Designing, Delivering & Evaluating Change at Scale

Lessons from ELFT's large-scale change programmes

House keeping

2-hour session	With breaks and interactive elements throughout.
Stay muted	Keep your microphone muted unless you're talking.
Breakout rooms	We'll automatically assign and move you into breakout rooms.
Cameras on	Please put your camera on, especially when you're in breakouts.
Post your questions	Scan the QR code on the next slide — we'll choose a selection to answer in a panel discussion at the end.

Your thoughts on large-scale change…

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ELFT CASE STUDIES SHARED TODAY

At ELFT, the large scale case studies shared today are at the Trust-wide level.

METHODS WORK BEYOND THE TRUST LEVEL

The methods we share today can be used at different scales

ELFT's approach to large scale programmes

The development and delivery of large-scale quality improvement (QI) programmes at the East London NHS Foundation Trust (ELFT) is guided by a structured, phased approach. This approach draws from the Institute for Healthcare Improvement's (IHI) **rapid cycle evaluation model** and is delivered through four key phases

Scoping Phase (1 month)

- Define scope and strategic alignment of programme
- Map & engage key stakeholders
- Review existing work & relevant data to inform programme

Design Phase (1 month)

- Develop high level programme design including aim, content theory, execution theory, results & learning and publication plan
- Based on IHI's rapid cycle evaluation approach
- Create infrastructure documents
- Decide governance structures & escalation plans

Recruitment & Onboarding Phase (4 months)

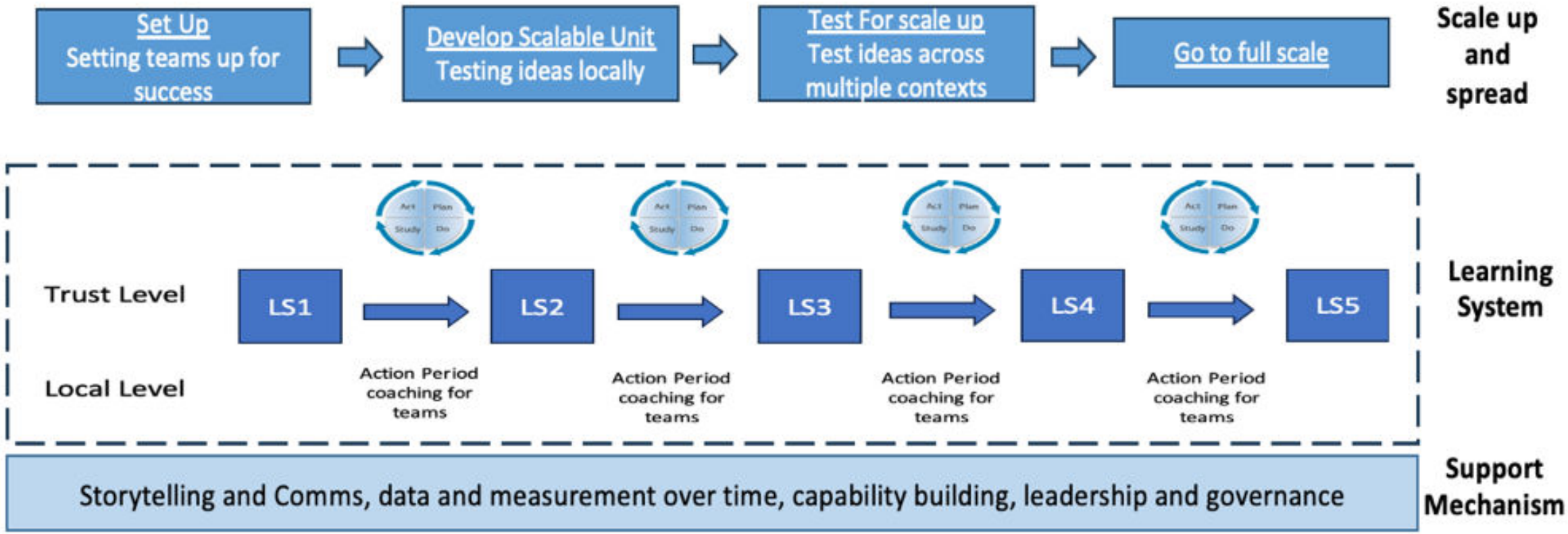
- Promote programme through multiple channels
- Engage clinical teams through formal sign up
- IAs support teams with onboarding (build a team, coach, sponsor, aim, theory of change, data)

Delivery & Evaluation Phase (10-12 months)

- Regular coaching sessions for teams
- Regular learning sessions to foster collaboration & shared learning
- Regular governance meetings
- Storytelling
- Programme review through learning log & end of programme evaluation

Approach for testing, scale, spread & learning

Adapted from the **IHI Framework for Going to Full Scale**, this model moves change initiatives from local testing to widespread adoption. Rather than simple replication, we focus on **adapting interventions** to different contexts. This process integrates continuous learning through regular collaborative learning sessions and small-scale tests of change using plan-do-study-act cycles at every stage.



CASE STUDY ONE

Observation to Engagement Programme

Redesigning how ELFT wards care for people at risk — replacing intermittent observations with safer, more engaging approaches to care.

50

mental health wards across the Trust

Apr 2025 – Mar 2027

programme timeframe, using IHI's Framework for Going to Full Scale

AIM

To introduce alternative approaches to care that actively engage staff, service users & carers, to safely eliminate the use of unnecessary intermittent observations.

HOW WE SCALED IT

PHASE 1 · TESTED

9 wards

41%

reduction in enhanced observation days

25+ change ideas tested; all 9 wards improved; top idea formed the CARE that counts bundle

→

PHASE 2 · SPREADED

21 wards

56%

reduction in enhanced observation days

CARE that Counts bundle spread; built degree of belief; 20 of 21 wards improved so far

→

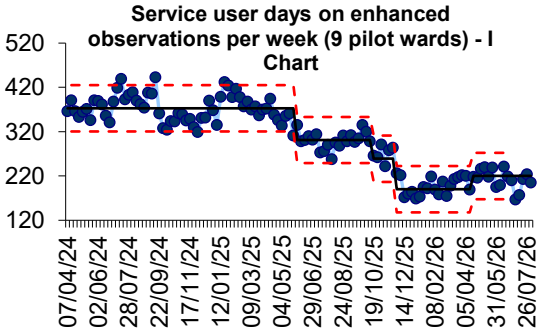
PHASE 3 · EMBEDDED

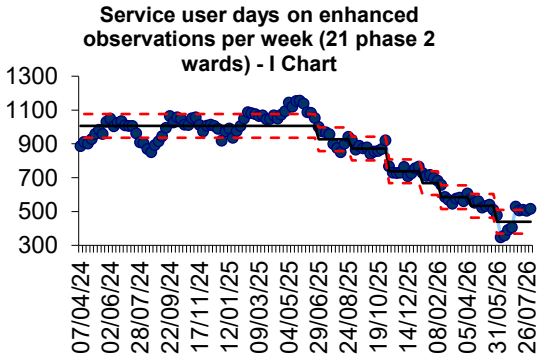
20 wards

Sep - Mar

Remaining wards join programme; Quality Control put into place

Delivered via the Improvement Leaders' Programme.





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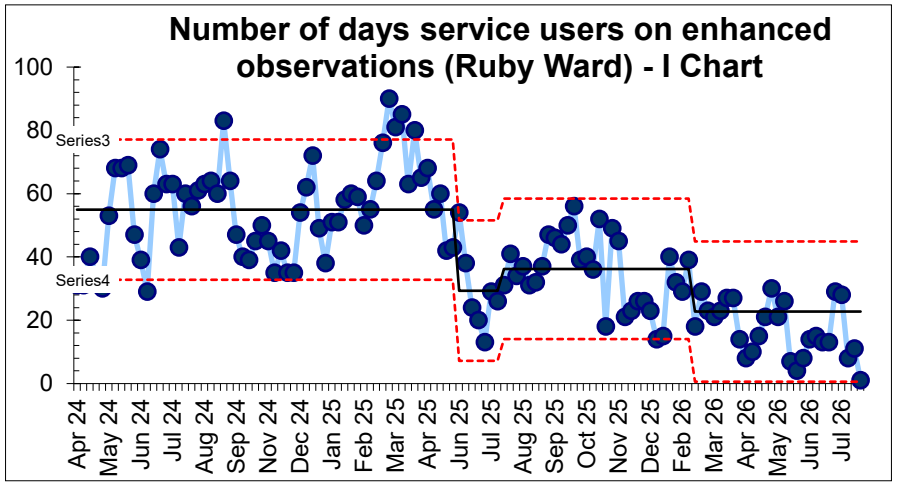
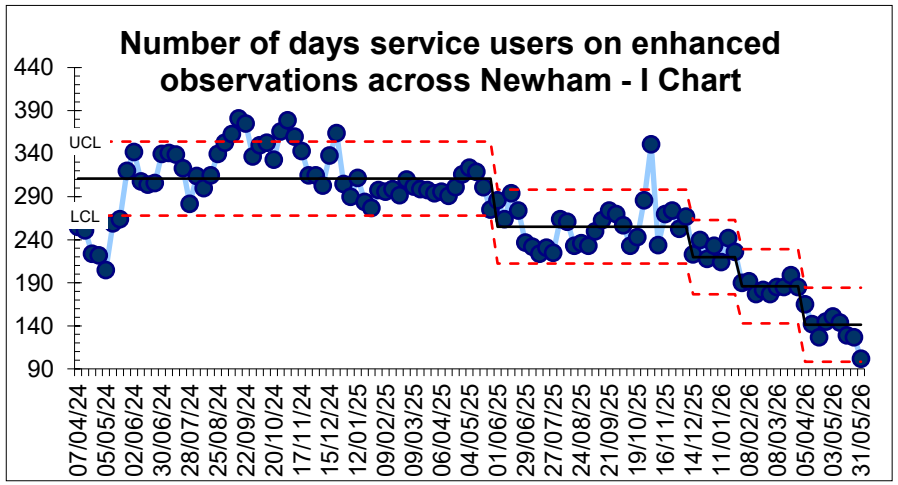
Spreading the CARE that counts bundle across Newham

Developing Scalable Unit
Ruby Ward (pilot phase)

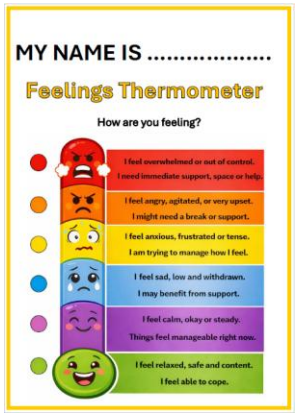


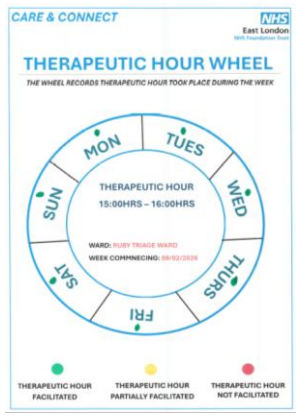
58% reduction

Going to full scale across all wards in Newham
(spreading what worked from Ruby)



54% reduction





- Weekly project meetings
- PET & zonal observations
- Challenges & wins

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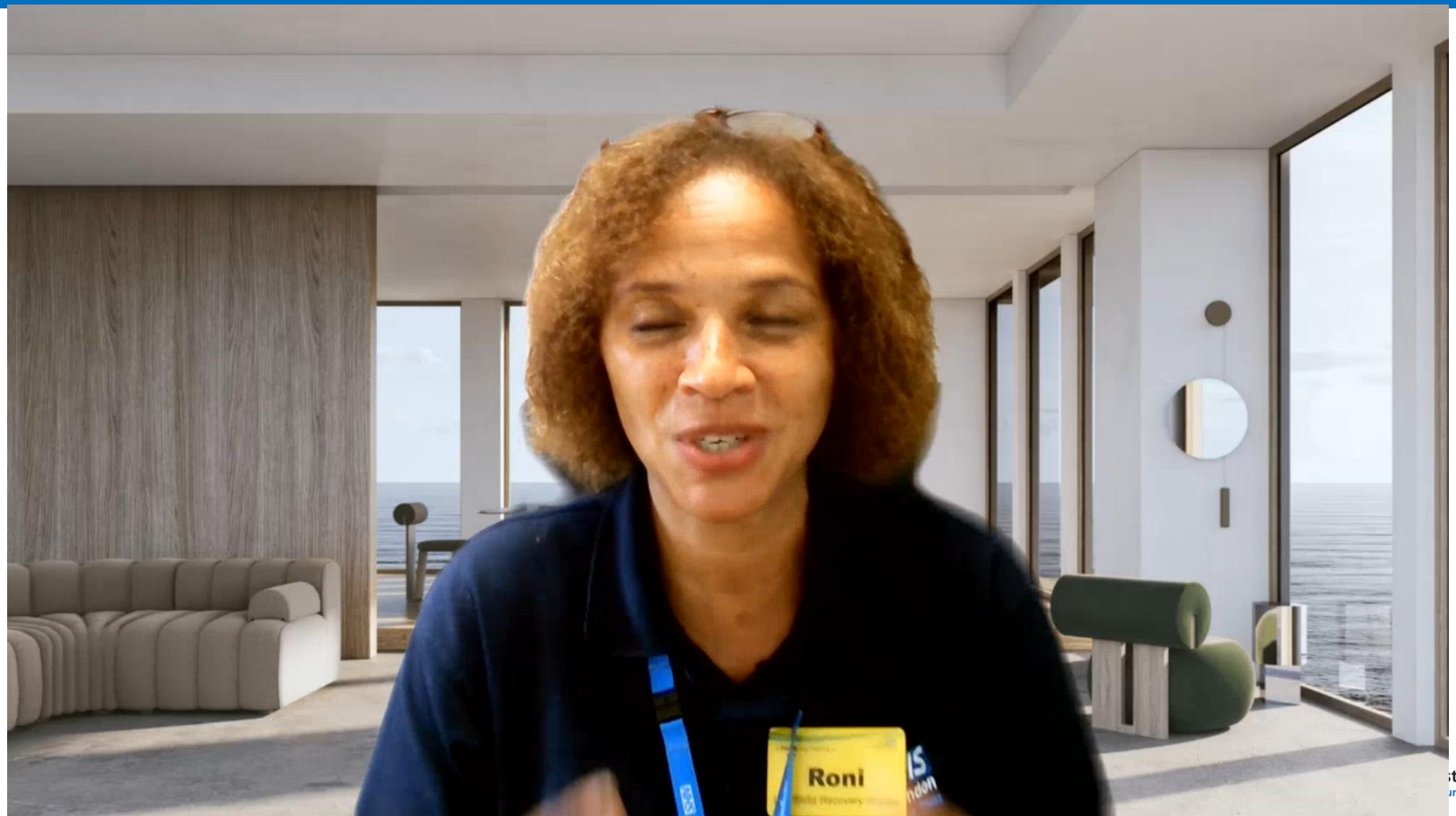
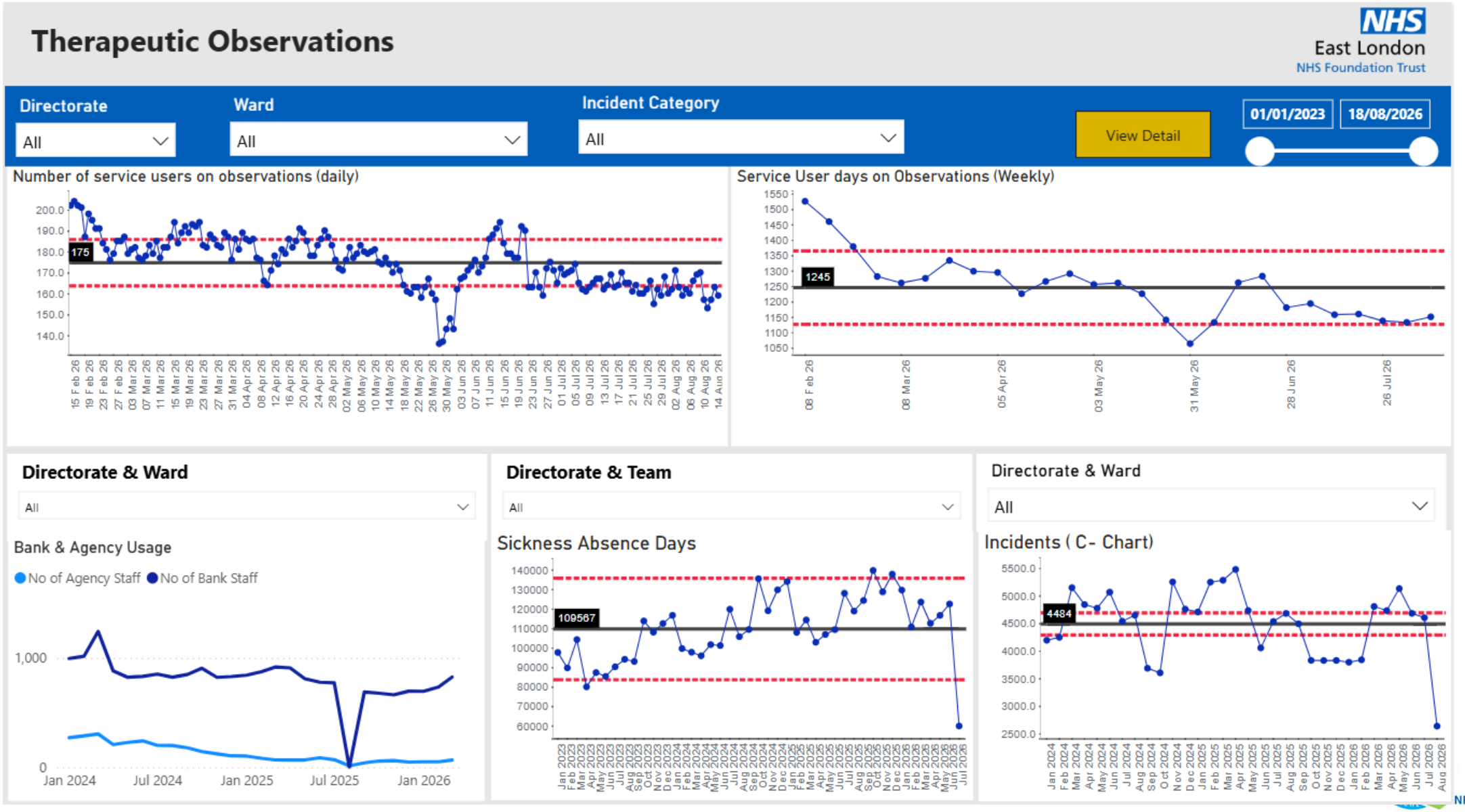
Welcome Video



Programme Governance Structures

	Executive space (6 weekly)	Senior Sponsors space (fortnightly)	Professional leads spaces (medic, nursing, AHP) (monthly)	Local directorate space (weekly)	LSP QI team space (weekly)
SPACES					
MEMBERSHIP & ACCOUNTABILITY	Membership: Chief Nurse, Chief Medic, Senior Sponsors, Head of Improvement Programmes (HOIP)	Membership: DoNs, Professional leads (psychology, AHPs, medics), Service User experts, HOIP	Membership: Professional leads, HOIP, DoN & BLNs	Membership: Sponsor of the work, IAs & participating teams	Membership: ADs, HOIP, SIAs, IAs
ROLES & PURPOSE	Updates and troubleshooting and messaging	Updates, data, troubleshooting and messaging	HOIP & DON & professional leads to give updates, troubleshoot and expectations. BLNs, medics & AHPs to feedback progress/support needs	Local teams to give updates on progress & troubleshooting at local level. Review local level data.	Impact and tracker updates. Troubleshoot as a QI team group.
PROVIDE FEEDBACK/UPDATES TO	1) Weekly LSP meeting 2) BLN / professional leads meetings	1) Weekly LSP meeting 2) BLN / professional leads meetings	1) Managers & matrons meeting 2) Dedicated observation space	IAs give updates at LSP huddle	QI department meeting SLT meeting, and emails to the team
ESCALATION		Critical/urgent to CMO	To Director of Nursing / other senior sponsor professional leads	To IAs who will escalate to HOIP	Raise content queries to ADs and critical/urgent to CMO

Data dashboards & regular monitoring



The CARE that counts bundle

Confidence building • Anticipating needs • Relationships & engagement • Every individual

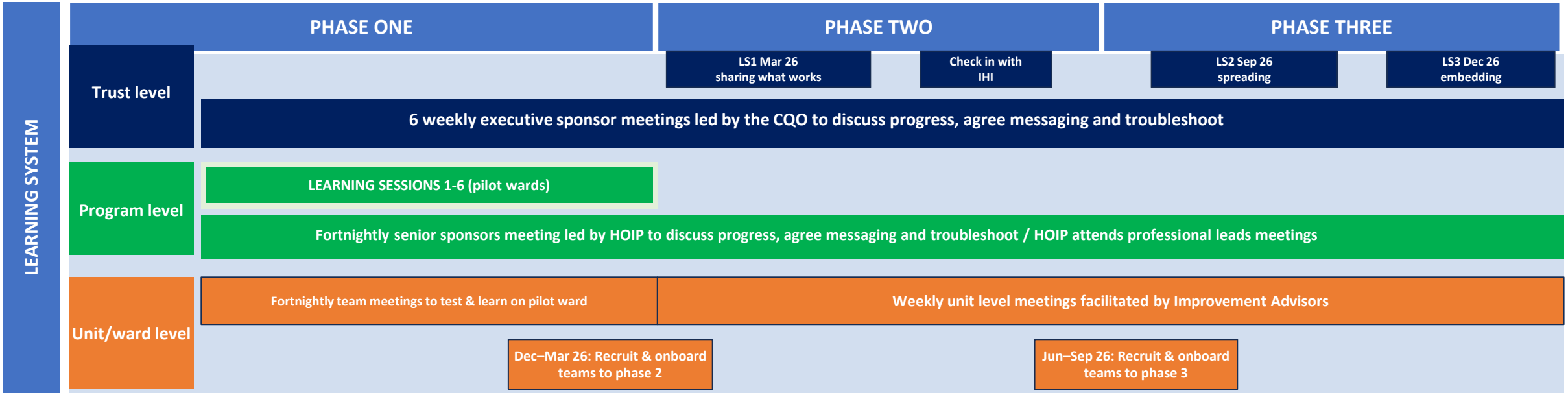
AIM

To introduce alternative approaches to care that **actively engage staff, service users & carers** in order to safely eliminate the use of **unnecessary intermittent observations** on a further 21 inpatient wards **by September 2026**, by scaling Phase 1 change concepts across diverse clinical settings

CHANGE CONCEPTS	MUST DO ELEMENTS	EXAMPLES OF LOCAL TAILORING	CULTURE OF CARE COMMITMENTS
Confidence building	Formal skills development Space for reflection Permission to make decisions	Reflective Practice Psychology Led Engagement Training **Art of Conversation Training** **Dialog+ training**	Staff support, transparency, safety, equality
Anticipating needs	Collaborative review Standardised information sharing Active risk assessment	**Reviewing Obs in Safety Huddle** Triage Template Feelings Thermometer Falls corridor zonal obs Early intervention record	Needs led, avoiding them, safety, environment, things to do on the ward
Relationships & engagement	Planned meaningful activities Spontaneous availability	**Protected Engagement Time** Planned Weekend Groups Activity Boxes run by volunteers Social Tea Floor nurse Zonal observations	Relationships, therapeutic support, lived experience, choice, things to do on the ward
Every individual	Tailored approaches to specialised groups Responsive care	**Dialog+ training & care plans** Pharmacy-led medication review Observation audit checklist Environmental adaptations e.g., sensory rooms	Needs led, choice, equality, transparency, environment

Supporting structures: Leadership across all levels, MDT working, permission from leadership, safety bundle, observations 1.0, policy change

The Learning System



FACES FROM THE LEARNING SESSIONS

Opening a learning session

Sharing progress across teams

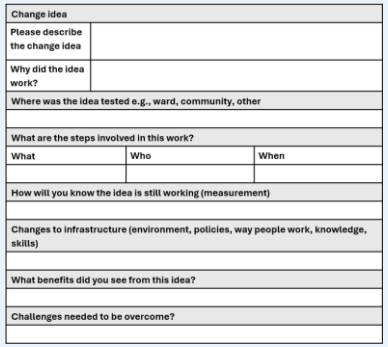
Reviewing the observation data

Ward teams presenting change ideas

Quality Control

Locally

- SOPs completed and saved locally



Change idea			
Please describe the change idea			
Why did the idea work?			
Where was the idea tested e.g., ward, community, other			
What are the steps involved in this work?			
What	Who	When	
How will you know the idea is still working (measurement)			
Changes to infrastructure (environment, policies, way people work, knowledge, skills)			
What benefits did you see from this idea?			
Challenges needed to be overcome?			

Three questions answered:

1. Where will observation & engagement practice be reviewed?
2. What needs monitoring to keep progress on track?
3. If practice slips, who escalates and to where?

Trust wide

- Same three questions
- Updated policy with CARE that counts bundle
- Updated policy with quality control processes
- CARE that counts bundle included in trust wide therapeutic engagement training

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Importance of Co-Production in QI – the Big I

Coproduction in QI refers to the **collaborative and equal partnership** between **professionals and those with living experience**

NHS England 2022 emphasises that coproduction is not merely consultation and that it involves equal power sharing from the inception to the evaluation of services and is foundational in Quality Improvement

Coproduction:

- Empowers patients, carers, and staff
- Improves experience, outcomes, trust, and sustainability
- Requires structural, cultural, and organisational support

How & why you did the role?

- Lived experience as a service user -How it has shaped my recovery
- Role as a peer tutor and the importance of CHIME
- Network Support to promote continued professional development

What has your role been in the programme

- Attending fortnightly meetings With updates from MDTs
- Co design, co production of & delivery" The Art of Conversation" workshops across directorates
- Co production on survey for QI project
- Data collation from pilot wards

Two key takeaways to help others involve service users at senior sponsor level

- QI and SU experience is essential for the future changes within our services.
- We care, We respect , We are inclusive

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What are our service users telling us?

Meaningful activities & engagement

SUs want activities that are more varied, purposeful and genuinely facilitated by staff rather than just “available”.

“I am very satisfied and enjoy the activities especially dancing and music.”

More access to clinicians

SUs want more meaningful 1:1 contact with doctors and psychologists — not just general ward support.

“I would like more opportunity to speak with my doctor regularly, the same as I am able to speak to staff on the ward.”

Feeling safe

Safety comments focus less on the physical environment and more on ward atmosphere, staff visibility and timely intervention.

“I would like to be reassured when first coming onto the ward that it is a safe place to be. It can be a very scary experience and can be traumatising.”

Over to you in breakouts!

5 mins

Thinking about your own service's improvement efforts, where is the service user voice already built into decisions, and where is it missing?

Pick one realistic gap you think is worth closing...

Stretch Break

5 mins

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CASE STUDY TWO

Pursuing Equity Programme

Reducing missed appointments for people in our most deprived neighbourhoods — and closing the gap in access to care.

16

teams across community health, mental health and specialist services

May 2024 – Aug 2025

programme timeframe, using the Model for Improvement and Sequence of Improvement

AIM

To reduce missed face-to-face appointments from 19.5% to 10% and close the gap between missed appointments in our most vs. least deprived neighbourhoods.

PROGRAMME DESIGN

APPROACH · LEARNING

16 teams

learning together, supported by Improvement Advisors & QI coaches

Developed a change ideas menu of ideas the literature said work to reduce missed appointments.

APPROACH · TESTING

25 ideas

tested locally using the Model for Improvement & PDSA cycles, tailored to each team's own context

Scale & spread were not designed into this programme from the start.

CONCEPTS THAT WORKED ACROSS ALL TEAMS

Scheduling with service users

Book the next appointment before they leave or call to arrange it together.

One clear DNA policy

Agreed, circulated and trained across the team, so appointments are recorded consistently.

Appointment reminders

Automated text reminders, plus a personalised text from staff at the point of booking.

RESULTS

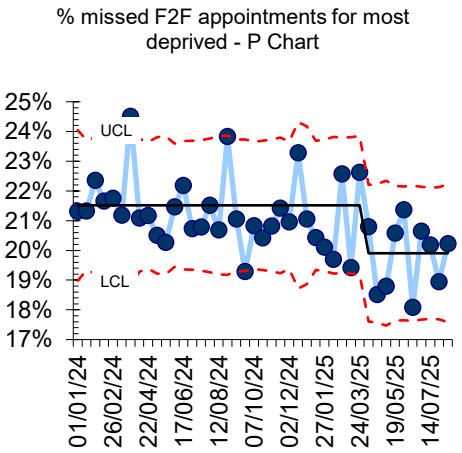
OUTCOME · EQUITY

2,046

additional appointments attended as a result of the programme

Equity Gap: 0%

the equity gap between most and least deprived is now closed



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Reaching out to our communities

Poverty Proofing Toolkit

- Identifies and helps overcome barriers to accessing services caused by having less financial resource.
- Developed with Children North East, who work with NHS Trusts, schools and cultural organisations.
- Covers transport, communications, patient empowerment, staff awareness, navigating the system, and an “Ask, Listen, Act, Advocate” framework.

Homeless Sex Workers — Primary Care

- A primary care team noticed homeless service users kept missing cervical screening appointments.
- By reaching out to the homeless community, they found the barrier: no way to shower or freshen up before the appointment, having come straight from work.
- A simple change to facilities addressed a barrier the data alone wouldn't have shown.

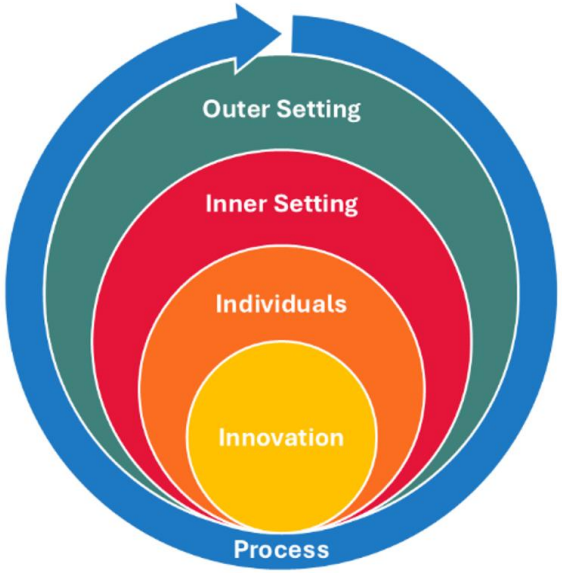
Eating Disorder Service — Tower Hamlets

- Outreach to the East London Mosque, sixth forms and universities largely stalled - schools cited a lack of capacity, and a planned mosque visit was cancelled with no clear route to reschedule.
- When community outreach stalled, the team pivoted to interviewing current and former service users directly to understand the barriers to access.

Evaluating the programme

HOW WE GATHERED THE EVIDENCE

- Semi-structured interviews with 7 of our 16 programme teams, 20–30 minutes each, via Teams
- Guided by the Consolidated Framework for Implementation Research (CFIR) shown in diagram below
- Analysed using reflexive thematic analysis, then mapped to CFIR domains



Findings mapped mainly to Individuals, Inner Setting, Innovation and the Implementation Process.

WHAT TEAMS SAID SUPPORTED IMPLEMENTATION OF THE WORK

INDIVIDUALS

"Really passionate" — "the dedication of staff and the drive to make things better."

Motivated staff who believed missed appointments mattered kept testing, even under competing clinical pressures.

INNER SETTING

"A good mix of people in the project group" that "made things a lot easier."

Diverse project teams with clear roles kept momentum, even where wider-team communication was patchy.

INNOVATION

"Not having to reinvent the wheel" — peer learning was "really helpful."

Ready-made change ideas, a driver diagram and QI coaching made the work feel practical and achievable.

IMPLEMENTATION PROCESS

"We would not be anywhere without our QI coach … we needed a lot of structure."

Peer learning, coaching and regular programme structures supported testing, reflection and spread.

Over to you in breakouts!

15 mins

In small groups, discuss the following as applied to your own organisations:

- Identify key barriers & enablers to delivering successful large-scale change
- How can you apply what you've learnt about ELFT's approach to your own settings?
- Share two things you've heard today that you'll take back to your organisations and why

Panel conversation

Bringing together different perspectives on delivering change at scale

Improvement Advisor

Perspective on supporting the work

Clinician

Perspective on leading and delivering the work

Service user

Recipient perspective

Programme leadership

Perspective on programme design and delivery

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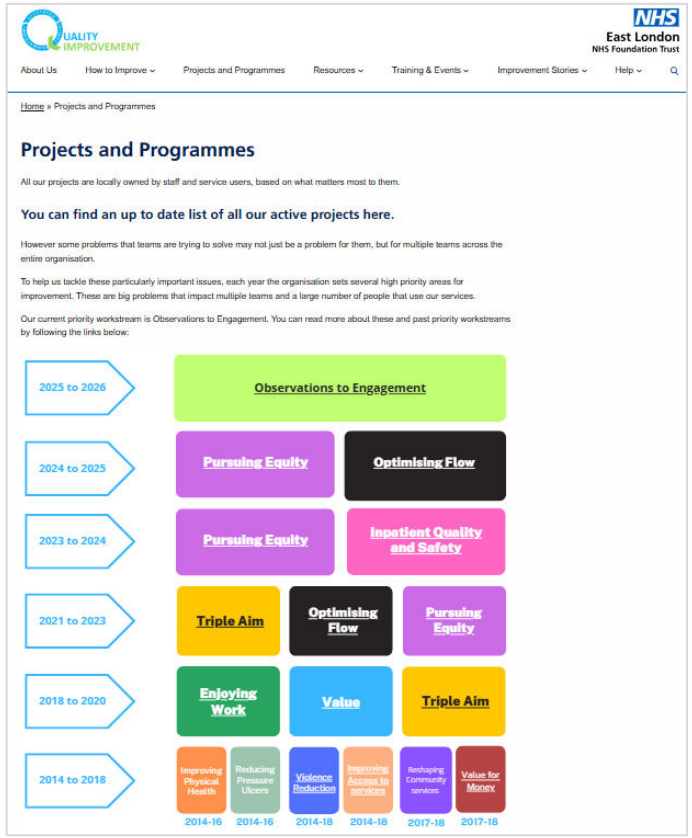
Close & key contacts



Microsite for more info about all our programmes, change packages and other resources:

https://qi.elft.nhs.uk/projects-and-programmes

For more information and questions, contact:

elft.qi@nhs.net

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