QI in City and Hackney

Practical Guidance for Staff

By City & Hackney QI Forum &
Jen Taylor-Watt, Improvement Advisor to City & Hackney, IAPT & lead on Violence Reduction

1st Edition - October 2017

Introduction by Dr David Bridle, Clinical Director & Lead for QI in City & Hackney, on behalf of the Directorate Management Team

The Directorate Management Team and I have the pleasure to frequently witness examples of what an amazing group of dedicated, caring staff work in City and Hackney - a group of people who we know come to work seeking to ensure our service users get the high quality care they deserve. However, as essential as this passion is, it is only part of the pre-requisite for achieving that goal - and it needs mechanisms to ensure all our efforts are co-ordinated and focused as effectively as possible.

Quality Improvement (QI) offers an effective, systematic approach to harness that passion and to support everyone in the directorate to make even more of a difference together. It moves us away from relying on the assumption that an idea or direction from a senior manager will be the right solution to improve or solve everything, as well intentioned as that may be. Instead it allows us all to work together to find meaningful solutions to the big challenges, and it channels the great motivation of everyone who gets involved, regardless of their role. Critically it also ensures that service users and carers' insights and views are harnessed as part of the process – which is aligned with our desire for increased co-production of services locally.

Consequently, as a directorate, we have embraced the QI approach in City & Hackney. We see it as an important part of our overall approach.

This guide is intended to help answer any queries you may have about how we are using QI here in City & Hackney. In keeping with QI, we are always open to developing our structure and set up, therefore this guide will be updated on an annual basis to reflect our learning and any changes to how we use QI.

Many, many people have played important roles in enabling the use of QI in Hackney, but I am only going to highlight and commend one person in particular: Jen Taylor-Watt has provided incredible initiative and support through her role as the Improvement Advisor to City & Hackney locally, including putting this guidance document together on our behalf.

We hope that the guide will be of help to anyone with questions about QI and how it operates in City and Hackney – for those completely new to QI through to those who are already well involved and only seeking clarity on a specific query.

Contents

1. Introduction

Purpose of this guide

This guide is designed to give a short introduction to how QI works within City and Hackney Adult Mental Health, particularly to support new project leads, coaches and sponsors, but also other staff with an interest in QI. It aims to answer the key questions that people who are new to QI are likely to have, particularly those which are specific to City and Hackney.

There are many other more general sources of information about QI at ELFT, which provide more detail; notably the QI Microsite (www.qi.elft.nhs.uk). Training courses, such as the Improvement Leaders Programme, incorporating the IHI's Improvement Science in Action, and Pocket QI also particularly focus on helping staff to understand how to use QI methodology (see section 3).

Whilst we have included some short guidance around key methodology in QI projects in section 4, these are brief pointers, and should be read alongside participating in training courses.

If you have any further questions, talk to your project's coach and/or sponsor, or the C&H Improvement Advisor.

This guidance will be reviewed annually. Please let us know if you think of other things to include/clarify by emailing Maryam Hussain, Quality & Clinical Governance Coordinator[1], Jen Taylor-Watt, Improvement Advisor to City & Hackney, Jen.Taylor-Watt@nhs.net (up until 1st December 2017) and/or Kelly Gale, Interim Improvement Advisor to City & Hackney (from 4th December 2017)

[1] Please note, email addresses are generally not noted in this guide because the Trust will soon be transitioning to NHS.net. Please therefore search for people on the Outlook system.

Summary of achievements

QI has achieved a lot in City and Hackney over the past 3 years. Thank you to all our teams who have put their energy and effort in to using the methodology and achieve the following results!

- **Average waiting times to 1st appointment have halved across Hackney services accessed via CHAMHRAS, from 36 days to 18.5 days and the percentage of people referred by GPs seen within 28 days has increased from 44% to 93%. This has been achieved during a period in which referrals have increased from an average of 187.5 per month to 480 per month (256%).**
- **% DNAs of referrals managed through CHAMHRAS have reduced from an average of 46.2% to 29.9%, with work in this area continuing.**
- **The % DNAs at Psychology Appointments in Assertive Outreach Team and the Community Rehab and Recovery Team reduced from 15% to almost 0.**
- **The Chronic Fatigue Service reduced DNAs by 63% (from 8.8% to 3.3%) and cancellations by 43% (from 16% to 9%).**
- **The time SpRs are taking to complete weekend management rounds has reduced by 50% from 89 minutes by patient seen to 45 minutes per patient seen.**
- **The Home Treatment Team has reduced the number of days from discharge to discharge notification being sent to the GP from 18 days to 4.65 days.**
- **There has been a 53% reduction in time taken to process clozapine serum levels (down from 17 days to 8 days).**
- **There was a 12.5% increase in number of patients taking clozapine in the former Assertive Outreach Service (AOS) and a 25% reduction in patients on high dose antipsychotic therapy and polypharmacy.**
- **There was also a 50% increase in physical health monitoring for weight, BP and blood tests monitoring in AOS.**
- **There has been an 64% improvement in evidence of recovery focused care planning in South CMHT, amongst a first test group of 4 care coordinators**
- **The Women's Health Questionnaire is now offered to all patients on Conolly and Gardner Ward within 7 days of admission.**
- **The number of people feeling they are having a positive experience of care on Gardner Ward has increased from 52% to 65%. This has included improvement in more people feeling safe, feeling they have enough information, feeling independent on the ward and feeling that the ward supports their recovery.**
- **Violence has reduced by 40% across the unit and upwards of 60% on the acute wards, using Datix data. Gardner Ward and Joshua Ward in City and Hackney have sustained 65-75% reductions in violence for 6-9 months. Bevan PICU has now seen a reduction of 39%.**

All of the above have been achieved through QI projects, led by City and Hackney teams and supported by our sponsors, coaches and our Improvement Advisor from the central QI Team.

What is QI?

Quality Improvement (QI) is a set of tools and techniques that help us understand the systems we work in and strengthen the way we work, in order to deliver improvement in outcomes.

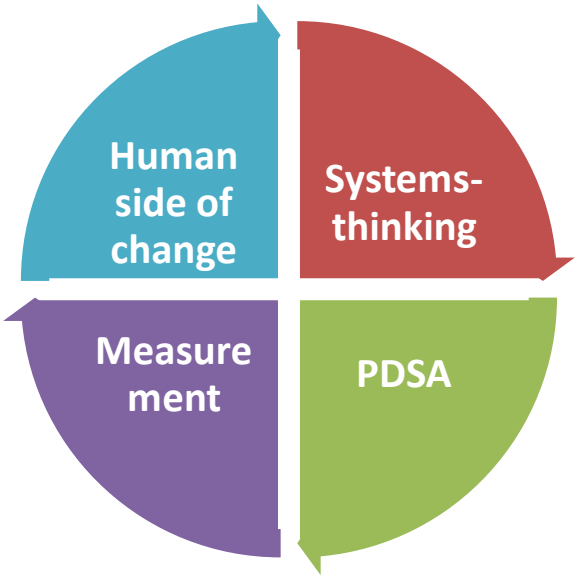
It involves 4 key dimensions, as shown in the diagram on the next page, which connect with each other:

1. Understanding that the services we work in are interconnected and complicated systems,

2. Using quick testing and learning in order to develop our understanding of what might help to improve the system (Plan, Do, Study, Act - or PDSA - cycles)

3. Having a robust system of measurement, using data over time, in order to know whether you are seeing improvement, and

4. Understanding and working with the human side of change



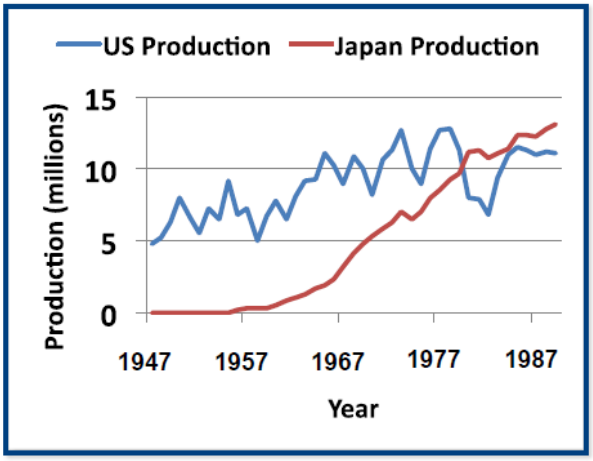
Quality improvement (QI) goes beyond traditional management, target setting and policy making. It utilises the subject matter expertise of people closest to the issue – staff and service users/carers – to identify potential solutions and test them.

Where does QI come from?

Surprisingly enough, QI stems originally from the work of a number of statisticians and engineers working within the manufacturing industries in the USA in the mid 20th century; Walter Shewhart, Joseph Duran & W Edwards Deming. They worked for companies like Western Electric and Bell Laboratories, helping to improve the quality and efficiency of these companies, through developing all 4 elements of QI methodology described above.

In the 60s and 70s, both Duran and Deming worked for a time in Japan and shared the approaches they had developed, notably within the Japanese car manufacturing industry. This input, which was further developed by companies like Toyota (who developed the ethos and ideas of “Lean”, which fit under the QI umbrella), is a major reason why the Japanese car manufacturing industry became so competitive within the latter half of the 20th century; out-performing by a long way, their major

competitors in the US, who had not been influenced by Deming & Juran (see charts below – these trends have continued since this data, reported in *The Machine that Changed the World*).



Selected Metrics for US & Japan Automobile Manufacturers		
Product Development (mid 1980s)		
	Japanese Producers	American Producers
Avg. Engineering Hrs per New Car (millions)	1.7	3.1
Avg. Development Time per New Car (months)	46.2	60.4
Employees in Project Team	485	903
Supplier Share of Engineering	51%	14%
Ratio of Delayed Projects	1 in 6	1 in 2

The Lean Academy: Massachusetts Institute of Technology

Despite this long history, QI is a relatively new thing within healthcare. It wasn't until the late 1980s and early 1990s that Don Berwick, a US paediatrician, and other colleagues, came across the ideas and started to bring these approaches into healthcare. Berwick set up the Institute for Healthcare Improvement (IHI) in the US in 1991, which now supports improvement programmes across the world.

Since then, organisations the world over have led transformative quality improvement programmes, delivering incredible outcomes (see box 1).

In terms of the UK, whilst both Scotland and Wales have nationwide Quality Improvement programmes, the NHS in England has been slower off the mark and ELFT is considered to be at the forefront of QI in England, particularly in the field of mental health[2].

ELFT is now one of 13 strategic partners of the IHI globally.

[2] Quality Improvement in Mental Health, King's Fund, July, 2017
Building the Foundations for Improvement, Health Foundation, 2015

Box 1: Impact of Quality Improvement programmes elsewhere in the world

Virginia Mason, based in Seattle, provides integrated health services to the people of the Pacific North-West of the USA. In 2002, the organisation embarked on an ambitious, system-wide program to change the way it delivers health care and, in the process, improve patient safety and quality. Using Lean principles, Virginia Mason has achieved improvements, including increasing nurse bedside time from 35% to 78% and reduced ventilator acquired pneumonia form 34 cases per year to 2.

From 2008 – 2010 NHS health boards and trusts across Wales joined the 1000 Lives Campaign, a two-year improvement initiative adapted from a successful American campaign run by the Institute for Healthcare Improvement (IHI). The 1000 Lives Campaign sought to save 1000 lives and prevent 50,000 episodes of harm in NHS Wales. Data analysed in 2010 showed it reached these goals.

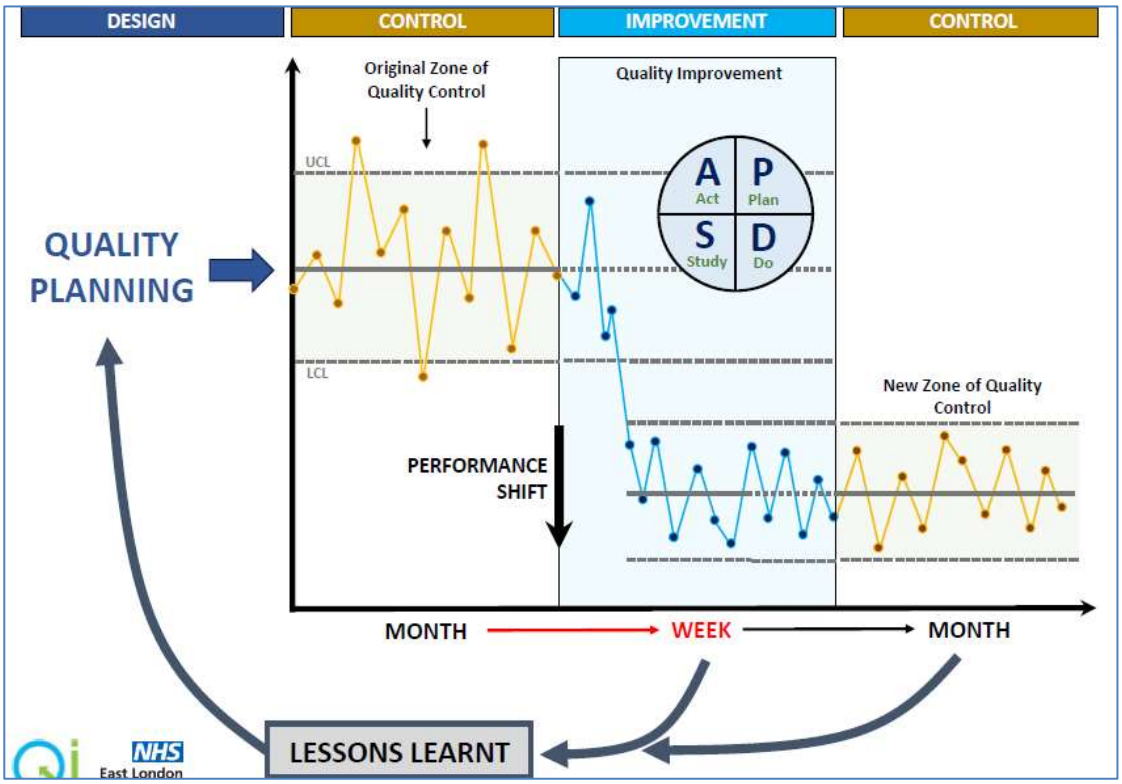
The Henry Ford Health System provides care to the people of Detroit and from 2001, began focusing on reducing suicides. The rate of suicide in Henry Ford's patient population decreased by 75 percent; from 89 per 100,000 patients to 22 per 100,000 in the first four years of the program's implementation. This is significantly lower than the annual rates for suicides in similar patient populations. In 2009 there were no suicides at all within Henry Ford Health System.

The Scottish Patient Safety Programme is a nationwide programme that aims to improve the safety and reliability of healthcare and reduce harm. From an initial focus on acute hospitals, the work has now extended to 6 areas including Mental Health and Primary Care. Achievements include a 21% reduction in 30-day mortality sepsis, a reduction of 19% in cardiac arrest rate across 11 hospitals, and, in the mental health programme, reductions in the use of restraint.

How does QI fit in to our broader leadership of Quality?

QI is just one part of our overall management and improvement of quality of care, experience and outcomes at ELFT. It fits with, and works alongside, the other key parts of quality leadership and management: quality planning, quality assurance and quality control.

In a nutshell, these elements work together as follows:



Firstly, we think about our strategic challenges and priorities for managing quality, as part of **quality planning** and we keep an eye on these areas through **quality assurance** systems like KPIs[3], PREMs[4], PROMs[5] and audit.

If we identify an area that needs improvement, we will need to think about the nature and complexity of the problem. If we think it is a really straightforward issue, it might just need to be managed through traditional structures; for example quick discussion with the team to agree how to resolve, or perhaps a simple action plan. If the issue relates to individual members of staff, then it will likely need to be managed through line-management structures.

Sometimes though, we hit on areas for improvement in healthcare that are more complicated and this is where **Quality Improvement** becomes really useful – in fact, we would argue it is critical to us being able resolve these problems.

For example, we've recently been working on reducing violence on the inpatient wards in City & Hackney (further detail is described in box 2). This was not something that a quick discussion or an action plan was going to resolve. Instead staff involved needed space and time to really understand

[3] Key Performance Indicators
[4] Patient Reported Experience Measures; e.g. Friends and Family Test
[5] Patient Reported Outcome Measures; e.g. DIALOG

what factors in our system lead people to be violent, and to test theories and ideas for what could help to address these factors.

If you use QI, you will measure your progress and once you have achieved improvement, you will have established a new level of performance. It is then really important that you ensure you hold the gains for the long term through what we call implementation planning (see section 5) and **Quality Control**.

Quality Control involves monitoring your data on a regular – and if possible and feasible, continuous – basis to identify if performance goes out of control, so you can then respond and take action. The connection between these areas of improvement is illustrated in the below diagram.

Box 2: City & Hackney Violence Reduction Collaborative

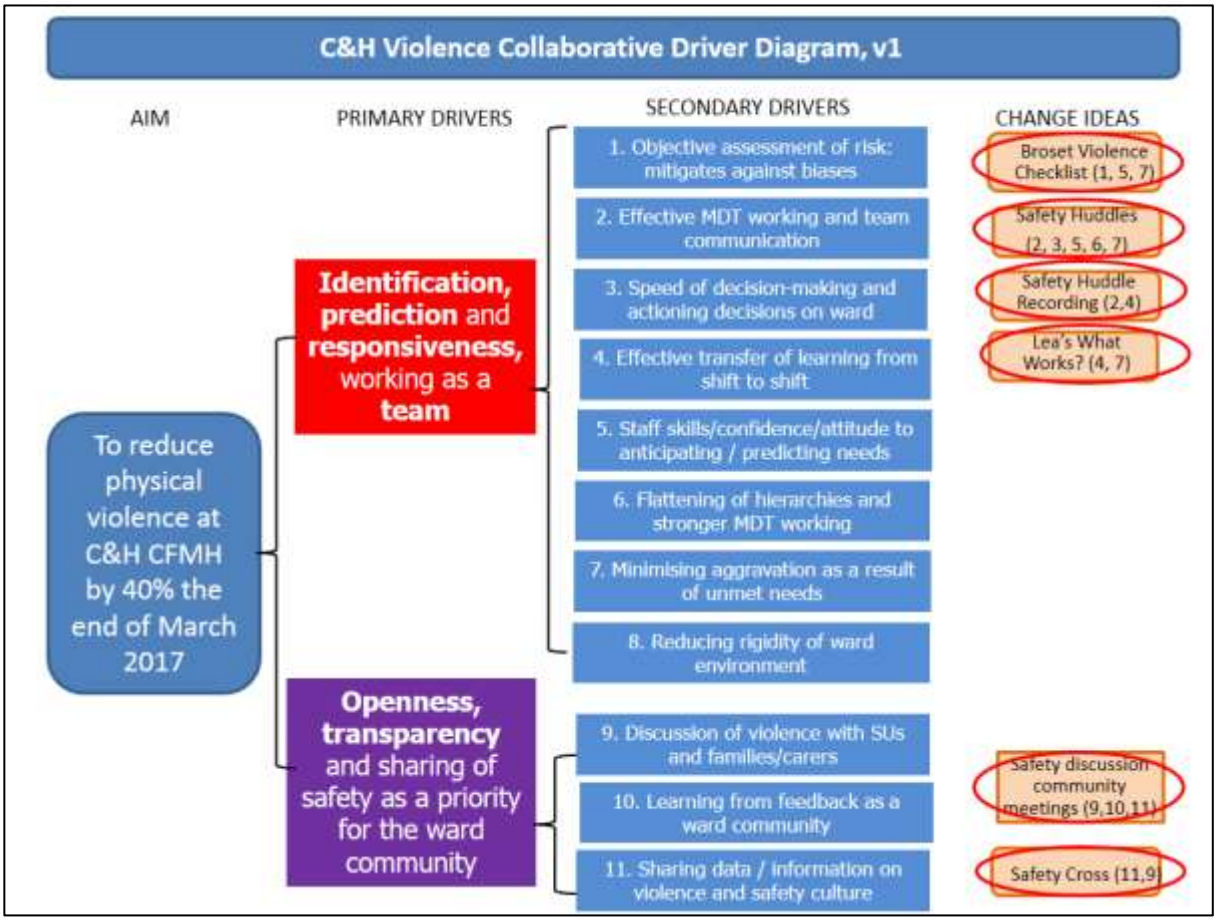
Unfortunately it is the case that in mental health inpatient units around the world staff, service users and families have become accustomed to violence and aggression being part of their experience of these settings. There is a common culture, whereby violence and aggression is expected. Early in their careers, staff receive the message that being verbally abused and assaulted is something they are going to have to put up with in their work because it's 'just the result of service users' mental health problems.' Likewise, service users are given a similar message when they witness incidents during admissions.

This situation has come to be for a range of different reasons; an important one being that services and staff haven't known what they could do to address it and make things different. We have not been able to find any evidence in the literature of interventions which have been proven to enable a sustained reduction in violence and aggression on inpatient wards.

From 2012, wards in Tower Hamlets began to work on this issue and achieved huge reductions in violence and aggression through developing a set of innovative change ideas. City and Hackney committed to joining this work in late 2015 and we launched the City and Hackney Violence Reduction Collaborative in February 2016. Staff from across the unit have met every 6 weeks as part of the Collaborative learning sets to progress the work and work through barriers and challenges together. Individual teams have also met with the City & Hackney Improvement Advisor every 2 weeks to focus on this on each ward.

As we've said, the starting point to working on this issue is to understand the drivers of reducing violence on wards and to develop tangible ideas for change to address these. These are set out in the driver diagram on the following page.

Violence and aggression fuels a toxic spiral; whereby factors feed off each other to make it more and more difficult for staff to provide high standards of care to service users. At the start of this work we talked to all teams at Away Days about their experience of violence and aggression and the impact it has. At the bottom of the next page is the feedback from one ward.



XXXXX Ward: Feelings / Experiences / Impact

- Scared
- Rejected
- Am I in the right job?
- Anger
- Let down
- Inadequate
- Anxious
- Divided
- Feeling am I the only one feeling this way?
- Feeling alone
- Why me?
- Not feeling supported
- Disappointed
- Gets to a point and you can't be bothered
- Low self-esteem
- Start questioning yourself >> what have a I done wrong?
- Feeling like I don't want to come to work
- Feeling low
- Feeling let down
- Sometimes encourages people to kick-off >> normal culture
- Affects staffing levels >> injury, sickness
- Reduced resources property damage)
- Reduced patient interaction time
- Service users feeling scared
- Wouldn't have faith in the service if I was a service user
- Would add to service users wanting to leave, but they can't
- Not therapeutic… aggravates things further
- Families feeling let down

Results

We are changing our system and are now sending the spiral in a different direction. No longer is it a toxic experience of deterioration, but instead these wards are on a journey of making things better and better.

- Violence has reduced by 40% across the unit and upwards of 60% on the acute wards, using Datix data.
- Gardner Ward and Joshua Ward in City and Hackney have sustained 65-75% reductions in violence for 6-9 months.
- Bevan PICU has now also seen a reduction of 39%
- There has also been a 54% reduction in use of restraint on Conolly Ward.

The huge impact on service users and staff, is evidenced by the following feedback:

Inpatient units are not closed systems, and can be really affected by things like increases in ward occupancy or a particularly difficult group of admissions (for example patients wards have never worked with before). The Collaborative is now working on its Quality Control strategy to strengthen the unit's resilience for the long term.

The City and Hackney (Christmas) Violence Reduction Collaborative

QI in projects

Quality Improvement in City & Hackney – and throughout ELFT more broadly – has largely been done through QI projects, whereby a team of people come together to work on a specific issue and then work through the key elements of the methodology (see further detail in section 4).

Running QI projects does take time and energy though, so it is important we ensure projects are focused on things for which the methodology is useful and needed, as described in this guide.

QI outside of projects

In addition to the above, City and Hackney DMT would like to encourage staff who have developed their knowledge in QI, to use what they've learnt and apply this to their day to day work to help improve things in our services.

If you haven't done any QI training, as yet, we'd encourage you to do so and develop your understanding of QI (see more detail on Training Options in section 3). Some examples of how QI methodology has helped in day to day work outside formal QI projects are:

- Using process mapping during a whole team meeting to understand a complicated process that a team suspected could be made much more efficient
- Using Nominal Group Technique (brainstorming with post-its) to get a team's thoughts on an issue within an away day; this is a powerful technique that ensures everyone has a voice (see detail in section 5).

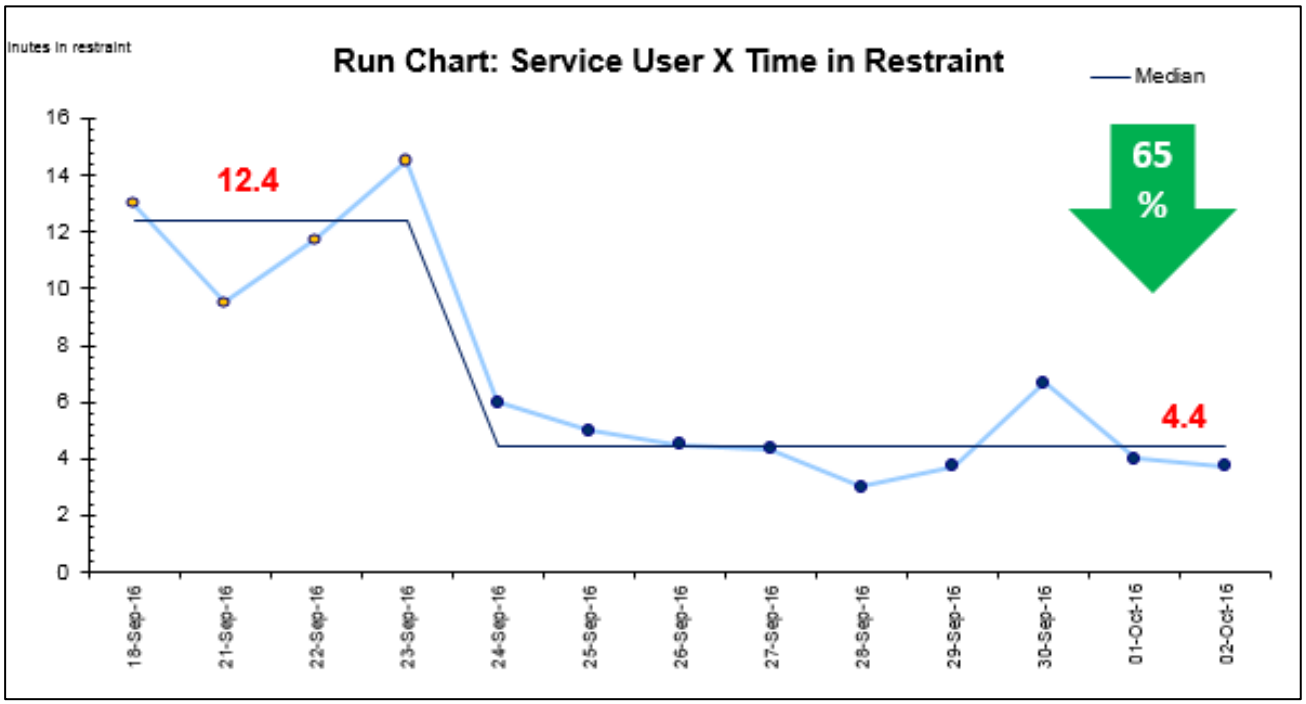
PDSA (see section 4) can be helpful to use in day to day work, as shown in the example in Box 3. The QI Team have QI booklets that you might find useful to jot down your PDSAs. Talk to our Improvement Advisor or your project team's coach to get one.

Box 3: Case Study: QI Outside of Projects – Using PDSA to minimise use of restraint in a person's care

Staff on Rosebank Ward, the female Psychiatric Intensive Care Unit (PICU) in Tower Hamlets found that they were having to use a lot of restraint with a service user and they wanted to ensure they were minimising this as much as possible. To support them to do this they used PDSA to learn about what was happening and a simple run chart on a piece of graph paper to chart their progress, which we then turned into the Run Chart below.

As you can see, they achieved a reduction in of 65% in restraint durations from 12.5 mins at admission to 4.5 mins within 4 days. Incidents were also maintained to one/day.

Some of the PDSAs that helped were increasing the number of huddles to plan together and keep staff updated on risks, having 1:1s with the patient, sending an email with key points on risk reduction communicated with all staff on same day of admission.



The rest of this guide is focused on QI in formal QI projects, but do remember that you don't always need a whole project to use elements of QI to help you achieve improvements.

2. How we lead QI in City and Hackney

City & Hackney Quality Improvement Priorities: July 2017 – June 2018

Each year, as part of their Quality Planning the City and Hackney Directorate Management Team lead a process via the City and Hackney QI Forum and DMT to set Quality Improvement priorities. Below is the list that has been set for July 2017 – June 2018.

Almost all formal QI projects in the directorate should fit under these priorities. If you have an idea for a project that does not fit, please speak with your manager/director before moving forwards with this idea (see section 3 for further guidance on Starting a new QI Project).

1. **Reducing inpatient violence and restrictive practices**
2. **Improving service user and carer experience of our services**
3. **Medicines: safety, appropriate use, value for money and information provision**
4. **Improving access & flow in our services**
5. **Shaping recovery in the community**
6. **Enjoying work**

The DMT will be speaking to teams over the coming year to review these priorities for 2018/19.

City and Hackney's priorities reflect all of the Trustwide priorities, which are:

Violence reduction

Value for money

Enjoying work

Shaping recovery in the community

Improving access and flow

The project team

The project team is the core of QI projects. It should involve about 4—6 people, who meet regularly to take forwards the project.

Frequency of meetings

As we've discussed above, QI involves using a specific methodology, which includes developing a deep understanding of your problem, developing theories and testing those theories through rapid learning cycles called PDSAs. It also involves continuous measurement to know if you're seeing improvement. You need to be getting together with a core group of people to be undertaking these activities. If you don't you won't be doing a QI project, but will just be making changes without testing.

On average QI project teams meet once every 2 weeks for an hour, however some teams they prefer to meet every week for 30-45 minutes or that they need longer sessions.

Project team membership and attendance at meetings

We recommend 4-6 people so you have enough to get multiple perspectives, but not too many to make the meetings hard to schedule and/or manage.

Sometimes it can obviously be hard for people to make regular meetings. For example, this can be really difficult on inpatient wards, where a lot of staff work shifts. Do your best, but don't feel too much pressure if some members can only make every 2nd or 3rd meeting. As long as they have a good basic knowledge of the project, you can catch them up so they can still participate.

You might find it works for you to have, say a group of 8 people involved in the project, although you expect 4-6 to come each time. Even if only 2 people can make it, think carefully before cancelling. Projects generally lose momentum if they aren't meeting regularly.

Project Leads should really try to prioritise QI team meetings. Although sometimes it's hard to feel it is a priority compared with operational pressures, projects will fall apart without consistent leadership and we will miss the chance to achieve the kind of major long term changes that are possible. If you're feeling constant pressure to prioritise other things, talk to your sponsor to help you. It can also be a good idea to think about naming a formal deputy from the project team to take on your responsibilities and run things if you can't be there. This continuity of leadership should not fall on the QI coach or Improvement Advisor, as they are a support function and do not have capacity to provide the core leadership of the project.

Who should make up a project team?

Project teams need to have representation from all the key groups that have a stake or role in the issue you are trying to improve. Most projects therefore need to ensure representation across the MDT. For example, in a Community Mental Health Team, that would likely include a Care Coordinator, an administrator, a doctor and perhaps a psychologist and/or an OT. Very importantly, in most cases project teams should also identify a service user and/or carer to join their project team (see further guidance in section 2 below).

Connecting with the broader team

QI projects, of course, impact the whole service involved, so it's really important that the work of the core project team remains connected with the whole team and doesn't become something that is done in isolation. It is important people feel involved and engaged in things that affect the work they do.

Quite soon, successful tests you've undertaken small-scale within the project team will need to be implemented and made business as usual across the whole team (see section 5). This is a lot easier if people feel sighted and involved in the work of the project at all stages.

To achieve this, discuss the project regularly at your whole team meetings to keep people updated and to get feedback on key questions. "Nominal Group Technique" using post-its and/or a simple voting system, are really easy ways to get the feedback from groups of people really quickly (e.g. on

which drivers feel the most important, which change ideas should we prioritise for testing, etc) (see further guidance in section 5).

We recommend having the QI project as a standing item on your whole team meeting agenda for this purpose – of course you will only be able to spare perhaps 10 minutes for this, but we have successfully got feedback from the QI Forum using post-its in under 5 minutes! Another reason to do this is that your project strategy (e.g. understanding of drivers, change ideas to start with, etc) is likely to be successful more quickly if you get a broader set of perspectives from people who have experience in the issue.

Some top tips on how to run effective project team meetings

Unfortunately we've all sat in meetings that have felt like a poor use of time, which go around and around in circles.

Here are some tops tips based on our first 3 years of QI projects meetings for how to get the most of your meetings and ensure they are as effective and efficient as possible, many of which will be obvious to you:

- **Schedule all meetings on a recurring basis** and send diary invites if people use Outlook diaries. Invite your QI coach and QI sponsor to these meetings. Your QI coach will attend most, particularly at the beginning. It's good for your sponsor to know when they are so they can drop in periodically.
- **Have an agenda**: Project leads should preferably think about and set an agenda in advance or, failing that, set it at the beginning of the meeting with the team.
  You may find it useful to have a standing agenda, to ensure the meetings are focused on the key elements of QI methodology that you should be working through together as a team: i.e.
  1. Understanding the problem, 2. Data, 3. PDSAs,
  4. Implementation/Quality Control.
- **Take actions**, agree and allocate these to members of the team and review these every meeting.
- **Do as much as you can within the meeting itself**: If you can possibly have access to a laptop or computer, type actions and PDSAs as you go and email them immediately, if you can, to team members (you can even type into an email if possible).
- **Be mindful of Service Users, Carers & Patient Liaison Workers** who attend meetings, ensuring they are well supported (see further information in section 2). Let them know with good notice if you have to cancel meetings, bearing in mind they may not have easy access to emails.

Roles, responsibilities and expectations

There are a number of different roles involved in QI, which play a key part in taking Quality Improvement work forwards.

Project Leads

The core of all QI projects is the project team and at the heart of the team is the Project Lead. Project Leads need to provide the energy and momentum to move QI projects forwards. This will involve committing to using QI methodology, with the help and support of QI coaches/Improvement Advisor (see further detail below), but also very importantly leading and organising the project team to move forwards. Any member of staff, service user or carer at ELFT can be project leads, as long as they possess the qualities and time to be able to lead the project and undertake the tasks and responsibilities as set out below. This will ultimately be decided by the QI Forum.

There is no getting away from the fact that this role will take some time. QI projects in C&H and across ELFT have achieved incredible things, but successful projects have always required this energy and commitment. We have also seen projects fail when this has been absent.

As noted above, in general, QI projects meet for an hour every 2 weeks, but sometimes more frequently and sometimes for longer. In addition to this, the project lead will be responsible for tasks associated with the project, such as those listed below, to ensure they get the most out of project team meetings and that they are as efficient as possible. This is not to suggest that the project lead has to do everything; but it is up to them to ensure things are clearly delegated across the team. Please also see the section on the previous page on top tips for running effective and efficient team meetings.

Project Leads: Responsibilities & Tasks

- Coordinate meetings: ensure all team members, coach and sponsor are invited[6], organise agenda (see above top tips), record actions, track actions between meetings
- Monitor progress of project and regularly update your sponsor on progress (at least monthly). You can do this verbally or by email
- Liaise with your sponsor and/or coach regarding challenges faced by the project team.
- Ensure the involvement of your customers (usually service users and/or carer) in the project and seek the support of the Patient Participation Lead for Hackney if needed to help with this (also see the section below)
- Ensure that the project team communicates and connects effectively with your broader service team, via broader team meetings, away days, noticeboards, etc.
- Encourage a participative and non-hierarchical dynamic within the team meeting, participating as a team member, contributing ideas and participating in the team processes and decisions.

[6] Coaches and Sponsors will not attend every meeting (Coaches will likely attend most meetings at the beginning), but it is helpful for them to have the meetings in their diaries so they know when they are happening, so they can attend when possible (see further information about Coach and Sponsor role below).

- Develop your knowledge in QI methodology and, with the support of your QI Coach/Improvement Advisor, do your best to apply this to the project
- Attend and share the progress of the project with the QI Forum when requested (see below)
- Become an active use of QI Life to manage the project and encourage team members to do the same.

QI Coaches

QI Coaches are people within our services, who have an enhanced level of training in coaching QI methodology and time allocated and agreed to support QI project teams. In City & Hackney the amount of time coaches have available is agreed with them individually and they are allocated a specific number of projects on this basis, based on the notion that they will attend most project team meetings and will spend up to an additional hour doing preparatory or follow-up work. Otherwise their time is spent in their standard role.

As a result, it is very important that coaches are not understood as the "do-ers" of QI projects. They are there to support project leads and teams with all elements of the methodology – and sometimes this will need them to actively undertake work for the project – but in most cases the tasks associated with the project will need to be undertaken by other members of the project team.

There is another important reason for this. We want the use of QI tools and methodology to be disseminated throughout City & Hackney, with all staff building confidence and skills. Coaches will therefore look to enable and develop project team members to use the tools themselves; coaching and teaching people to use them with their team, rather than doing it for them. They will often therefore recommend doing and leading things in partnership with the project lead/team; such as building a spreadsheet for capturing data or facilitating a process mapping session with the broader team to help develop others' skills.

QI Coaches also have a broader role beyond their project teams, supporting sponsors to lead QI more broadly in the directorate. They will therefore be expected to prioritise the monthly QI Forum. Specific tasks and responsibilities of QI Coaches are outlined below. The C&H Improvement Advisor (see below) provides support to the QI Coaches.

QI Coaches: Responsibilities & Tasks

- Helping to engage people and teams in QI
- Supporting both potential (pre-approved) and existing project teams to develop ideas and strategy, using QI tools and advising on how to complete project documentation
- Attending their allocated project team meetings as required (this frequency should be discussed with the project lead and will likely vary over the course of the project. New project teams generally require more support than well-established project teams, so coaches will likely attend almost all meetings in the beginning, but reduce the frequency and things progress and the project achieves results)

- Supporting project teams to use all elements of QI methodology, including the key areas of data over time, testing through PDSA, understanding the interconnectedness of our system, the human side of change, the implementation stage of QI projects and scale-up
- Develop skills and confidence in facilitation, teaching and explaining the use of QI tools and methods
- Attend the monthly QI Forum and monthly support session with the directorate Improvement Advisor
- Develop relationships with QI sponsors and contribute to the strategic leadership and development of QI in the directorate (for example via the QI Forum, annual IHI visit and other opportunities)
- Update the coaching progress notes on QI Life and liaising with the project sponsor if there are concerns about the project (there is an opportunity to do this within the QI Forum (see QI Forum Terms of Reference – Orange Flags below)

If you are a project lead and don't know who your coach is please contact the City & Hackney Improvement Advisor.

QI Sponsors

QI Sponsors are senior members of the Directorate Management Team, who are responsible and accountable for leading the QI Programme in City and Hackney. This includes both the progress of individual QI projects, but also strategic thinking and leadership around the broader programme (see further detail below).

Each QI project in City & Hackney has a QI Sponsor to which the project is accountable for progressing the work. Sponsors will have between 2-5 projects which they sponsor and in almost all cases these will be aligned to their operational responsibilities.

If you are a project lead and don't know who your sponsor is please contact your Improvement Advisor.

The monthly QI Forum provides a core mechanism to enable sponsors to undertake this role, alongside other members of the DMT, who will also support this work. It is therefore expected that QI sponsors prioritise attending the Forum in their diaries.

The Improvement Advisor from the central team supports QI sponsors in all elements of their role. This is mainly via the QI Forum and monthly meetings with the lead Sponsor and directorate lead for the QI Programme in City and Hackney, Dr David Bridle, however sponsors also contact the Improvement Advisor directly for individual support and discussion.

Specific tasks and responsibilities of QI Sponsors are outlined below, split into their programme leadership role and their role in individual projects.

QI Sponsors: Responsibilities & Tasks – QI Programme Leadership

- Developing the Directorate's quality improvement priorities and engaging in dialogue with teams to align projects
- Allocation of resource and effort to the directorate's QI work
- Approval of new QI projects & determine when projects should be closed (via the QI Forum)
- Thinking and leadership around scale-up of QI work
- Identifying and recruiting appropriate people for different levels of QI training & identification of new QI coaches
- Troubleshooting, strategizing and taking action around general issues/restraining forces within the QI programme
- Ensuring we celebrate, share and learn from successful projects
- Scan the monthly reports on progress of QI projects in C&H
- Prioritise attending the monthly Qi Forum in the directorate

QI Sponsors: Responsibilities & Tasks – Role in QI Projects

- Provide support and constructive challenge to the project lead around the formation of the project team and strategy (e.g. Is there a stable team, are all key stakeholders represented/engaged? Is there progress service user/carer involvement?)
- Provide support to address and blockers and issues in the project (particularly of a service nature, as opposed to use of QI methodology, which the Coach will help with)
- Provide supplementary leadership if required to get projects moving to the testing stage (although this should be largely provided by the project lead and should be flagged to the QI Forum if there isn't quick progress with this)
- Ensure they have a sense at all times about how their allocated projects are progressing, or seek updates from the Project Lead if this is the not the case.
- Review closely the progress notes on their projects, provided by the coach and liaise with coaches directly if needed

Clinical Director; Directorate Lead for the QI Programme in City and Hackney

The Clinical Director, Dr David Bridle is the overall lead and, in effect, the lead sponsor for the QI Programme in City and Hackney. He provides visible leadership to progress the QI programme, overseeing all programme leadership responsibilities & tasks of sponsors. He is also accountable to the central QI Programme Board, chaired by the Chief Executive, for the progress of the City & Hackney QI Programme.

Specific tasks and responsibilities of the Directorate Lead for the QI Programme in City and Hackney are as follows:

- Providing additional leadership and drive to deliver all programme sponsor leadership responsibilities and tasks, as set out on the previous page

- Ensure effective functioning of the structures and processes within the directorate to support QI
- Appoint QI sponsors and coaches and work with sponsors/ managers to ensure roles are embedded in job plans and appraisal objectives
- Understand the role of QI within the whole quality system and work towards a balance between Quality Assurance, Quality Improvement, Quality Control and Quality Planning
- Lead the DMT, QI Forum and other sponsors in planning capability building and talent development in relation to QI and deploy skills and capacity to QI efforts
- Chair the QI Forum
- Work with sponsors and coaches to address any challenges they are experiencing in undertaking their role
- Meet with the directorate's Improvement Advisor and others regularly to take forwards the above objectives

City & Hackney's Improvement Advisor

Improvement Advisors support a number of directorates to progress their QI Programme, as well as delivering training to staff, helping to promote and share the successes of the QI programme and leading work on Trust high priority areas. In terms of high priority areas, the role includes leading the Trustwide strategic approach, organising and supporting Trustwide meetings and forums and providing first line support for projects working on these areas within their local directorates. In this latter sense, the Improvement Advisor role in high priority projects is like that of a QI coach, described above. Specific tasks and responsibilities of Improvement Advisors in directorates are below. The Improvement Advisor supporting City and Hackney is Jen Taylor-Watt. Jen will be on leave from 1st December 2017 and C&H's Interim Improvement Advisor will be Kelly Gale.

Improvement Advisor: Responsibilities & tasks in directorates

- Providing first-line coaching support to high priority projects, as described above under QI coaches
- Strategic support to the directorate QI programme in all respects: in defining improvement priorities, aligning QI work, identifying whether issues are suited to QI projects, supporting thinking around scale-up of QI work, etc.
- Troubleshooting, strategizing and taking action around general issues/restraining forces within the QI programme
- Attending, helping to coordinate and developing the approach of the QI Forum
- Supporting the directorate to celebrate, disseminate and learn from successful QI projects
- Provide monthly group supervision to QI coaches and individual support/shadowing opportunities to coaches when needed
- Be attuned to progress of projects across the programme and highlight to the sponsor/Clinical Director/QI Forum when projects aren't progressing or when the support structure is weak

People Participation Lead (PPL)

People Participation Leads play a key role in supporting and enabling service user and carer involvement in all respects across ELFT, including QI.

Ways in which the PPL can support project leads and teams are outlined in the section below. The PPL for City and Hackney is Helena Maine.

Quality & Clinical Governance Coordinator

City & Hackney's Quality & Clinical Governance Coordinator, Maryam Hussein, supports the work of the City & Hackney QI Forum, alongside other responsibilities covering audit, clinical governance, etc.

Maryam works with the Improvement Advisor to help coordinate the QI Forum and undertakes other ad hoc tasks to link and communicate with services around QI.

Overleaf are photos of many of the people in the roles noted above for City & Hackney. Please note though that these do sometimes change in the course of the year in between updates to this guide.

Amrus Ali

QI Coach- Tower Hamlets

Andrew Horobin

QI Sponsor- City and Hackney

David Bridle

QI Sponsor- City and Hackney

Dean Henderson

QI Sponsor- City and Hackney

Emelie Landin

QI Coach- City and Hackney

Jane Kelly

QI Sponsor- City & Hackney

Jen Taylor-Watt

Improvement Advisor to City & Hackney, IAPT & Violence Reduction

Laura Shrieves

QI Coach- City and Hackney

Sarah Canning

QI Coach- City & Hackney

Sheraz Ahmad

QI Sponsor- City & Hackney

Susana Fontelonjano

QI Coach- City and Hackney

Susham Gupta

QI Sponsor- City & Hackney

Timothy Stevens

QI Coach - City & Hackney

Waleed Fawzi

QI Sponsor- City & Hackney

Service user, carer and customer involvement

"To involve service users, you must listen to what they are saying, and be seen to be acting on their feedback with support. This in turn will empower them to take more control of their destinies especially when they see positive change taking place"

Steve Terney, Patient Liaison Worker, City & Hackney

"I feel I am on an even pegging and feel just as valued member of the `team in my experience"

Feedback from a Service User member of a C&H QI project, QI Evaluation 2016

It's really important to involve the customers of the issue you are working on in your QI project as much as possible. In most cases this will be service users and carers within your service. This is important so that the work of projects is shaped by the views, experiences and perspectives of the people who are the customers of our services, as well as that of staff.

In what ways do we involve service users and carers in QI?

We have 2 different levels of involvement in QI:

- Involvement with a **little i** means asking the people who use your service, have they noticed the improvements. This can be done via survey, focus groups etc.
- Involvement with a **Big I** means involving service users and carers directly in your project and Qi development and delivery.

In most cases you should strive for Big I involvement in your project, so you have service users and/or carers working alongside you in the project team, co-producing what the project is doing. That way, you ensure you have a service user's perspective within all decisions you make as a team and to help you see things from this perspective. Big I involvement can be transformative for QI projects and for individual members of the team.

It can also be really helpful to undertake Little I type consultation periodically as part of your project, so you get broader perspectives of service users and carers on the work of your projects. You can use tools like Nominal Group Technique (see section 5) within existing service user and/carer forums to do this, or use other types of feedback mechanisms, such as surveys.

As you can see from the Gold Standards Project case study in box 5, projects can utilise lots of different types of service user involvement to determine the ongoing direction of their project – in this case it was totally critical to the project existing at all.

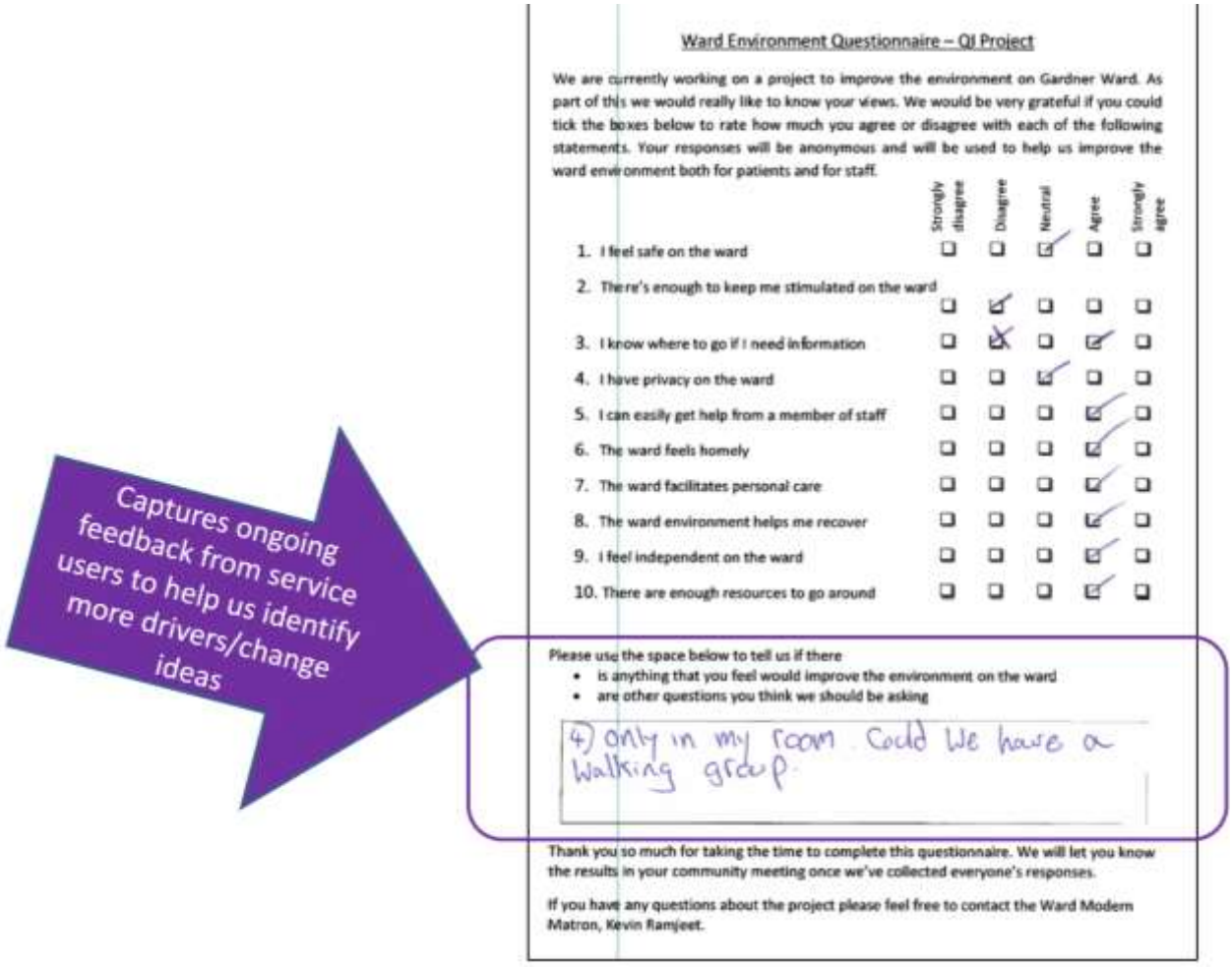
Your People Participation Lead (PPL)

People Participation Leads play a key role in supporting and enabling service user and carer involvement in all respects across ELFT, including QI. Ways in which the PPL can support project leads and teams are outlined in the below section. The PPL for City and Hackney is Helena Maine.

Box 5: Case Study – Service User Involvement at the heart of the Gold Standards Project

The Gold Standards project is focused on improving the environment on Gardner Ward in City and Hackney Centre for Mental Health. We are working on this because being cared for in a positive environment is really important to people's recovery. A project team for this work meets fortnightly and includes the Ward Manager, Life Skills Recovery Workers, Head of Art Therapies, Psychologist, Improvement Advisor **and Big I involvement of a Patient Liaison Worker and a service user, who joins the meeting by teleconference.**

To understand what the project needed to focus on, the team started with **focus groups with service users**, discussing what was important to them in the ward environment. This identified 10 main areas: safety, being occupied, information, privacy, getting help, homeliness, personal care, supporting recovery, independence and sufficient resources.



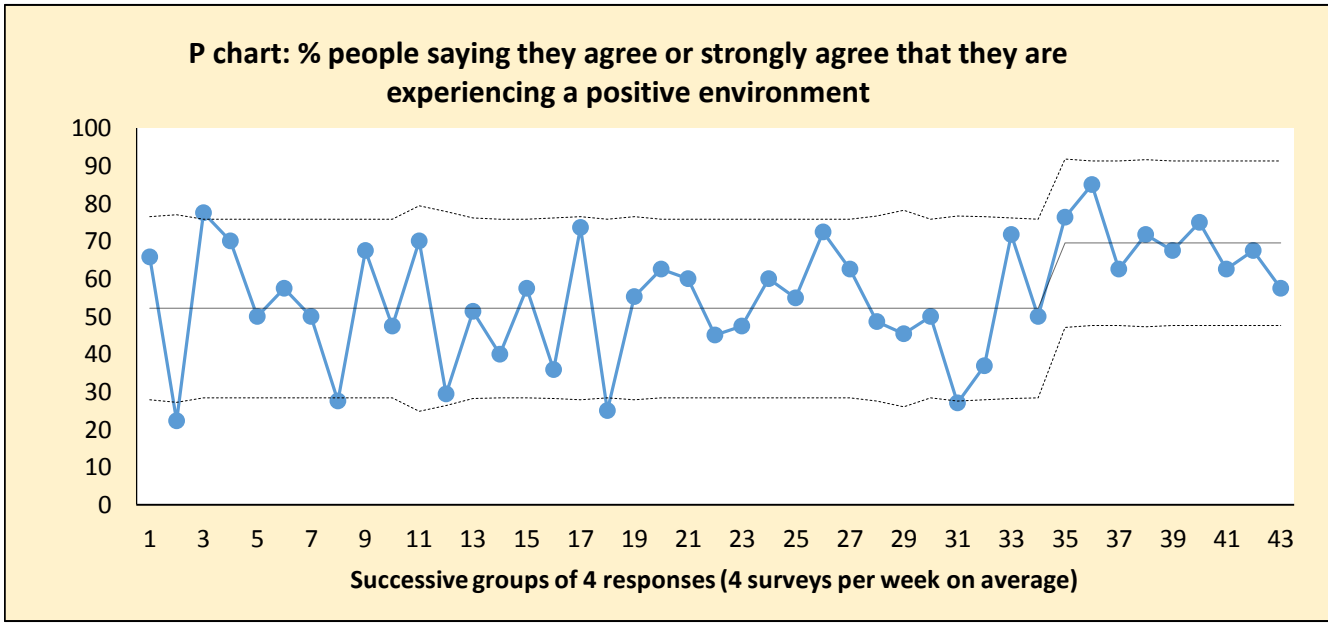
To understand whether changes are leading to improvement, **service users are completing surveys about their experiences across these 10 areas**. Gardner Ward's **patient liaison worker, Steve, plays a crucial role in supporting service users to complete the questionnaire**. He comments, "My reasons for getting involved in these projects were that as a long time service user, I wanted to help patients input into improving the experience of being on the ward by empowering them to honestly express how they really feel, and to improve things for themselves and others in the future".

Tests of change

So far we have tested a range of change ideas to improve people's experience of care in terms of feeling more occupied, supporting recovery and independence and supporting personal care.

Change ideas have included:
• Introducing Daily Planning meetings to boost engagement in group activities
• Enabling people to occupy themselves on their own through access to materials and support
• Creating a welcome pack of information and toiletries to give people a good experience of arriving on the ward and to facilitate personal care

Whilst in the beginning 52% of people agreed or strongly agreed they were having a positive experience of the environment, this has now increased to 65%. Steve comments, "I am getting positive feedback from patients who have noticed an improvement in their experience of being on the ward and I think they are also empowered by the changes!"



Holly Smith, Service User in the Gold Standards Project – My experiences and perspective on being involved in a QI project

Having been a patient and being on the receiving end of care I wanted to help. I know how much a few small things can make a real difference to someone when they're feeling very vulnerable and being cared for. With small changes it is easy to raise the standard of care on a ward and directly impact a person's experience of being there. Little things can go a long way to helping recovery on a mental health ward.

I also needed something to challenge me straight after being discharged, so I got involved straight away. It meant that my experiences of being a patient on the ward were fresh and I could give a unique perspective of what it is like to be on the receiving end of care and what is good or bad.

As to fitting in this extra work into my schedule – I haven't had any problems. My role is advisory and making sure the aim of the project and perspectives are right. I am able to dial into meetings too, so I don't have to make long journeys to join the team. It's quite flexible.

Professionally I have experience of project management. QI methodology is a little bit different, but it's been very interesting using these methods and there have been occasions in my own job where I have applied them; for example, in planning sessions where there have been loads of ideas floating round and it's difficult to sort them out, I have used nominal group technique with my team and analysed the ideas using an affinity diagram.

Based on my experience of QI, I believe the role of the service user should be reminding the team what the key focus is for their work and what the objectives are of the whole project. Service users can also offer a unique perspective on whether suggestions and changes will actually help, as they know what it's like to be on the receiving end of care. I think this input helps keep the team grounded and remember that they are doing this all to help the service user.

A working example of this on our project has been staff wanting to add magazines in wards. It sounds like a good idea, but some magazines sell ideas of what the ideal body image is, or how you should look, or perhaps buying or having certain things will make you happy, popular or find love.

To a vulnerable person having a tough time on a mental health ward and trying to recover, these subliminal messages are unhelpful. So it is better from a service user point of view to have magazines that focus on positive messages, such as health and wellness, hobbies etc.

My impression of quality improvement in the project I'm involved in is that staff have found and are finding this work incredibly valuable. They are not dictated to from the top. They chose to do the project, and it has all come from them. These are busy frontline staff who are passionate about their work and the care they deliver to patients. I think that's one of the most important aspects of improvement work; staff need to buy in to QI. There's a created and shared responsibility within the project team to keep things going. e.g. safety huddles; these are more likely to succeed due to created responsibility.

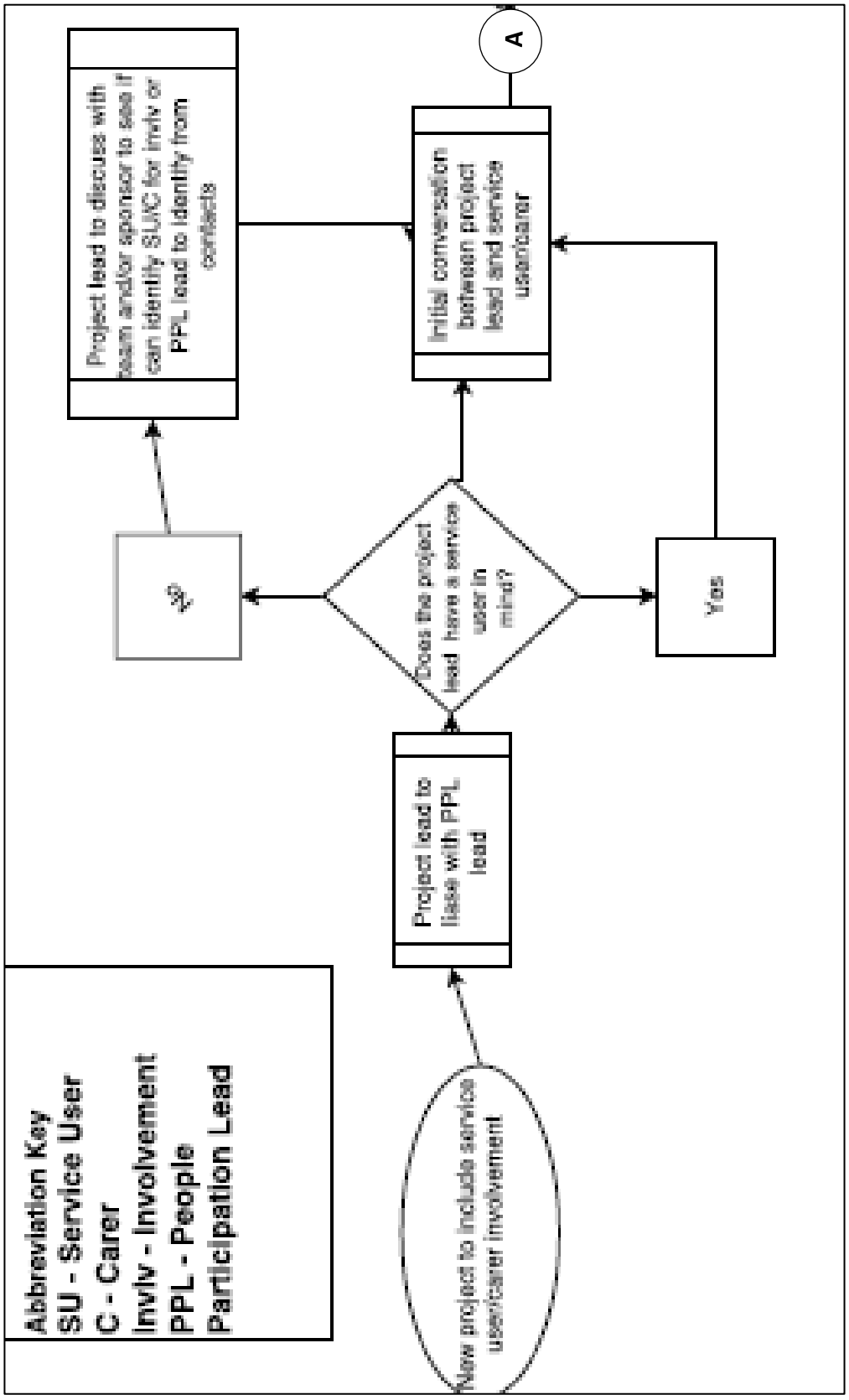
It's so important to get service user input in quality improvement work, project teams will find it very valuable. However, it's important to remember that service users cannot be around 24/7 and for the whole duration of an improvement project. Some may only want to help for a certain period of time, and that's OK. It's still great to use them and their skills to help you! You may want a service user to give you feedback on one survey question, or provide ideas for one particular aspect of your project. They may have a particular interest or skill with that you can utilise in the overall project. So, involve them! It'll still be a valuable and rewarding experience for them and you!

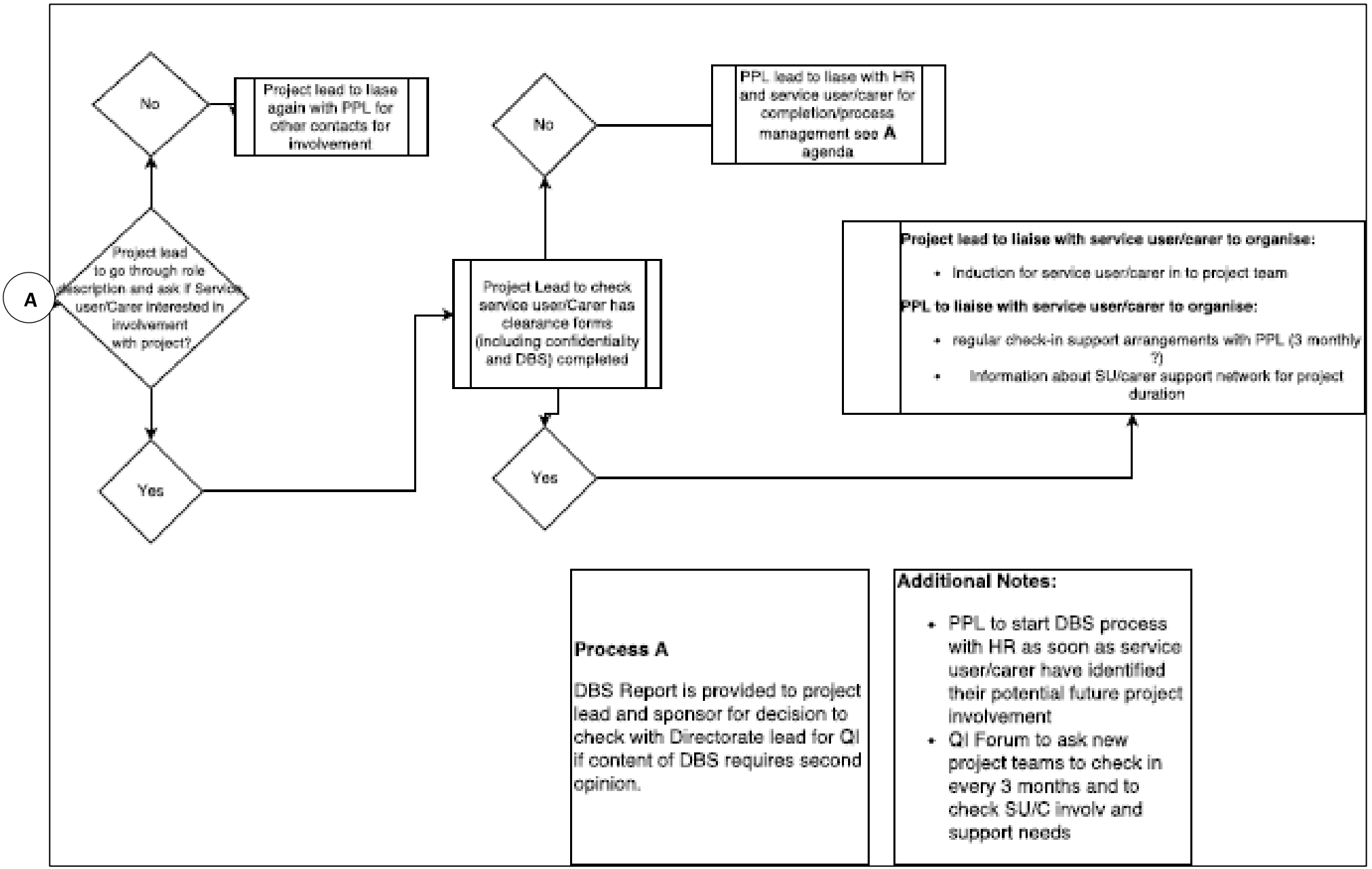
The above was an excerpt from an Interview with Holly. Read the full interview here: https://qi.elft.nhs.uk/my-quality-improvement-journey/

The earlier quotes from Steve Terney, Patient Liaison Worker, are also from another interview on the QI microsite. Read this here: https://qi.elft.nhs.uk/an-interview-with-a-patient-liaison-worker/

How to involve service users and carers in QI Projects; process, payment & clearance levels

The diagram on the following 2 pages illustrates the process project leads can take to identify service users and carers and organise their involvement in QI projects, supported by their directorate and particularly the City & Hackney PPL. Further guidance on the steps noted in the flow chart is below and further information on key points is included afterwards.




A
Project lead to go through role description and ask if Service user/Carer interested in involvement with project?
No
Project lead to liase again with PPL for other contacts for involvement
Yes
Project Lead to check service user/Carer has clearance forms (including confidentiality and DBS) completed
No
PPL lead to liase with HR and service user/carer for completion/process management see A agenda
Yes
Project lead to liaise with service user/carer to organise:
Induction for service user/carer in to project team
PPL to liaise with service user/carer to organise:
regular check-in support arrangements with PPL (3 monthly ?)
Information about SU/carer support network for project duration
Process A
DBS Report is provided to project lead and sponsor for decision to check with Directorate lead for QI if content of DBS requires second opinion.
Additional Notes:
PPL to start DBS process with HR as soon as service user/carer have identified their potential future project involvement
QI Forum to ask new project teams to check in every 3 months and to check SU/C involv and support needs

Key points on how to identify and organise service user and carer involvement in QI projects

- In general project teams should try to identify a service user to join their QI project, rather than asking the PPL to do this at the outset. This is because it is best for representatives to come from the team that is involved in the project. E.g. if your project is based in EQUIP, then you'll want the perspective of an EQUIP service user or carer and your team will likely be most able to identify someone. If you are having difficulties identifying someone though, the PPL and directorate QI sponsors are there to help you, so get in touch with them.
- Once you've identified someone, a first step is for the project lead to meet with the person to talk to them about the project. You need to let them know things like: what you plan to work on, why you feel it is an important priority for the team and what contribution you think they could make. You also need to hear from them about what they are interested in, what is important to them and what they can commit to. The People Participation Team have put together a short set of questions to cover. Fill this in[7] with the service user if they are happy to be involved and give them a copy of this, so you both know what you've agreed. The PPL can also join you for this first meeting.

    1. Project title:
    2. Project Leads:
    3. Time Commitments:
    4. Where will you be based?:
    5. Accountability and Responsibility:
    6. Payment:
    7. Length of project: (e.g. 6 months to be reviewed)
    8. Contact/Supervision/Support: (1:1 time, training needs)
    9. What do you hope to get from this work?

- Service users and carers involved in QI projects will need to sign a confidentiality agreement and have a DBS check if this hasn't already been carried out. The confidentiality agreement is available here[8]. PPLs will lead on organising DBS checks, so get touch with your PPL to help with this. See further guidance on Clearance Levels below.
- Service users and carers involved in QI projects need to be paid for their time. It is the responsibility of project leads to organise this, but if you have any questions/need help with setting this up, get in touch with your PPL. Please see the further guidance below.
- At the first meeting with the whole team, make sure you spend time introducing everyone and bear in mind all the content will be new, so take things more slowly. At the end of the meeting check in with the service user/carer once others have left to see how they experienced the meeting and check if they want to talk anything through with you. Do this periodically, as you go through the project, so you make it easy for service users/carers to raise questions and/or anything they are finding difficult.
- PPLs will also arrange regular support with them every couple of months for all service user/ carer members of QI projects to provide them with a clear space to share their experiences and address any problems. PPLs will also provide information about SU/carer support networks.

[7] Template available here: https://qi.elft.nhs.uk/resource/service-user-and-carer-qi-role-descriptions/
[8] https://qi.elft.nhs.uk/resource/confidentiality-form/

Organising payment for service user/carer members of QI projects

Once part of a QI project team, service users and carers need to be paid for their contribution to the work of the team

There are various options for payment for service user/carer time.

Option 1- Under Reward and Recognition Policy

If you are involving service users and carers in any meetings, focus groups or any regular commitment then:

Under 2 hours- £10

Over 2 hours – £20

Payments are made via BACS and no cash payments should be made.

BACS forms and user payment forms are available to download[9].

Option 2- Permitted Work (for people on benefits)

If you require more and sustained input into a QI project (someone to regularly measure satisfaction on a weekly basis for example) then the People Participation Team can help support the QI project to place someone on Permitted Work (via the Job Centre). Your local PPL is listed on this page.

This allows a service user to earn up to £104 a week (work up to 15 hours a week) without affecting their benefits so that people can be given a regular task or project.

Payments are made via BACS and no cash payments should be made.

Option 3 – Employment by the Trust on temporary/bank contract (for those people not on benefit, retired and in employment)

Initially graded an AFC Band 3 employee.

A temporary bank contract.

This would be regarded as taxable earnings

Making payments

All costs related to the above are to be met via budget code related to the host team for the QI project (unfortunately we do not have central funds for this).

All completed BACS and payment forms should be sent to SUC-payments@elft.nhs.uk for processing, except Bank payments which will be made in the usual manner.

If you have any questions or problems with these processes, get in touch with your PPL, or Paul Binfield, Head of People Participation.

[9] https://qi.elft.nhs.uk/resource/weekly-payment-form-for-service-users-and-carers/
https://qi.elft.nhs.uk/resource/bank-details-form-for-service-user-and-carer-involvement/

Managing clearance levels for service user/carer involvement

The following is taken from a brief guidance document for QI Projects and QI Forums around service user/carer involvement in QI work and the level of clearance/checks required to fit with Trust policy.

We need to organise for the appropriate level of clearance, depending on the sensitivity of information that the person is subject to, as set out in the table overleaf. Project Leads need to review the table to decide on level of clearance required then let PPLs know who will support with organising DBS checks. Templates and instructions are available via hyperlinks below.

Once you have reviewed the below, if you have any uncertainties about the level of clearance required, talk to your project sponsor. If you don't know who your project sponsor is, get in touch with your Improvement Advisor.

Please note, although your current project tasks may be at level 1, you may still want to process a DBS in case this changes in future. It can sometimes be hard to predict what will be involved in your project at the beginning and this will avoid delays/awkwardness if the nature of information changes and becomes more sensitive.

The results from DBS checks will be returned to directorates, who will be responsible for reviewing and making decisions about whether someone can proceed with being involved in the QI project. It is up to directorates to establish appropriate structures and processes for managing this. The costs of processing DBS checks for directorate QI work will be met by directorates.

Please note, this guidance is not designed to replace that related to clinical work within teams. Please see the note after the table about QI involvement, which is closely linked to clinical practice.

Level	Description & Example Tasks	Clearance required
1 – Generic/ Involvement (no sensitive information)	Tasks and project team discussion does not involve any personal or sensitive information, nor 1:1 contact with service users and carers; e.g. • Contributing to generic project strategy (discussion of measurement approach, discussion of drivers of problems, change ideas, process mapping) • Reviewing/commenting on generic materials (patient information leaflets, template appointment letters) • Being involved in sessions at Away Days to promote service user involvement	• Confidentiality agreement[10]
2 – Handling sensitive information & patient identifiable information	Tasks and project team discussion involves handling sensitive/ patient identifiable information and/or 1:1 contact with service users and carers; e.g. • Contacting/interviewing service users and carers or carers to get their views on a service (thereby having access to contact information) • Hearing case examples of service users and carers' experience of services • Having access to patient identifiable data in project datasets or other materials	• Confidentiality agreement • DBS check[11]
3 – Handling patient records (Peer Support Worker)	Not usually required for QI projects, but PSW tasks are noted below for information: • Have access to RIO, handle patient sensitive info and writing in progress notes	• Confidentiality agreement • DBS check • Formal role as Peer-support worker

[10] https://qi.elft.nhs.uk/resource/confidentiality-form/

[11] Let your PPL know this is needed and they will help with processing this

Service user QI Involvement linked to clinical practice

Sometimes you may be working with service users, as part of clinical care and include discussion linked to QI projects; for example, running discussions during ward community meetings about experiences of violence and aggression. In these cases, because the nature of involvement is part of standard clinical practice, it is unlikely you will need to get service users to complete formal written confidentiality agreements, but you should instead follow your normal clinical protocols (e.g. requests that service users not to discuss others experiences outside of a therapy group, etc).

In all such cases it is good practice to be clear about how feedback/content of discussion will be used in relation to the QI project; e.g. that notes of themes from the safety discussion will be kept for us to learn from, but these won't be attributed to individuals. You should also make clear that involvement in this consultation is voluntary.

Where a current service user or carer within a clinical setting is intended to be directly involved with a project team as a core ongoing project member, working directly with materials as part of a QI project team role, then confidentiality would need to be obtained as suggested above. If in doubt around the need for a confidentiality agreement or enhanced DBS checks the project sponsor needs to be contacted.

Supportive service user and carer involvement

> *Since meetings were alien to me, I really did not know the "rules" of a meeting and felt I couldn't leave the room when I needed to*
>
> *A simple matter: meeting rooms not being very welcoming with no windows and dark rooms*
>
> *I didn't have any personal reference or training to know how to behave and I felt like an actor, not truly being myself.*
>
> *I feel this is positive work and we should not have to feel like its "Them and Us", these barriers are slowly eradicating. It's "Us and We", staff, service users and carers are all looking after the mental health and emotional wellbeing of each other. I found the interactions are wonderful and very positive. It is about being human and thinking outside of the box.*
>
> Feedback from service users on experiences in QI projects - Trustwide

As with elsewhere in the Trust, within QI projects it's important to reflect on how to effectively support service users and carers well within your project team. Above are some comments from service users across the Trust, which reflect both positive and negative experiences and should prompt some thinking. Below are some key principles and tips to bear in mind, based on our learning over the first 3 years of QI.

It is acknowledged that many of these will be common-sense to staff - but at the same time, it can be easy to slip up sometimes and forget about them when we're busy and they make a real difference to people's experience when part of projects - so it's important to remind ourselves of them.

Top Tips for Supportive Service User Involvement

- Try to avoid QI jargon and acronyms in project meetings – most things can be explained my simply, but if not, take the time to explain what QI terminology means
- Make sure you introduce everyone in the project team to new service users and carers
- Be aware of how intimidating meetings can be in terms of the environment and not having met and/or worked with people in what can feel like quite a formal format before; think about what you can do to make things more comfortable
- If you're going to use papers for meetings, make sure these are explained
- Check in with service users and carers periodically, to make sure they feel comfortable. PPLs will do this too separately, but it's important that project leads take a lead on this when service users/carers attend meetings, etc.
- Provide clarity to service users about the length of time they will need to be involved in the project and what they role is at the outset
- Make sure you have a main contact in the team for service user/carers members, who are responsible for ensuring they are supported in meetings, and with logistical stuff like getting paid, etc.

City & Hackney Monthly QI Forum – Terms of Reference

The City and Hackney QI Forum is the core mechanism for leading and progressing QI in City and Hackney. It is central to supporting all the work of project leads, teams, QI coaches, QI sponsors, Improvement Advisor and directorate lead for QI, as described above. For this reason the Terms of Reference are included here in full for the information of all those involved in QI, to understand how the QI Forum manages these responsibilities:

1. Overview

- The City and Hackney QI Forum is the monthly opportunity when the directorate leadership in Hackney comes together to take forward Quality Improvement work.
- To this end it has 2 key objectives and focuses (see further detail on these objectives below):

    1. To provide individual QI projects with an opportunity to share their progress and learning with the QI Forum and to receive support on any blockers/issues identified

    2. To provide a forum for the strategic management and leadership of the QI programme, which is led by sponsors and DMT

- The QI Forum is 60 minutes on the last Tuesday of the month 9:30am – 10:30am. The time is split roughly equally between these two areas of focus.

2. Membership and attendance

- The City and Hackney QI Forum has core members and additional members.

2.1 Core members

- Core members, who are expected to prioritise the QI Forum, are:
    - QI Sponsors
    - Other members of City and Hackney DMT who are not sponsors
    - QI coaches
    - PPL
    - Performance Lead
    - Quality and Clinical Governance Coordinator (QCGC)
    - Improvement Advisor for City and Hackney from the central QI team

2.2 Additional members

- Project leads and members will be invited by the QCGC to attend when it is their turn to present.
- Invites will be sent for the QI Forum to all project leads, service leads and managers in City & Hackney and anyone is always welcome to attend the QI Forum for their learning, development and interest.

3. Actions

- An action log will be kept for the QI Forum, by the Quality and Clinical Governance Coordinator.

4. Chairmanship

- The City and Hackney QI Forum is chaired by the Clinical Director, who is the lead for QI within City and Hackney and lead sponsor.
- If the Clinical Director can't attend, they will arrange for a deputy to chair the forum who is also a QI sponsor.
- The specific agenda for the QI Forum will be developed and agreed by the Chair, with the support of the Improvement Advisor.

5. Objectives/Priorities

5.1 Project Learning and Support

The objectives of the ***Project Learning and Support*** session is as follows:

- To provide a realistic amount of time for meaningful discussion and support, projects will be rotated through the QI Forum, with 2-4 projects presenting each time.
- The Clinical Director (& chair of the C&H QI Forum) will decide which projects will be invited each time, with support from the Improvement Advisor.
- Selection of projects will consider factors such as how recently they have attended, the extent to which they are progressing, level of strategic priority for the directorate and whether the project sponsor will be in attendance.
- The Quality and Clinical Governance Coordinator will invite project leads to the QI Forum when identified, with the support of the Improvement Advisor
- Projects will be asked to focus their update on key questions to give the QI Forum a sense of how they are progressing in their project, including applying QI methodology and functioning according to good practice for QI projects; e.g. involving MDT and customers. (See full set of questions/discussion points after this Terms of Reference).
- Members of the forum will provide support and constructive challenge to help projects move forwards.
- Learning will be captured and added to the QI Forum project learning log.
- Sponsors will particularly listen and elicit if there any blockers or issues which they can help resolve which are linked to service issues or helping to develop buy-in, if the project lead is struggling with this.
- Coaches and Improvement Advisor will particularly focus on challenges with QI methodology.

5.2 Strategic leadership and management of programme

- The ***Strategic leadership and management*** component involves a number of priorities.

5.2.1 Recommendations to DMT to sign-off new projects (including new testing projects and scale-up projects)

- C&H QI has a pathway for the sign-off of new projects (see section 3). Project ideas will come to the QI Forum at an early stage, following discussion with a sponsor and coach/Improvement Advisor.
- Prospective project leads will usually be asked to complete a "Starting a new QI Project Form" so that the QI Forum can determine whether the idea should move forwards as a QI Project. This recommendation will be taken to DMT immediately afterwards, at which the final decision will be made.

- When provisional ideas come to the QI Forum, the Forum will ensure the project has sufficient support from a coach or Improvement Advisor, and sponsor, to understand the issue in greater depth, build engagement and ultimately develop their charter
- New project charters will come back to the QI Forum when completed for information.
- New project leads will be invited back to the forum within 3 months, so that the QI Forum is able to oversee progress and provide support (as we have learnt there is greatest risk of project failure before their start testing (before score 2.5).

5.2.2 Recommendations to DMT to agree closure of projects; including overseeing implementation steps of successful projects

- The QI Forum will oversee the closure of projects to ensure that successful projects have undertaken sufficient implementation planning and that learning is captured from projects that are being closed before they have achieved improvement
- Management of implementation is a very important stage of projects once improvement has been achieved and involves steps to ensure successful change ideas are integrated into business as usual for the whole team. Projects that have achieved improvement will be expected to use the implementation planning template, available on the QI Microsite[12], supported by both coach and sponsor. This document shall be brought to the QI Forum for the closure discussion, so that the Forum is assured implementation planning is sufficient and can provide further input.

5.2.3 "Orange Flags"; discussion of risks and issues in progression of programme and individual projects

- The QI Forum will include a standing item called "Orange Flags; Worries and Niggles". This is a space for members for the QI Forum to raise any concerns - no matter how big or small - which they have about projects or the programme as a whole.
- The aim of this space is to ensure that any problems are raised quickly (particularly for the attention of sponsors and senior leadership) and receive the input of the whole Forum to resolve.
- It mitigates against the risk of concerns being held by individuals without the awareness of other stakeholders, who can help address them.

5.2.4 Strategic thinking to strengthen Quality Improvement work

5.2.4.1 General

- The QI Forum will discuss items related to the strategic progress and development of the programme, such as service user involvement, how to support the efficiency of projects, how to effectively manage the implementation and quality control stage of projects, etc.
- Because of time, the above discussions will be short, however the Forum will also meet 1-2 times a year for longer groupwork discussion to reflect on strategy. One of these meetings will be during the IHI visit in October.

[12] https://qi.elft.nhs.uk/collection/implementation-and-sustaining-the-gains/

5.2.4.2 Quality prioritisation process

- Increasingly, QI work in City and Hackney should reflect the strategic priorities of the directorate, so that there are fewer projects which are focused on what really matters to the directorate and our service users and carers. This will mean energy across the programme (from sponsors, coaches, etc) is concentrated on the areas of highest priority.
- The QI Forum needs to be assured that the priorities reflect the issues that matter most and the feelings and experiences of service users and carers. Other intelligence gathering and discussion/conversation, creative approaches may be needed to arrive at priorities. The C&H QI Forum is responsible for deciding on and leading that process, with the support of the Improvement Advisor.

5.2.5 Management of operational tasks associated with programme

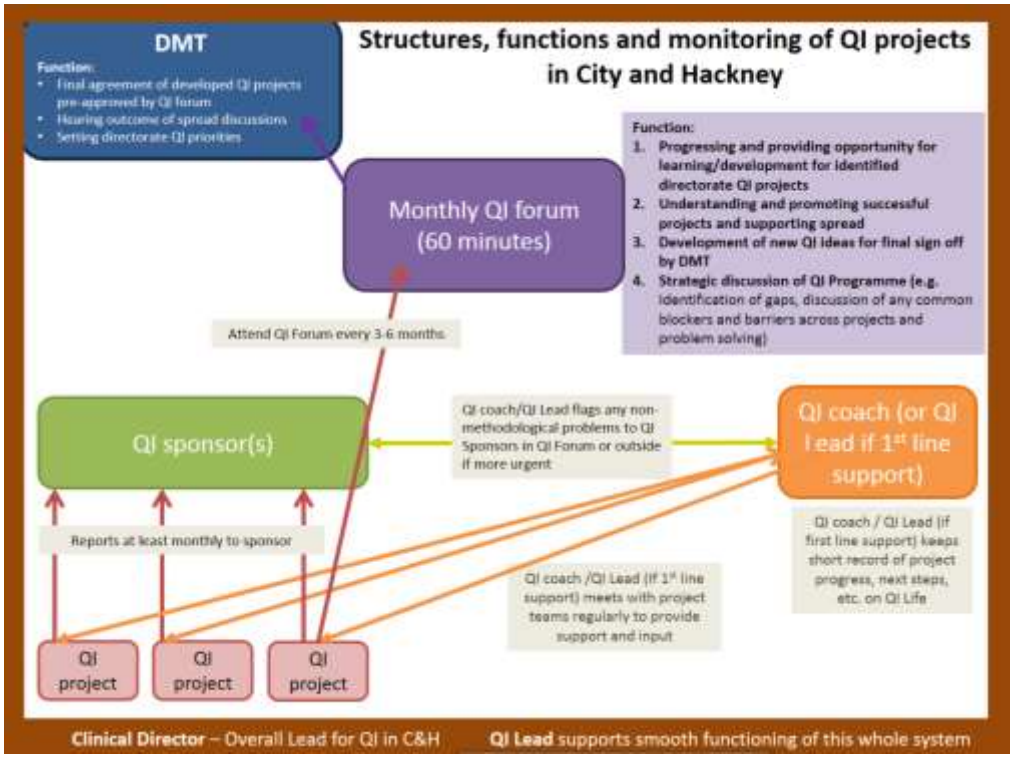
- The City and Hackney QI Forum will be responsible for any operational tasks related to the QI programme in Hackney. This will include, but not be limited to, the following:

5.2.5.1 Identification of staff for QI training & recruiting coaches

- The QI Forum will identify staff for the waves of ISIA QI training, which is mainly designed for project leads and senior leadership.
- The QI Forum will also manage a process for recruiting suitable coaches when coaching training is offered. This will involve working with service leads and managers to identify suitable staff.
- QI Forum members will also have a role in promoting Pocket QI Training

5.2.5.1 Planning events and visits

- The success of the ELFT QI programme, including the work in City and Hackney, generates a lot of external interest, which is also an opportunity to celebrate successes. The City and Hackney QI Forum will plan and manage these events to get the most out of these opportunities.



Project updates to C&H QI Forum - Guidance to project leads

As noted in the TOR, the purpose of project leads attending the QI Forum is to identify and discuss enablers and challenges to the progression of projects with sponsors, coaches and other project leads, in order to learn together and help move projects forwards.

Each project has 5 minutes to update, with 3-5 minutes for questions. Please focus on the most relevant questions below in your update. Please ensure your charts and other project information is up to date on QI Life before you attend the QI Forum.

Key questions to focus on in your update:

1. Have you run any PDSA tests of change in the last month? If not, what is stopping you from testing?
2. Are you collecting and looking at data over time regularly? If not, what is holding you back?
3. Are there any factors that are holding the project back? If so, what are they?
4. Is there anything else that you need help with?
5. What is your plan for the next month?
6. Who is on your team? Are all stakeholders in your issue represented?
7. How are you involving your customers in your project (for most C&H projects this will be service users and/or their carers)?
8. Do you have any learning you could share about how to make QI work as efficient as possible? (It is a priority of the QI Forum to gather and support the dissemination of ideas around efficiency in QI projects (whilst still adhering to the QI method)

If you have any questions about this, please discuss with your QI coach or Improvement Advisor.
The below diagram illustrates how the key roles and structures for QI in City and Hackney fit together and how monitoring and oversight works.

QI Life

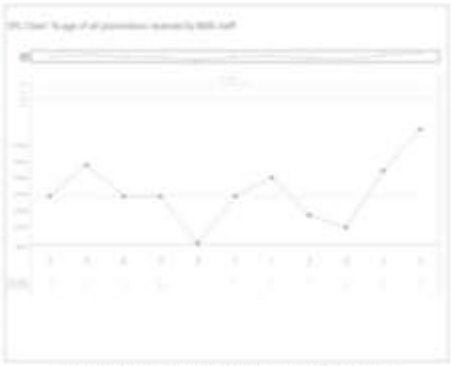
We use the QI Life system to manage QI projects at ELFT. Previously we had real challenges around there being lots of different documents for projects, saved all over the place. Almost all of this can now be done in the QI Life system, which means it is also easy for the whole project team, sponsor and coaches to keep up to speed with how a project is doing. A big benefit is the charting section, which enables projects to create their charts really easily, by just pasting in their data. It was previously much harder to do this in Excel.

It also has the benefit of producing reports for directorates automatically, which helps to make us all more efficient. See some images of the charting section from QI Life are below.

All members of project teams, sponsors and coaches need to have accounts on QI Life. To create an account on QI Life, go to this page https://life.seedata.co.uk/login/signup/ and enter your email address to be sent an invite to the system.

See QI projects across the Trust

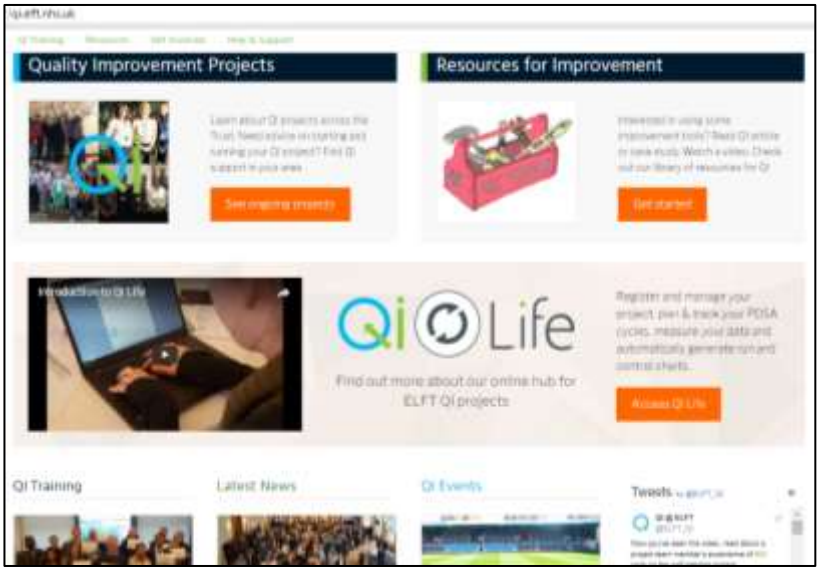
Manage your project


Generate Run and Control Charts

QI Microsite

The QI Microsite provides lots of information about all things QI at ELFT, including for example:

- More detailed information about the methodology and useful tools
- Information about successful projects; for example published articles, conference posters, etc
- Information about structures and processes for managing QI across ELFT, similar to that described in this document.



3. Getting more involved in QI

Becoming a Project Lead & starting a new QI Project

If you think you might be interested to start a new QI project, the steps to move forwards in City & Hackney are:

1. Talk to your manager or director and review the list of City & Hackney QI priorities in section 1. If you're in agreement that you may have a suitable idea to take forwards that fits within these priorities, have a think together about the questions shown in the diagram below. These are some of the key things the directorate will need to think about to determine the readiness and suitability of the issue and team for QI project. If you think you are ready to proceed, get in touch with a C&H QI Sponsor, QI Coach or Improvement Advisor.

2. Have a discussion with a QI sponsor, QI coach or Improvement Advisor about the area you think might be suitable for a QI project[13]. If they think it is ready to go as a provisional idea to the City and Hackney QI Forum, they will support you to complete a short form with these questions to take to the Forum[14]. Please see the next section below with some further notes about questions on this form. Once you have completed, send this to the Improvement Advisor.

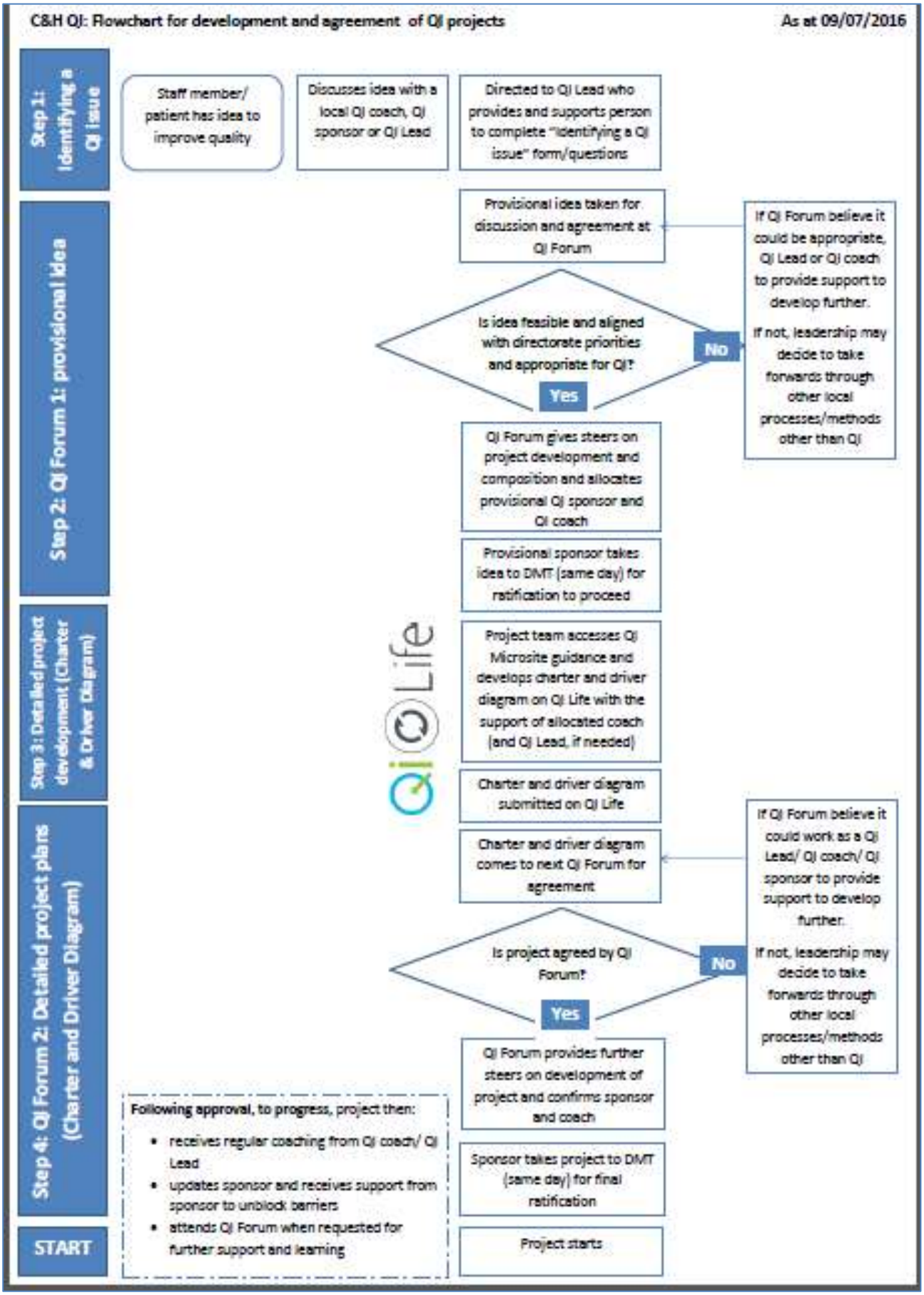
3. The Improvement Advisor will let you know the date of the next QI Forum to attend and discuss your proposed project.

4. If the QI Forum supports this to move forwards and become a QI project, they will give you steers on how to develop the project and allocate you a provisional sponsor and coach to help you do the thinking required to create a full project charter on the QI Life system (see section 2).

[13] Current sponsors and coaches for City & Hackney are listed on the QI Microsite at https://qi.elft.nhs.uk/help-support/find-your-local-support/?fwp_directorates_drop=city-hackney-adult-mental-health
[14] https://qi.elft.nhs.uk/collection/starting-a-qi-project/

5. When completed, the charter will then come back to the QI Forum (usually a month or two later) for agreement and further steers, and your ongoing coach and sponsor will be confirmed (usually the same people who were allocated on a provisional basis).

Note you will then be invited back to the QI Forum within 3 months to update on progress and receive further support. This is because we know from experience that the first stage of the project is the most difficult in terms of maintaining momentum, developing engagement and understanding how to use QI methodology. The QI Forum therefore wants to do its best to support you to get your project through this and into the testing phase. The flowchart on the following page shows the 'Development and agreement of QI projects' process in detail, as well as what happens if it is decided that the project is not suitable to move forwards.


C&H QI: Flowchart for development and agreement of QI projects
As at 09/07/2016
Step 1: Identifying a QI issue
Staff member/ patient has idea to improve quality
Discusses idea with a local QI coach, QI sponsor or QI Lead
Directed to QI Lead who provides and supports person to complete "identifying a QI issue" form/questions
Step 2: QI Forum 1: provisional idea
Provisional idea taken for discussion and agreement at QI Forum
If QI Forum believe it could be appropriate, QI Lead or QI coach to provide support to develop further.
If not, leadership may decide to take forwards through other local processes/methods other than QI
Is idea feasible and aligned with directorate priorities and appropriate for QI?
No
Yes
QI Forum gives steers on project development and composition and allocates provisional QI sponsor and QI coach
Provisional sponsor takes idea to DMT (same day) for ratification to proceed
Step 3: Detailed project development (Charter & Driver Diagram)
QI Life
Project team accesses QI Microsite guidance and develops charter and driver diagram on QI Life with the support of allocated coach (and QI Lead, if needed)
Charter and driver diagram submitted on QI Life
Step 4: QI Forum 2: Detailed project plans (Charter and Driver Diagram)
Charter and driver diagram comes to next QI Forum for agreement
If QI Forum believe it could work as a QI Lead/ QI coach/ QI sponsor to provide support to develop further.
If not, leadership may decide to take forwards through other local processes/methods other than QI
Is project agreed by QI Forum?
No
Yes
QI Forum provides further steers on development of project and confirms sponsor and coach
Following approval, to progress, project then:
receives regular coaching from QI coach/ QI Lead
updates sponsor and receives support from sponsor to unblock barriers
attends QI Forum when requested for further support and learning
Sponsor takes project to DMT (same day) for final ratification
START
Project starts

Identifying a Quality Issue and Starting a QI Project Form

Is this right for a QI project?

As we said in section 1, not everything needs a QI project – more simple things can often be resolved with approaches you are probably already more familiar with (e.g. action-planning, team discussion, line management, etc).

Instead - and we think this is the good news - QI is there to help us with the more complicated issues in healthcare; perhaps the things that we've struggled to make progress on in the past, the things that can feel 'impossible', like reducing violence on inpatient wards or halving waiting times in community services during a period when referrals are more than doubling (something else that has been achieved in City and Hackney – see box 6). Sometimes these issues are referred to as 'Wicked Problems'.

Saying all this, we believe areas for improvement exist on a scale in terms of complexity, and some issues that are moderately complicated, rather than mind-bogglingly complicated, may still really benefit from this methodology - so don't be immediately put off if you think your issue is perhaps a 6 or a 7, rather than a 10 on the 'complicated scale'.

We think that 2 key 'Litmus Test Questions' to think about first of all to decide whether to take your project forwards using a QI approach are:

1. **How complicated is your problem?** **and**

2. **Will the problem and/or solution need learning to understand what's going on and what will help?**

If it's a yes to both of those, it's highly likely QI could be a good approach for you. Some other things to think about are shown in the diagram below.

Signs your problem is right for QI	Signs another approach is needed for your problem (not QI)
Problem requires learning	Problem is clear
Solution requires learning	Solution is clear
No one knows the answer!	Knowledge, skills resident within organisation. Clear task within existing job roles.
May need to learn new skills and approaches	Work often sits with authority
Works sits with stakeholders	Generally linear / cause & effect
Non-linear, can be unpredictable	We've done it before
May be a new situation / scenario	Success is usually resolution or finite
Success is often just about making progress – may never be completely solved	No change in values, beliefs, loyalties or priorities necessary
Values, beliefs, loyalties and priorities may need to shift	

Scope & Project Design

Sometimes is can be difficult to decide what level to work on and what the scope of projects should be. Most projects in City and Hackney work at team or service level (e.g. an inpatient ward, a community team, etc).

It is also possible for projects to work on a larger scale, but this does obviously make them bigger, involving more stakeholders. These types of projects therefore tend to be developed directly by the DMT and QI Forum and will include additional structures to ensure they move forwards.

For example, the City & Violence Collaborative has involved 7 wards testing different ideas to reduce violence. This has required project leadership on ward level, but also overall leadership from the Associate Clinical Director for Inpatient Services and DMT. Each team has met regularly on the wards to take testing forwards and representatives have also come together at a 6 weekly Collaborative meeting to share and learn together.

City & Hackney DMT / QI Forum has also recently launched a project to focus on ensuring our service users are only in hospital when they really need to be, through addressing problems in admissions and discharge processes, as well as potential efficiency and improvement of care processes when people are on the wards. A key outcome measure of this project will be bed occupancy.

This project has huge potential scope, as it touches all parts of the adult mental health system in City & Hackney, including all inpatient wards, community teams, Home Treatment Teams, Homerton Psychological Medicine and partners beyond ELFT, such as housing and the police. For this reason, sponsors have thought in detail about the structures needed to manage this project (including a core senior leadership group, broader engagement of stakeholders via the bed management meeting and testing units at ward and partnerships of ward/community team level. This project will need close attention and involvement from senior leadership throughout, so will also have a standing slot at DMT.

Something more common may be if you choose an issue that affects your team and another team you work with closely; like for example if you wanted to improve the experience of discharge from a ward, you would definitely need to have both the ward team and the community mental health team involved in the core team of the project.

Crucially, whatever the issue you choose, you need to make sure the key people who are involved in that issue are involved. Without this, the project simply won't work, so you would really need to think twice about starting it at all.

If the issue does involve a lot of stakeholders, it will need closer leadership from QI sponsors and DMT and further thinking about structures needed to ensure it progresses.

Joining an existing project team

There are around 15-20 QI projects being run across City and Hackney Adult MH at any one time and almost all of our services are involved in a project. If you are interested to get more involved in a project team, speak firstly to your manager about whether there is a project involving your service, which you can join.

If they are unsure, get in touch with Quality and Clinical Governance Coordinator Maryam Hussain, Improvement Advisor or attend the City and Hackney QI Forum, which is held from 9:30am – 10:30am on the 4th Tuesday of the month in the Management Office meeting room.

Becoming a coach

QI Coaching training is run roughly once a year, for which more coaches for the directorate are recruited. The City & Hackney QI Forum will seek nominations for this training from service managers and make final decisions on who should be put forwards onto the training course and take up this role as part of their job plan. The QI coach role and tasks were outlined in section 2. The qualities required of coaches are set out below. If you think you might be interested in becoming a QI coach, discuss this with your line manager. They can then raise this with your relevant service director to consider when the next wave of coaches is recruited.

Qualities of QI Coaches

- A deep interest and commitment to improving services, to better support our service users
- A willingness/aptitude to think innovatively and creatively around challenges
- Self-starting, requiring little oversight and direction to identify what needs to be done and work towards this
- Reliable and organised; understanding the value of people's time so keeps to commitments
- Enjoys working with and supporting others
- Broadly comfortable working with data (data is a means to an end in QI and it is emphasised you do not to be a maths whizz to do this role; this is an area which we can develop people's skills and confidence)
- Have capacity in their current workload to fit in 1-2 meetings with teams per week; so there is a low risk of them feeling overwhelmed by this additional responsibility

"Training helps contextualise the experience of using QI"

Staff member, QI Evaluation - 2016

There are a number of different training options in QI offered by the QI Team. Everyone on project teams should at least complete Pocket QI, so they have a basic understanding of the methodology:

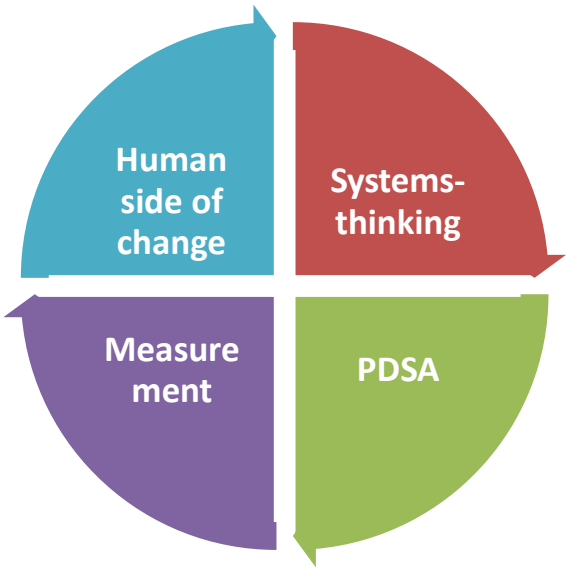
For project leads and others with a big role in QI, such as sponsors and team leaders, we recommend the **ELFT Improvement Leads Programme**, which includes the Improvement Science in Action, accredited by the Institute for Improvement. The course is 8 days, with the days split and run over a 6 month period. We run this course roughly every 9 months. Recruitment to this course is managed by the C&H QI Forum. Talk to your manager if you are interested to attend this. More information is available here: https://qi.elft.nhs.uk/training/elft-improvement-leaders-programme/

We also run a shorter course, called Pocket QI, which is designed for anyone who wants to get a basic introduction to QI methodology. It runs over 2 half days and includes a lot of games and interactive activities. More information is available here: https://qi.elft.nhs.uk/training/pocket-qi/

Finally we also have access to e-learning, provided by the Institute for Improvement. Further information is available here: https://qi.elft.nhs.uk/training/ihi-open-school/

4. Key Points on Quality Improvement Methodology

As noted above, QI involves 4 key dimensions, as shown in the diagram, which connect with each other:



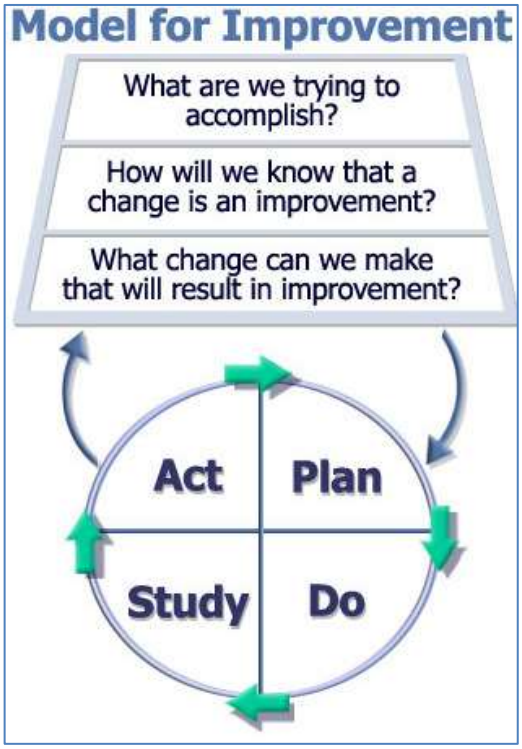
1. Understanding that the services we work in are interconnected and complicated systems,

2. Using quick testing and learning in order to develop our understanding of what might help to improve the system (Plan, Do, Study, Act, or PDSA, cycles)

3. Having a robust system of measurement, using data over time, in order to know whether you are seeing improvement and

4. Understanding and working with the human side of change

The Model for Improvement



At ELFT we use a particular model that brings these ideas together called the Model for Improvement (MFI). This is the model developed by the Institute for Healthcare Improvement (IHI), mentioned earlier.

As shown in the diagram, the model includes 3 guiding questions, the first two of which, you need to have a clear answer to when you start your project.

Firstly, you need to develop a clear aim, in order to focus your project, through answering the question *What am I trying to accomplish?*

In order to know whether you achieve your aim, you also need to develop a measurement system: *How will I know that a change is an improvement?*

Unlike a lot of change in healthcare, which goes unmeasured - and therefore means we don't know whether changes have actually improved things in the system - an essential part of QI and the MFI is developing measures that can give us this understanding. This is really important so we don't commit time and resource to spreading ideas, which have no impact – or even worse - a negative impact on the broader system. Unfortunately this happens a lot within healthcare when quality improvement principles are not used, wasting resource and destabilising systems.

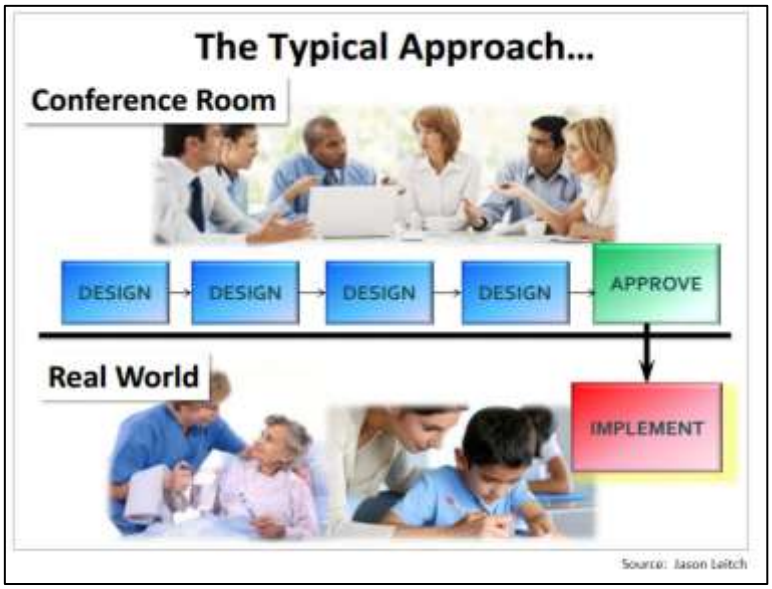
The Model for Improvement also includes a third question regarding *What changes can we make that will result in improvement?* As you take forwards your project, you will use the tools and techniques of quality improvement to help understand your problem and build your theory of change around what is driving your issue and what might help to make a difference. So, you may not have an answer to this third question at the start of your project, but this will develop as you progress things.

Plan, Do, Study, Act – PDSA - cycles

Finally the bottom of the Model for Improvement shows the PDSA cycle, which is core to how we progress QI and can be described as 'the engine' of QI projects. It is this which sets QI work apart from how we've tended to approach resolving issues in the past.

The slides below, courtesy of Scotland's National Clinical Director and QI expert, Jason Leitch, illustrate this and why we need PDSA…

Historically when we've needed to address an issue and improve something in healthcare, there has been a tendency to sit apart for the real world, perhaps in a conference room within provider Trusts – or sometimes even within an entirely different layer of organisation that oversees providers – to come up with 'the answer' to the problem. All the time is spent away from the frontline analysing, thinking and designing the solution and then once this is arrived at, it is implemented and everyone affected is told to change their ways of working and adopt the new practice.



In contrast, Quality Improvement understands that there is a fundamental problem in this approach, in that, if you are dealing with a complex problem, you cannot possibly know the answers when you are apart from the real world.

Instead, you need the opportunity to explore your issue in depth, to develop theories around what might make a difference, and to be able to test these theories, small-scale, in the real world to find out if you've got them right.

You then need to expand these tests to check that the idea works under different conditions (e.g. when used by different team members, on different days of the week, etc), and make any adjustments that are needed. This testing and learning is our PDSA cycles.

Driver Diagrams & more on aims, drivers and change ideas

It's helpful to have your project strategy available to everyone involved in the project in a simple format. For this, we use what we call Driver Diagrams, which summarise things on one page, as shown in the example Driver Diagrams in Box 2 and Box 6. The key elements of driver diagrams are:

Project Aim

- Shown on the far left
- Like with other areas of strategy development beyond QI, aims need to be SMART: specific, measurable, achievable, relevant and time-bound. They need to make clear *How good?* you want to be and *By when?*
- Note, you may need to work with what we call a 'concept aim' initially, whilst you work out your measurement system, which can take some time, particularly if your project is focused on measuring service user experience. For example the Gold Standards Project team knew they wanted *to improve service users' experience of the ward environment*. This is an 'concept aim' rather than a fully workable aim, because it doesn't fulfil the SMART criteria; particularly, it isn't specific and measurable, nor is it time bound. As you read in Box 5, this project had to do a lot of consultation to understand what was important to service users and what would comprise a good experience of the ward environment. Once the team had done that, and developed a measurement system, involving a 10 part survey, they were able to capture a baseline and set a SMART aim.

Drivers

- These are the forces or factors that your team believes will contribute to improvement in your issue. These are split into Primary Drivers and Secondary Drivers. Primary Drivers are the big buckets of factors, which are usually made up of a number of components, called secondary drivers.
- Drivers need to be framed positively, although when developing drivers, sometimes it can be helpful to think about "What are the factors that contribute to this problem?" (usually using Nominal Group Technique with your whole team and service users/carers – see section 5). If you use this approach they need to be flipped around so that they are positive on a driver diagram

Change Ideas

- Change ideas are different from drivers in that they are tangible ideas for things we could do differently, rather than factors or forces. They connect very much with drivers though, in that they should be ideas which can help you realise and/or strengthen the driving forces that you believe will help you achieve your aim. A test which often works for determining a driver from a change ideas is c*ould we actually do this next week?* If not, your idea probably needs a bit more development by the team to make it something tangible. Some examples are below

Driver	Change Idea
Access to information & educational materials	Scope community resources and create a library on the ward
Improve communication across the team	Introduce a team huddle in the morning

Measurement

At the outset, it is important to emphasise that, like the rest of this methodology section, there is limited detail provided here on measurement. This is a particularly big, and probably a bit more complicated, area of QI, so it is really important that you are properly supported to understand how we use data to know if you are seeing improvement. See section 3 on training to find out how to access QI training courses, if you haven't done one already. Some key fundamentals, though, to keep in mind:

Family of measures

One measure will not be enough to know whether you are seeing improvement and what is resulting in improvement. Instead you need to identify 3 types of measures to help you do this:

Outcome Measures: Measures that tells us whether the aim is being achieved

Process Measures: Measures the things you are changing to try to achieve improvement

Balancing Measures: Measures of what happened to the system as we improved the outcome and process.

These are important to picking up if there are any unanticipated consequences from making changes; for example we don't want to achieve reductions in length of stay on inpatient wards through experiencing an increase in the number of readmissions, so it's important to keep an eye on this.

Data over time

Once you have your measures, then the way we look at them in QI is what is called "data over time". This is a particular type of statistics, called *analytical statistics*, which is used a lot in engineering and manufacturing industries to understand how their system is functioning. It is a completely different type of statistics from enumerative statistics, which is commonly used in research.

Those with a research background will be familiar with ideas from enumerative statistics, such as testing for significance, t-tests, p-values, etc. These tests are used to develop confidence in research findings, particularly in terms of how generalizable they are beyond the research trial to the broader population.

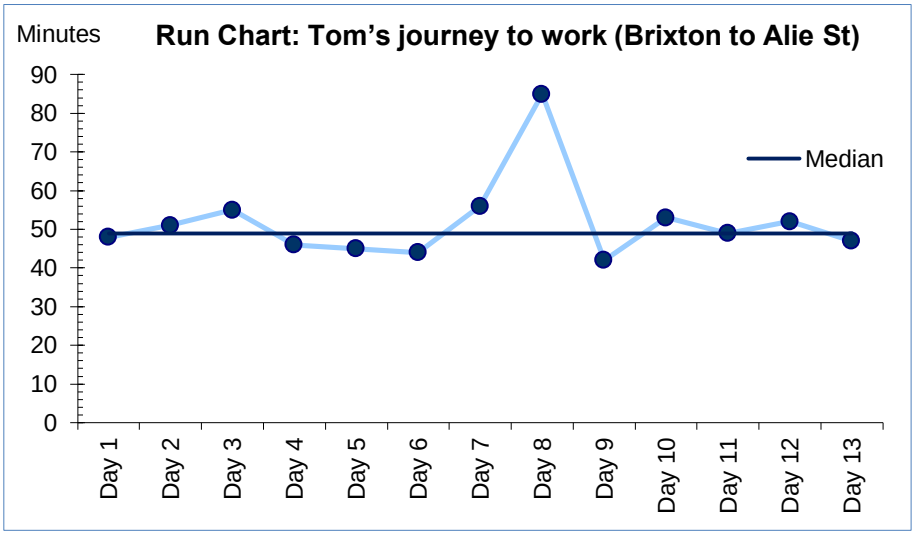
In contrast, Quality Improvement has a different focus, which is to improve the care our service users and their carers receive within a service, in terms of efficiency and effectiveness[15]. We are not focused on knowing whether improvements are generalisable to the broader population, rather we need to know whether we are seeing improvement in our service. The way we do this is using the rules of analytical statistics, which sit behind data over time.

[15] There are a number of other ways in which the aims and practice of Quality Improvement differs from research, as well as other ways in which we use data, like Assurance/Accountability processes (such as commissioning). For information on this, read the Health Care Data Guide, chapter X.

Variation

Understanding data over time is about understanding the principles and rules of variation. If you think about it, all processes in life vary. For example, your journey to work will not be the same every day you do it. It is going to be affected by a whole range of factors, which are going to mean it varies.

Tom's journey to work from Brixton to Alie Street is shown in the figure below. *What do you think when you look at this data? Does anything stand out as looking a bit different?*



Tom's chart shows us that his journey to work varies from between about 42 minutes and 56 minutes, but on day 8 it took him 85 minutes.

Do you think there might have been anything special about day 8 that resulted in this much longer length of time for his commute?

In fact, there was a specific reason that Tom's journey took 85 minutes on day 8 and that was because there was Tube strike, which meant Tom had to battle in to work via a combination of buses and walking.

This example illustrates the two types of variation we experience in any process. There is the normal variation that you just see in the general run of things in your system; in Tom's case the difference between 42 minutes and 56 minutes. This variation is sometimes called "random variation" or "common-cause variation"; i.e. it is occurring just because of the common causes in the normal system.

Then there are the times when something specific happens to affect the performance of the system – e.g. a tube strike. This type of variation is sometimes called "non-random" or "special cause", because it is not occurring just by chance, but because of something specific, or special.

As well as what we have seen in Tom's example, there are a number of other different rules we can use to identify if the patterns we are seeing in our data are non-random special causes; i.e. they are very unlikely to just be occurring by chance in the normal running of the system. These rules depend on the type of chart you are using to chart your data; Run Charts or the more sophisticated Control Charts (see further info below), and both sets of rules are provided in full in Appendix 1. If you have not yet had training in data over time, as part of Pocket QI or the

Improvement Leaders Programme and are involved in a project, please get in touch with your Improvement Advisor or QI Coach to help you understand these.

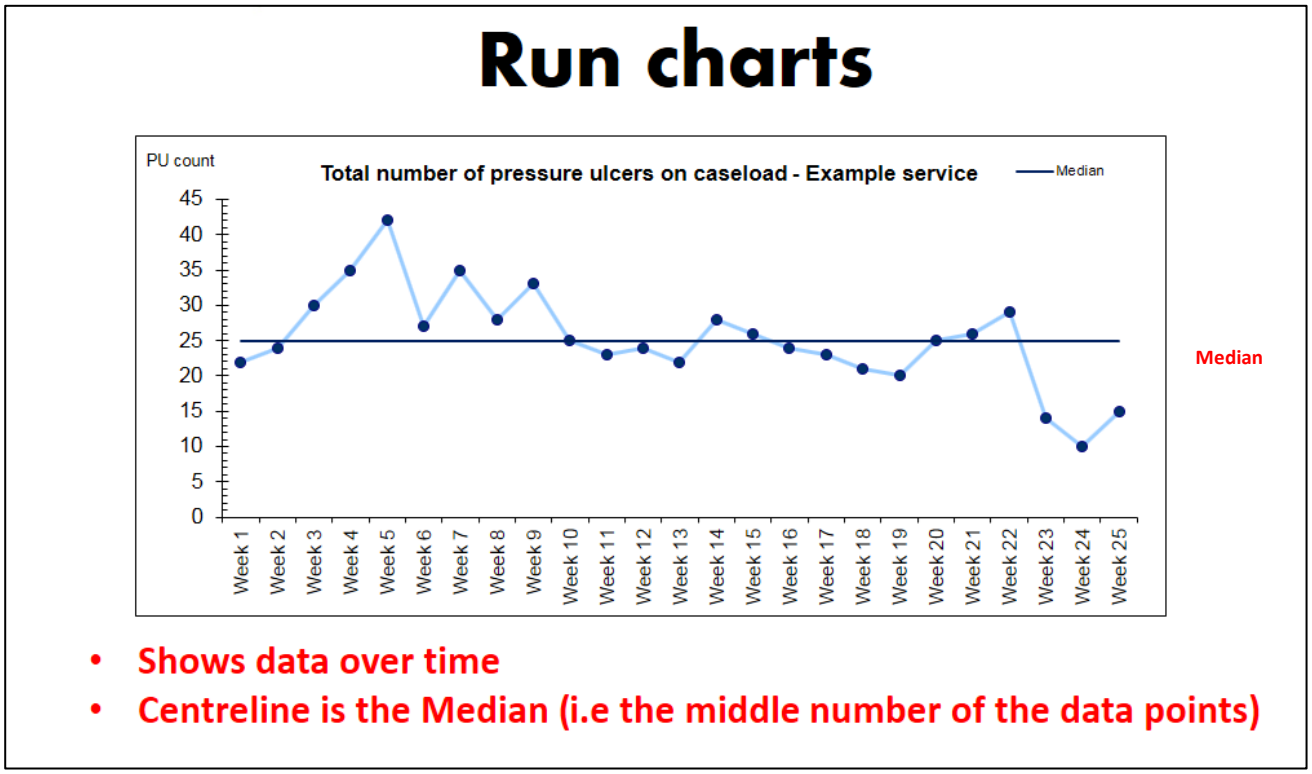
To provide an example of another rule in action, Box 6 has a summary of the CHAMHRAS Waiting Times project, showing an outcome measure *% of people seen within 28 days.* You can see the centreline showing the average has been moved a number of times on this chart. This is because we could see that performance had genuinely improved through there being 8 successive points all above the centreline on the chart.

The key point is you could get 7 points just due to chance, but not 8, so these 8 points are a sign that something has changed the system - in this case the work of the QI project. 8 points above or below the centreline on a Control Chart is one of the rules for detecting special cause variation called a shift.

Run Charts & Control Charts

As mentioned above, we use 2 different types of chart to understand data over time, as shown in the figure below and on the next page. As you can see, these look quite a lot like line charts, which you might be familiar with from school or elsewhere - but they have some important features which set them apart.

Run Charts are the simplest type of chart we use, and the thing which makes it a Run Chart is that we plot the *median*[16] of the points on the chart. Medians are a 'measure of central tendency' and it means we can look at how all the points of the chart are moving in relation to this centreline.



[16] The Median of a set of numbers is the central number when ordered in sequence and counting in from either end; so for example: 1, 3, 6, **7**, 9, 11, 14: 7 is the Median. If you have an even set of numbers, you work out the average of the middle 2 numbers.

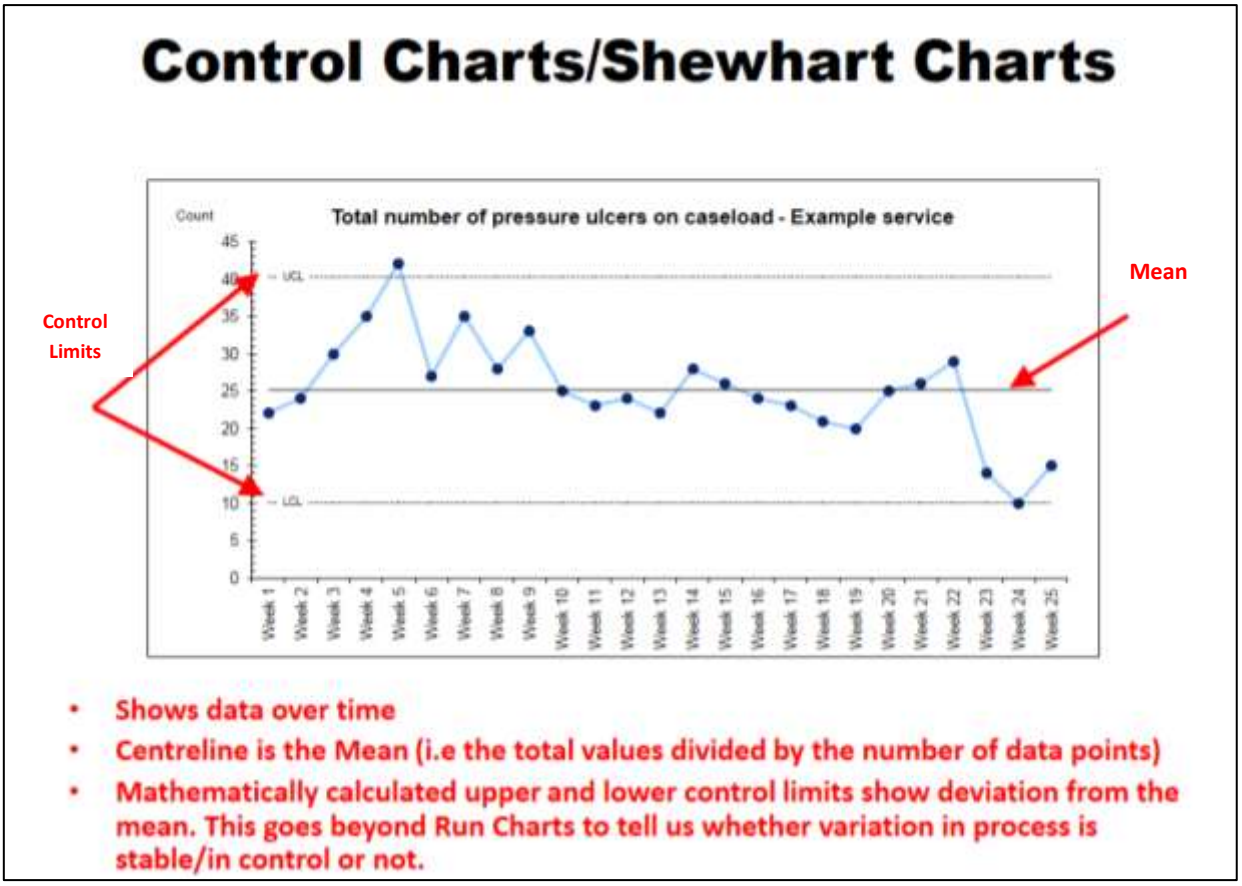
Control Charts, the more sophisticated type of charts are very similar, except for 2 key features:

Firstly, instead of plotting a median, we instead use a *mean*[17] as the measure of central tendency.

Secondly the mathematics behind the chart also enables us to calculate what are called 'control limits'. There are usually two control limits on a control chart, the *Upper Control Limit* and the *Lower Control Limit*. These are the dashed lines you can see above and below the centreline. *The Control Limits show you exactly what the extent of variation is that you can consider as normal in your process*. Any point falling outside these limits is a special cause.

A final point to note about Control Charts is that, unlike Run Charts, there are different types of chart that we use for different types of data. For example we use one type of chart for data which is a count of something, like violent incidents or pressure ulcers (C Chart), and a different type of chart for data which is showing a percentage, such as % DNAs (P Chart).

This is an advanced point and your QI Coach/Improvement Advisor is there to help you work out which type of Control Chart you need. A decision-making tool is also provided in the Appendix if you have already been taught this for reference.



[17] The Mean is what most people think of when they think about an average of a set of numbers. To calculate a Mean you add up all the figures and divide by the number you have. So for example, for the set: 1, 3, 6, 7, 9, 11, 14 the Mean is 7.29 (Total of 51/7)

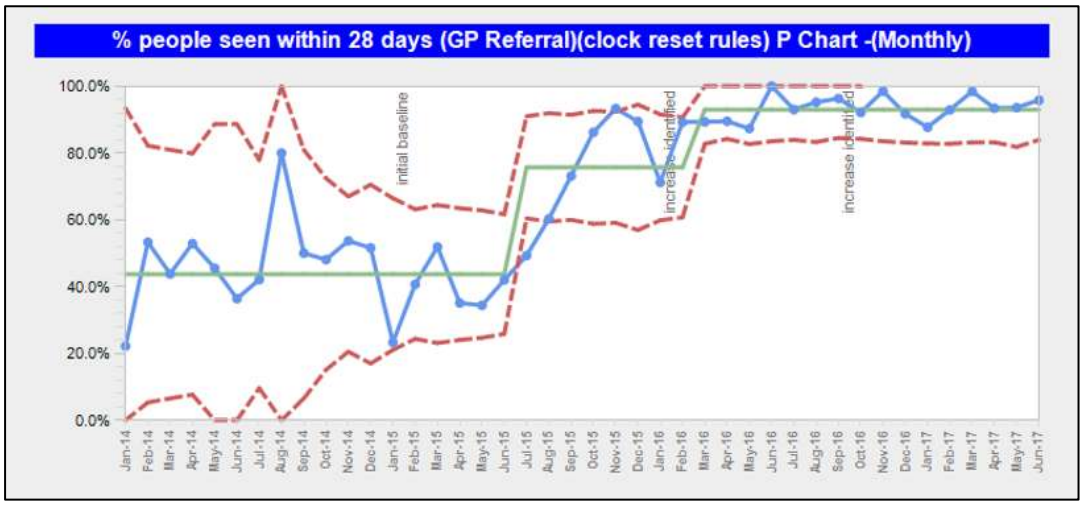
Box 6: Example Project: Improving Access in City and Hackney Adult Mental Health, led by City and Hackney Mental Health Referral and Assessment Service (CHAMHRAS) – Part 1 (Overview)

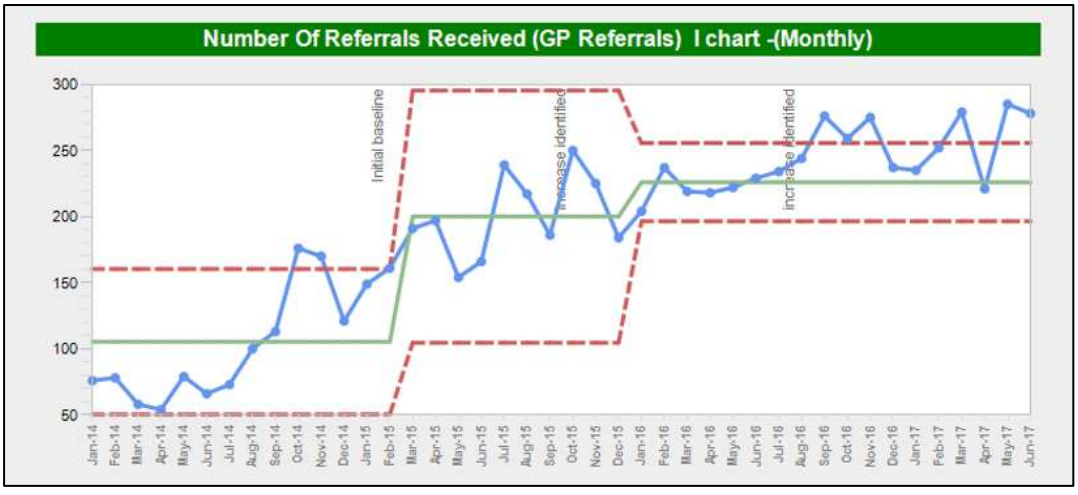
Waiting Times for adult mental health services were a big issue in City & Hackney a couple of years ago. The DMT made this a priority and a multidisciplinary team, involving administrators and clinicians who manage referrals, came together and set an aim to reduce waiting times, so that 95% of patients to be given an appointment for face-to-face contact with any HCP within non-specialist services in City & Hackney within 28 days by December 2015. Only 30% of people were being seen within 28 days in late 2014/early 2015.

The team worked really hard and achieved incredible results:

- The % of people referred by GPs, who are seen within the 28 day target has increased from 30% in 2014 to an average of 93% now.
- As well as looking at the % of people seen within 28 days we also look at average wait time. This has halved from over 36.6 days in 2015 to 18.5 days now.

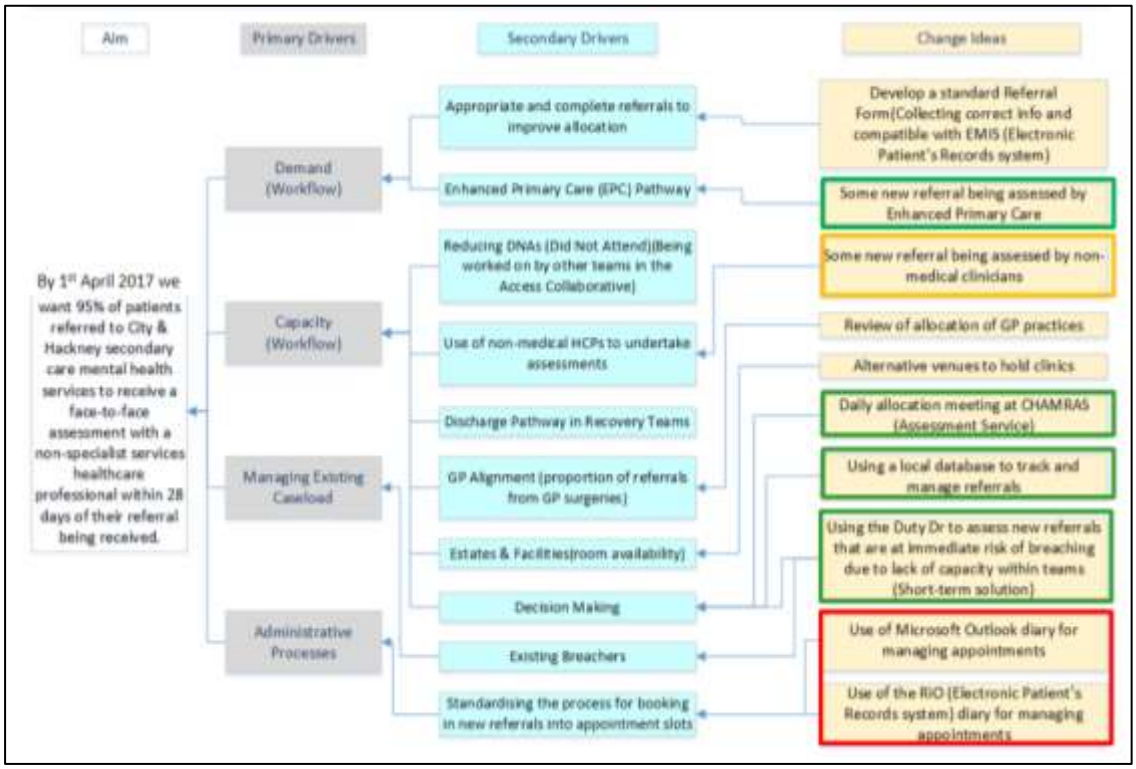
The results have been achieved during a period in which referrals have hugely increased. Whilst in 2014 we received on average 105 referrals from GPs per month, in 2015 this increased to 200 and is now 248 (a 236% increase).





City & Hackney has achieved these results through leading a change in culture, whereby there is now shared understanding of the importance of seeing people as soon as possible, and within the 28 day target. The team used PDSA to help align people and systems to achieve this, including introducing the following change ideas:

1. Daily allocations meeting at CHAMHRAS
2. Developing a local database to check and manage referrals
3. Reminder emails (easily sent from info in database)



5. Progression of QI projects

Your Improvement Advisor will give your project a score, based on how far you've got with your project, using the system and definitions shown below. This can be split into 3 key stages of projects:

Formation/Pre-testing (1.0 – 2.0)

This covers when you are getting your team together and refining your understanding of your problem and the issue you are focusing on. You will also need to be fully defining your measures during this stage and capturing baseline data.

1.0	**Charter and Team Established** A charter has been completed and reviewed. Individuals or teams have been assigned, but no work has been accomplished.

1.5	**Planning for the Project has begun** Organisation of project structure has begun (such as: what resources or other support will likely be needed, where will focus first, tools/materials need gathered, meeting schedule developed).
2.0	**Planning for the Project has begun** Initial cycles for team learning have begun (project planning, measurement, data collection, obtaining baseline data, study of processes, surveys etc.).

Testing (2.5)

This is when you have starting testing ideas for change, using PDSA. You will also need to be gathering your data and charting over time to be able to know if your changes result in improvement

2.5	**Activity, but no changes** Initial cycles for testing changes have begun. Most project goals have a measure established to track progress. Measures are graphically displayed with targets included.

Achieving & sustaining improvement and taking implementation steps (3.0 – 5.0)

From 3.0 onwards, you are seeing and sustaining improvement and making changes, which have made a difference, 'business as usual' within the day to day operations of your team. This is what we mean in QI when we talk about "implementation". To do this, a number of specific steps are needed, as shown in the CHAMHRAS Waiting Times example in box 7. It's very important that these are undertaken systematically and comprehensively to ensure that gains are held for the long term.

Taking implementation steps will be one thing the Improvement Advisor is looking for to increase your project score from 3.0 up to 5.0. The other will be seeing improvement in your outcome measure sustained over time.

3.0	**Modest Improvement** Successful test of changes have been completed for some components of the change package related to the team's charter. Some small scale implementation has been done. Anecdotal evidence of improvement exists. Expected results are 20% complete.
3.5	**Improvement** Testing and implementation continues and additional improvement in project measures towards goals is seen.
4.0	**Significant Improvement** Expected results achieved for major subsystems. Implementation (training, communication etc.) has begun for the project. Project goals are 50% or more complete.
4.5	**Sustainable Improvement** Data on key measures begin to indicate sustainability of impact of changes implemented in system.
5.0	**Outstanding Sustainable Results** Implementation cycles have been completed and all project goals and expected results have accomplished. Organisational changes have been made to accommodate improvements and to make the project changes permanent.

Box 7: Example Project: Improving Access in City and Hackney Adult Mental Health, led by City and Hackney Mental Health Referral and Assessment Service (CHAMHRAS) – Part 2 (Implementation Planning)

Box 6 above described the CHAMHRAS waiting times project. This project was closed in July 2017, having achieved improvement AND satisfying the C&H QI Forum that the project was sufficiently integrated into business as usual, with a clear plan for outstanding implementation steps. Key details from the implementation plan are included below, along with the prompt questions for each area of focus:

1. Standardisation & Documentation:

- *To what extent have you standardised the new ways of working, developed through your project?*
- *Where are these new ways of working written down & saved?*
- *Have relevant policies been updated?*
- *What is your process for keeping new ways of working fresh and reflective of new knowledge?*

Update Operational Policy to include:

- Standardized booking and tracking system
- Reminder emails out
- Weekly referral meetings

Provide guidance on how to access breaches and key charts on Reporting Services / screen shots

2. Staff education/ training / induction / support processes

- *How are new ways of working integrated into HR processes noted above (think about current team members and new team members, including whole MDT)*

Quarterly Training for Admin – delivered B5 in CHAMHRAS

- Escalation procedure if identify appointment is outside 28 days
- Smooth transfer of patients into PCL, resulting in coding problems – protocol written
- Booking and tracking system

3. Measurement & Quality Control:

- *What is your system for knowing whether level of performance is maintained? This may be ongoing measurement over time (e.g. using Quality and Performance Dashboards), oversight of team data or periodic audit*
- *Where will you discuss this data if there is deterioration?*

Data & Visual Management

- Review data on Reporting Services – daily report & Quality & Performance Dashboards
- Nixon's responsibility for looking at Dashboard on daily basis
- Discussed in ongoing biweekly QI meeting for CHAMHRAS DNA project. Following closure, will be discussed in Andrew's monthly management meeting
- Also discussed by Andrew individually with CHAMHRAS manager Maria
- Monitored by DMT

4. Are there any ongoing resource implications associated with the new ways of working you have developed through this project (e.g. do you need funding for any resources?)

- *If so, have you established how these will be met and agreed with senior managers if necessary?*
- None – integrated into business as usual, although we need a waiting list module in the long-term to reduce burden of manual systems

5. Maintaining engagement across your team

- *What actions have you taken to support the engagement and leadership of this work across the whole team?*
- *What forums have you used to build engagement in the project? What forums could you use to keep an eye on the issue, as a whole team?*
- *How would you re-engage the team in the issue if performance deteriorated and staff started to go back to old ways of working?*
- Admin Business Meeting, team level meetings, DMT meetings, Weekly referral meeting, Data visibility: standard emails

Tools to help at different stages of QI projects

There are a range of tools that can help you during the different stages of your QI project. You will learn about these on QI Training and your QI Coach/Improvement Advisor can also help you identify which tools to use depending on the stage you at are.

There is also further signposting to useful tools on the QI Microsite, broken down by stages of project, as shown in the diagram to the left. This information is available here: https://qi.elft.nhs.uk/resources/improvement-tools/

We have included an example of one of our favourite tools which is useful throughout QI projects, on the next page - Nominal Group Technique - but there are many others, so do have a look at on the QI microsite.

Nominal Group Technique

Something we've mentioned a few times in this guide already, is Nominal Group Technique (NGT), which is a really useful tool for generating and gathering ideas and perspectives from groups of people.

It is similar to Brainstorming, but has the following key exceptions:

- Each member of the team is given a pile of sticky notes.
- Each person is asked to **write one idea on each sticky note**.
- Usually about 5-10 minutes is sufficient to get people's ideas down on the sticky notes.
- The sticky notes are placed on a flipchart

We then usually follow this up with creating an Affinity Diagram, which is when you ask the group to organise the sticky notes into themes.

This can be a great exercise to help you identify priorities for focus within a team, or to get people's ideas on drivers and/or change ideas for your team's project.

It has big advantages over brainstorming in that it:

- Gives all people space with their thoughts before hearing from colleagues
- Avoids only hearing from the "loudest voices"
- Avoids people feeling pressured to offer an idea or embarrassed if they don't have one

Give it a go if you want to get people's ideas about something!

6. Celebrating and sharing learning and success

There are a lot of different ways to celebrate and share learning and success in QI projects at ELFT. You can present at conferences, QI Open Days or visits. We often have people visiting from other Trusts to hear about our work, both specifically within City & Hackney and centrally.

All successful projects need to complete a summary poster, so this can join the other 50 successful projects already on the QI Microsite, and the story and learning of your project is easily available to others: https://qi.elft.nhs.uk/resource_category/completed-qi-project/ . We'd also really you to consider publish your project…

Publication

Publication of QI work is pretty easy, thanks to our partnership with BMJ Quality Improvement Reports, a worldwide journal and repository of global quality improvement evidence and best practice. This journal understands the ways in which QI is different to research, so the template fits with the structure of QI projects. A quick guide to publication is below. Talk to your QI Coach or Improvement Advisor if you have any concerns/questions.

- Use this SQUIRE template to write up your project[18]
- Send your completed template to us at qi@elft.nhs.uk so we can review for you.
- Visit BMJ Open Quality[19] online and create a new account
- Use the Author Dashboard to start a new submission.
- Select the publication type (Quality Improvement Report), add a title and a summary/abstract.
- Complete steps 2-7 of your online submission when you are ready and upload up to 5 supporting documents.
- When submitting East London NHS Foundation Trust projects please remember to use our organisation code: 6532822773

Quarterly Newsletter

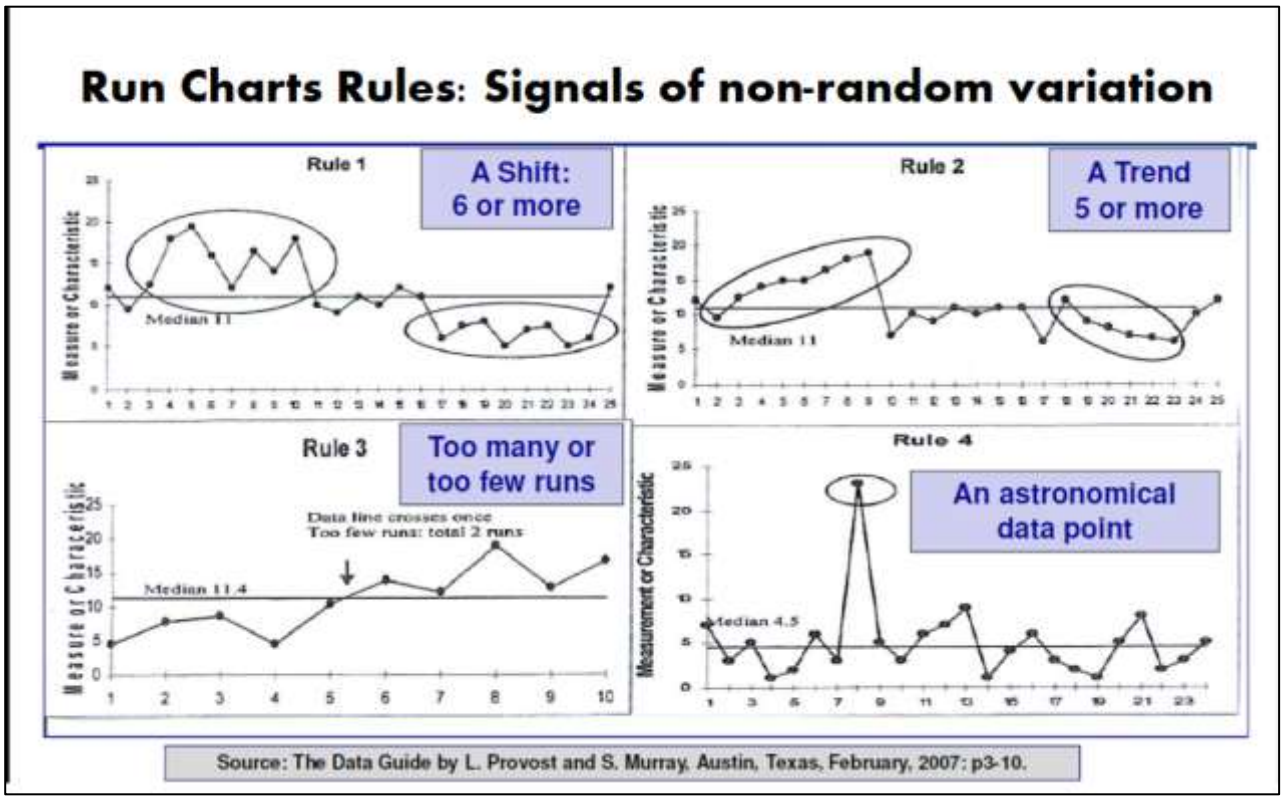
Before the end of 2017 we'll be launching a short quarterly newsletter in City & Hackney, which will have stories about QI projects.

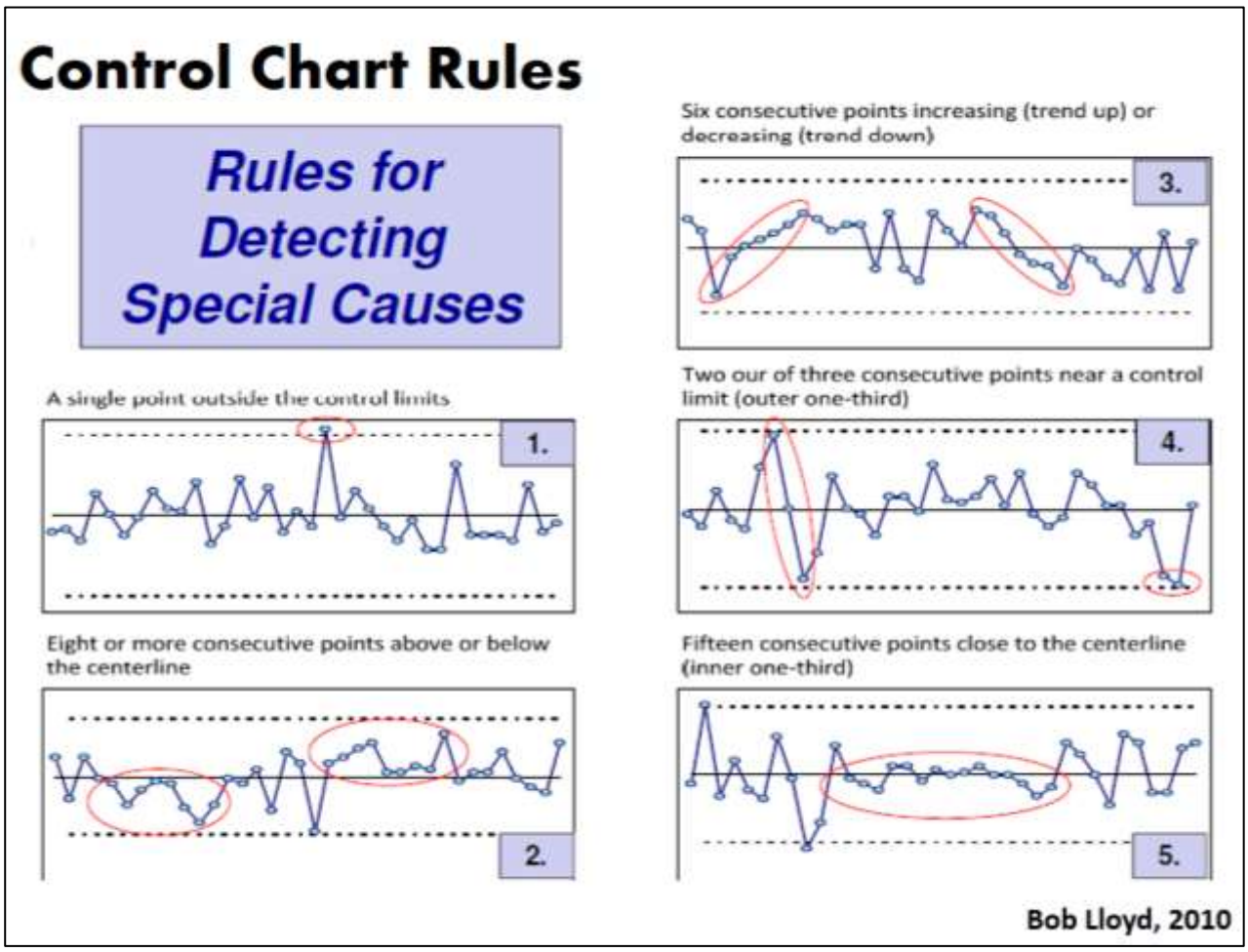
This aims to support us to keep the whole directorate more involved in what is happening with QI work in C&H; new projects, successful projects, opportunities to hear and learn more about QI, who's who in terms of support structures, etc.

Key an eye out for this and let us know if you have any stories you'd like to include: email the C&H Improvement Advisor or Quality & Clinical Governance Lead Maryam Hussain.

[18] https://qi.elft.nhs.uk/resource/squire-template-for-bmj-quality-report-submission/
[19] https://mc.manuscriptcentral.com/bmjoq

Appendix 1: Run & Control Chart Rules[20]





[20] If you have not received training on these as yet and you are already part of a project, please talk to your QI coach

Table 3.4 Runs Rule Guidance—Table for Checking for Too Many or Too Few Runs on a Run Chart

Total number of data points on run chart not falling on median	Lower limit for number of runs (< than this is "too few")	Upper limit for number of runs (> than this is "too many")
10	3	9
11	3	10
12	3	11
13	4	11
14	4	12
15	5	12
16	5	13
17	5	13
18	6	14
19	6	15
20	6	16
21	7	16
22	7	17
23	7	17
24	8	18
25	8	18
26	9	19
27	10	19
28	10	20
29	10	20
30	11	21
31	11	22
32	11	23
33	12	23
34	12	24
35	12	24
36	13	25
37	13	25
38	14	26
39	14	26
40	15	27
41	15	27
42	16	28
43	16	28
44	17	29
45	17	30
46	17	31
47	18	31
48	18	32
49	19	32
50	19	33
51	20	33
52	20	34
53	21	34
54	21	35
55	22	35
56	22	36
57	23	36
58	23	37
59	24	38
60	24	38

Table is based on about a 5% risk of failing the run test for random patterns of data.

Source: Adapted from Frieda S. Swed and Churchill Eisenhart.[7]

[7]Ibid.

In Health Care Data Guide, p80

Appendix 2: Control Chart Selection Guide