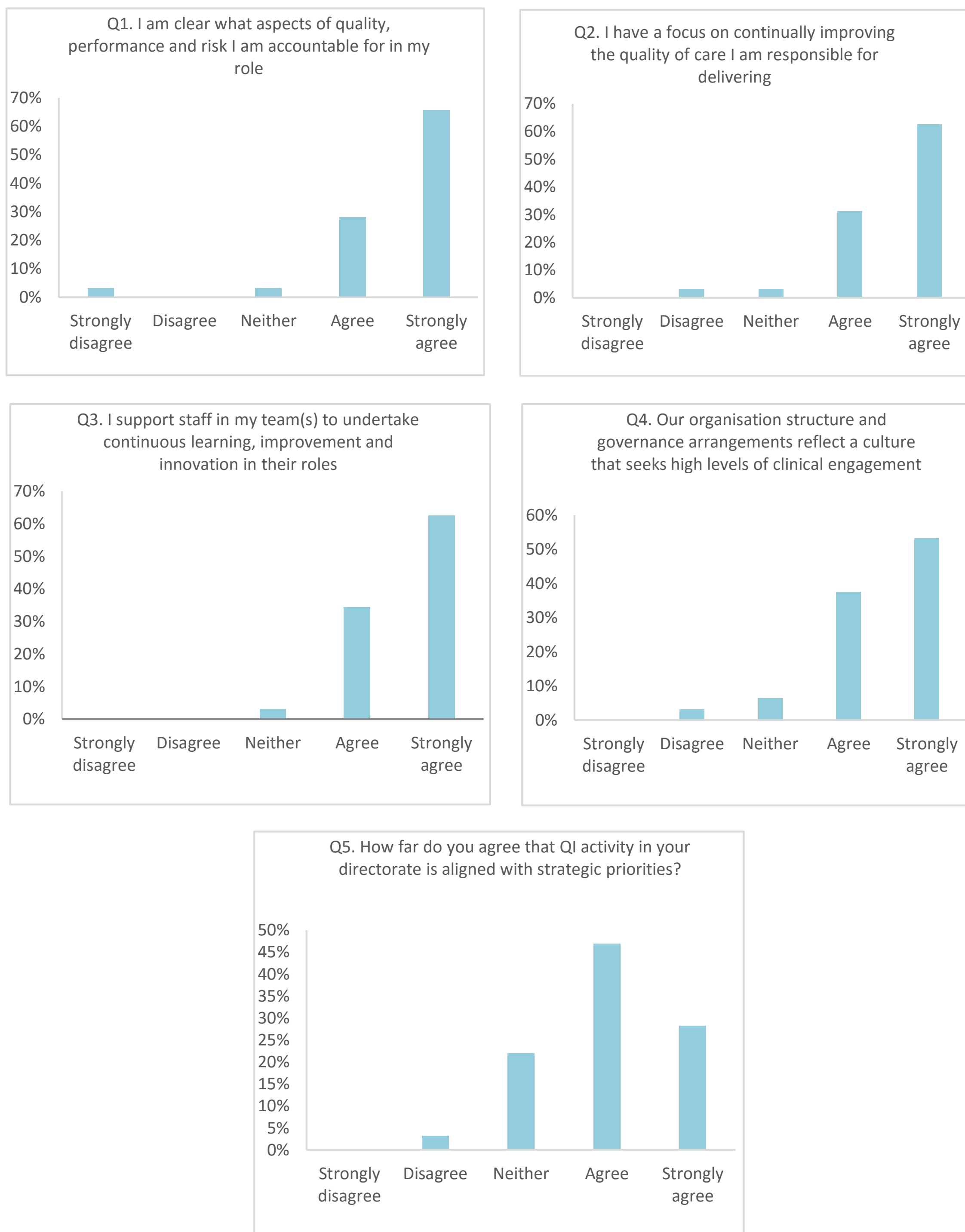
"Not placing QI in the context of other methods of improving quality Less focus on non-clinical staff

Directorate management teams survey

A separate survey was sent out to all members of the Trust's ten directorate management teams.

1) I am clear what aspects of quality, performance and risk I am accountable for in my role
2) I have a focus on continually improving the quality of care I am responsible for delivering.
3) I support staff in my team(s) to undertake continuous learning, improvement and innovation in their roles.
4) Our organisation structure and governance arrangements reflect a culture that seeks high levels of clinical engagement.
5) How far do you agree that QI activity in your directorate is aligned with strategic priorities?

Figure 38. Responses to the directorate leadership teams survey



Qualitative comments from senior staff

How engaged do you feel your teams are in continually improving their service using QI?

There was a mixture of responses ranging from well engaged to partially engaged within services, amongst the answers, time and prioritisation of QI have been a reoccurring theme. This gives QI a focus to work on ways to make QI methodology impact services better in building the will for continuous QI work; in the responses more than one service has expressed that all of their teams have an existing QI project, the idea would be to learn what worked well to reach out within these services and apply that across other services.

" Inpatient teams - highly engaged - much more mixed picture in the community."

"Not embedded in staff culture throughout the service, still an 'add on' to existing roles rather than integral part of it"

"Overall good engagement although some are more pro-active than others in applying QI methodology, but leaders are inspiring and energizing."

"Some teams are more engaged than others. There still needs to be more of a inclusion to entire teams to become involved in QI projects as it still feels that it only involves staff who attend the project meetings. This is one of our challenges."

"They are all QI trained. 50% of team are QI minded i.e propose QI ideas"

What would help your teams to use quality improvement to continually improve their service?

Senior staff sense that with time the training and support in methodology that are currently available from the QI programme will have a positive effect on continuous improvement, they think having dedicated time for QI work to raise highlight its importance and effectiveness would be a good thing. Overall the feedback shows that there is currently a healthy level of involvement in QI.

"Training -Management buy in (both of which I feel are currently in place) -Keeping things simple and applicable in terms of methodology"

"staff have more ring-fenced time to think together and share ideas"

"Most staff members are engaged on QI to change the way care is providing"

"training and supporting junior staff in the methodology."

What aspects of our approach to quality improvement do you think are particularly helpful to you in your role?

One aspect of the programme which most participants in this survey find useful is the support structure around QI work provided by the QI programme, they specifically mentioned QI coaches, QI leads, data support and QI forums have been effective in providing continuous support. Other important factors highlighted were high staff engagement within directorates and raised awareness of QI work.

“Support from central QI team The resources on the microsite Support from coaches”

“QI Coach, web platform, data driven, QI forums.”

“The on-going support to coaches The accessability of the QI team The openness and relaxed atmosphere of 'Learning sessions' for coaches The QI links to each Directorate The information provided Recognition for our achievements Feedback and positive approach”

“High staff engagement within Directorate.”

“Raised awareness, everyone has heard of QI.”

What can we do to support and encourage service user and staff involvement in quality improvement?

In addition to current effort to build the will for more service users and staff to get involved in QI work, it has been suggested to incorporate more examples of successes and display studies into what went well in these projects in user and staff forums: as-well as having a realistic view of what type of involvement can be achieved, clearer guidelines and different options to accommodate different levels of involvement from service users. Feedback also senses that QI training has been having a positive effect on increasing staff engagement and interest. Another proposal is to approach and engage senior managers to move from a performance mindset to QI mindset.

“Learning from successes and failures: 1. Share the success stories with staff 2. Rewarding staff for their efforts and commitment 3. Explain why some projects have failed”

“Need to build a good base of service users/carers who are interested in participating. Promotion of QI and examples of results and how these were achieved in short(!) articles.”

“maybe present results at user forums to show the effectivenes and then use that to request more ideas about service improvement?”

“Support and engage senior managers to move from performance mindset to QI mindset”

Is there anything else you would like to say about the Trust’s approach to quality improvement?

“it is a remarkable and highly engaging thing to be part of. very proud”

“We should start thinking about how to liberalise QI in the future.”

“Moving in right direction just needs further push”

“excellent way of devolving responsibility and allowing local ownership of quality”

All staff survey

All members of staff at East London NHS Foundation Trust were invited to contribute to this evaluation by completing a brief online survey. The survey had two elements: The IHI's improvement capability survey, and a Safety Climate survey.

The IHI's improvement capability survey tool helps understand an organisation's capability for improvement in six key areas. For each of the questions asked to participants was a description of levels of capability, ranging from Just Beginning through to Exemplary. The six areas assessed are summarised below:

1. Leadership for Improvement - The capability of the leadership of the organisation to set clear improvement goals, expectations, priorities, and accountability and to integrate and support the necessary improvement activities within the organisation

2. Results - The capability of an organisation to demonstrate measureable improvement across all departments and areas

3. Resources - The capability of a organisation to provide sufficient resources to establish improvement teams and to support their ongoing work and success

4. Workforce and Human Resources - The capability of an organisation to organise its workforce to encourage and reward active participation in improvement work, clearly define and establish improvement leadership roles, and ensure that job descriptions include a component related to improvement work

5. Data Infrastructure and Management - The capability of an organisation to establish, manage, and analyse data for improvement in a timely and routine manner to meet the objectives and expected results of the organisation's improvement plan

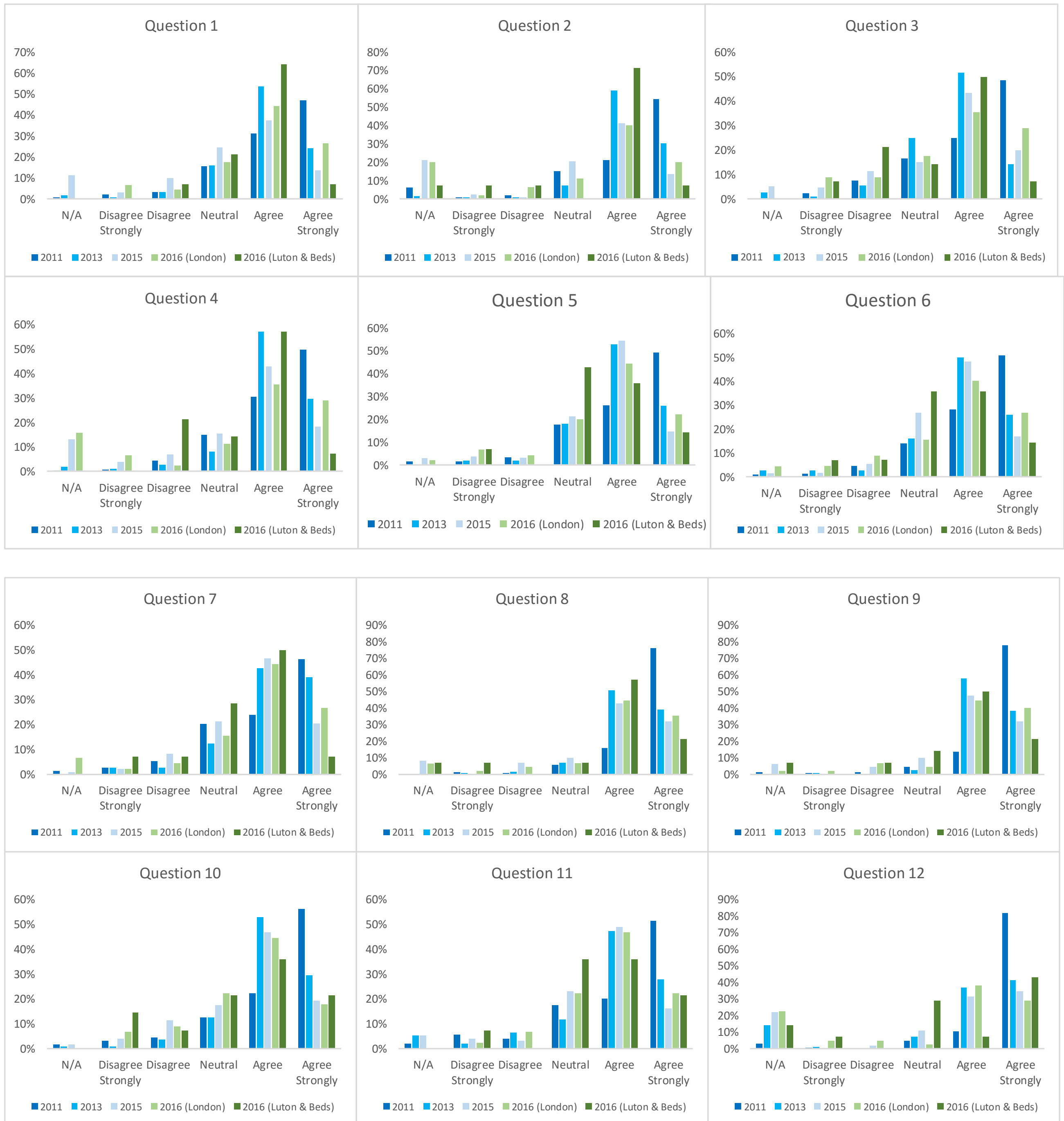
6. Improvement Knowledge and Competence - The capability of an organisation to obtain and execute on the skills and competencies required to undertake improvement throughout the organisation

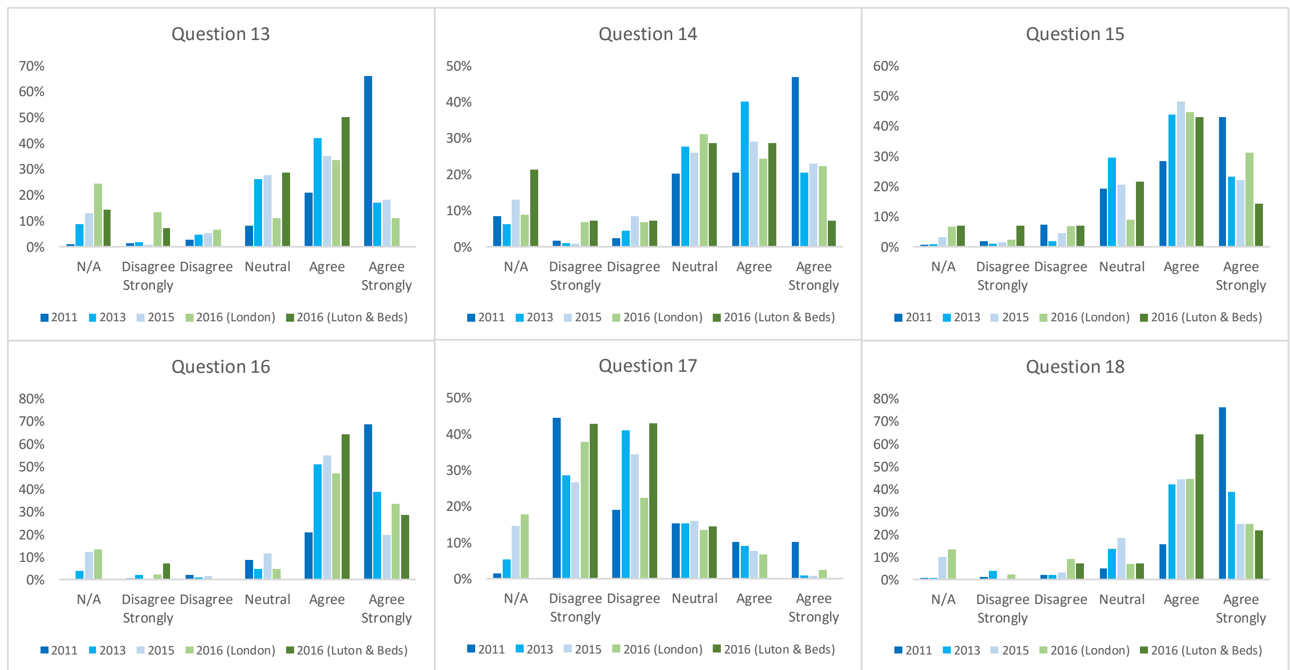
Figure 39: Results from IHI Capability survey

The safety climate questions are listed below:

1) The culture of my team makes it easy to learn from mistakes of others.
2) Errors are handled appropriately in this clinical area
3) The senior leaders in my service listen to me and care for my concerns.
4) The clinical leaders in my area listen to me and care for my concerns.
5) Leadership is driving us to be a safety-centred organisation.
6) My suggestions about safety would be acted upon if I expressed them to management.
7) Management/Leadership does not knowingly compromise safety concerns for productivity.
8) I am encouraged by my colleagues to report any patient concern I may have.
9) I know the proper channels to direct questions regarding patient safety.
10) I receive appropriate feedback about my performance
11) I would feel safe being treated here as a patient
12) Briefing staff before the start of a shift (i.e., to plan for possible contingencies) is an important part of patient safety.
13) Briefings are common here
14) This organisation is doing more for patient safety now, than it did one year ago.
15) I believe that most adverse events occur as a result of multiple system failure, and are not attributable to one individual's actions.
16) The staff in my team take responsibility for patient safety.
17) Staff frequently disregard rules or guidance that are established for this clinical area.
18) Patient safety is constantly reinforced as the priority in my team

Figure 40. Safety climate survey results





Qualitative comments from staff

In addition to the quantitative surveys, staff were asked a number of qualitative questions.

[For those that stated they had not been trained in QI yet] **What is the reason you haven't taken up the opportunity to be trained in quality improvement?**

The majority of participants said they are enrolled on some form of QI training that is yet to begin. The reasons why they did not get involved previously were due to not feeling QI was a priority, a lack of encouragement from team leaders and managers, but they felt that attitudes are slowly changing now. Time and conflicting priorities remain obstacles for people from participating in QI work, this has been mostly expressed by clinical staff working in busy work environments, but again encouragement from seniors has led more staff to understand the value of implementing quality improvement methodology to their services overall.

"Have registered, course not taken place yet. Previously, the reason was that I felt it a low priority compared to other development opportunities e.g. specific clinical trainings."

"no time away from clinical to do this and no encouragement from Team leader"

"Lack of time, competing priorities and last minute requests for new pieces of work with short deadlines. No capacity to take on more, however that is not to say that continuous improvement does not happen just that the particular model chosen by ELFT is not used"

"I'm booked on training in September - this was earliest date available"

What factors do you think are helping our progress with quality improvement?

Members of staff really appreciated the level of importance given to QI work by senior staff and Trust directors which they felt have filtered down through managers. They see the Trust giving them space to be creative as satisfying and motivating to further get involved in QI work. Having the protected time to focus on quality improvement and having training provided by the QI team have all been positive factors as well.

"Staff are also given time to take part in the QI training and the QI team are approachable."

"Motivation of senior leaders at HQ. Filtered down but local managers using QI to ensure targets are met"

"The trust providing (deliberately or otherwise) space to be creative"

"QI Team are enthusiastic and effective. Also pro-active in providing support. Our QI Forum is on a conference call - hoping this will increase engagement as it is a good way to keep in touch."

"Service user feedback and discussion forums Protected time for staff to train and develop QI projects Support from management and direct links of QI projects to staff supervision,"

"Board level engagement/support."

What factors do you think are holding back our progress with quality improvement?

The most pressing issues are time and resources to dedicate to QI work and this has been expressed mainly by clinical staff with busy schedules. Some areas have felt demotivated due to the lack of information/prioritisation about QI from more senior staff.

"QI projects are not part of our service, even if there are examples in other services across the Trust. It is not embedded in our ethos or way or thinking - or at least not known to clinicians/ therapists. Line managers need to lead on this to share the enthusiasm as well as part of the responsibility."

"Making space in the day job to take QI forward."

"Poor communications. Confusing managerial structures. No accountability. No goals or objectives for improvement."

"demotivation of staff, lack of resources and protected time. Low staff satisfaction"

"lack of recognition/ acknowledgement shown to QI project teams that make substantive progress eg improving access"

Interviews

In July and August 2016 the evaluation team conducted semi-structured interviews with thirteen teams across the organisation, including a mix of those involved and not involved in QI. The people participation team used working together groups and contact lists to capture thoughts from service users about what has helped and hindered their involvement in QI (see pages 37-40). The questions were aimed at better understanding what has helped and hindered the progress of QI and to find out if there were any suggestions for how to further improve the way we approach QI across the Trust.

A number of services including some with and some without experience of running a QI project were randomly selected from a list generated by the QI department. The evaluation team contacted the services and they were asked if they would like to take part within the QI Evaluation. Of the 30 teams contacted, a total of 13 services responded (10 with a QI project and 3 without). During July and August 2016, two members of the evaluation team attended the business meetings at each of these teams and interviewed staff members with questions tailored to whether or not the team had prior involvement in a QI project. All interview responses were transcribed and then analysed using thematic analysis to identify any key themes.

Overall, there were five core themes that emerged and were most commonly mentioned across the surveys and interviews including: involvement, resources,

raising awareness, structures and processes and culture & impact. Each core theme was then divided into a sub category in each area and will be discussed briefly in turn.

Involvement:
Overall the staff responses grouped under this theme were quite sharply divided; there was clear evidence from several teams that they were either inactive or reluctantly engaged in the QI process; this included a number of teams that were already involved in a QI project. Inpatient teams tended to express more engagement with QI, whereas the picture was more mixed in community teams.

> *"QI doesn't become a priority unless someone is pushing you"*

> *"In the long term I expect it will make an impact, but it hasn't really had much effect on our service as yet and not really touched the team. I expect once it picks up we will get more involved. The team is still in early days of the project"*

At the other end of the spectrum, a number of teams were also highly engaged and motivated to take part in the QI process and could clearly see the benefits for the Trust as well as their individual service. Teams mentioned they felt that they were given the support they required if they needed it to get started.

> *"Everyone taking part, learnt from seeing it from other people in the team's perspective… …attitudes have changed; people do want to change things"*

> *"Staff are not fully engaged but they can see benefits of the process…If you say a project is QI you will get your Manager behind this and then you get linked in with a sponsor and coach – so that's good"*

> *"It is a remarkable and highly engaging thing to be part of. Very proud"*

A common ingredient of a successful project widely identified across all groups was the involvement of Service Users in the project from the outset and where service users were involved in a leadership role. External partnerships similarly were mentioned in relation to particularly successful and innovative projects.

> *"Service user perspective – in my practice it has had an impact"*

“Clinical leadership/Patient engagement - this needs to be improved”

“QI tends to come first, SU involvement is added in later - for some things this is fine but for really changing there needs to be more focus on SU involvement at an earlier design phase”

Resources:
Resources came up frequently and with prioritisation, funding concerns and workload capacity/time routinely identified across the surveys as threats to QI’s chances of success. Overall, this was quite a negative theme and teams suggested it was difficult to prioritise QI along with their daily workload whilst managing a caseload. Also, given the timing of the evaluation exercise, the CQC inspection was mentioned as a factor as to why some teams had not previously engaged with the process.

“Constant tension with team targets and the QI work”

“The CQC has taken up a lot of our time to prepare for this and that’s why we haven’t started a project before but we would like to get involved”

A number of teams also mentioned that lack of funding to services played a part in the team’s engagement level.

“Service wants to improve but the service doesn’t have the resources”

“A lot of money has been invested into the department and the need to focus on developing and improving but it is difficult especially when there are cuts in the services”

Raising Awareness:
This theme groups together the engagement and training work going on to promote QI at the Trust. Feedback from teams about the training, especially the new pocket QI offering, was highly commended. However, it was mentioned that it would be useful to have more condensed and tailored training specific for teams as well as refreshers for previous graduates of the ISIA training.

“Really exciting during the training, enjoyed this learning process”

"Pocket QI seems really good, I enjoyed it. It would be useful if this was condensed so front line teams don't have to go out for 4 x afternoons. Need to make training more accessible"

Furthermore, it was highlighted the importance of having have face-to-face interactions with both the QI team and other services to enable better outreach to new teams as well as sharing and learning from existing QI projects.

"Make the time to come and talk face-to-face with the team instead of sending emails"

"Sharing of previous QI projects – found it difficult to learn about similar previous projects. Where can we find these for sharing and learning"

Structures and Processes:

The internal methodology and the process of conducting QI across the trust was another common area mentioned across the feedback streams. It was highlighted for effective QI projects to be undertaken, continuity and personal contact is key to project success.

"QI lead has been really supportive and responsive with any questions"

"Assign a mentor to help us with the project"

The methodology and data was another topic emphasised as being a difficult area to understand for staff and service users. There remains considerable apprehension around elements of the QI methodology including the data 'jargon' and understanding statistics, though there is evidence from the staff surveys that this situation has improved since last year's evaluation.

"Confusing methodology, haven't done QI training, the primary and secondary drivers are confusing. Keeping it simple, overcomplicated in the driver diagram"

"Stats can be quite difficult to understand and can be quite off putting for staff"

Positively, service users fed back they were actively engaged in their local QI meetings. However some teams found the directorate forums not always useful

as not everything was directly relevant to other teams; there was positive feedback around the Collaborative meetings due to the common interest in the subject area.

> *"Love how SU and Carers are included in majority of meetings"*

> *"Not always useful to hear about other teams as often as once a month at Forums. Not everything is directly relevant"*

Momentum was highlighted as a core component for an effective QI programme going forward, with concerns raised about the implementation, sustainability and scale-up element of successful projects. It was identified that starting a project can be difficult but there was more concern around keeping project members engaged and maintaining the momentum in staff teams.

> *"Takes a lot of effort to keep things going and momentum in the services"*

Culture and Impact:
This theme saw the most uniformly positive responses in the evaluation and clearly there is evidence of a genuine changing of attitudes and QI is having a real impact across the Trust, both at an executive level and with staff and service users.

> *"The general ethos, services are interested and change is now seen as helpful to improve services"*

> *"Fresh ways of looking at a consistent prolonged issue is great for moving forward"*

A key area for embedding QI into Trust culture is ensuring this forms part of business as usual and allowing QI to be part of the daily role.

> *"Embedding QI culture within the team, so it's not an afterthought. This can be achieved by creating space & time for QI thinking"*

Although QI seems positively embedded and there is strong investment at senior management level, it is clear there is still more work to be done at a staff level.

> *"Board and senior executive personal commitment"*

“Trust has invested heavily and I see the value”

“In the long term I expect it will make an impact, but it hasn’t really had much effect on our service as yet”

Recommendations

A number of recommendations emerged from the thematic analysis of the qualitative and quantitative findings from the surveys and interviews:

1. There is a clear divide between teams engaged and not engaged with the QI programme at ELFT; one strategy to address this would be to focus engagement efforts on community teams, ensuring there is the option for face-to-face outreach meetings in those services’, away days and business meetings.

2. More needs to be done to engage service users into the process from the beginning of a project and to further develop a leadership role for service users.

3. Ensure work load and prioritisation are actively protected for staff to strengthen engagement and momentum within projects.

4. Remove apprehension around methodology ‘jargon’ and ensure there is more simplified wording around data and methodology and support given with the process.

5. More needs to be done to bridge the gap between senior buy-in and staff on the ground.

6. To ensure there is clearer and simpler sharing and learning process and to utilise other forms of communication across the services.

7. To provide further refresher QI training and tailoring of training for staff groups.

4 Change ideas and next steps

From the data collected in the mixed method evaluation, each Trust directorate is reviewing their progress and challenges in order to develop an individual and locally relevant set of change ideas for immediate testing. In addition, there are a number of programme-level and Trust-level change ideas that have been identified for testing:

- Increasing capacity of QI leads and aligning more closely with directorates
  - This is aimed at providing closer strategic support for directorate leadership teams, in their goal of developing a culture of continuous improvement.
  - This is also aimed at providing a named support for the directorate's QI coaches, and developing a local support structure for QI coaches across each of the Trust's directorates.
  - This transition should also make is clearer who, from the central QI team, is working within each directorate at multiple levels – supporting high priority projects, supporting coaches and supporting the leadership team.

- Discussion with clinical and service directors about how to better protect the ring-fenced time for QI coaches, and develop a pipeline of people for the QI coaching role.

- Providing refresher training options for those who have completed QI training already, so that everyone can regularly brush up on aspects of the method.

- Continue and re-energise efforts to engage and involve all in QI, through QI leads running sessions at team away days and bespoke sessions of Pocket QI for whole services.

- Continue and re-energise efforts to involve service users, carers, families and the community in QI work through the strategic leadership of the service user and carer QI steering group. Multiple change ideas have been developed and are being tested, as described earlier in the report.

- Engage operational leaders in discussions about how to integrate and embed QI into routine work. A new development programme for operational leaders has been designed which will begin with community-based team leaders.

- Having begun the programme with complete freedom for teams to identify their projects based on what matters to them and their service users, the programme has transitioned to start identifying directorate-level priorities to which teams can link their projects. The next phase will involve being clearer about a small number of Trust-level strategic priorities, where we can apply the considerable expertise in improvement knowledge that we have developed. This occurs to some extent already, where the central QI team provide a greater level of support for projects working on violence reduction and improving access to community services. However, we will need to develop further Trust-level strategic priorities (which may extend beyond clinical quality to also include cost of care or population health), and to build robust support structures within local directorates, so that the central QI team focuses on strategic support for directorates and the Trust-level strategic improvement projects, and provides less support for other work.

- Continue to explore new ways to encourage teams to examine existing ways of working, stop activities of lower value and integrate QI work into their daily routine. One idea to be tested, in order to support these behaviours, is that of a 'break the rules week'.