Improving the quality of mental health and community services

Successes and lessons from the first year of ELFT's Quality Improvement Programme

August 2015

Foreword

Providing high quality care for our service users is the reason why most of us work in the NHS, and why we often go far beyond the limits of our job descriptions in our efforts to ensure every service user receives care that we are proud of. Often though, we experience a sense of frustration and helplessness that the system just isn't helping us do our jobs as well as it could.

At East London NHS Foundation Trust (ELFT), we have been working hard to provide an environment where all our staff feel that they have the authority, the skills and the support to make the system work for them and the communities that they serve.

Our Quality Improvement (QI) Programme is designed to change the very culture of this organisation, to shift power and decision-making to the frontline, where teams and service users can work together to tackle some of our most complex quality issues and unleash their creativity and innovation. Increasingly, this is being recognised outside of ELFT as best practice and the route to transforming care delivery at the scale and pace needed to ensure the NHS survives and flourishes.

The QI Programme launched in February 2014 and is a vehicle to help us achieve our mission of providing the highest quality mental health and community care in England. Our focus on Quality Improvement has already demonstrated significant impact, not just in terms of numbers and 'hard outcomes' but, just as importantly, in the way that people feel – whether as a recipient of care or as someone working within the organisation.

Just as we ask our teams to continuously reflect on the quality of care being provided and make iterative adjustments, so too is the QI Programme continuously adapting to changing needs and environments. At the end of the first year of the programme we undertook an internal evaluation to help us understand the factors helping and hindering our approach to quality improvement: we want to learn how to adapt our approach. As QI is such a core element of our strategy as an organisation, this evaluation is critical in helping us learn and improve.

We would like to thank the service users, staff and senior team who are making the Quality Improvement Programme a success and who shared their ideas and insights with us so freely.

We would also like to thank members of the evaluation team, who were drawn from different parts of the organisation:

- Forid Alom, Quality Improvement Data Analyst
- Dr Shweta Anand, Higher Specialist Trainee in Psychiatry
- Mallissa Edward, Quality Outcomes and Experience Coordinator (and project manager for this evaluation)
- Duncan Gilbert, Health Care Governance Manager
- Selina Hossain, Social Therapist
- James Innes, Head of Quality Improvement
- Dr Omer Malik, Higher Specialist Trainee in Psychiatry
- Odud Miah, Quality Outcomes and Experience Analyst
- Simon Tulloch, Head of Quality, Innovation and Patient Experience

Professor Debra de Silva and Chris Singh from The Evidence Centre helped us along the journey.

We feel privileged to work in an organisation with such passionate and caring staff; where it genuinely feels like quality of care is our number one priority. We hope that you find this evaluation an interesting read, and that we can use the findings to improve the way in which we support and inspire all our staff, service users, carers and stakeholders to provide the highest quality care.

Dr Kevin Cleary
Medical Director

Dr Amar Shah
Associate Medical Director for QI

Key messages

Why Quality Improvement?

East London NHS Foundation Trust has set itself a mission to provide the highest quality mental health and community care in England. The Trust has developed a large scale Quality Improvement (QI) Programme to support teams to continuously improve the quality of care provided.

The QI Programme was officially launched in February 2014 and two initial stretch aims were set: to reduce harm by 30% every year and to ensure that every patient receives the right care, in the right place at the right time. To date, the QI Programme has focused on building motivation throughout the organisation to use QI approaches, enhancing people's knowledge and skills in QI, supporting teams working on QI projects associated with the two stretch aims and ensuring that QI work is aligned and embedded into business as usual.

How was the Quality Improvement Programme evaluated?

The Trust wanted to understand the impact of the QI Programme over the first 12 to 18 months, so an internal team was drawn together to compile evidence. The evaluation team examined:

- the extent to which there is increased will to implement QI
- whether staff have increased knowledge and skills related to QI
- the extent to which systems are aligned with the QI approach
- whether there has been a reduction in harm
- whether QI approaches are helping to deliver the right care, at the right place and time
- what is helping and hindering the implementation of QI

Over a three month period, the evaluation team used qualitative and quantitative methods to draw out key learning about how the Programme is being delivered and what lessons have been learnt thus far. Methods included compiling existing statistics; interviews with service users, staff and Board members, and surveying people who had and had not taken part in QI training.

Building the will

The evaluation found that the Trust has undertaken a large and multi-faceted communication campaign to build awareness around the QI Programme. This included face-to-face engagement through a series of launch events, roadshows and conferences, the creation of a bespoke QI microsite, regular digital and paper-based internal and external newsletters and the use of social media. Moreover, recognising the power of narrative, every Trust Board meeting features a staff or service user story. The evaluation team found that communications are welcomed by staff and service users, but there remains scope for wider reach and accessibility of information.

Building capability

The QI Programme aims to increase staff knowledge and skills about QI. A centralised QI team has been in place for over 12 months. A six-month Improvement Science in Action (ISIA) course has been delivered to 365 people, 225 people have used an online training course (IHI Open School) and 30 QI coaches are beginning a six-month improvement coaching course. Training initiatives appear to have had a positive impact, with a shift in staff perceptions of capability within the organisation between 2014 and 2015. However, the evaluation also found that the length and accessibility of training may be a barrier to involvement, so there is further work to do in this regard.

Alignment

The Trust aims to integrate QI into operational structures and systems so that QI work is aligned and embedded into business as usual. There are more than 160 QI projects running throughout the Trust. QI project teams now have access to a local support structure that includes QI sponsors, coaches and forums attended by QI Leads and People Participation Leads. The Trust has built support systems to enable QI work to flourish. However, more could be done to increase levels of service user and carer involvement in QI projects, address the time and resources required to undertake QI work and help teams understand how other improvement methodologies sit alongside the QI Programme.

Reducing harm

The Trust set itself the aim of reducing harm by 30%, year on year, across the organisation. Analysis of routinely collected data suggests that that there has been a reduction in harm associated with physical violence (6%), pressure ulcers (33%) and restraint (15%) across the organisation. These changes may not be solely attributable to the QI Programme, however a comparison of participating versus non-participating wards and units found that those taking part in the QI Programme had greater improvements in violence reduction and reduced use of restraint. There was no change in the rate of falls across the Trust. No Trust-wide measures are available to determine the impact on medication errors.

Right care, right place, right time

Another key goal for the Trust is to ensure that every service user receives the right care, in the right place, at the right time. It is difficult to evidence changes in this stretch aim owing to a lack of organisation-wide measures, though case studies from individual projects are beginning to show changes. Work on this aim began in 2015 and collaborative learning systems have been put in place to support teams aiming to improve access and improve physical health.

Helpful and hindering factors

The evaluation found that a number of factors supported implementation of the QI Programme. Helpful factors included engagement of frontline teams, support from the QI team and strong leadership. The three most commonly identified barriers were unclear expectations regarding the QI Programme, lack of support structures and communication issues. QI training was identified as both a helping and hindering factor. Training was perceived to help by offering a creative programme to spark ideas and support change. On the other hand, there was a perceived lack of accessibility and a lack of flexibility of training options which impacted on the extent to which some frontline staff felt they could engage with the Programme.

Lessons learnt

1. A well-functioning support structure is critical to enable QI work

Drawing all of the evaluation information together, there are some key lessons learnt. QI projects surrounded by a well-functioning support structure have found it easier to progress. Projects that were part of collaborative learning systems made significant progress, with more examples of improvement in outcomes. Having someone such as the ward manager, matron or consultant leading projects was particularly helpful. This may be because these team members could find ways to create a structure that enabled QI to be incorporated into day-to-day work.

2. Training has had a positive impact on those who have attended, as well as the volume and progress of projects. However, there is room to develop more accessible training approaches.

Rolling out training on a large scale has helped many teams understand and implement QI approaches. However, a number of staff highlighted a perceived lack of access to training. People interviewed and surveyed during the evaluation suggested that most staff trained to date are senior, that current training options are not flexible enough and there is limited awareness of the range of alternative learning resources that the Trust has made available.

3. Time and resources are critical issues for those attempting to use QI approaches.

The impact of time and resourcing was a theme running through many of the evaluation interviews and survey responses. This included the time and resource required to undertake QI training and the time and resource needed to undertake QI work itself. Where clinical leaders were not only involved but leading QI projects, they were often able to create a structure and space to incorporate QI into day-to-day work. There is more work to do to consider how QI can be further integrated into the usual business of the Trust, so that it is seen as a fundamental priority rather than an add-on.

4. The QI Programme is using numerous communication channels and there is scope to extend this further.

The Trust has undertaken widespread communication to raise awareness about the QI Programme. The evaluation suggests that there is scope for ongoing development in this area. The Trust could report more widely on the outcomes of QI projects, create more awareness about what has been learnt from QI projects, improve communication about how to access different types of training and learning resources and communicate about how QI links with other improvement work undertaken.

5. Service user involvement in QI work could be strengthened.

Overall, one third of QI projects report some level of service user input (35%). It is positive that some projects have service user input, but there is much to be done to increase this figure. Interviews with a small number of service users suggested that people were unaware of the QI Programme. A broad range of activity is underway to increase service user input into QI projects and there could be more communication about what QI is and how service users could get involved.

Recommendations

Based on all of the feedback and data collated, the internal evaluation team makes the following recommendations:

1. Support structures around QI projects need to be strengthened. Whilst collaborative learning systems are in place for high priority topic areas, directorate leaders throughout the Trust need to create a clear support structure for QI so that this work becomes business as usual.

2. Directorate leaders and QI sponsors should look at what work could be done differently, or not all, to make space for tackling complex issues through QI.

3. More QI training options should be available, of varying lengths and depths, to make training more accessible for a diverse group of service users, carers and staff.

4. QI-related communications should include more emphasis on the outcomes from QI projects and help staff understand how the QI Programme integrates with improvement work previously undertaken in the Trust. This would emphasise that the QI Programme is not just the 'latest thing', but a fundamental component of the Trust's identity and future. More could also be done to increase access to information about QI projects so that other teams can learn and harvest ideas.

5. More needs to be done to engage a broader group of service users and carers. This may involve wider and more user-friendly communication as well as strengthening the structures and processes to support service user involvement.

Over the past 12-18 months, the QI Programme has increased improvement skills, structures and motivation. Demonstrable improvements are beginning to emerge in reducing harm, which is a significant achievement in such a short space of time. The staff and service users of the Trust can be proud of all that has been achieved – and further motivated by the benefits that will accrue as the recommendations from the evaluation are implemented.

Contents

1. Setting the scene

Overview

East London NHS Foundation Trust helps many thousands of people every year, providing much-needed mental health and community healthcare services. The Trust is committed to helping people fulfil their potential and is equally committed to providing the very best care for service users and carers. Services are provided in East London, with some specific specialised services in other parts of London, Hertfordshire, Essex and Bedfordshire. The Trust operates from more than 100 community and inpatient sites and employs almost 5,000 permanent staff.

The Trust embraces continuous improvement and learning. The organisational mission is to 'provide the highest quality mental health and community care in England' and the Trust has set two broad aims to help achieve this goal:

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

One of the key ways that the Trust hopes to achieve these aims is through building the motivation, structures and skills for service users and staff to continuously improve quality and safety using systematic quality improvement approaches. This report describes the Quality Improvement (QI) Programme launched in February 2014 and its outcomes over the first 12-18 months. The purpose is to summarise what is known about the QI Programme, to celebrate successes and to provide a platform to continue learning and developing to promote sustained change. This section sets the scene. The next section explores impacts to date and the final section compiles lessons learnt and recommendations.

Rationale

The Trust was delivering high quality care and was recognised as a centre of innovation and excellence. However, as is the case in many large organisations, there was some inconsistency and variation so the Trust made a commitment to quality of care being the foremost priority. The Trust recognised that achieving its goal of providing the highest quality mental health and community care in England by 2020 would require a new approach to quality. The Trust chose to undertake a large scale QI Programme for a number of reasons, including:

- consensus across all the Trust's stakeholders that quality of care should be the primary focus;

- a number of recent national reviews which highlighted the need to focus on developing compassionate services, with systems and structures in place to support continuous improvement;

- the relationship between staff satisfaction and patient outcomes;

- the desire to shift the power balance in the organisation so that staff in closest contact with service users and carers feel engaged and able to drive change and improve the quality of care;

- the economic climate, which requires organisations to innovate, adapt and identify new models of care at scale and pace.

Figure 1: Factors influencing the setting up of the QI Programme

The right thing to do	Francis, Keogh and Berwick reviews	Engaging our staff	The economic climate
• Improving quality of care is our core purpose • Of greatest importance to all our stakeholders • Build on the excellent work already happening to improve quality	• The need to focus on a more compassionate, caring service with patients first and foremost • More structured and bottom-up approach to improvement	• The desire to engage, free and support our staff to innovate and drive change • Engaged and motivated staff leads to improved patient outcomes	• The need to do more with less: – improving quality whilst reducing cost

In 2013, three landmark reports about quality and safety in the NHS espoused the development of an organisational culture which prioritises patients and quality of care and pursues high quality care through continuous improvement (Francis report, Keogh review and Berwick report). In addition but not unrelated, funding for the NHS is likely to remain static or possibly decline in real terms. Achieving year-on-year efficiency savings by focusing on rationalising inputs to the system (workforce, assets) is increasingly difficult and is likely to affect staff morale and quality of care. Clinical processes can be a source of inefficiency, and frontline teams have the knowledge and ideas to change this. Redesigning clinical pathways with the ambition of providing patient-centred, high value care offers the potential to realise continued savings from the health economy whilst delivering an improved quality of service. Successful redesign at this scale requires improvement expertise, dedicated resources, rigorous application of a consistent methodology and a fundamentally different approach to quality, which involves putting patients and the families at the heart of the design and improvement work.

The Trust recognised that providing consistently high quality care requires continual improvement – always seeking to do things better. The work required to achieve this may take several years and involve embedding improvement alongside assurance, performance management, research and innovation to develop a holistic approach to quality. The Trust's strategy takes a whole-organisation approach to quality improvement and is built on experience and best practice from healthcare organisations and systems across the globe.
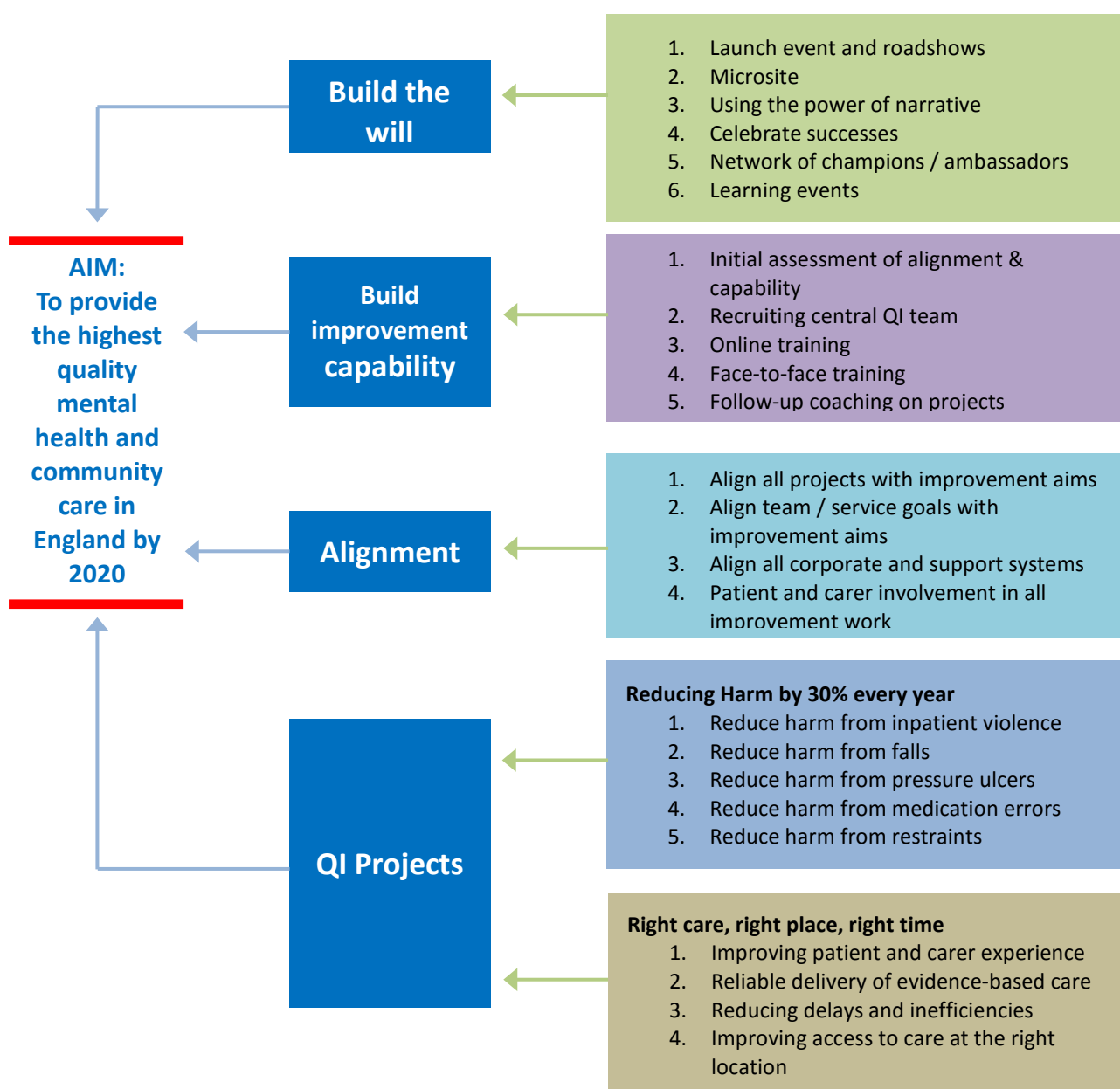
Underpinning principles of the QI Programme

The QI Programme aims to:

- support frontline staff to work in partnership with service users and carers, providing teams with the skills and freedom to innovate and test out ideas which could make a real difference;

- support hundreds of quality improvement projects at the frontline, measuring their impact and spreading those ideas that have been shown to improve the quality of care;

- help teams focus on the aspects of care that are of most importance to service users and stop activity that is of less value;

- embed a culture of listening to staff, service users and their families in efforts to continuously improve our services;

- measure the impact of making changes over time;

- build improvement teams involving a range of staff and service users that work together to flatten hierarchies, capture diversity of opinion and ideas, and engage everyone to be part of improvement work.

Components of the QI Programme

The theory of change underpinning the QI Programme is that improving motivation to take part, increasing QI skills and aligning support structures and systems will all lead towards improved quality of care. Figure 2 sets out the specific interventions that were used over the first year. For instance, launch events, an online microsite and learning events were used to build the will to take part. The exact activities and outcomes are described in more detail in Section 2.

Figure 2: Driver diagram representing theory of change of QI Programme

AIM:
To provide the highest quality mental health and community care in England by 2020

Build the will
1. Launch event and roadshows
2. Microsite
3. Using the power of narrative
4. Celebrate successes
5. Network of champions / ambassadors
6. Learning events

Build improvement capability
1. Initial assessment of alignment & capability
2. Recruiting central QI team
3. Online training
4. Face-to-face training
5. Follow-up coaching on projects

Alignment
1. Align all projects with improvement aims
2. Align team / service goals with improvement aims
3. Align all corporate and support systems
4. Patient and carer involvement in all improvement work

QI Projects

Reducing Harm by 30% every year
1. Reduce harm from inpatient violence
2. Reduce harm from falls
3. Reduce harm from pressure ulcers
4. Reduce harm from medication errors
5. Reduce harm from restraints

Right care, right place, right time
1. Improving patient and carer experience
2. Reliable delivery of evidence-based care
3. Reducing delays and inefficiencies
4. Improving access to care at the right location

Key elements of the QI Programme include setting goals and having central coordination from a **QI team**. The team comprises improvement facilitators who work with frontline teams on improvement projects and organise training, learning collaboratives and other resources.

The Trust recognised that to change the culture of the organisation, people at all levels and areas of the organisation needed to be involved, including staff, service users, carers, volunteers, commissioners, Governors and members of the public. The '**building the will**' workstream focused on using engagement channels to raise awareness alongside starting to build a grassroots movement. Traditional engagement activities included a formal launch event for the programme in February 2014 attended by around 250 people and road-shows across every major Trust site between March and May 2014. The grassroots campaign relied on developing local champions, using a publicly available microsite and attempting to make improvement opportunities widely available.

Another strand of the programme involves **building improvement capability**. The Trust partnered with well-known leaders in healthcare improvement, the US-based Institute for Healthcare Improvement, to build improvement skills in the workforce.

The Trust reviewed and **aligned corporate systems** to support improvement work. This included making data about successes and complaints more visible; reviewing policies and procedures to ensure they support the development of a just culture; reviewing the clinical audit programme; refreshing the induction process, and ensuring that quality improvement is embedded within all internal training and development.

A short video clip is available summarising the first year of the QI Programme at https://vimeo.com/121658198.

The report now turns to explore how the impacts of the QI Programme have been measured.

Evaluation approach

The Trust recognised that it was essential to track progress of the QI Programme. Whilst it was not expected that there would be significant changes in outcomes over the first 12-18 months, it was important to understand whether the Programme was on the right track and what factors may most help and hinder.

A small internal team was brought together from different parts of the organisation, including frontline staff, the QI team and managerial and analytical staff. This team developed and implemented an evaluation focusing on the following questions:

- To what extent is the QI Programme achieving its objectives to build the will, build capacity, align systems, reduce harm and improve the provision of the right care in the right place at the right time?

- What factors are helping and hindering the QI Programme?

The evaluation used a mixed methods approach to draw together data from a range of sources. The evaluation process included compiling pre-existing data, repeating baseline surveys and supplementing these data with new information, primarily qualitative data drawn from interviews, focus groups and additional surveys.

Figure 3 summarises the methods used over the three month period between May-July 2015.

Figure 3: Evaluation methods used to assess QI Programme progress

Project Evaluation					
Quantitative data		**Survey**		**Interview**	
Trustwide	Directorate Level	Cross-sectional (trustwide)	Board level	Individual	Group
% reduction in harm (for areas of QI work: violence, medication safety, falls, pressure ulcers, restraints) * % improvement in patient experience * % improvement in staff engagement *	number of quality improvment projects undertaken number of people trained in QI methodology & Open School lessons completed impact of training on improvement science knowledge	Safety Culture Survey * IHI Improvement Capability Self Assessment * QI Building Framework Assessment (abridged version?)	'From the top' Board self assessment *	Organisation level self assessment discussion questions for QI (amended version?)	Staff group specific semi-structured tool (to be developed) Ward/service specific semi-structured tool (to be developed)

*Denotes baseline data available

Statistical data sources

The quantitative data sources used were wide and varied. They included:

- incident reporting data extracted from Datix;

- QI Programme statistics extracted from the QI mastersheet. This is the central hub where all the data for each QI project is stored ie project title, topic, aim, team members etc. This allowed the team to calculate statistics about all of the projects, including breakdowns by directorates, by trust priority projects and by project status;

- IHI Open School data downloaded from the online IHI Open School portal. This provides information about the number of people signed up and modules completed;

- BMJ Quality reports sent monthly to the QI team. This is a platform for project teams to share their progress;

- QI microsite statistics extracted from the Wordpress statistics page which gives a breakdown of website visits. Usage was monitored up until May 2015;

- Data extracted from the following sources:
  - NHS Mental Health Benchmarking Framework (2013, 2014)
  - NHS District Nursing Benchmarking Framework (2014)
  - NHS CORC Benchmarking Framework (2013, 2014)
  - Quality Health Community Service User Survey (2013, 2014)
  - National Audit of Schizophrenia (2011-12, 2013-14)
  - NHS Staff Survey (2010-2014)

Surveys

The evaluation team drew on surveys that staff completed before and after QI training and on Trust-wide surveys to assess perceived capability and progress across the organisation.

Trust-wide baseline surveys were conducted in April 2014 and follow-ups were undertaken in June-July 2015. here possible, the evaluation team tried to keep the respondents to these surveys as similar as possible to allow for more direct comparison. For example, the Board 'Improvement Capability Self-Assessment' survey was completed by very similar individuals (the Board has remained stable over the last year and response rates were high at both time points). For other surveys, a cross-sectional sampling frame was used. The aim was to include similar respondents at times one and two, although they were not identical respondents.

Staff were also surveyed before and after attending QI training. Surveys were handed to staff on the first day of the three-day training and then the last day of the three-day training. In Wave 1, 42 people completed the surveys before training and 44 people completed surveys at the end. In Wave 2, 84 people completed surveys before the training and 109 people completed surveys at the end. A before-and-after data analysis was conducted.

Interview methodology

The evaluation team spoke with staff and service users to understand people's perceptions of the QI Programme and learn 'from the ground up' about what has helped and hindered the Programme. During June and July 2015, over 70 interviews with individuals and clinical teams across the organisation were conducted. A further 68 surveys were completed online in response to interview-style questions. Data were analysed using a thematic analysis to draw out general themes.

Table 1 shows the number of people invited for interviews and those who took part.

Staff members were chosen at random from a full staff list provided by the Human Resources Department, a list of people who are formally registered as being involved in a QI project and a list of staff that have completed the internal QI training.

All senior members of staff (Directorate Management Team members) were contacted and asked if they wanted to participate. Of the 61 who expressed an interest, 20 were chosen at random to participate in a telephone interview. The remaining 41 were sent the same questions via an online survey. Eleven people completed this survey.

The team also spoke with key people involved in managing implementation of the QI Programme, including the Head of Quality Improvement, Senior People Participation Lead and the Programme Manager.

Table 1: Number of people interviewed

Interview Group	Invited	Interviewed
Senior staff	20	18
Individual interviews with frontline staff trained in QI	10	6
Individual interviews with frontline staff involved in the Programme	10	6
Individual interviews with frontline staff not involved in the Programme	33	9
Group interviews with teams involved in the Programme	7	4
Group interviews with teams not involved in the Programme	5	5
Service users*	3 teams	7 service users

* The evaluation team aimed to speak with service users on the same occasion as visiting ward teams and then interview as many people as were available and willing. Six of these interviews came from two teams who did not have a formal QI project registered and one came from a team with an active QI project.

The interview questions were developed by the QI evaluation group, drawing on past work and existing discussion tools. The focus was on gaining an understanding of people's current knowledge and experience of quality improvement, to understand better what has helped and hindered progress, and gather thoughts from people on the ground about ways the Trust can support future QI work. The questions themselves were slightly different for each category of respondents. The team aimed to keep the interviews short so a maximum of six questions was used. The People Participation Team checked questions to ensure the service user questions were meaningful.

Most of the interviews with individuals were carried out over the telephone to maximise the number of people that could be spoken with during the evaluation timeframe. Group interviews took place when the evaluation team visited frontline team meetings to speak with as many of the team members as possible with minimal disruption to their working day. The interviewers made notes during these interviews. Thematic analysis was performed on all notes, broken down by categories of people to ascertain any common themes. Illustrative quotes were extracted.

Method for strategy group

The evaluation team set up a subgroup to develop an ongoing evaluation strategy for the QI Programme. The strategy group used the following method:

- Internet search to inform evaluation report and strategies;
- Group discussion to identify key elements of the evaluation strategy, method, measurement plan, sample size and resource requirements;
- Report back to the whole evaluation team for feedback.

Information from all of the methods was drawn on when analysing the progress of the QI Programme. For example, interview feedback was used to help assess building the will, capability alignment, and helpful and hindering factors. Quantitative data was similarly used across report sections.

The report now turns to examine findings about the impacts of the QI Programme. The findings are broken down into what the Trust describes as the 'primary drivers' for the Programme: building the will, building capability, alignment, reducing harm and providing the right care in the right place, at the right time. These span a mix of process and outcome indicators.

2. Impacts

2.1 Building the will

Activities to build the will

Building the motivation and will amongst teams to take part in the QI Programme was a central activity in the first year. As outlined in Figure 2 previously, core activities to build the will included:

- Launch event and roadshows
- Microsite
- Using the power of narrative
- Network of champions / ambassadors
- Celebrate successes
- Learning events

Each of these is explored in turn. Learning events are covered in the section about building capability.

Launch event and roadshows

The QI Programme officially launched on Friday 28th February 2014. Over 200 delegates attended the launch event. The partnership with the Institute for Healthcare Improvement was developed, a central QI team was established and the programme provided staff with access to the BMJ Quality platform to document their QI projects and publish their work.

Following the launch event, there were 26 roadshows at 15 sites across the Trust. During roadshows, the QI team met with over 750 staff, service users and carers to begin the conversation about what quality improvement is, and how it might support better quality care.

Microsite

A website was set up with QI resources. As of May 2015, there had been 61,648 views of the microsite. The frequency of visits to the microsite increased over the year (see Figure 3).

During evaluation interviews with senior staff and staff directly involved in QI projects, people said they valued the microsite as a useful tool in their QI work.

Figure 3: Monthly number of visits to the QI microsite
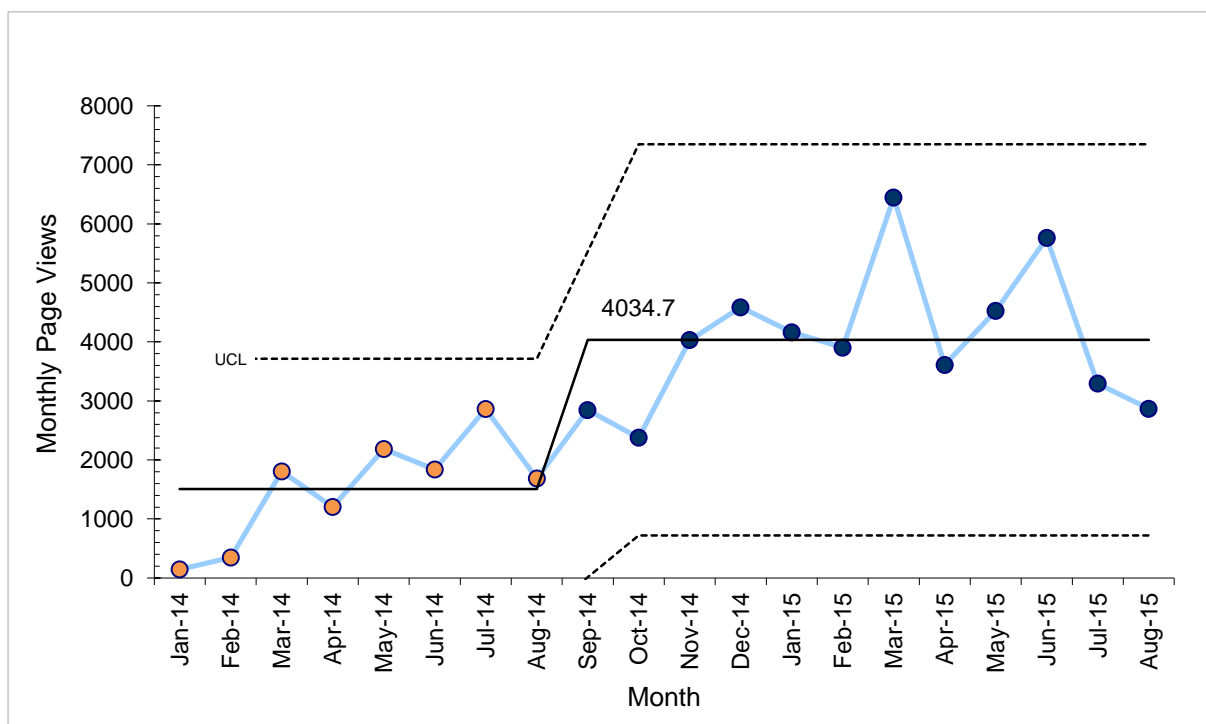
Narrative

The Trust also put in place processes to use narratives or stories to support improvement. For example, each Trust Board meeting begins with a patient or staff story and Board meetings also now include an improvement story presented by a frontline QI project. Case studies and stories are also used in QI newsletters (described below).

Network of champions / ambassadors

At the beginning of the QI Programme, the team consisted of 2.5 full-time staff. Over the course of the first year this grew to include three clinical fellows (2.5 whole time equivalent) and a data analyst.

The support structure includes 50 QI sponsors spread across each directorate of the Trust. Each directorate has recently appointed QI coaches, who will have ring-fenced time in their job plans to support QI project teams from August 2015 onwards.

Figure 4 illustrates the roles supporting each QI project. The Trust is in the process of training more local champions as QI coaches. The coaches will provide advice, coaching and support on using the QI methodology. QI sponsors have also been put in place to help tackle barriers to change.

As well as operational teams, leadership is important for building the will and role modelling. A survey administered to staff in 2014 and again in 2015 found a trend towards improved perceptions of the extent of leadership for improvement (see Figure 5). While most responders in 2014 felt the Trust was 'just beginning' or 'making progress', the majority of respondents in 2015 thought that the Trust's leadership for improvement was 'making progress' or having 'significant impact'. There was an increase in the number of people scoring the Trust at the 'more effective' end of the spectrum, with 18% rating the Trust as having made significant impact and 7% rating the Trust as exemplary. Both of these figures are increased from the previous year, suggesting that leadership structures are continuing to develop that align with the aims and needs of staff.

Figure 4: Champions and support surrounding each QI project

Role of project sponsor:
- A senior member of staff with influence over the system that the team is working on
- Not necessarily an expert in improvement methods
- Provide help in overcoming barriers faced by the team
- Champion the cause
- Link the team's work with high-level goals, so the team knows how their work fits into the big picture
- Support DMTs in development of annual improvement priorities, and planning QI capability building within the directorate

Role of an improvement coach/QI Lead:
- Deeper knowledge of improvement methods and tools
- Support and facilitate QI teams within local directorates
- Coach teams and project leads, meeting on a frequent basis
- Teach and explain use of QI tools and methods
- Support the team to build momentum through rapid cycle testing
- Support the team to use data over time to guide QI work
- Liaise with sponsor regarding any challenges faced by QI team

Project sponsor

QI lead or improvement coach

QI project team
(including project lead)

Role of project lead:
- The day-to-day leader of the project, driving progress, assuring that tests are implemented and overseeing data collection. It is important that the project lead understands the details of the system being worked upon, and the various effects of making changes in the system. This person needs to be able to work effectively with the other members of the team
- Coordination of team meetings, organising agenda and recording of outputs from the meeting, tracking actions between meetings
- Monitoring progress of the project, and allocating team resources effectively to ensure the project remains on track and focused
- Encourage, involve, educate and communicate with the team
- Ensure involvement of service users / carers / voice of the customer within the project
- Actively participate as a member of the team, contributing ideas and participating in the team processes and decisions
- Responsible for reporting on the project within the wider organisation
- Key point of contact for the project sponsor

Figure 5: Staff views of Trust-wide leadership for improvement over time

However, interviews conducted by the evaluation team suggested that whilst leadership and support from the QI team was helpful, more support would be welcomed, particularly more local leaders to support teams.

"Quality champions to encourage/motivate/reinforce positive behaviour, giving them recognition."

"Champions have only just been identified and their impact on the ground is not felt. It is clear who the QI leaders are. I think the Trust are a long way from establishing a culture where all staff see QI as integral to their everyday work. There remains considerable resistance to QI and scepticism about it."

"I definitely think having an assigned person from the QI team that focuses solely on our centre perhaps would be ideal."

Service users said that having peers as role models might encourage further involvement of service users.

Celebrating successes

The Programme developed a QI e-newsletter which is sent to all staff in the Trust each month (approximately 5,000 people). There has been an increase in people opening the newsletter from 12% at the beginning of the year to more than 70% recently.

The QI team also sends a quarterly paper edition of the newsletter to sites across East London. The December 2014 edition was sent to 203 Trust sites, 154 GP practices, 70 local community groups and 139 other partners.

There have been many celebrations of success to date. The first annual QI Conference was held on 10 March 2015. Over 270 staff, governors, service users and external partners came together for a half-day conference. In total, 37 QI project teams presented their work as posters, with eight teams presenting on the stage. The event was live-streamed and there have been over 500 views of the video to date.

Partly due to its work on improving quality and safety across the organisation, ELFT was recognised as Trust of the Year at the Patient Safety Awards in July 2015.

The Trust has been shortlisted in the Nursing Times Awards in the Care of Older People category. The Mental Health Care for Older People (MHCOP) team has been shortlisted as Team of the Year at the Royal College of Psychiatrists annual awards on the basis of their QI work on reducing violence. Bevan ward and MHCOP were shortlisted for the BMJ Quality Awards based on their QI projects. The QI training programme has been shortlisted for an HSJ Value in Healthcare award.

Enhancing communication

The Trust has done a lot to communicate with and engage teams. Evaluation interviews suggested that the tools and support were appreciated, but there was a desire for more communication, particularly amongst people who were not yet engaged in the programme.

Service users suggested that it would be useful to seek the views of service users about what can be improved, and suggested that the Trust could do more to inform people about how to get involved with user-friendly information and sharing of projects and experience.

Below are examples of comments from different types of people about ways that the Trust could continue to improve communication and further build the will for QI.

Service Users
"Talk to them. Tell them about what's going and tell them how to get involved. More letters, posters on the wall."

"I know there are other people and services and projects out there that you don't hear about there. If you don't have a care coordinator you don't hear about it [...] I would like to know about things but I still don't know."

Senior staff
"Raising awareness among staff and service users as there can be communication issues, concept can be difficult to grasp."

"Clear objectives, what do you want to achieve, staff can feel confused. Make it understandable for everyone."

"More communication/resources and easy access - not very clear, translate it in a way frontline staff understand."

Staff and teams not involved in the Programme

"I've seen emails regarding it but I've never known what it actually is."

"A forum or conference or something would be great, if it was held monthly people who are doing projects can share their experiences to let us know what is going on"

"I don't get the time to sit there and read emails and websites like the microsite, clinical work tends to be off the computer, hardly get opportunity."

"Regular news to tell people in the trust about what is going on, not everyone will be sitting at a computer, especially our frontline staff and they are the ones with the formulations most of the time"

"All information about the QI projects happening across the trust should be accessible so that people can read about it in Trust Talk. So we know. Patients should know too."

Key messages

To summarise the key messages from activities to build the will:

- The Trust has invested resources in building the will across the organisation, which is a key foundation for the organisation's improvement journey.
- The Trust has conducted large events and roadshows and developed a dedicated QI team.
- Building enthusiasm and inspiring teams has been a key building block in the QI process.
- From the evaluation, it has become evident that there is a need to raise awareness further, focusing on frontline staff and service users in a user-friendly manner.
- There may also be a need for stronger local leadership and support. The Trust is putting in place strategies such as QI coaches to boost localised leadership.

2.2 Building capability

Activities to improve capability

A foundation of the QI Programme involves helping staff develop knowledge and skills in quality improvement. This section examines the extent to which capability is being developed. The methods used to assess capability included:

- Review of training data (surveys and statistics);
- Repeat of the capability survey undertaken in 2014 to track changes. As part of this staff were asked what they felt is driving forward capability building, what is holding it back and what might remove those barriers ('force field analysis'). All staff were emailed an invitation to complete the survey anonymously online. In total, 132 staff completed the survey (approximately 4% of the staff population);
- Interviews conducted for the evaluation

As outlined in Figure 2 previously, key aspects of building of capability in the QI Programme were:

- Initial assessment of alignment and capability
- Recruiting a central QI team
- Online training
- Face-to-face training
- Follow-up coaching on projects

To date the following has been achieved in relation to these activities:

- Developing a strategic partnership with the Institute for Healthcare Improvement (IHI), to help the Trust build capability at scale and pace.
- A baseline capability survey was undertaken in April 2014.
- A QI team has been in place for over 12 months.
- Online training is available from the IHI Open School via the Trust microsite. In total, 226 staff have signed up to use the resource and 1,470 modules have been completed.
- The Trust has been delivering Improvement Science in Action training in conjunction with the IHI. Two cohorts ('waves') have completed the training (207 staff), and third wave is scheduled to graduate in November 2015 (189 staff).
- 30 QI coaches are now in place to support improvement projects.

Figure 6 illustrates the strategy the Trust set out for building capability at the beginning of the QI Programme and progress to date.

Figure 6: Progress towards building capability

Where are we?

On track to train over 400 people through 5 six-month waves of learning between 2014-16. First 3 waves delivered with the IHI

On track. All senior staff being encouraged to join QI training over next 2 years

New need recognised. Developing Improvement coaches programme will train 30 QI coaches in 2015

On track. Most Executives will have undertaken the ISIA, and all will have received Board training with the non-Executives

Currently have 3 improvement advisors, with 1.5 wte deployed to QI. Will need to build more capacity at this level.

Estimated number = 3300
Requirement = introduction to quality improvement, identifying problems, change ideas, testing and measuring change. g
Timeframe = train 10-20% in 2

Estimated number = 250
Requirement = deeper understanding of improvement methodology, measurement and using data, leading teams in QI. Timeframe = train 30-50% in 2 years

Estimated number = 25-30
Requirement = deeper understanding of improvement methodology, understanding variation, coaching teams and individuals. Timeframe = train 100% in 2 years

Estimated number = 10
Requirement = setting direction and big goals, executive leadership, oversight of improvement, being a champion, understanding variation to lead
Timeframe = train 100% in 2 years

Estimated number = 5
Requirement = deep statistical process control, deep improvement methods, effective plans for implementation & spread
Timeframe = train 100% in 2 years

Experts

Frontline staff

Clinical leaders

Directorate improvement leads

Executives

Experts

Effect of training

Amongst those who have attended QI training, responses to pre and post training questionnaires suggest that waves 1 and 2 of the Improvement Science in Action training have helped to develop the capability of those who attended, with all aspects of the training measured showing movement towards an increased level of perceived competency.

There is evidence that training is associated with an increase in the number of QI projects. Before formal training began in September 2014, there were 67 improvement projects registered. Of these, 40 had stalled, 20 were getting ready to become active and seven were actively testing ideas (10%). By the end of the wave 1 training in December 2014 the number of projects had increased to 112, of which only five had stalled, 55 were getting ready to become active, and 42 were actively testing ideas (37%). Following graduation of the staff who undertook wave 2 of the training in May 2015 the number of projects increased to 176.

In a survey sent to all staff in 2014 and again in 2015, staff were asked to rate Trust-wide improvement in knowledge and competence on a five point scale from 'just beginning' through to 'exemplary' (see Figure 7). Survey responses show a shift along the spectrum of capability, with significantly fewer respondents rating the Trust as just beginning improvement in knowledge and competence in 2015 (19%) compared to 2014 (34%). Notably more respondents rated the Trust as either making significant impact or exemplary in 2015 (26%) compared to 2014 (13%). This positive change is based on a sample size of 132 in 2015 compared to 71 in 2014. Some caution is required given that the sample size is small as a proportion of all staff.

Figure 7: Perceived QI knowledge and competence in the Trust
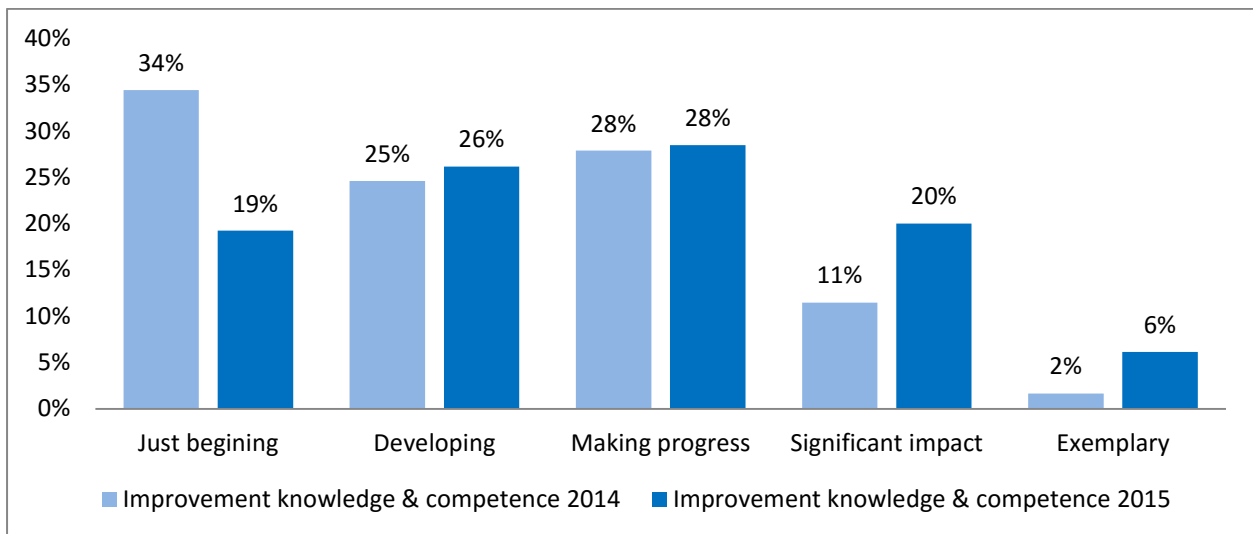
However, in open-ended feedback to the survey some staff said that skills and knowledge were not being spread as far as they could be because:

- QI work is happening in pockets.

- Projects are underway, but the outcomes are unclear or they are not being spread.

- Training is not reaching all levels of staff.

- There is some debate about the validity and effectiveness of the QI methodology amongst some teams.

Staff also contributed to a force field analysis, thinking about the things that are facilitating and acting as barriers to building capacity and spreading improvement (see Table 2).

Table 2: Feedback from staff survey about QI capacity and capability

What forces are driving us to move forward with building improvement capability and capacity?	What barriers or forces are holding us back from building improvement capability and capacity?	What actions could we take to reduce these barriers?
- Organisational commitment to improvement methodology - The passion and enthusiasm of individuals - Freedom and empowerment of staff afforded by the improvement methodology - Increasing the effectiveness and efficiency of services - Improving service user experience	- Resource pressures – time, money, staff - Prevailing culture within teams – healthy scepticism or resistance to change? - Quality of leadership - The feeling that embracing quality improvement will increase workload - The perception that training is exclusive – only available to senior/experienced staff	- Keeping improvement at the heart of day-to-day work - Training opportunities based on inclusive meritocracy - Reducing bureaucracy and target culture - Improving feedback on the outcome and impact of projects - Increasing funding, or improving efficiency and organisation in order to release additional resource, to support QI work

Perceptions of training reach

The evaluation feedback suggests that some staff perceive that QI training is somewhat exclusive and only available to certain staff. This seems to be driven by the way that training is publicised, authorised by management, and the time taken to undertake training which takes people away from frontline care delivery.

For example, staff responding to the survey said:

"I'm only admin, I don't get a choice in developing myself further."

"Not all MDT [multidisciplinary team] members are engaged, training is yet to reach the lower bands of staff."

"Most of the training is only for higher 'ranking' employees."

And these sentiments were also evident in the semi-structured interviews undertaken with a cross section of staff:

"There's loads of training on the intranet but in terms of for me it seems like its finding the time for do the training and the modules. The modules are all lengthy and comprehensive. It would take a week. There's something about the Trust recognising that if we are all doing this something has to give. It's hard because I was invited to so many meetings but it is a choice between seeing my clients and doing something to do with quality. It becomes paradoxical. There needs to be a balance."

"Seems to be a lot of training but I haven't been able to go on the training because it is on certain days. If you are not working full-time there is a bit of a disadvantage. There could be more local stuff."

"The Trust should communicate better with what [training] is available."

Staff perceptions are backed up to some extent by statistics about which type of staff take part in training. Managers are the most highly represented in training (see Figure 8).

Figure 8: Number of staff that have taken part in QI training
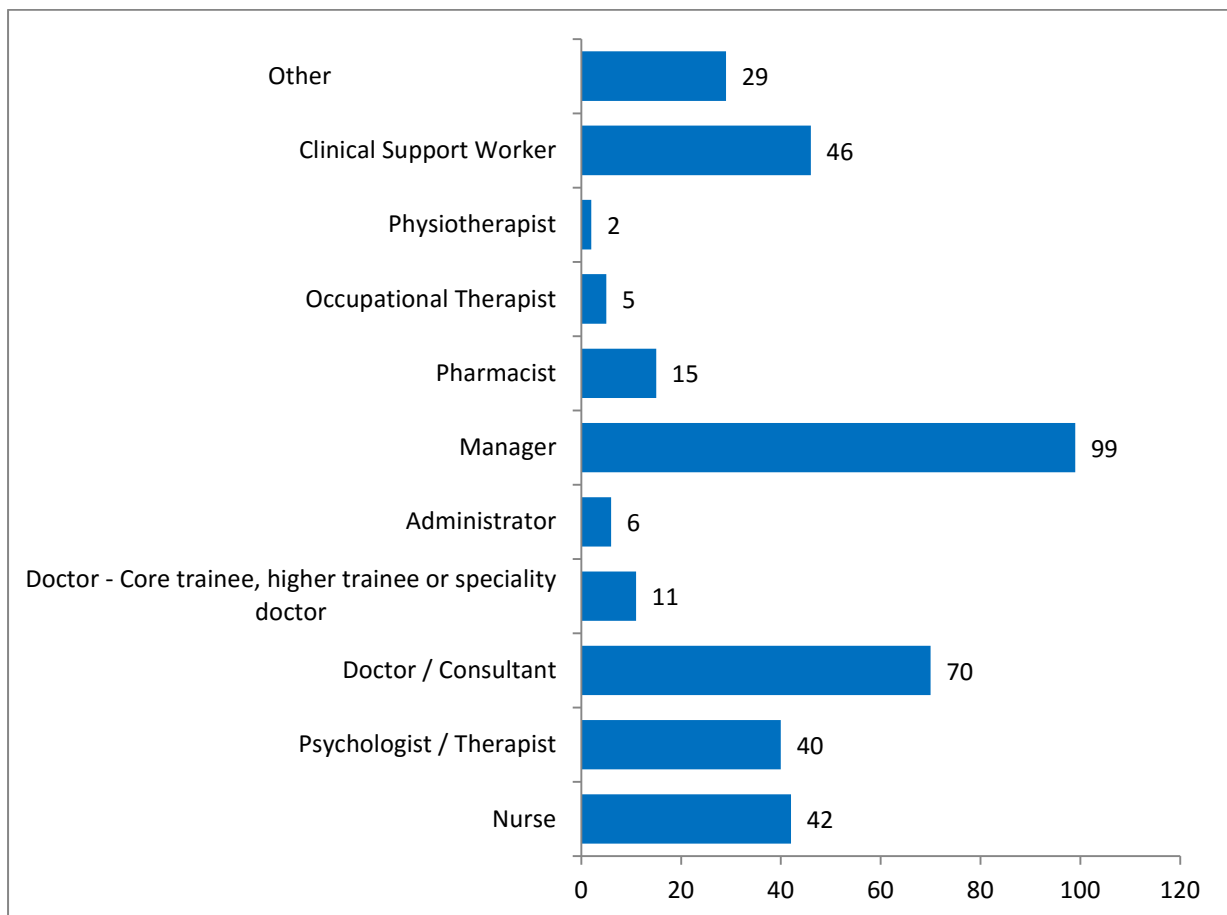
The Trust has begun training service users and carers to enable meaningful participation in improvement projects. To date around 50 service users and carers have attended training sessions, and a further three have completed the full six-month Improvement Science in Action course. Future evaluation could include an assessment of the impact of this training.

Key messages

The key messages about building improvement capability are:

- The Trust is implementing its strategy for building capability. Large numbers of staff have received training that has been found to improve their perceived knowledge and competence across a number of dimensions. In addition, increased levels of training within the organisation correlate with increased improvement activity measured by the number of projects initiated.

- However, there are barriers to building of capacity, including a perception amongst some staff that the QI training is inaccessible by virtue of the time commitment required, a lack of awareness of the availability of training amongst some staff, facilitation of attendance by management, and a perception that training is aimed at or provided for senior strata of staff.

- Going forward consideration could be given to:

  - collecting more detailed data about the demographics of those completing training, specifically role and band/grade;
  - publishing training data in the spirit of transparency;
  - broadening how training availability is marketed across the Trust;
  - introducing briefer training modules that can be accumulated into formal qualifications.

2.3 Alignment

The Trust has been reviewing and realigning many corporate systems to support improvement work. As described in Figure 2 previously, key aspects under the 'alignment' component of the QI Programme include:

- Align all projects with improvement aims
- Align team / service goals with improvement aims
- Align all corporate and support systems
- Patient and carer involvement in all improvement work
- Embed improvement within management structures

This section explores what has been done to implement these activities and what the outcomes have been. The following data sources were drawn on:

- Online IHI Capability Survey and Safety Climate Survey
- Online survey of Board members
- Interviews with senior staff (including an online version of the questions)
- Interviews with teams who either had an active QI project or had no QI project
- Interviews with individual staff who had or had not completed QI training
- Interviews with individual staff who were or were not involved in active QI projects
- Interviews with service users
- Review of papers to the Board
- Feedback from the Head of Quality Improvement, the Senior People Participation Lead and the QI Programme Manager

Integrating into systems

This section explores how effectively the Trust is integrating quality improvement into operational structures and systems.

Activities

QI Programme update reports to the Trust Board are publically available at: http://www.eastlondon.nhs.uk/About-Us/Trust-Board-Meetings/Trust-Board-Meetings.aspx. These provide details of a range of activities helping to integrate and align systems.

ELFT has established a steering group to engage commissioners, external partners and academics in QI work. This aims to foster an environment whereby commissioning objectives are amenable to the QI work carried out by the Trust. These meetings have started conversations about how to use key performance indicators (KPIs), performance reporting, CQUINs[1] and other drivers in a more sophisticated manner to support quality assurance and quality improvement.

The Trust will be joining the 3-year iQUASER evaluation project (http://www.clahrc-norththames.nihr.ac.uk/iquaserworkshop/), studying organisational and cultural factors influencing QI. ELFT will be a comparator Trust within this study, which is taking place across five countries. Other academic collaborations include working with academic leads on the evidence basis for violence work happening within the Trust. The aim of building these networks is to reinforce the idea that the Trust is participating and aligned with the wider healthcare quality community.

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1 The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.

One of the Trust's initial aims for enabling QI work was to support every team to have a space to discuss the quality of care they are providing and share ideas about how to improve and support the development of a listening and learning organisation. To achieve this, a central QI team has been set up alongside developing leaders and champions in all directorates. The following roles are now established:

- *Sponsors:* Senior members of staff whose primary responsibility is to oversee projects, champion successes and align projects with directorate priorities.

- *Coaches:* Members of staff within the directorate who have one protected day per week to support a portfolio of projects.

- *QI Leads:* Core members of the QI team who have oversight of Trust-wide initiatives, support collaboratives (groups of projects directly aligned to Trust priorities) and provide specialist support to those projects that are particularly instrumental in achieving the Trust-wide objectives.

- *Service user and carer involvement representatives*: two core members of the QI team work one day per week to represent the views of service users and carers.

- *QI Forums*: Monthly forums across all directorates to discuss borough/service specific quality improvement aims and efforts. Attendees include those outlined above.

Changes over time

The IHI Capability Survey undertaken in 2014 and 2015 suggests that there has been some improvement in how the Trust manages systems to support QI.

For example, staff perceptions about the resources in place to establish improvement teams and to support their ongoing work and successes show some signs of improvement, with more people scoring the Trust as exemplary in 2015 compared with 2014 (see Figure 9).

Figure 9: Staff perceptions of changes in resources available to support QI
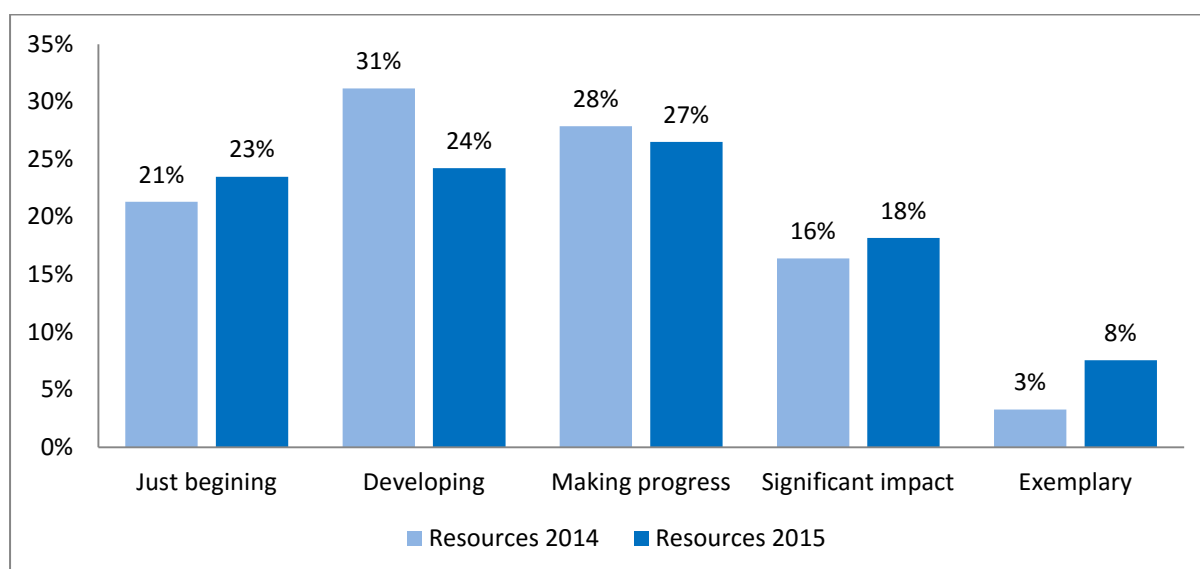
The NHS Safety Climate Tool offers insight into developing a culture whereby staff feel supported in learning from mistakes. There were no significant improvements in 2015 compared to 2014. However, responses were still positive, with all responses averaging at either Agree or Strongly Agree. These results must be treated with caution because surveys were completed by a small number of staff.

A survey of Board members provided a particularly interesting picture. There were a number of questions on how well the Board perceive QI is integrated into operational structures. The questions outlined in Figures 10 and 11 help to understand some of the operational drivers behind providing a safer environment.

The results appear positive on the whole. Most of the questions show an increase in Board confidence that the Trust has systems to support safe care. Some areas show a decrease in confidence, such as identifying a small set of high level quality and safety measures.

Although the Trust is showing improvement between the years, there may be scope for further work around Board exposure to learning from other organisations and how quality is integrated into performance reviews.

Figure 10: Change between 2014 and 2015 in Board feedback about system integration and alignment

Standards	6	11	13	14	15	17	18
Not in place	0%	0%	0%	-9%	13%	0%	0%
Just beginning	-10%	20%	-10%	27%	-16%	-50%	-10%
Established	10%	-20%	10%	-18%	2%	50%	10%
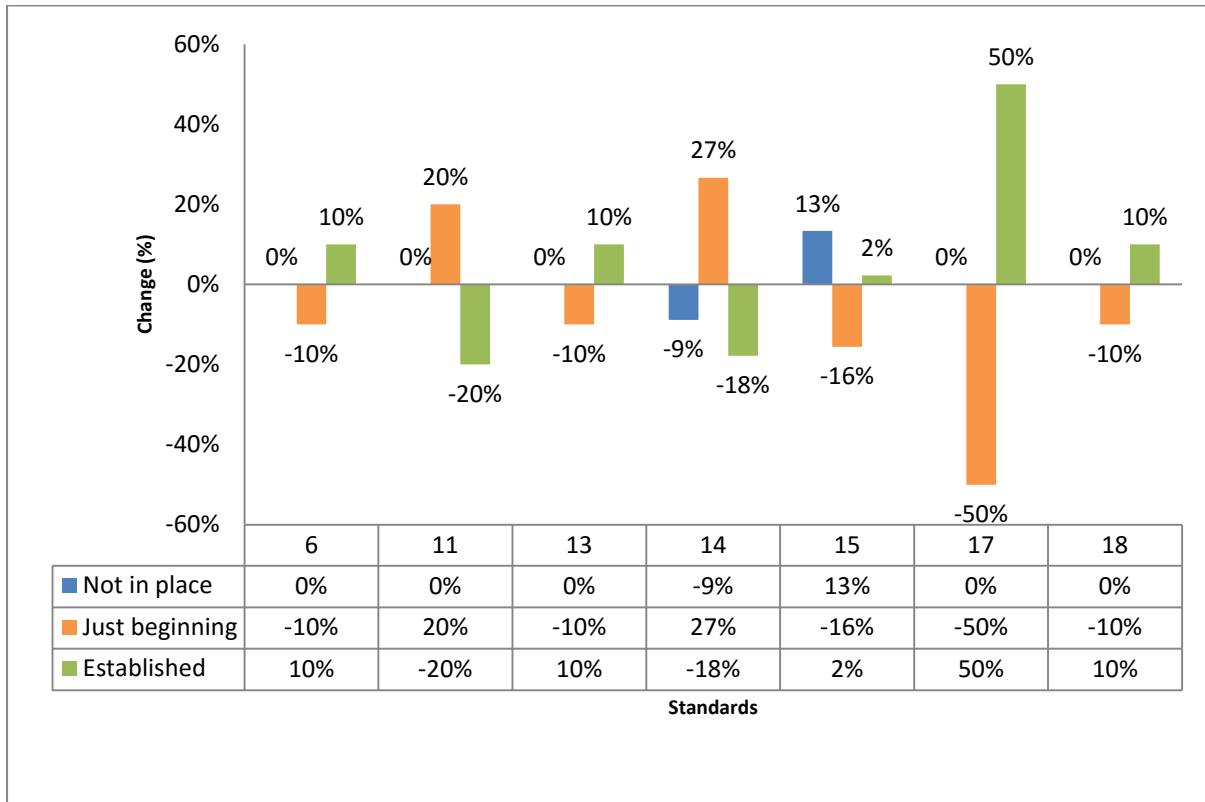
Note: The statements graphed are as follows:

6. We review measures related to patient safety and harm at every Board meeting
11. Our organisation has identified a small set of key "high level" quality and safety measures
13. The measures on our quality and safety dashboard are timely (no more than a month old) when presented to the Board
14. The same dashboard presented to the Board is regularly shared with all staff
15. The same dashboard presented to the Board is regularly shared with patients, families and the public
17. This organisation aggressively works to maintain an environment that is just and fair for all those who experience pain, harm or loss as a result of avoidable harm
18. The Board has approved policies that protect staff members from retribution and punishment when they report an error or patient safety incident

Figure 11: Further changes between 2014 and 2015 in Board feedback about system integration and alignment

Standards	19	20	21	26	27	28	29
Not in place	-10%	-10%	0%	-10%	0%	0%	-40%
Just beginning	-30%	-40%	-40%	10%	20%	-20%	40%
Established	40%	50%	40%	0%	80%	20%	0%
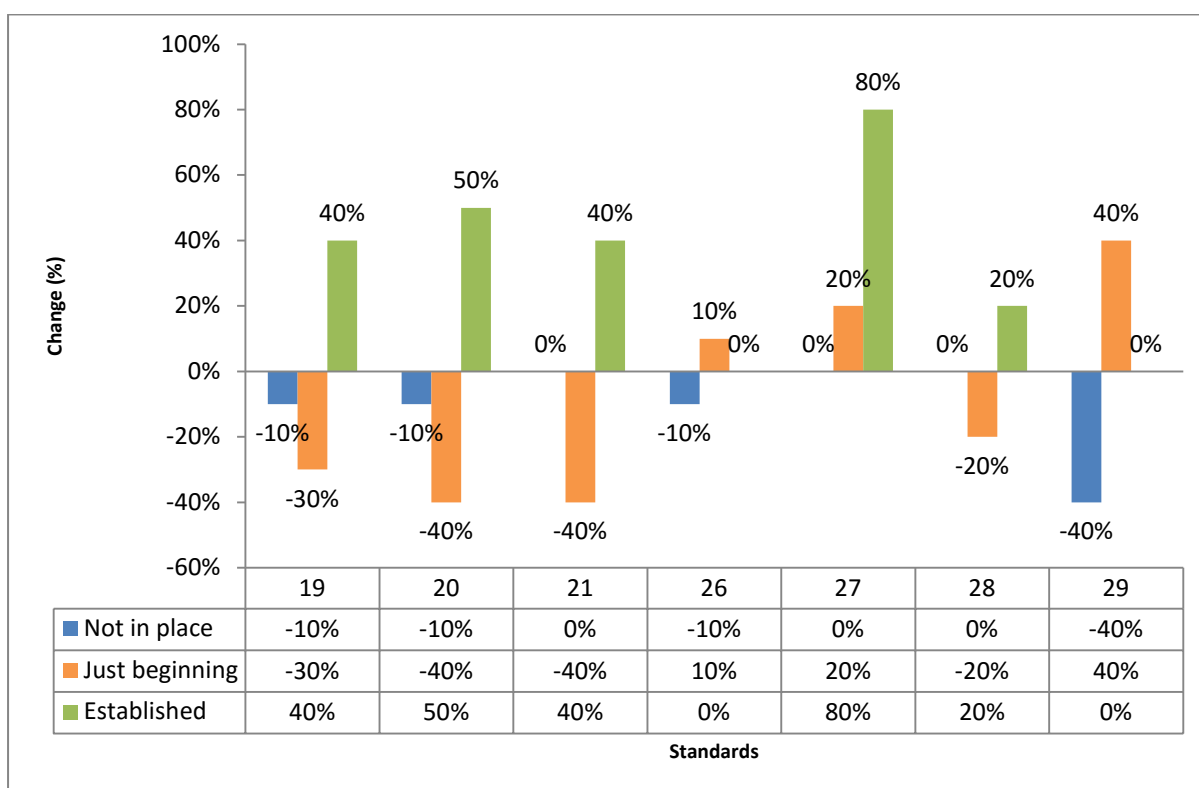
Note: The statements graphed are as follows:

19. The Board has regular conversations with clinical leaders to ask how they are helping achieve the organisation's quality goals
20. The Board has sent a clear signal to management, nursing, and medical leaders that it is serious about safety policies, and expects them to be followed
21. The Board has sent a clear signal that all staff who are working to uphold our safety policies will be supported, all the way to the Board.
26. The Board is regularly exposed to learning from organisations (inside or outside of healthcare) that are viewed as benchmarks in the area of quality
27. The Board has approved and resourced a strong plan to build the knowledge and skills of staff (both clinical and non-clinical) in the area of quality
28. The Board has made it very clear to the senior management team that they are expected to achieve results: (i.e. reducing harm and right care, right place, right time)
29. Executive performance reviews are directly tied to the achievement of measured quality and safety results

Feedback from staff and service users

In the evaluation interviews, a common theme emerged around hierarchy and the culture of QI. Most staff interviews identified that QI work ought to function around a bottom-up approach, however there were mixed views about how much this is happening.

> *"Originally the message was it has to be bottom up, and then it changed so now there's more of a senior steer."* (Senior staff)

Staff who did not have direct involvement in a QI project seemed to feel more strongly that there are hierarchical structures in place that make it difficult to make improvements from the bottom-up. Those who were involved in QI projects seemed to feel that they had more autonomy and felt more empowered to make changes.

There were comments about new wards not having any ingrained cultures to change, meaning that most team members were open-minded about this approach and adopting this working style.

> *"We are a new service and had to do a lot early on so it may not be in the form of a formal project but we are already doing lot of audit and improvement work"* (Team without an active QI project)

> *"This ward was new so it brought the ward together … There were no ingrained cultures to break. Everyone came with an open mind."* (Team with an active QI project)

The overall impression was that the Trust is beginning to achieve its aim of embedding improvement within management structures in some areas, but more work is needed. This work might include ensuring that a common message about the culture of QI is consistent, robust and also reflects the reality on the ground.

There was a sense from interviews that some staff feel like the current QI Programme is another fad that will fade. Many highlighted that attention to improvement is not new and staff have been and will continue working with various methodologies. There could be scope for a review of the communications strategy as this was mentioned frequently in many staff and service user interviews and could impact on how motivated staff are to committing to the QI methodology.

Strong leadership and support from senior staff as well as staff within teams were identified as helpful factors. Having leaders who were trained in QI and were confident with the methodology appears to be something all the staff groups interviewed identified as necessary for the QI Programme to be integrated into routine structures. It may be that the extended support structure (additional QI coaches etc) might address some of the concerns raised in the senior staff group around the structures needed to sustain momentum.

Involving service users and carers

One of the Trust's alignment aims is to involve service users and carers in QI projects. This section examines how effectively this is occurring.

The Head of Quality Improvement, Senior People Participation Lead and Associate Director of Patient and Carers Experience meet bi-weekly to review ways in which they could include service users and carers more fully. They identified two tiers of involvement:

- Big I: service users and carers are part of a project team, who work on the improvement project on a regular basis.
- Small i: service users and carers contribute towards projects less frequently, perhaps on a consultation basis.

Table 3 summarises the number service users involved in QI projects as of August 2015. At present, 57 out of 163 active projects have service user representation (35%). From reviewing the QI Project Charter, there were no trends in which projects were more likely to have service user involvement.

The Quality Improvement Programme Manager suggested that service user representation may be under-reported in the project proposals so the QI team have recently launched a communications campaign to share learning about service user involvement and encourage more accurate reporting.

Table 3: Number of service users involved in projects as of August 2015

Involvement level	Service users involved
Big i	21
Small i	33
No	133
Total number of service users involved	**187**
Total projects with service user involvement	57

Reports to the Trust Board outline the key activities and next steps for the QI Programme. The last update about patient and carer involvement was dated September 2014, suggesting that more emphasis could be placed on this in reporting.

> *"Patients and carers are involved in all levels of QI work. This includes representation at the QI Programme Board and steering group, producing an alternative version of the QI newsletter for patients and involvement in every frontline QI project occurring in the Trust."*
> (May 2014 and September 2014 QI report to Trust Board)

To gain further insight, information was gathered from the QI team and the Senior People Participation Lead (PPL) for the Trust. Feedback from these sources suggested that service user involvement is progressing but there is more to be done. It may be that there is some anxiety from staff about service user involvement or staff may want to involve service users but be unsure of how to do this.

The evaluation team aimed to ascertain how well the Trust involves service users and carers by interviewing staff and service users. There was very little mention of service user involvement in staff interviews compared to the amount of rich data about how the Trust can support staff. This may be because the questions were broad and focused on what could be done to support improvement moving forward. It may also be because there is still further work to do in regards to shaping a culture whereby service user involvement is at the forefront of people's minds. Staff expanded on questions and gave examples about their clinical roles and team structures, workload and training requirements even when they were not directly asked, however few people commented on user involvement.

Of the comments that were about user involvement, there did not appear to be many clear themes. From the senior staff group, there were suggestions about incentivising involvement, creating a recruitment system, providing training and perhaps having peer support workers in the directorates.

One group interview with a team involved in a QI project described working alongside service users. The team said it was important to have trust in service users and allow them space to be involved.

One person with no direct involvement in QI commented on how collaborative working with service users is already a part of their role, but not necessarily a formal QI project. Although this statement cannot be generalised on a Trust-wide scale, it does fit alongside statements that improvement work is not a new thing and perhaps service user involvement is happening within the Trust already that may not be formally recorded; much like how service user involvement in QI may be under reported.

"I do so many QI projects that do not really come under QI. Like designing welcome packs, giving educational talks about self-harm, training, getting service users to have a say, I mean -------- is a QI project in itself but did anyone bother approaching us? No." (Frontline staff, not involved in active QI project)

The evaluation team interviewed seven service users in community and inpatient settings. Six of the seven people were using services that did not have a registered QI project. Most interviewees had not heard of the QI Programme. This suggests that there might be scope for further work around improving communication. Communication is one of the themes that emerged from all of the data, with service users suggesting that staff could talk with them about what improvements they thought were needed and also speak with them about how to get involved.

A number of service users related involvement in QI to activities (such as groups at MIND or pool games on the ward). Others mentioned not wanting the 'hassle' of getting involved.

Other work to increase service user involvement is outlined below. There are no clear measures to assess whether these workstreams are having an impact:

- Guidance for staff about how service users are paid and recognised for work is being developed by the People Participation Team. This has been sent to all Borough Lead Nurses and Directors for review. This document has been developed from queries that had been asked by staff and service users.

- People Participation Leads (PPLs) will be joining the QI forums to link in with projects and ensure service users and carers are represented. This work is in development.

- PPLs are part of the Improvement Science in Action training programme. They facilitate a space whereby staff can talk openly about the difficulties they have been facing around involvement and work creatively with the PPLs to generate solutions.

- Two service users were employed to develop the QI microsite so that it can be more instrumental in raising awareness about projects. The aim was to help service users and carers can see what they would like to be involved with.

- A service user and staff collaboration group has recently been set up. It was developed based on a Trust-wide QI Physical Health Collaborative that covers a range of physical health initiatives. It is still in its early stages. The group aims to provide a space where staff can present their projects to a group of service users and gain feedback and where the service users can think about projects they would like to set up or get involved in. The group is also developing a process map that staff and service users can use as guidance about involvement. This includes information about how service users are recognised for their work. Future plans include visiting teams directly to talk about service user involvement and exploring ways to approach outreach work to link up with service users in the community.

- Bespoke half day QI training sessions specifically for service users and carers have been running for several months, with 50 people so far having completed this.

- Three service users have completed the Improvement Science in Action training.

- A project within Tower Hamlets is run solely by service users. The two QI Service User and Carer Involvement representatives are currently learning from that project with a view to start more user-led projects.

Support systems

This section examines the extent to which Trust support systems are facilitating improvement work.

Over the past year the Trust has been reviewing and realigning systems to support improvement work. This includes enhancing the Datix system, reviewing clinical audit processes and developing integrated quality dashboards at Trust, directorate and team level.

Quality Dashboards

The Trust is in the process of developing integrated quality dashboards to help view clinical data from the data warehouse in real-time, from Board to individual level, using statistical process control. Programme update reports to the Board suggest that progress has been slow due to competing demands on the Informatics team's time. This may be a critical enabler in supporting teams at all levels to use data for improvement. New arrangements for managing the Informatics team mean the work is being accelerated.

Open RiO

ELFT moved to using the open RiO records system in April 2015. This platform allows greater control over the data collected in the Trust's electronic clinical record system. This means that should teams want to review the impact their QI project has had on waiting times or patient reported outcome measures, for example, they will be able to see this data in a timely fashion with greater accuracy.

Using this clinical records system is part of people's daily working practice so has not increased workload. However, during Executive Walk around visits and in evaluation interviews, people reported that this system runs slowly and staff are struggling to use it efficiently. Further information is contained in the Quality and Safety Report publicly available at
http://www.eastlondon.nhs.uk/About-Us/Trust-Board-Meetings/Trust-Board-Meetings.aspx

*"The computers take too long. And they expect us to wait and use it!!!!
This makes it difficult to look at data."*

Audit process

The Trust reviewed the use of clinical audit in 2014 in an effort to focus audit on locally meaningful safety processes. The uptake has been varied, with some directorates being more open to this process than others. However there does appear to be a common language that is now being used.

Further work may be needed to clearly identify the purpose and function of QI and audit work as each has a distinct role.

It is unclear to what extent changes in the audit process have improved clinical practice. In the first quarter of the new process many change ideas generated as a result of audits were shared, but this has declined as the year progressed. Moving forward, the Trust will place more emphasis on encouraging teams to think about change ideas and relay this information Trust-wide. The Quality Outcomes and Experience Team are reviewing how audits can be added to the Trust-wide Intranet so that learning can be shared and staff have easier access to their data.

Datix

A number of changes have been made to the Datix system. Some of these changes were part of specific QI projects aiming to improve patient safety, such as falls reduction. Examples of changes included reducing the amount of data recorded, updating the required information so that it is relevant to clinical care, simplifying the incident categories to increase accuracy in reporting and providing information about best practice approaches to handling a given situation so as to be a learning opportunity. Since the redesign of the form and classification of incidents, there has been an increase in the number of incidents reported (see Figure 12). This suggests there is more accurate data from which to build improvement work.

Figure 12: Number of patient safety incidents reported
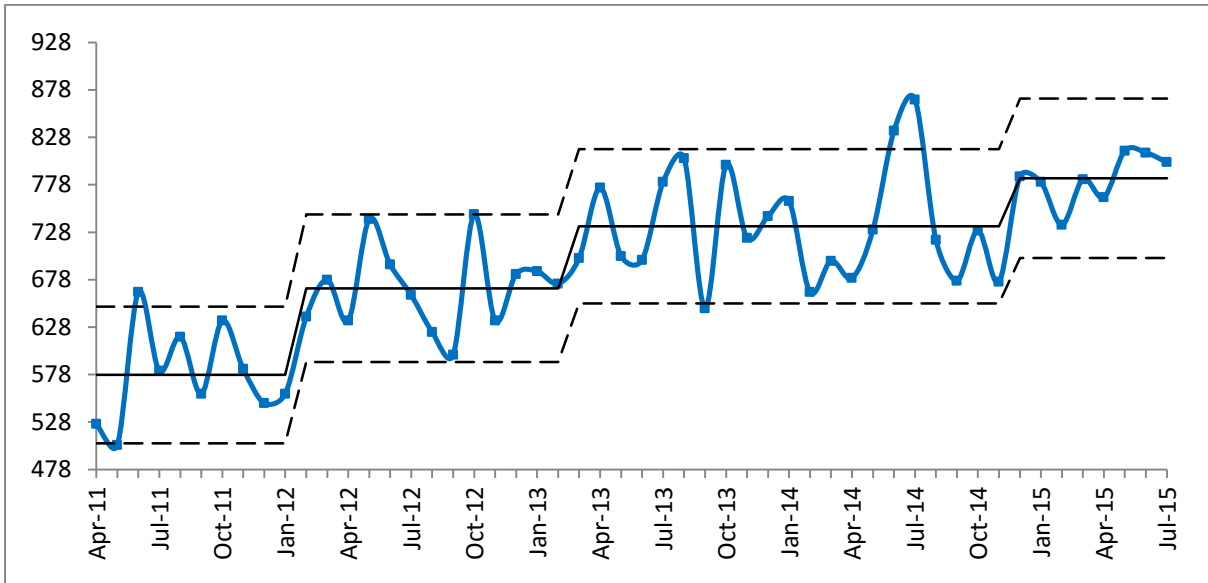
Perceptions

Results from the Capability Tool survey suggest that staff are seeing improvements with regards to Data Infrastructure and Management, with more staff scoring the Trust towards the exemplary end of the scale than the previous year (see Figure 13). The change is, however, small and the majority of people still think that the Trust is at the 'developing' stage.

Figure 13: Staff perceptions of Trust data infrastructure and management
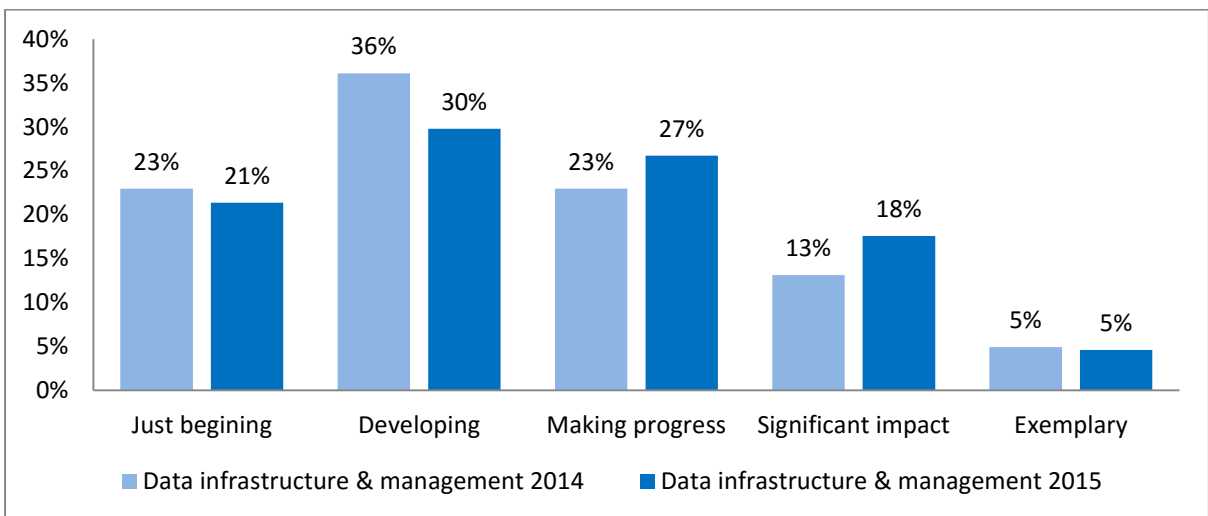
Survey feedback from the Safety Climate Tool suggested no significant change in staff confidence in the Trust's infrastructure to support a safe environment. Responses were positive, with most staff either agreeing or strongly agreeing with various positive statements (see Figure 14).

Figure 14: Staff perceptions of aligned systems in 2013 and 2015 (5 point scale)

	3	8	15	17
Average 2013 (112)	3.75	4.26	3.80	4.28
Average 2015 (132)	3.66	4.09	3.74	4.06
Average Change	-0.10	-0.17	-0.06	-0.22
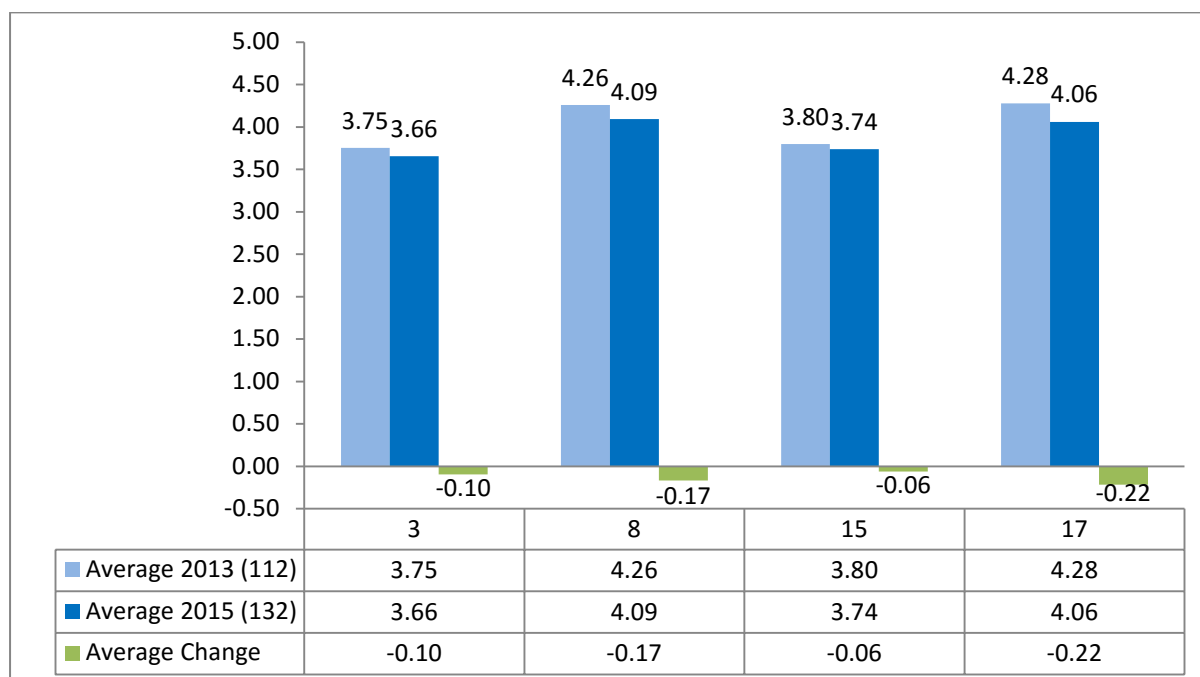
Note: The questions asked were:

3. The senior leaders in my hospital listen to me and care for my concerns.
8. I am encouraged by my colleagues to report any patient concern I may have.
15. This institution is doing more for patient safety now, than it did one year ago.
17. The personnel in this clinical area take responsibility for patient safety.

Trust Board members were also surveyed about the extent to which systems are aligned with improvement work. Figure 16 shows the change in Board member's confidence in meeting alignment standards between 2014 and 2015. The area perceived most positively was having timely data presented to the Board. This may be due to the new quality dashboard.

An area for improvement appears to be around how this same data is shared with staff.

Figure 16: Change in Board views between 2014 and 2015

Standards	8	13	14	15	*16
Not in place	-10%	0%	-9%	13%	0%
Just beginning	20%	-10%	27%	-16%	0%
Established	-10%	10%	-18%	2%	0%
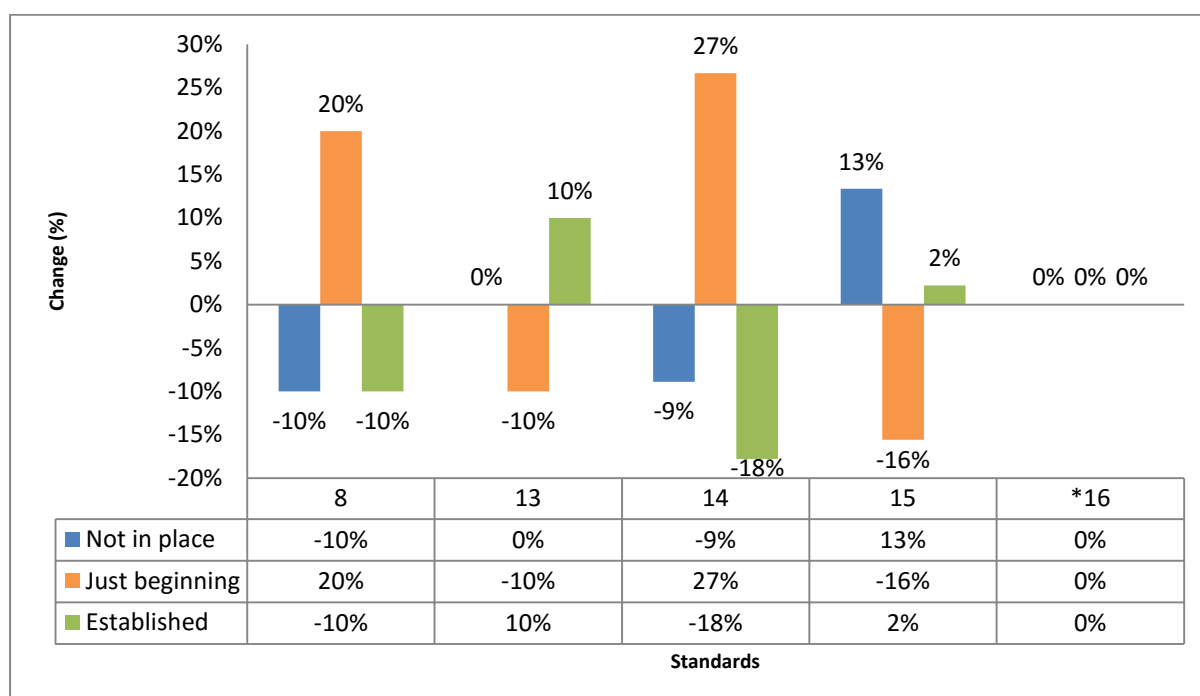
Note: The following questions were asked:

8. The Board has viewed recent data to determine the extent of harm in our care delivery system
13. The measures on our quality and safety dashboard are timely (no more than a month old) when presented to the Board
14. The same dashboard presented to the Board is regularly shared with all staff
15. The same dashboard presented to the Board is regularly shared with patients, families and the public
*16. The Board asks as many hard questions about the quality and safety dashboard as it asks about the financial reports (note that this standard stayed at 100%).

Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of the Trust's income to supporting the improvement of quality of care and innovation in service delivery. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis. It could also be argued that this creates an annual plan of service delivery which is performance managed.

The CQUIN scheme is guided by national priorities but is a locally agreed package of quality improvement goals and indicators, which in total, if achieved, enables the Trust to earn its full CQUIN payment (calculated as 2.5% of the Actual Outturn Value of the provider contract).

The focus for CQUINs is guided by NHS England priorities listed as a range of prepopulated indicators. The purpose of this list is to aid commissioners by saving time and effort locally in developing local indicators for inclusion in the CQUIN scheme. The number and content of local CQUIN schemes is for local agreement, however NHS England recommends designing a scheme with a small number of indicators linked to high impact changes as opposed to a large number of indicators covering a wide range of conditions.

For ELFT, there is reportedly a tension between externally driven quality improvement targets versus internal priorities driven by Trust strategy and the QI Programme. Increasingly, the Trust is collaborating with commissioners to increase shared oversight and improve the delineation between target-driven areas of improvement and areas targeted using the QI methodology.

Key messages

To summarise the key messages about activities to align systems to support QI work:

- From reviewing various sources of information, it appears that the Trust has developed many systems to support QI work.
- ELFT is building networks with key strategic partners to help the Trust along its improvement journey.
- Areas for improvement appear to be around service user involvement, though efforts are underway to enhance this.
- There may be scope for further efforts in communication.
- It may be important to review how QI sits alongside other improvement methodologies to ensure the benefits of those methods are not lost.
- Staff report feeling supported by management but there are concerns about whether the culture of QI is really 'bottom up.' It may be that the Trust could review its stance on this and consider ways in which culture change can be spread.
- Further development of technological resources appears to be of interest to staff. There have been important changes but more work may be needed, particularly around the speed of RiO.
- Further work is also needed around how QI is embedded alongside performance management, research and innovation and assurance.

2.4 Reducing harm

Overview

As outlined in Section 1, the Trust set two stretch aims that QI projects were developed to address: reducing harm by 30% every year and delivering the right care, at the right place, at the right time. Figure 16 shows the breakdown of projects focusing on each aim. This section focuses on the extent to which harm has been reduced by 30% over the past year.

Figure 16: Distribution of QI projects across Trust stretch aims
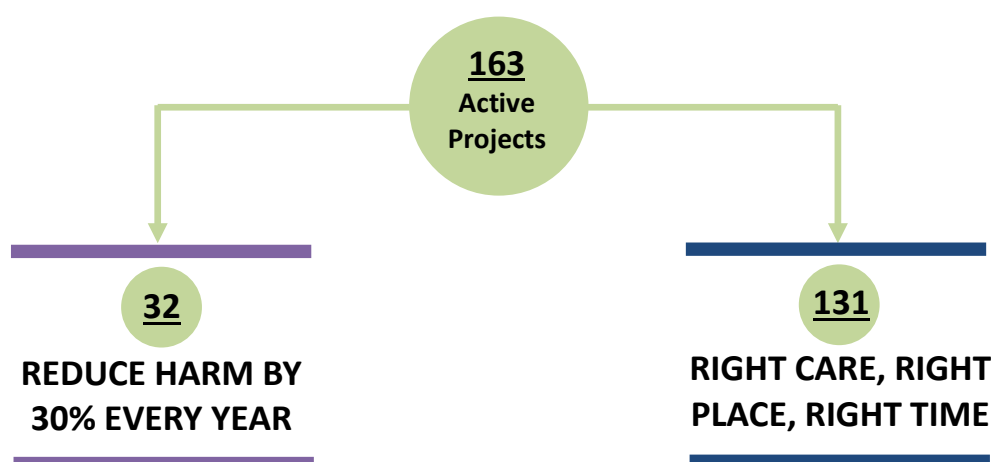
Under the umbrella of reducing harm by 30% every year, there were five key focus areas:

- Reducing harm from inpatient violence
- Reducing harm from falls
- Reducing harm from pressure ulcers
- Reducing harm from medication errors
- Reducing harm from restraints

Each of these is described in turn.

However before examining the data, it is important to emphasise a caveat. In April 2014, at about the same time as the launch of the QI Programme, the Trust carried out major work on its incident reporting software (Datix). Staff reported that the Datix form took too long to fill out and did not ask relevant questions. The form was redesigned to make it shorter and more relevant. Certain categories were removed and other categories were introduced. Following this, a greater number of incidents began to be reported, perhaps because the form was more user-friendly (see Figure 17).

Figure 17: Number of patient safety incidents reported on Datix system
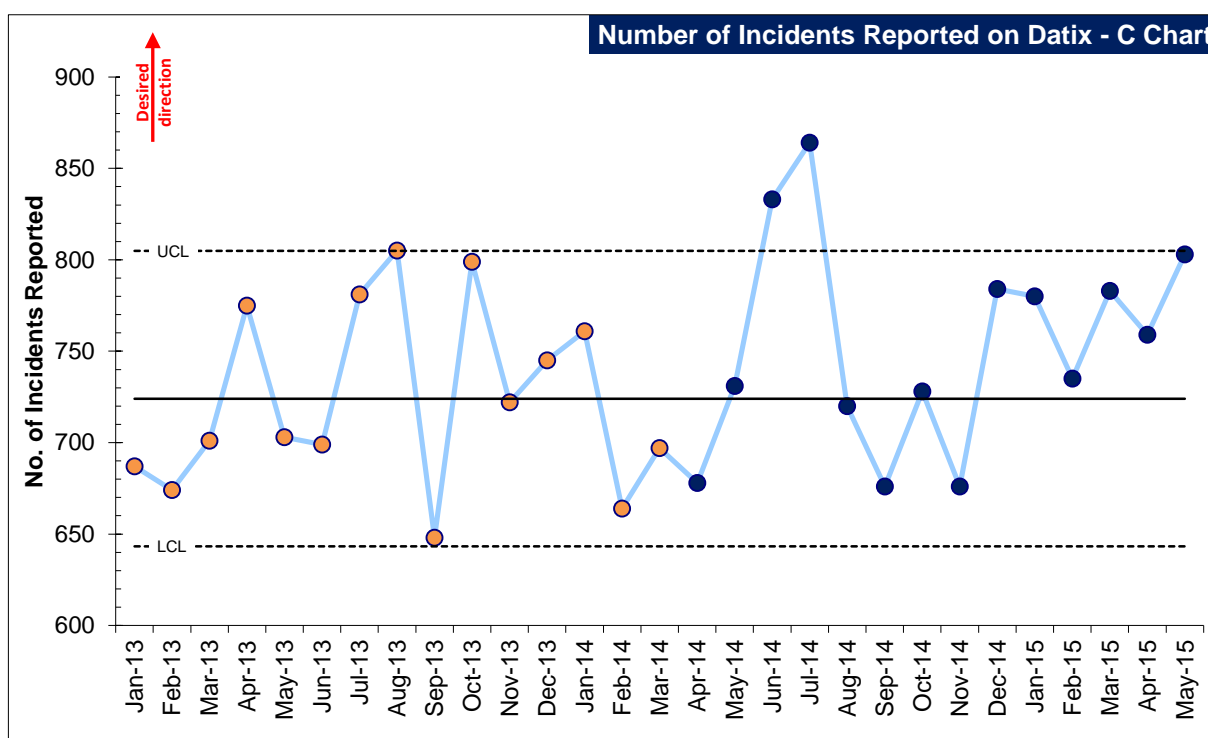
This change in the reporting form at around the same time as the introduction of the QI Programme confounds the data somewhat. Prior to April 2014 incidents may have been more under-reported. This limits the ability to compare data before and after April 2014.

Findings from the NHS Mental Health Benchmarking Framework suggest that violence towards service users and towards staff at ELFT has improved compared to the average of other metal health services, moving from being above the upper quartile to either being below the national median or being just on it (see Figure 18).

Figure 18: Data from the NHS Mental Health Benchmarking Framework
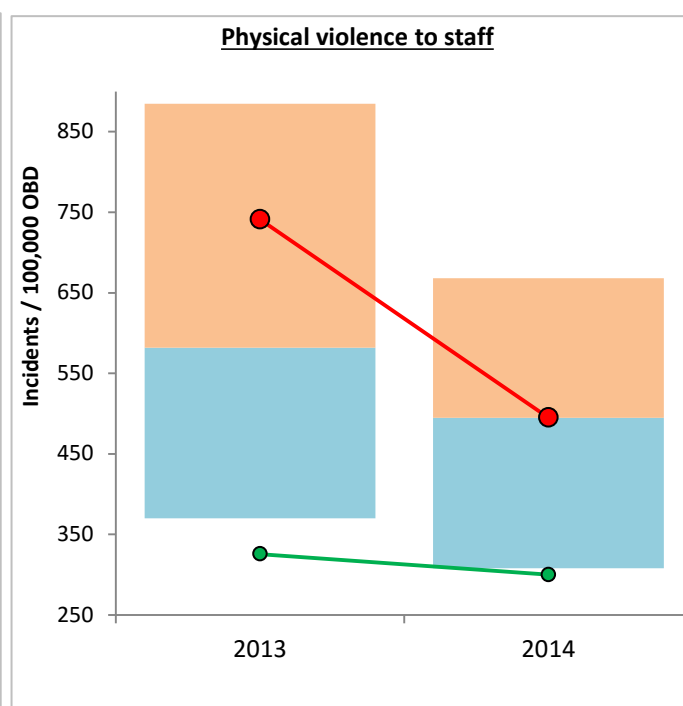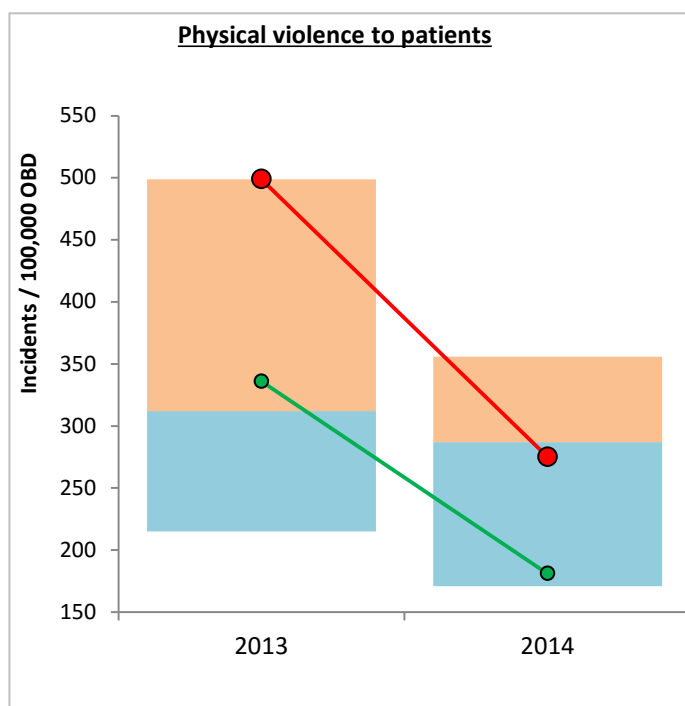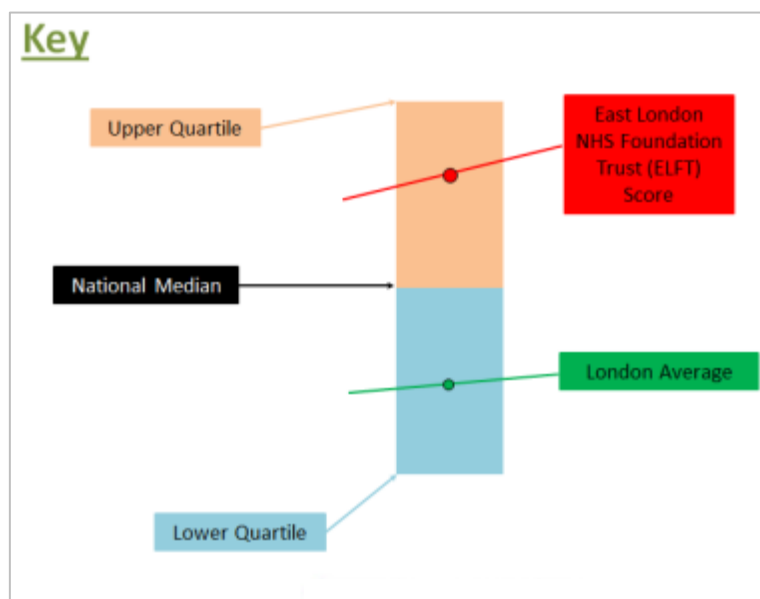
Since the introduction of the QI Programme there have been significant changes in the number of incidents resulting in physical violence reported within the Trust. Over a 29 month period spanning before and after the QI Programme, the number of violent incidents reported reduced from an average of 171 per month to 103 per month. Figure 19 suggests that there has been a decrease in variation from July 2014 onwards, accounting for the number of occupied bed days.

Figure 19: Trust-wide physical violence incidents per 1000 occupied bed days
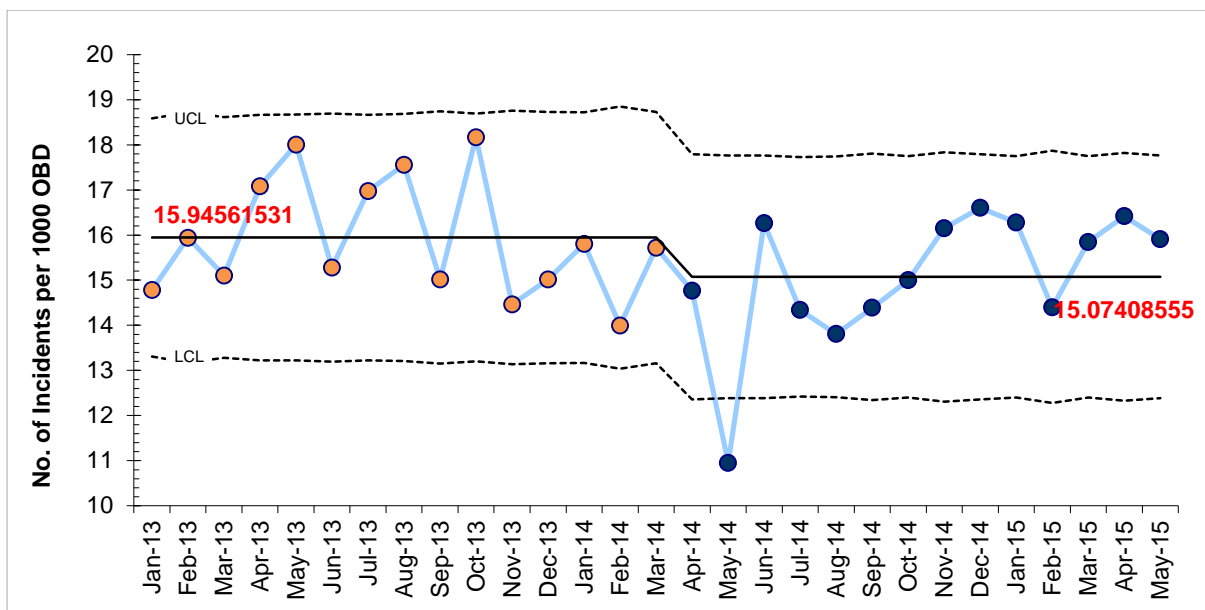
It is possible to look in more depth at specific wards. Out of 44 relevant wards, 13 are actively part of physical violence reduction QI projects while 31 are not.

Comparing before and after the QI Programme began, the average number of incidents resulting in physical violence reduced in both participating and non-participating wards. The changes occurred in April 2014 which is around the time the QI Programme launched – and around the time changes were made to the Datix recording system.

Looking at the difference in rates per 1,000 occupied bed days suggests that there was a greater decrease for participating wards compared to non-participating wards. Also, there is greater variation visible in participating wards compared to non-participating wards, which is a positive sign that the changes being tested are disrupting the stability of the system (see Figure 20). Participating wards started with many more incidents per ward, but had a greater reduction over time.

Figure 20: 13 wards doing violence reduction QI projects vs 31 other wards
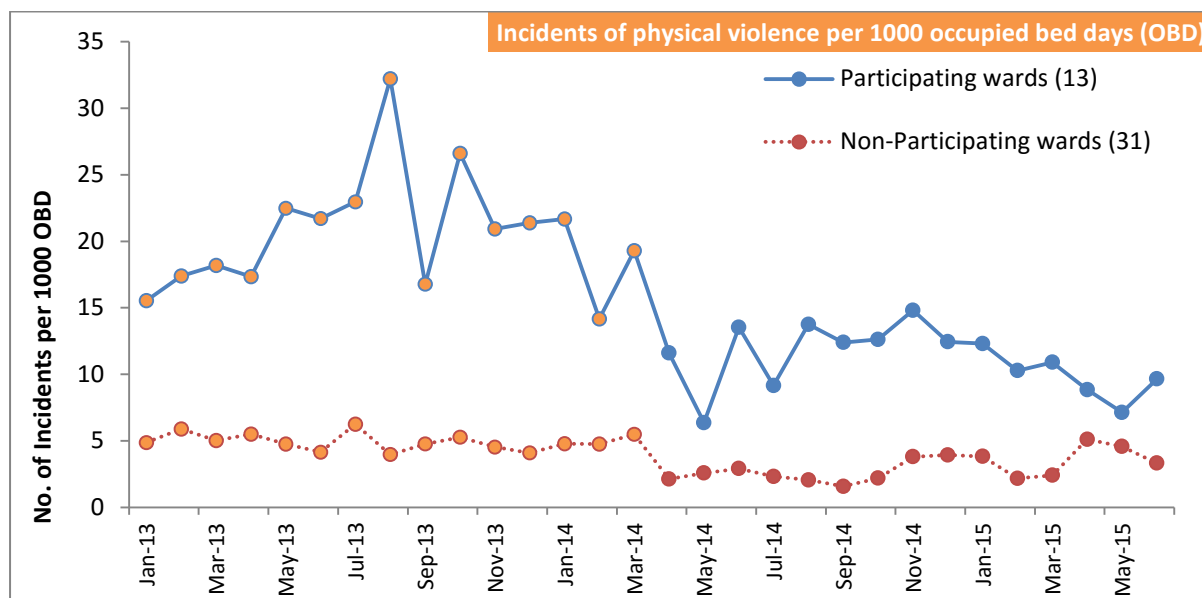
Four directorates within ELFT are currently running programmes to reduce inpatient violence: Tower Hamlets, Mental Health Care for Older People (MHCOP), Forensics and the Coborn Unit. The first two of these have been operating for some time, so the impacts of these are examined briefly in turn. The other two projects are just getting underway so there is insufficient data to report outcomes.

Tower Hamlets

Tower Hamlet's Globe Ward implemented a violence checklist. Over the space of two years, the average time between incidents increased from 5 days to 11 days, a 100% increase. The learning from this ward was spread to the other five inpatient wards in the Tower Hamlets directorate using a collaborative learning approach. The teams taking part in the violence collaborative meet every six weeks to discuss results and plans. Since the beginning of the project, Tower Hamlets has seen a **37%** decrease in incidents of physical violence (see Figure 21). The average number of incidents resulting in physical violence has dropped from 12 incidents every two weeks to 8 incidents every two weeks.

Figure 21: Physical violence incidents in Tower Hamlets directorate
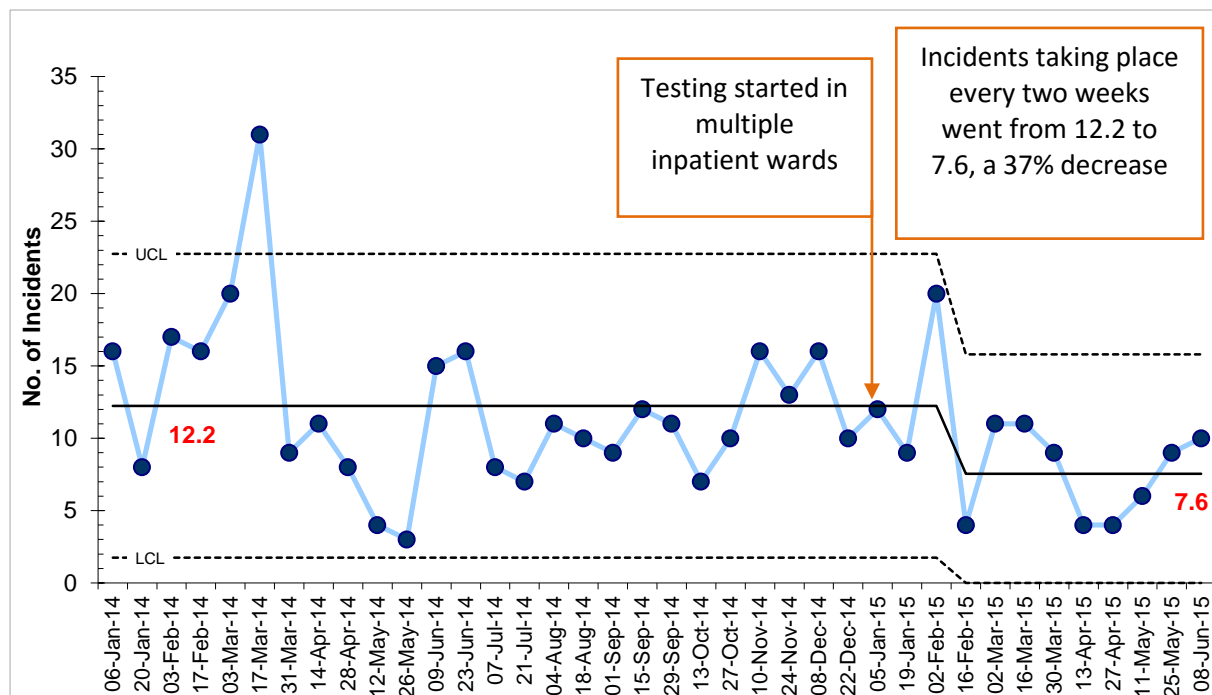
Dividing the data further, the four acute wards at Tower Hamlets have seen a 59% reduction in reports of physical violence. The two Psychiatric Intensive Care Unit wards have variable achievements, with one experiencing a 43% reduction and the other seeing no change.

Mental Health Care for Older People

Three wards are undertaking a violence reduction project for older people. The teams began their QI work in January 2014 and began to see a noticeable change in August 2014. The average time between incidents of physical violence changed from 3 days to 8 days, a 163% increase.

There has also been a reduction in staff injury and staff absence. Days between incidents resulting in staff injury increased by 108% and staff absence across the three wards reduced by 36%.

As yet there have been no overall changes in the number of falls at the Trust that result in harm (see Figure 22). On average, there are about 10 falls resulting in harm per month and these falls make up about one third of all falls reported (34%).

Figure 22: Falls resulting in harm per 1,000 occupied bed days
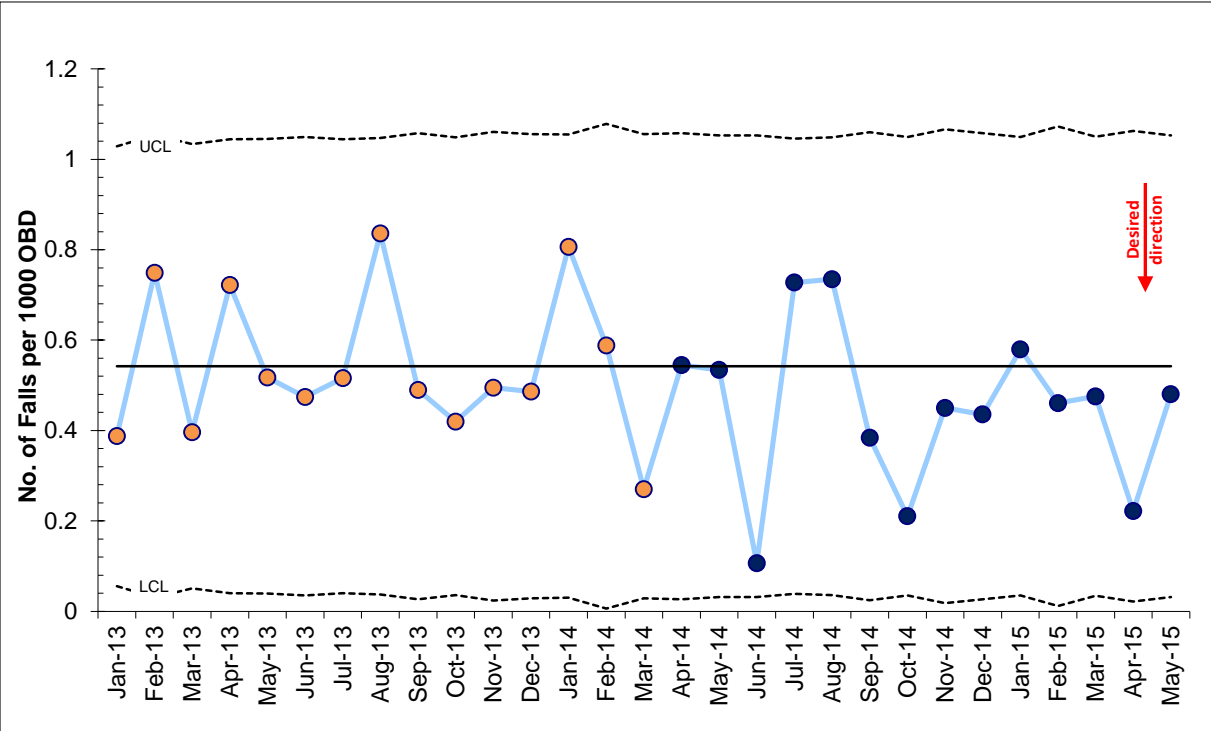
Although Trust-wide improvement is not yet visible, three wards are working on falls reduction. As yet there is no evidence that these wards have reduced falls more than wards not undertaking improvement projects (see Figure 23). However these wards had a much higher rate of falls to begin with than other wards.

Figure 23: Falls per 1,000 occupied bed days (OBD) in 3 wards undertaking falls reduction projects versus 41 other wards
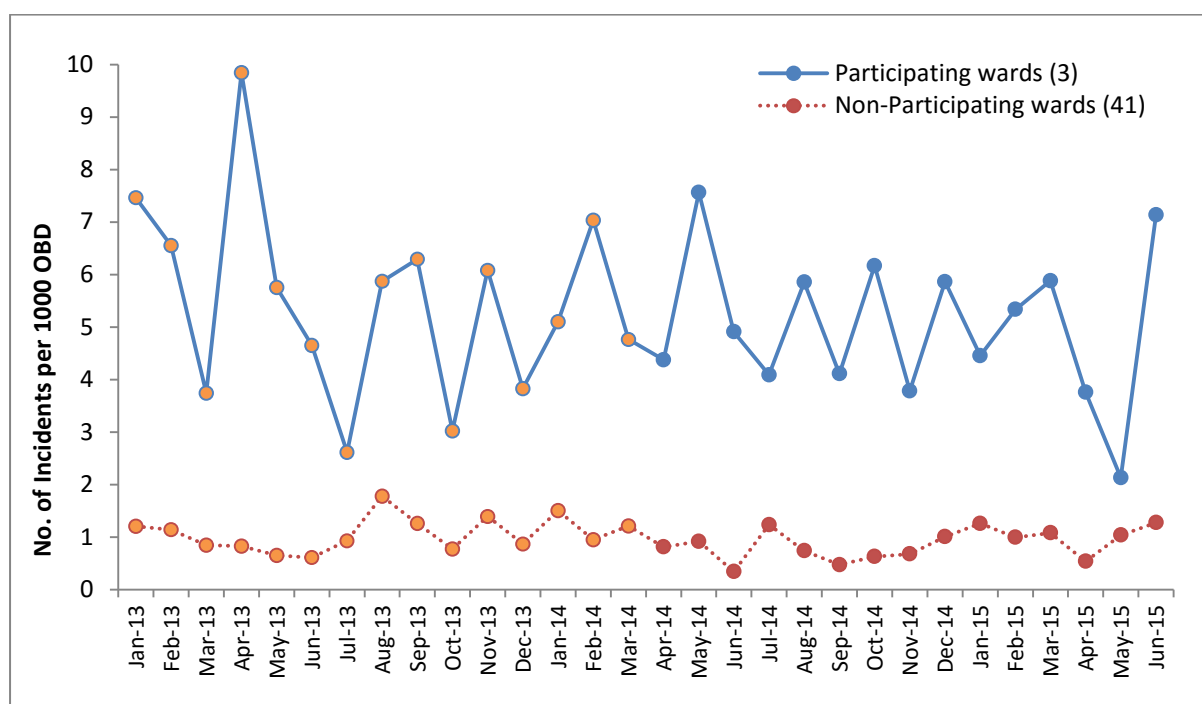
The rate of pressure ulcers has been fluctuating. For example, the average number of grade 3 and 4 pressure ulcers originating at ELFT has varied (see Figure 24).

Figure 24: Grade 3 and 4 pressure ulcers acquired at ELFT per 1,000 occupied bed days (OBD)
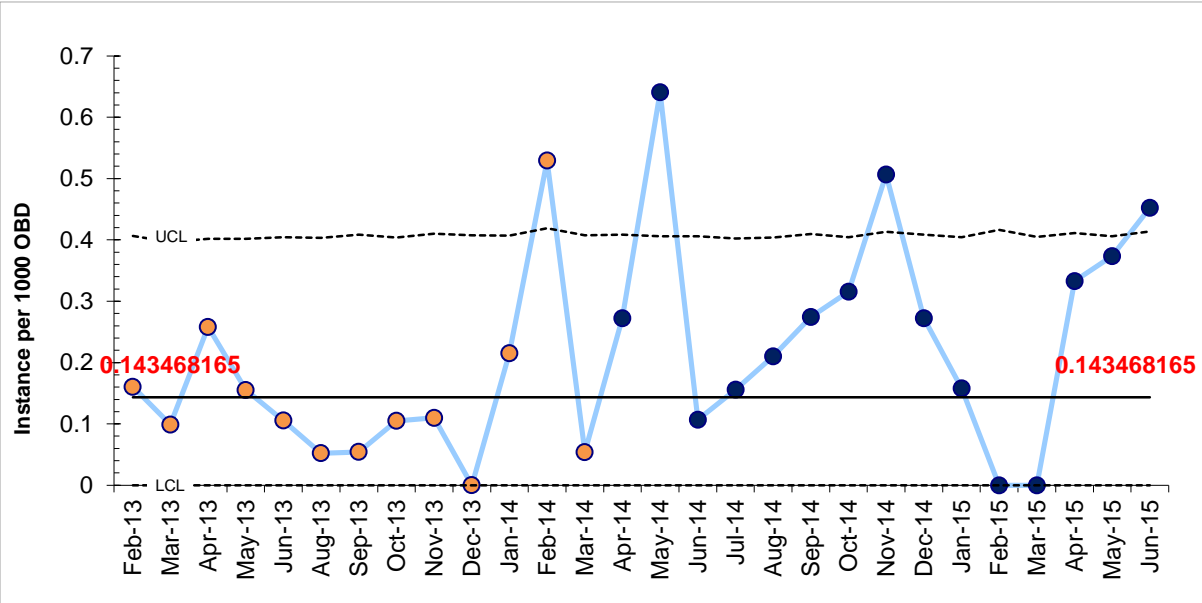
There are some positive signs from work being undertaken by the eight teams in the Community Health Newham (CHN) directorate. The frequency of acquired grade 2 pressure ulcers has reduced by 50% (from 6 to 3 per month). However this is based on raw numbers rather than accounting for occupied bed days and the actual change in numbers is low (see Figure 25).

Figure 25: Change in grade 2 acquired pressure ulcers in CHN directorate
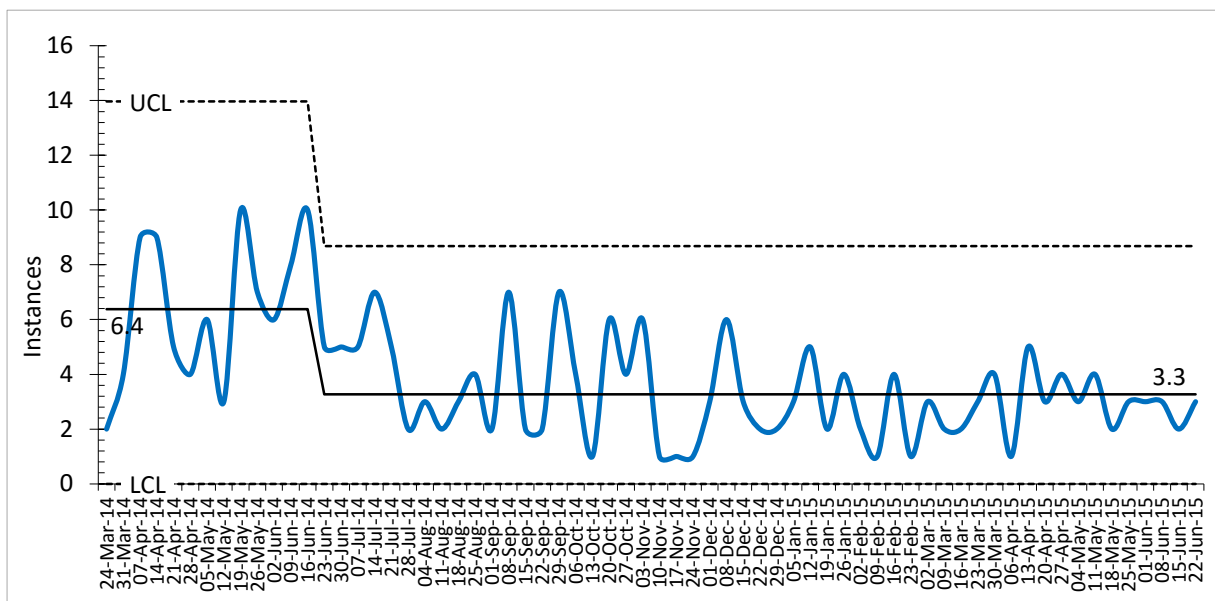
There have been improvements in process measures in this directorate, with the teams moving from 57% reliability to 96% reliability in completion rates for Waterlow risk assessments.

ELFT does not have a single measure of medication errors across the Trust. Medication incidents are being measured but a recent observational study in ELFT found that these are under-reported, with fewer than half of medication errors reported.[2]

The Trust collects data more reliably about incidents involving 'high risk' medication. Here there has been no significant change in rates over time (see Figure 26).

Figure 26: Incidents involving high risk medication per 1,000 occupied bed days
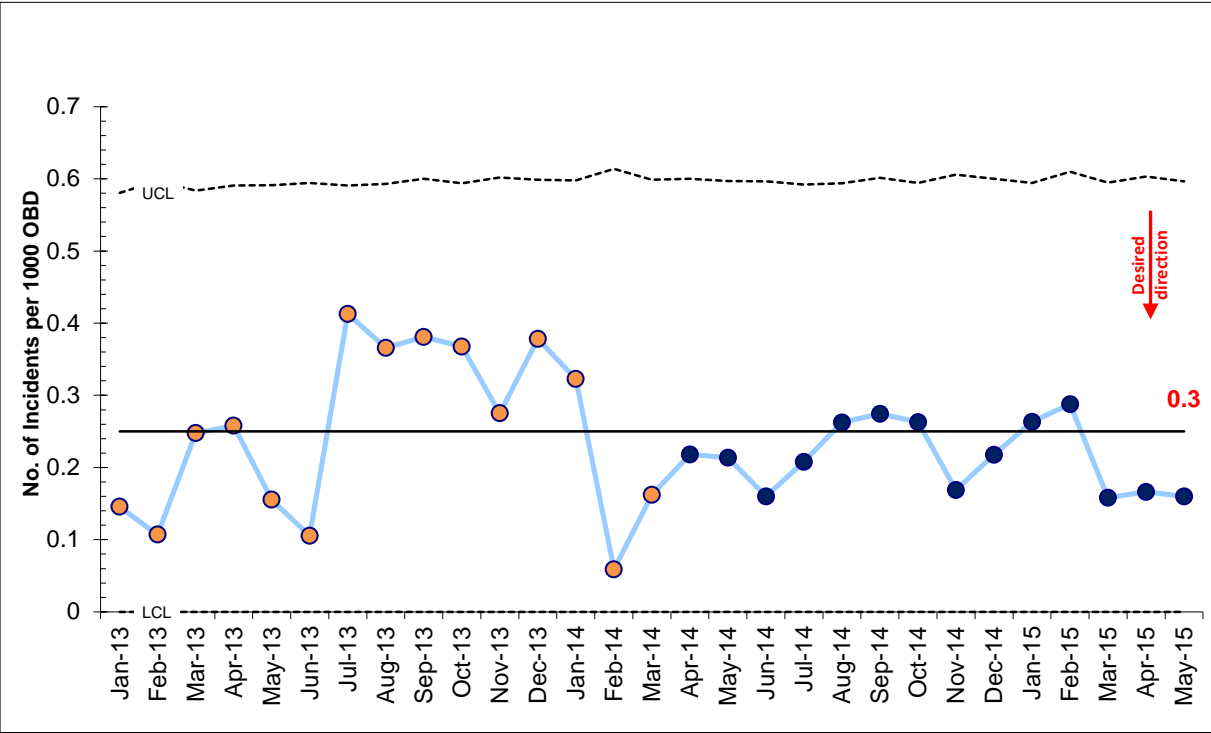
2   Cottney A, Innes J. Medication-administration errors in an urban mental health hospital: a direct observation study. *Int J Ment Health Nurs* 2015;24(1):65-74.

A small number of teams are focusing on reducing medication errors within their directorates. For example the MHCOP directorate aimed to reduce the number of missed doses. Rather than using Datix-reported incidents, the teams looked at medicine charts to calculate missed doses. The teams have reduced the percentage of missed doses across six wards within the directorate. The average number of missed doses (as a percentage of total doses due) changed from 1% per week to 0.25% per week. This represents a 78% reduction in missed doses. Although the percentage change seems small, it accounts for 2,717 missed doses prevented.

Similar trends can be seen in charts from the NHS benchmarking report (see Figure 27). ELFT has moved from being near the national median for drug administration errors to being in the bottom of the lower quartile. For prescribing errors, ELFT has sustained a low rate of prescribing errors.

Figure 27: Comparison of ELFT with national benchmarks for medication errors
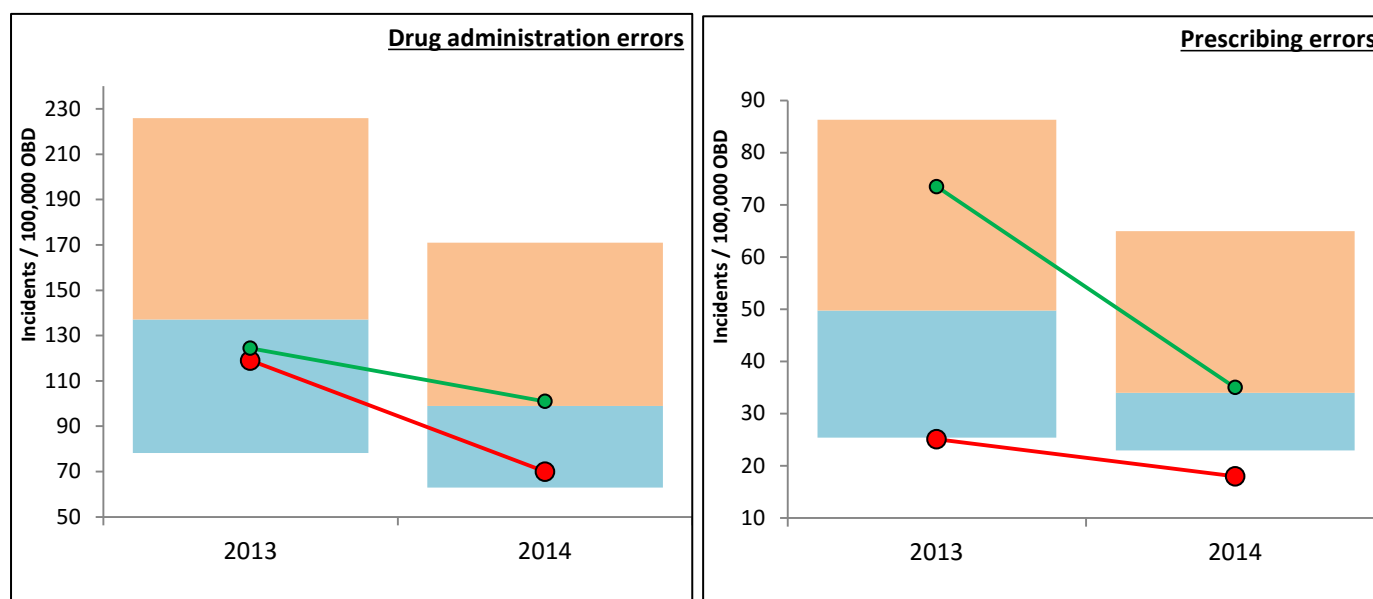
Reducing use of restraints

Since the beginning of 2013, ELFT has been working to reduce the use of restraints, in particular prone restraints.

There have been reductions in the number of restraints and prone restraints. The average number of incidents resulting in restraint changed from 134 per month to 114 per month, a reduction of 15%. The average number of prone restraints reduced from 59 per month to 33 per month, a **45% reduction**. Figure 28 shows the reduction, taking into account occupied bed days.

Figure 28: Incidents resulting in restraint per 1,000 occupied bed days
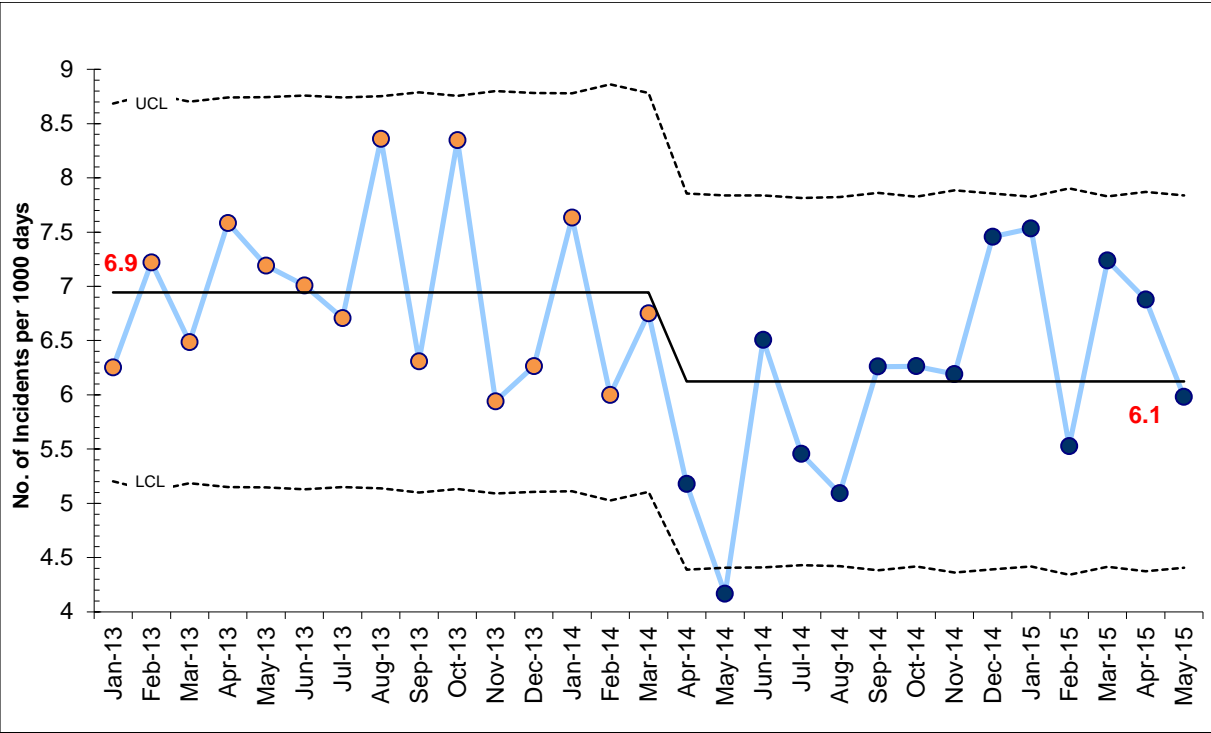
These improvements are reflected in national benchmarking (see Figure 29). ELFT moved from the upper quartile in terms of use of restraint to being below the national median. However, the Trust has a high number of incidents resulting in prone restraint.

Figure 29: National benchmarking about the use of restraint
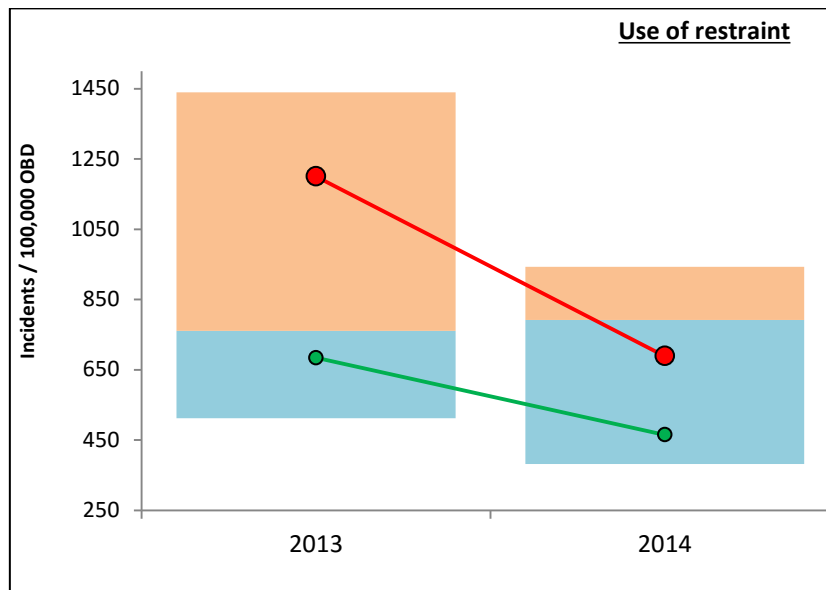
It is not certain that the improvement is a result of the QI Programme. There has been a reduction in the use of restraint in both participating wards (57%) and non-participating wards (52%) since the introduction of the QI Programme.

There is much greater variation in non-participating wards compared to participating wards (ie those undertaking a QI project to reduce restraints). The 13 wards that are undertaking a QI project in this area have a much higher rate of restraint use than others (see Figure 30).

Figure 30: Incidents resulting in use of restraints per 1,000 occupied bed days - comparing 13 participating and 31 non-participating wards
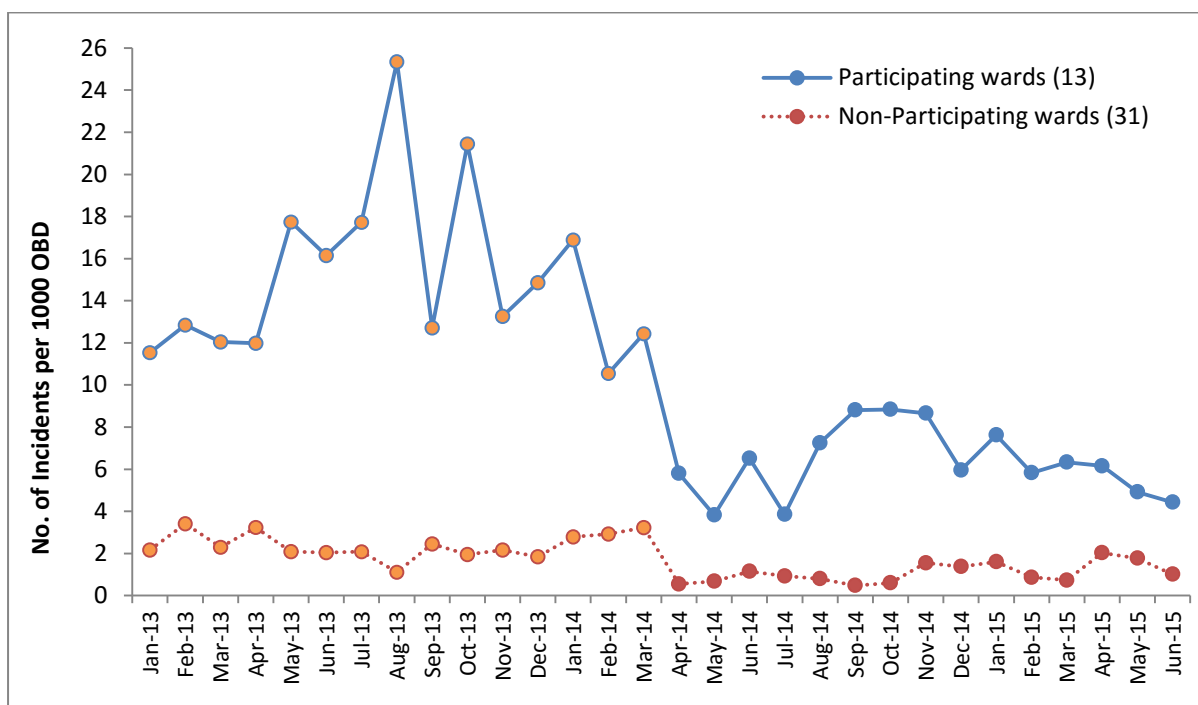
Key messages

Table 4 summarises key trends in harm reduction before and after the QI Programme. There have been reductions in physical violence, pressure ulcers and restraint use. There may be more work to do on fall reductions and medication errors.

Table 4: Summary of key trends in reducing harms

Focus	Reduction over time
Physical violence	Reduction
Pressure ulcers	Reduction
Restraint	Reduction
Medication errors	No Trust-wide measures
Falls	No change

2.5 Right care, right place, right time

Overview

Of the 163 QI projects currently active, the majority are working towards the 'Right care, right place, right time' aim. At the start of the QI Programme in 2014, most projects were working towards reducing harm but there has been a significant growth in projects looking at 'Right care'. Many of these projects are in their early stages and a collaborative learning system was set up to support projects working in this area in April 2015. Thus it is too early to see improvements in outcomes at Trust-level. For this reason, this section focuses on describing individual QI projects working towards this aim, using data from a range of sources to help understand the impact so far.

The projects within the Right care workstream fall within four areas:

1. **Improving patient and carer experience**
   - Adults Service User-Led Standards Audit
   - Friends & Family Test / Patient Report Experience Measures
   - Patient Safety Climate Audit
   - Community Mental health Survey
   - Complaints and Complements
2. **Reliable delivery of evidence-based care**
   - Reducing omitted doses of medication on the Mental Healthcare of Older Peoples' (MHCOP) Wards
   - Record Keeping Audit
   - Care Plan Approach Audit
   - Medication Controlled Drugs Audit
   - Infection Control
   - Clinical Effectiveness
3. **Reducing delays and inefficiencies in the system**
   - Community Mental Health Team (CMHT) Waiting Times - Referral to First Appointment
   - Trust-wide CMHT Waiting Times - Referral to First Appointment
   - Child and Adolescent Mental Health Service (CAMHS) Referral
   - Newham Child and Family Consultation Service (CFCS) Project
4. **Improving access to care at the right location**
   - Newham Weight Gain Project; Reducing mean weight gain by 30% on Acute Wards

Each of these four areas is examined in turn, providing detail about the projects and measures available.

Improving experience

Adults Service User-Led Standards Audit

A number of measures are being used to track progress in patient and carer experience over time. The Service User-Led Standards Audit (SULSA) began in quarter one of 2013.

Figure 31 shows findings from the Service User-Led Standards Audit for the last five years. The audit collects information across ten service user developed standards; asking two questions per standard. Service users on adult inpatient wards across the Trust take part.

This tool has not found an improvement in patient experience since the QI Programme began. There is a stable score in the three directorates and some variation in patient experience across the different directorates.

Friends and Family Test

The NHS Friends and Family Test (FFT) is an important way for service users to rate their experience of care. Monthly reports are published on all wards to prompt discussion about potential change ideas.

Figure 32 shows that the data are varied, fluctuating from month to month. The collection and use of this data is ongoing.
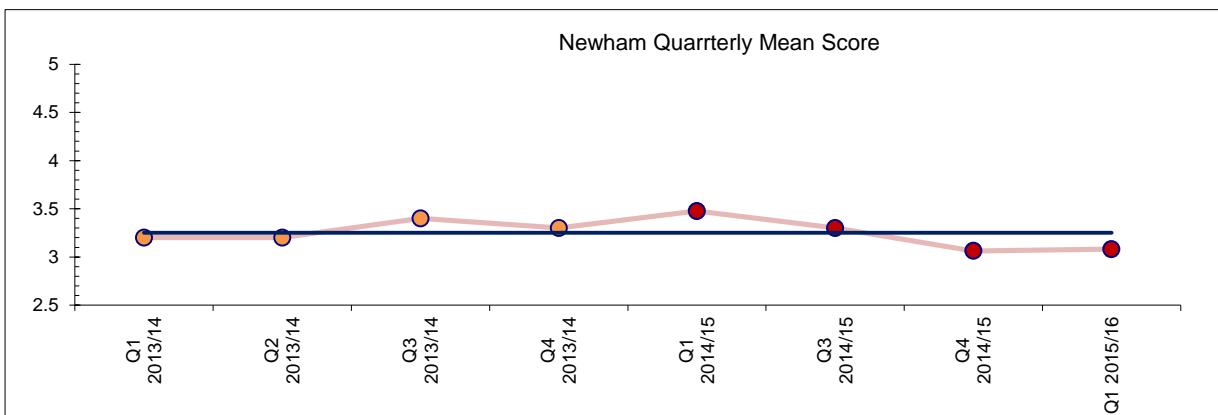
Figure 31: Service User-Led Standards Audit

Tower Hamlets Quarterly Mean Score
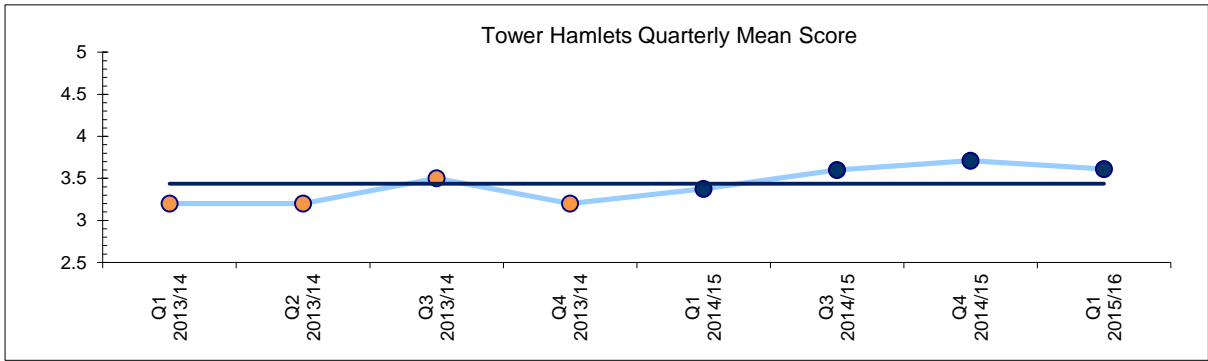
Mean score of 3.5, the last three have scored above the average.

Hackney Quarterly Mean Score
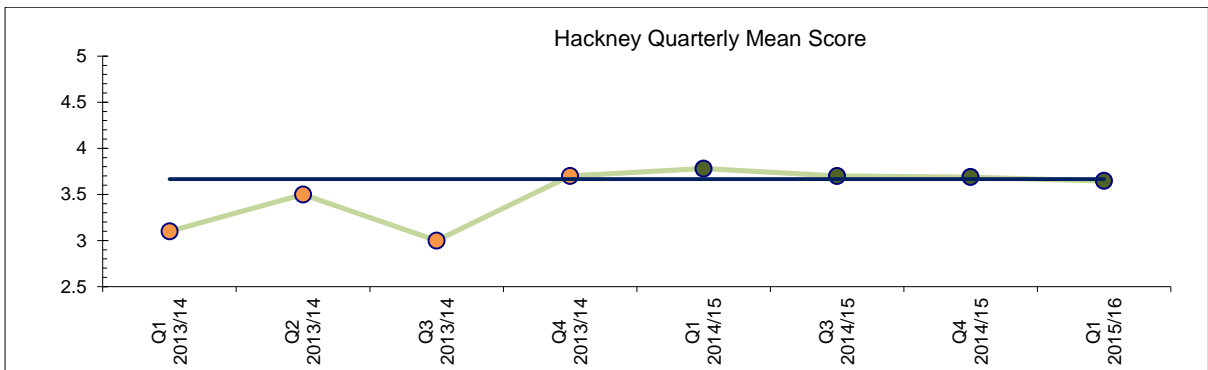
Mean score of 3.7, the last five have scored almost on the average.

Newham Quarrterly Mean Score

Mean score of 3.2, the last two scores have been below the mean.

Figure 32: % that would recommend the Trust (Friends and Family Test data)

TrustWide

88% 61% 83% 77% 83% 71% 72% 83% 68% 92% 83% 89% 91% 83% 87% 66% 74% 65% 66% 77%

Newham

86% 75% 80% 69% 90% 41% 92% 85% 87% 93% 86% 92% 92% 83% 85% 78% 100% 75% 69% 91%

Tower Hamlets

100% 22% 88% 92% 80% 91% 54% 100% 55% 100% 83% 89% 100% 77% 80% 76% 79% 53% 68% 72%

Hackney

75% 87% 85% 79% 76% 72% 77% 71% 56% 82% 75% 81% 85% 88% 95% 63% 68% 53% 59% 77%
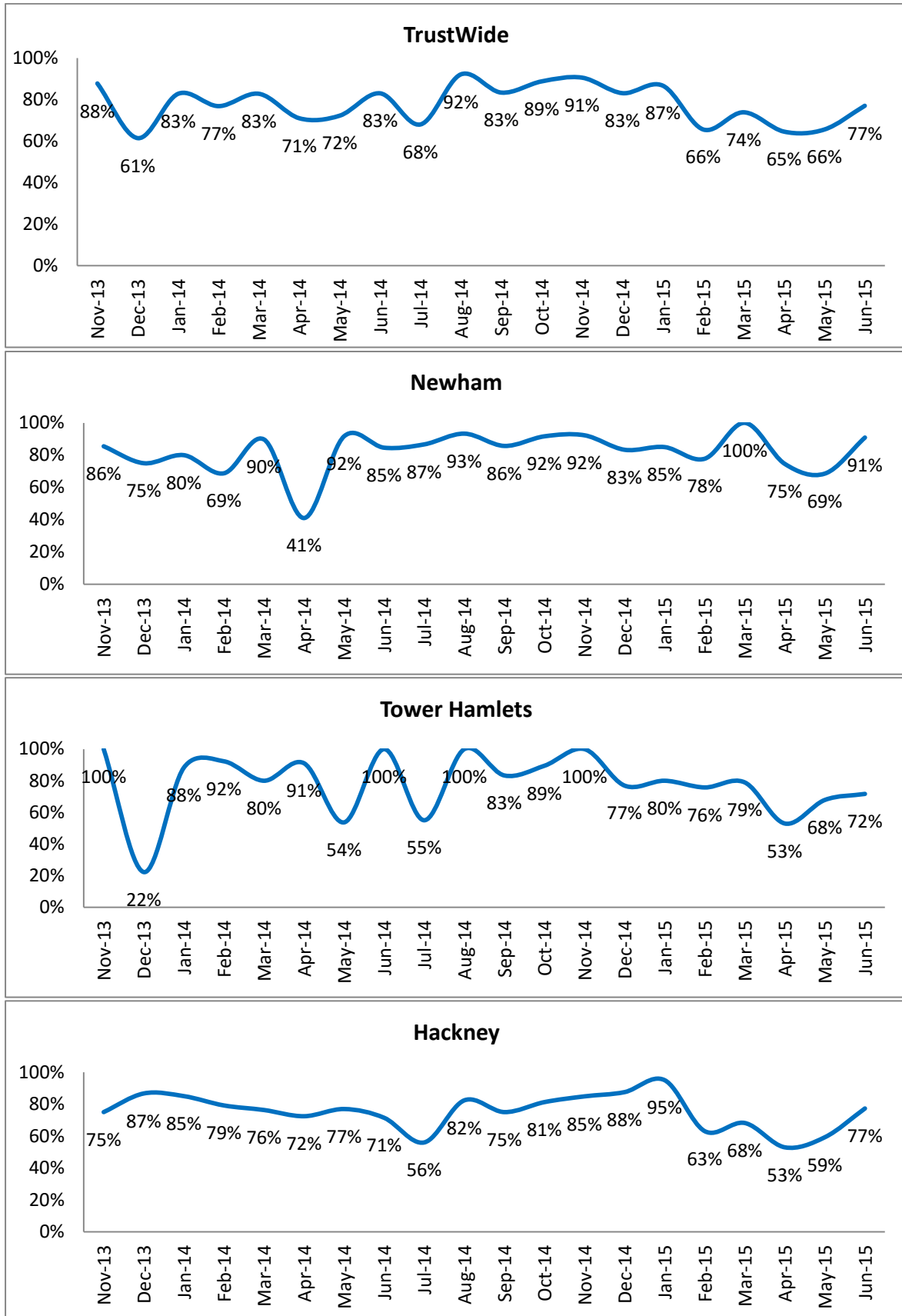
Patient Safety Climate Audit

The Patient Safety Climate Audit was conducted once in quarter one 2015 on mental health inpatient wards. The audit is designed to enquire about environmental, relational, medical and personal safety.

As this audit has been carried out only once, it cannot be used to assess changes over time at this stage. The qualitative and quantitative data has been fed back to individual teams so that this can stimulate discussion with staff and service users about how to promote an environment in which all service users feel safe.

Complaints and Compliments

The Trust records the number of complaints and complements it receives. This data is publicly available.

Over the past year there has been a trend towards a reduced number of complaints and an increased number of compliments (see Figure 33).

*Figure 33: Number of complaints and compliments received*
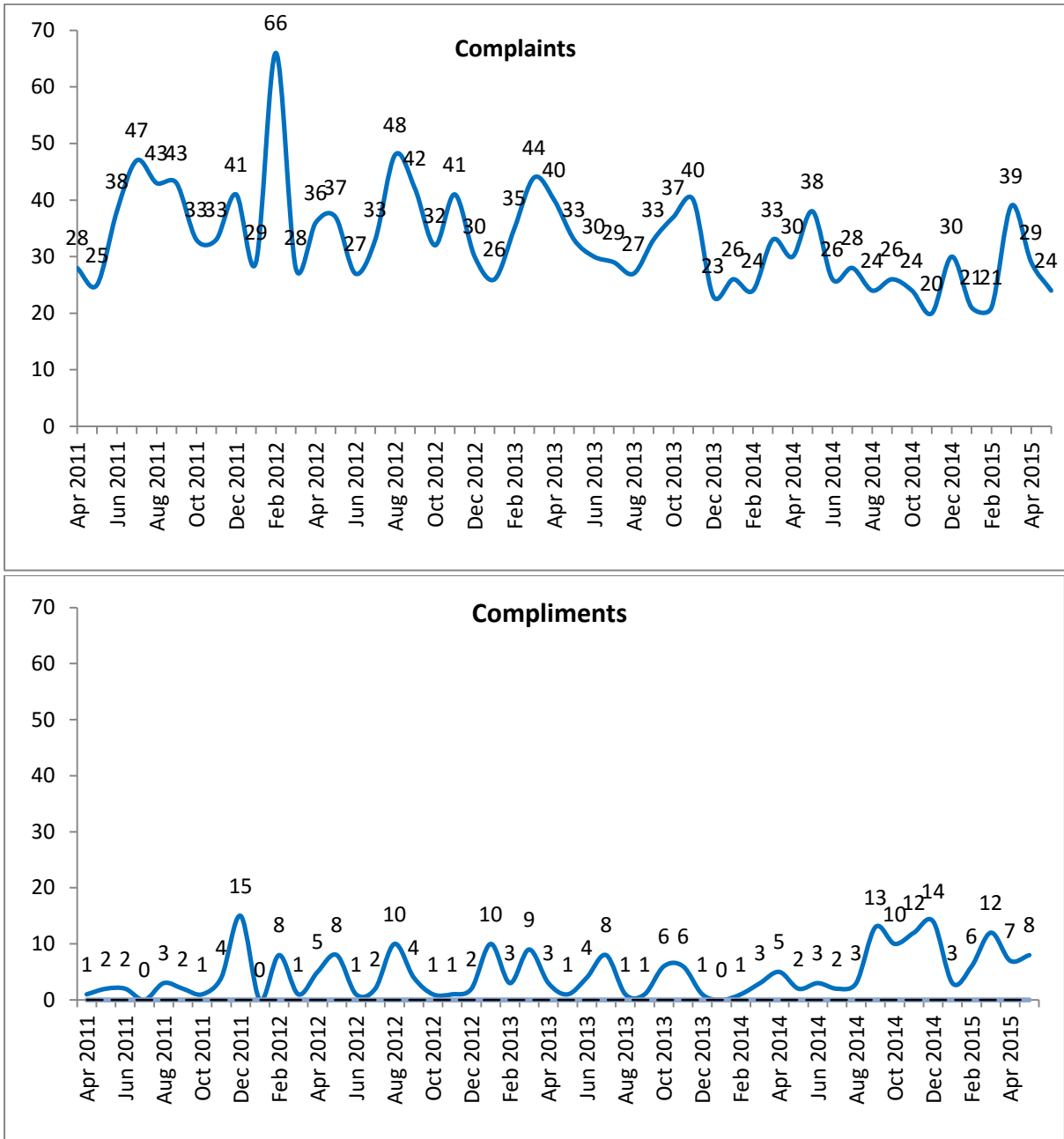
Reducing missed doses

A number of wards have set up QI projects to increase the reliable delivery of evidence-based care. For example, as outlined in the 'Reducing harm' section, Mental Health Care of Older People's Wards are working to reduce omitted doses of medication. Figure 34 shows that before the project the missed dose rate during six-weeks of monitoring was 1% (2,871 missed doses per year). After the project, over a six-week period the rate was 0.06% (154 missed doses per year), meaning about 2,717 missed doses were prevented.

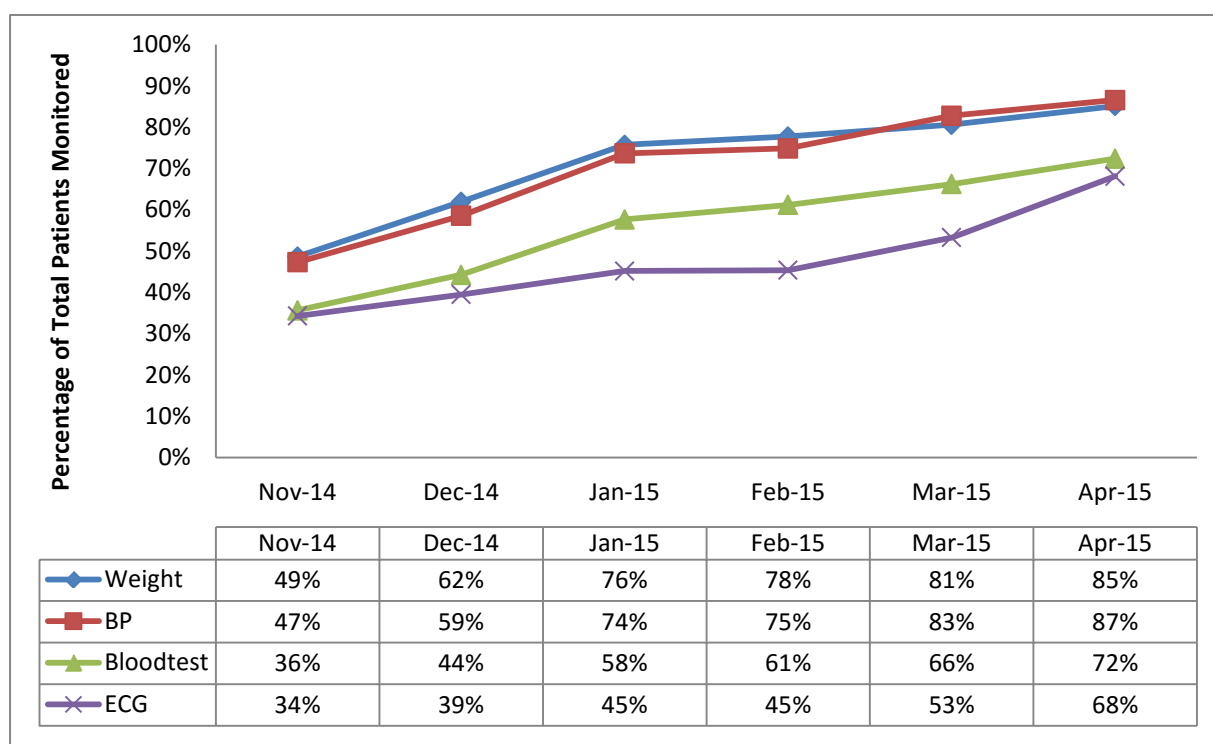*Figure 34: Missed doses of medication on MHCOP wards*
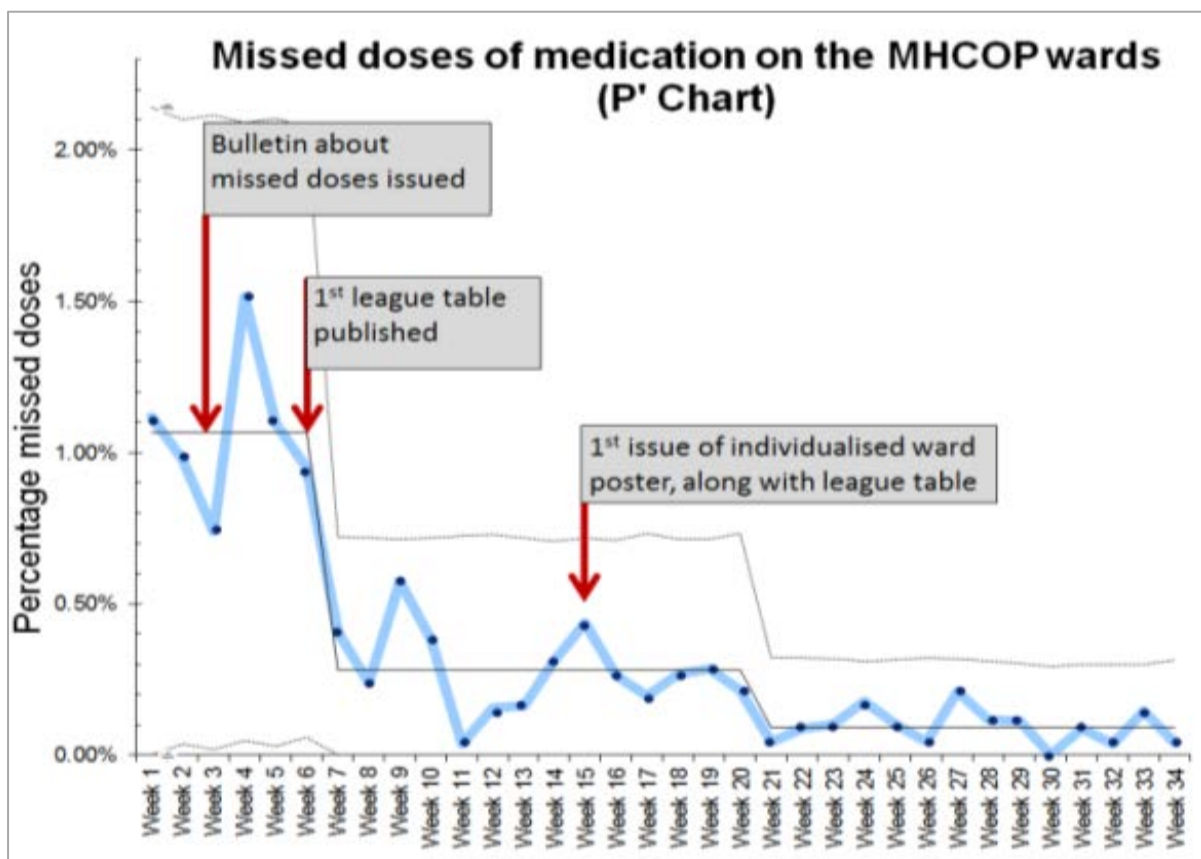
Monitoring physical health

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

In 2014, the Report of the Second Round of the National Audit of Schizophrenia noted that "although monitoring of physical health risk factors were about average in ELFT, it was still below what should be provided and was particularly poor for monitoring of glucose control and lipids."

The assertive outreach team in City and Hackney have been testing ways to improve physical health monitoring in their patients using QI methodology. There have been improvements in the reliability of physical health monitoring (see Figure 35). These findings are now informing the development of standards and electronic forms which will be incorporated into the electronic clinical system and spread across the Trust.

Figure 35: Monitoring of physical health by assertive outreach community team

|	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Weight	49%	62%	76%	78%	81%	85%
BP	47%	59%	74%	75%	83%	87%
Bloodtest	36%	44%	58%	61%	66%	72%
ECG	34%	39%	45%	45%	53%	68%

Waiting times

QI projects are also focusing on reducing delays and inefficiencies in the system and improving access to care at the right location.

For example, the Newham Child and Family Consultation Service is aiming to reduce waiting times for a first appointment from 11 weeks to 9 weeks and improve patient experience of the referral process by offering a more responsive service. Since October 2014, the average wait from referral to assessment has reduced from 61 days to 48 days (see Figure 36).

The learning is being shared with the two other Child and Adolescent Mental Health Services, which have commenced projects with similar aims.

Figure 36: Waiting time between referral and appointment at one service
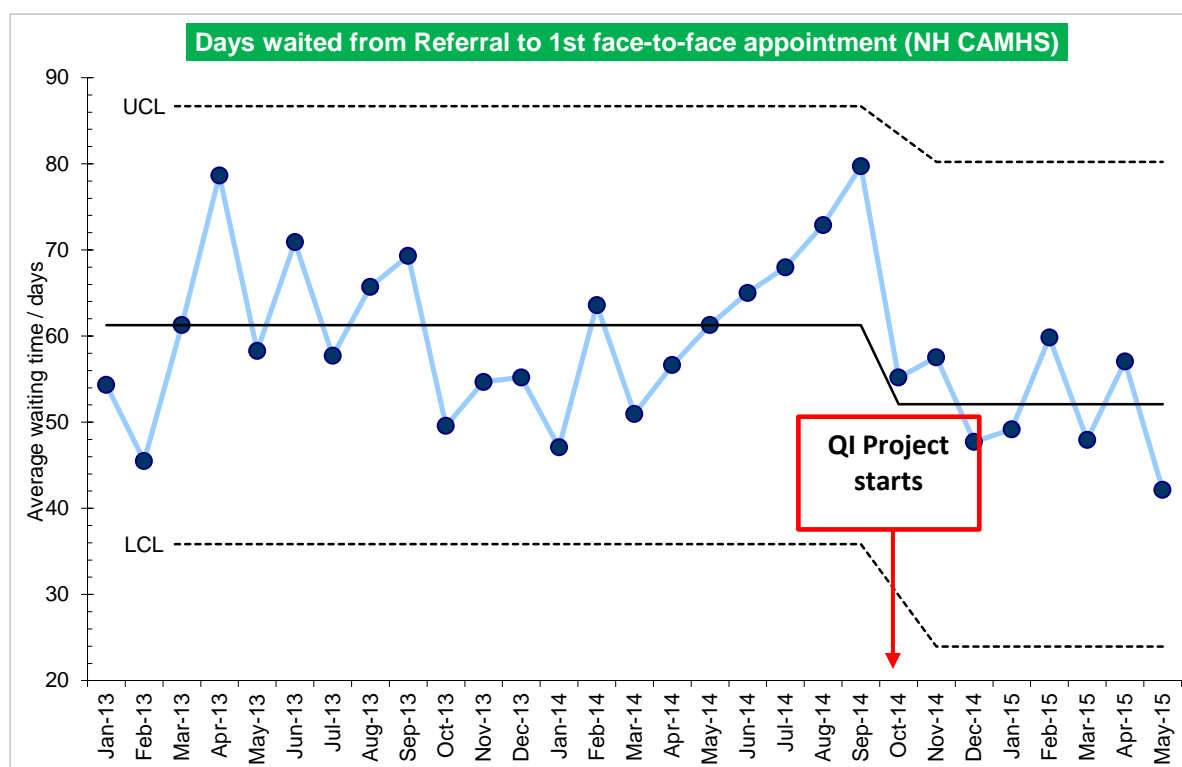
In February 2015, it was agreed that the QI Programme would have four priority areas of work, two aligning with each high-level aim:
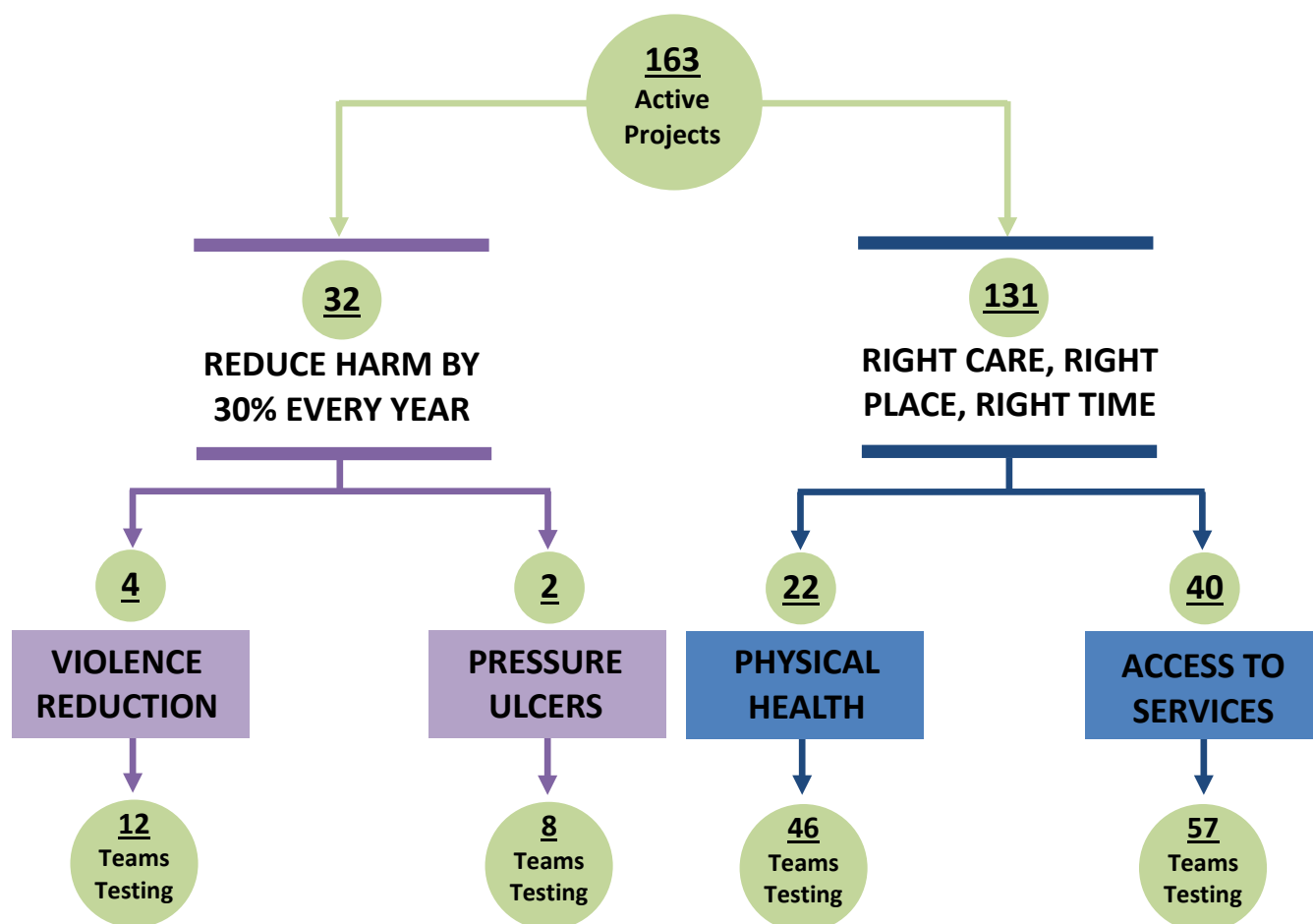
Reducing harm by 30% every year
- Violence reduction
- Pressure ulcers

Right Care, Right Time, Right place
- Physical health
- Access to services

Figure 37 illustrates the number of projects in these workstreams.

Figure 37: Number of active projects and teams testing changes

```
                         163
                        Active
                       Projects
              ┌───────────┴───────────┐
             32                       131
       REDUCE HARM BY          RIGHT CARE, RIGHT
       30% EVERY YEAR          PLACE, RIGHT TIME
        ┌──────┴──────┐         ┌──────┴──────┐
        4             2         22            40
     VIOLENCE      PRESSURE   PHYSICAL     ACCESS TO
     REDUCTION     ULCERS     HEALTH       SERVICES
        12            8         46            57
      Teams        Teams      Teams        Teams
      Testing      Testing    Testing      Testing
```

From April 2015 the QI Programme put in place a support structure for projects on each of the physical health and access to services priority areas to come together and learn collaboratively.

Figure 38 compares the waiting times for teams participating in the access to services collaborative and those not participating. The QI Programme is working with teams with longer waiting times. Some early impacts are visible, though it remains too early to draw any conclusions.

Figure 38: Waiting times for participating and non-participating wards
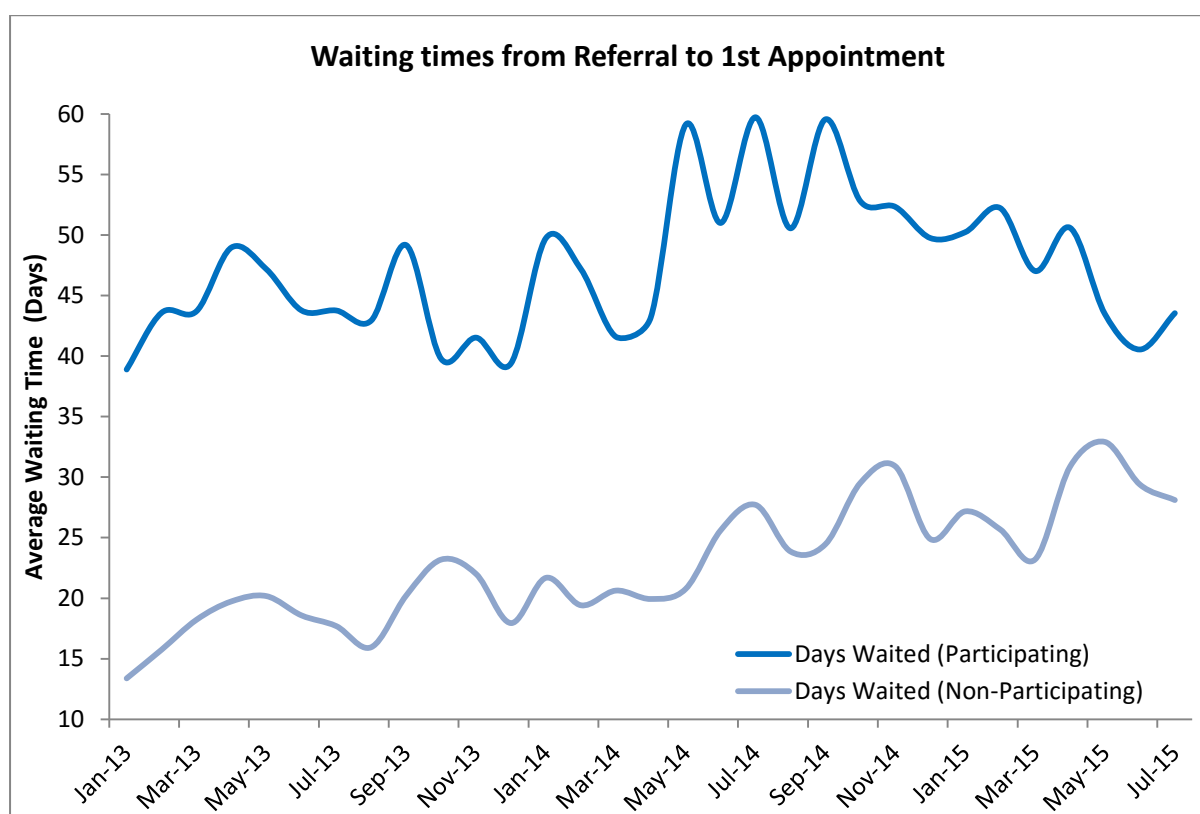
Key messages

Overall, work targeting the Right Care, Right Place, Right Time aim has grown over the first year of the QI Programme. Collaborative learning systems were put in place for projects working on physical health and access to services in April 2015. Some of the individual QI projects are showing improvements in outcomes, but Trust-level change is not visible at this stage.

3. Lessons learnt

3.1 Helpful and hindering factors
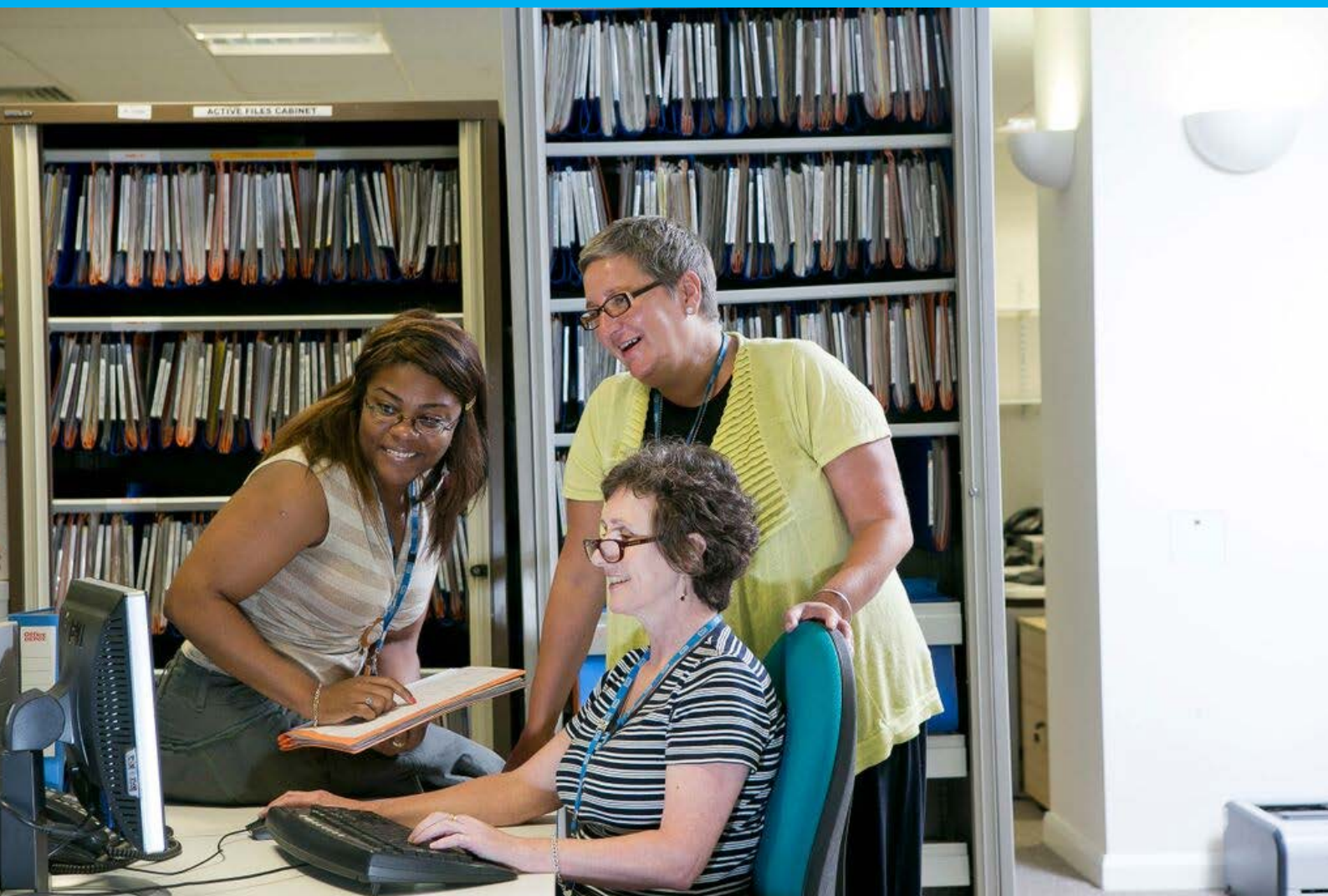
Helpful factors

During June and July 2015, more than 70 individuals and clinical teams were interviewed and 68 people were surveyed for the evaluation. This section summarises the key factors that those interviewed and surveyed felt were helping and hindering implementation of the QI Programme.

The most commonly mentioned success factors were:

- Engaging frontline teams
- Training in quality improvement
- Support from the QI team
- Leadership support

Each of these is explored briefly in turn.

Engaging frontline teams

Three quarters of people interviewed spoke about the commitment that frontline staff have to improving the services they provide. This included the desire to drive positive outcomes, have patient-centred values, build on ideas from those who spend the most time with patients and ensure ideas are proactively followed through.

As outlined in the Alignment section, staff reported that QI has been promoted as a bottom-up approach, allowing frontline clinicians to develop improvement ideas and put this into practice. Some teams reported that this led to an increased sense of engagement and ownership. In this view, rather than giving teams 'instructions' or a new policy to follow, creating a bottom-up approach has empowered people to work together and solve a problem in a creative way, where 'failing' is not seen as a negative, but as a lesson learnt.

> *"The ways it engages people is useful, taking a more fresh creative approach. The trust is now listening to people, previously people would be scared to bring ideas forward or make mistakes, and well not being able to do anything until given the go ahead by executives."(Senior staff member)*

> *"QI is not just for service users it's for staff as well and to make our lives enjoyable too."* (Team without an active QI project)

Senior staff members who observed QI projects within their teams reported seeing increased confidence and more ideas being circulated. Project members also said they felt subjective changes, such as an increase in team work and collaborating with higher staff grades such as doctors and management.

> *"All staff have things they can bring to improvement. Including staff from all backgrounds and levels helps the engagement process and facilitates colleagues working in partnership and collaboration."* (Senior staff member)

> *"Improved the feeling of a community and togetherness. Because it does encourage you to communicate with each other and sing from the same hymn sheet and it needs clarity in how you approach a project. It feels like a tighter network. The team created the project."* (Team with an active QI project)

> *"It has improved the relationships among themselves. There is a sense of appreciation and recognition."* (Team with an active QI project)

The interviews suggested that engaging in QI projects not only resulted in positive outcomes for service users, but also brought together staff teams. People said that conducting QI projects within a team encourages members to communicate more regularly. It was motivating to have a sense of ownership when creating something and seeing the results. Many staff interviewed and surveyed felt proud of what they achieved and feel motivated to start another project. Some people had observed increased morale and less staff absence.

> *"Because of the team effort involved and it being something exciting for everyone, less people going off sick"* (Team with an active QI project)

QI training

The Trust's QI team and IHI have collaborated to develop a training programme for frontline teams. Feedback about the face-to-face training was positive from all grades of staff. Both content and structure were described to be helpful and engaging, especially for those who have had no experience of research or improvement methodology.

"Each session in the training is different. The tempo changes which is very engaging and doesn't become boring like some training programmes can. They get you out of your comfort zone, and it's a nice way to meet people from different areas of the Trust."(Senior staff member)

No interviewee described the three-day workshop, learning set or any other training feature to be boring or unhelpful.

Only two interviewees commented on other resources.

"As a senior staff the training was very interesting, there was no formal structure as such and the resources offered are helpful like the forums where people can share concerns, ideas etc…Learning tools are great too" (Senior staff member)

Although the QI Programme offers resources such as the microsite and newsletter, there was a general feeling that the three-day training was the main approach for learning the theory and steps of QI.

Support from the QI team

As outlined previously, the QI department has recruited QI leads for directorate projects. These team members act as facilitators, guiding projects and acting as a first line of support. About ten percent of interviewees expressed gratitude to the QI team and suggested they were a key success factor.

"The Quality Improvement team have been extremely helpful, especially regarding the current project ongoing. Before Quality Improvement there was no direct help or support to keep things moving and now there is a lot of help. We have people that help make sense of what needs to be done and what data collecting should look like." (Senior staff member)

Leadership

Those surveyed and interviewed said that strong clinical and managerial leadership was key to the success of projects.

"Leadership definitely a key. There has been an enforcement of things getting done now, rather than an add on to day-to-day work. [Manager] takes a very proactive approach to making sure staff are on board."
(Team with QI project)

Having someone such as the ward manager, matron or consultant not only being involved, but leading projects was found to be helpful.

Teams with staff who have direct contact with someone who has trained in QI or a QI sponsor seemed to have more confidence and energy to bounce back from setbacks.

Hindering factors

Staff and service users also reflected on the barriers or key challenges when implementing the QI Programme. The most commonly mentioned were:

- Attitudes and expectations
- Support for staff
- Training
- Communication

Attitudes and expectations

Some staff noted that there have been improvement initiatives at the Trust before the QI Programme. They wondered whether the Programme was a 'rebranding exercise' to encourage staff to do more with less time and resources. Others pointed to low staff morale and inertia to embrace change, perhaps reflecting a fear of the unknown.

"Lack of acknowledgement for QI work that took place before the QI Programme started. It's always been a part of training for clinical psych. It's undermining that the programme has been rolled out as something revolutionary when it's always been there." (Senior staff member)

"If everyone's involved in QI there's a risk that some people think QI gets in the way of clinical work, even though QI and clinical work is all part of the same thing" (Senior staff member)

"Another tick box exercise for staff by the top people?" (Frontline staff, not involved in a QI project)

Others said that there was already a lot of improvement work occurring and they felt like the QI Programme had been imposed without recognising this.

> *"The people at the top need to stop and take a look around at what is going on already. Because if they had done this they would have seen that there are so many things, so many great amazing things that are going on within the Trust and individual wards. If they would just help these people they would see the results"* (Frontline staff, not involved in a QI project)

Some people felt the QI Programme was 'done to' them.

> *"Is this their way of eliminating hierarchy. I don't think so, it's using people at the frontline to do their jobs for them, using their ideas and taking credit for it, it's all politics."* (Frontline staff, not involved in a QI project)

The small number of service users interviewed did not feel empowered to influence QI projects and were not sure of QI outcomes. They did not feel a sense of ownership.

Support for staff

Whilst some staff acknowledged the benefits of the QI Programme in principle, they said it was difficult to have the time and resources to put QI principles into practice. One of the main themes from the interviews was a lack of support for staff in terms of time and resources. This led to staff questioning Trust preparedness in rolling out QI and Trust commitment to supporting QI on a long-term basis.

> *"It has been an on-going problem with this Trust for years; they really do not support you. They continue to have these great ideas for people to do without any plan on how to help staff, its defocused at times."* (Frontline staff, not involved in a QI project)

Staff said that not having enough support to implement QI work impacted on multidisciplinary team work, meant there was not enough reflective space and projects could stall, thereby affecting staff morale. There was a call for more enabling IT systems to support staff.

> *"Management need to help staff with their hours, to get these extra things done. Otherwise people are keen to make improvements, I myself would be very interested in getting involved I have many ideas."* (Frontline staff, not involved in a QI project)

> *"QI is time consuming, it really is, you have to put a lot into it to get a lot out of it, some people do not want to do that."* (Senior staff member)

QI training

Whilst training was identified as a helpful factor for many staff, it also seemed to act as a barrier or challenge. There were concerns about the accessibility, length, content and flexibility of QI training. Despite some people's keenness to learn QI methodology, there were practical barriers preventing the spread of QI training.

"There should be training but not in the current format, [listed all of the conferences and teleconference] it should be accessible and doable and should fit in with people's schedule." (Team not involved in a QI project)

"I've been on it [wave training] but I would've liked more support about how to move from training to actually doing the project ward based, in a clinical environment from the classroom." (Team not involved in a QI project

The QI website was not deemed user-friendly and the online training resources were seen as time-consuming by some.

"There's load of training on the intranet but in terms of for me it seems like its finding the time for do the training and the modules. The modules are all lengthy and comprehensive. It would take a week." (Team not involved in a QI project)

Furthermore some staff were resentful that they had not been invited to QI training, thereby cultivating a sense of being abandoned from the QI journey. Some staff also noted limited engagement of service users in QI training.

"How are they going to know the opportunities when it's only aimed at a selective group of people." (Frontline staff, not involved in a QI project).

"The trust has been making sure that the top people within the organisation are aware and getting trained first, so when I go to tell my team about the benefits of starting projects and looking into service evaluation, we are almost trying to sell them a dream. They find it hard to believe that we are trusting them with this, putting it in their hands…I believe training should've started with the band 3 and 4s first personally. We would then be less likely to have to be faced with deteriorating staff motivation and morale… it is psychologically and emotionally draining for them to do on top of everything else…" (Senior staff member)

Communication

Apart from projects they were directly involved in, staff and service users were generally not aware of QI project outcomes. This reinforced doubts about the validity and effectiveness of QI processes. It was suggested that the QI team could try to create more awareness around the QI Programme, especially sharing learning from different QI projects across the Trust.

"I think we need to see that change is happening." (Team not involved in a QI project)

"If we had some examples of where it's been effective. Real examples of where improvements are being made. People are talking about it but there's nothing concrete." (Team not involved in a QI project)

"All information about the QI projects happening across the Trust should be accessible so that people can read about it in Trust Talk. So we know. Patients should know too." (Team not involved in a QI project)

Thus whilst staff generally acknowledged the importance of the QI Programme and willingness to be a part of it, pragmatic issues were highlighted as a barrier. People provided multiple solutions such as making QI training more accessible through local training, shortening the duration of training (one-day training) and tailoring the content of training to be geared towards a pragmatic rather than theoretical basis. Furthermore people felt that support structures need to be formalised to enable frontline staff to implement QI projects by allowing them time away from their usual jobs.

One proposal was to have a QI symbolic torch akin to an Olympic torch, to undertake a journey through the Trust, highlighting various QI projects and then ending its journey after a year at the QI annual conference, before embarking on another annual journey.

Key messages

In summary, the top three factors that may be most helping QI implementation include:

- **Support** from the QI team and from senior staff and direct clinical management.

- **Training** and tools to help people start projects.

- **Attitudes**, including teams focused on improving services for patients and being willing to break out of an old system.

The top three hindering factors were thought to be:

- **Attitudes**, particularly where staff perceived QI as being an additional thing to do rather than an integral part of their duties and where there was inertia and a lack of acceptance as staff were not sure if QI would work.

- **Training** was sometimes thought to be inaccessible. There was a call to make face-to-face training more accessible by having local workshops; reducing the length of training so that more staff can be released; and tailoring the content of training to participants' needs by incorporating more pragmatic implementation approaches.

- **Time** was a significant barrier. Some staff said they were keen to pursue QI but needed protected time. QI projects require time commitment and it is very difficult for staff to take time out of busy working schedules. Due to limited time, regular multidisciplinary team QI meetings are difficult to schedule, potentially resulting in impaired progress and subsequent impact on staff attitude and morale.

Whilst some of these comments may appear negative, they were generally given in the spirit of aiding improvement. Only a very small number of individuals expressed dislike or resentment for the QI Programme. These individuals had no direct involvement in the QI Programme.

Interviews with those directly involved in the Programme suggested the strategy was beginning to make a difference.

> *"We are happy that there has been a surge in something research and evidence-based, good things will come out of this… The QI Programme just needs a few tweaks and a different format."* (Team with an active QI project)

Table 5 lists the most commonly provided suggestions for improvement made by different types of people.

Table 5: Suggestions for further developing the QI Programme

	Top three improvement recommendations
Suggested by Service users	1. Incentives / motivation to be involved in QI 2. Communicate opportunities to be involved 3. Communicate about improvements
Suggested by Senior staff	1. QI sub teams 2. Communicating sustainability and raising awareness 3. Pool of service users for QI projects
Suggested by teams / individuals trained in QI or with QI project	1. Shorter training days 2. Learning to be shared and disseminated 3. Protected time by managers to conduct QI work
Suggested by teams / individuals without QI project	1. Service user feedback from outside ward 2. QI lead within team 3. Short modules for staff who cannot attend three-day training

3.2 Next steps

Drawing information from throughout the evaluation together, five main themes have emerged:

1. A well-functioning support structure to enable QI work is critical.
2. Training has had a positive impact on those who have attended, as well as the volume and progress of projects. However, there are significant issues around the accessibility of training.
3. Time and resource are critical issues for those attempting to use QI in practice.
4. Numerous communication channels are being used by the QI Programme, but some communication needs are not being met.
5. Service user involvement in QI work is currently low.

Support structure

A large part of the QI strategy involves ensuring that QI work becomes integrated and part of business as usual, aligning with service improvement priorities. Work has been undertaken in the Trust to ensure that underlying support systems and structures are in place to make this easier. The past year has seen a number of system-level advancements, including the development of Quality Dashboards which enable teams to see their clinical data and performance over time; a switch to Open Rio, enabling teams to have greater control over the data collected; a new audit process that aims to reduce the number of standards reviewed and further align audit with QI, and a number of improvements to the Datix incident reporting system.

Work has also been undertaken to ensure that a structure is in place to support QI project work. Every directorate in the Trust now has QI sponsors, coaches and project leads in place. Almost all directorates have QI forums operating on a monthly basis. The Trust has also set itself high priority areas of activity around reducing violence, pressure ulcers, improving access and physical health. In each of these areas there are additional collaborative learning systems to support project team work.

It is evident that those projects that have benefited from a well-functioning support structure have found it easier to make progress.

Collaborative structures are learning systems that provide project teams the opportunity to meet regularly with each other, QI sponsors and members of the QI central team. During the course of a collaborative, teams receive a wide range of additional support to help them develop ideas for change as well as measure and test these ideas. The quantitative analysis suggests that more projects that have been part of collaborative structures have made progress, with clear improvements in outcomes (for example reductions in violence, pressure ulcers and restraints).

The qualitative analysis noted that it was helpful where projects had someone such as the ward manager, matron or consultant not only being involved but leading projects. This was because these clinical leaders could create a structure that enabled QI to be incorporated into day-to-day work. Moreover, teams with individuals that had direct contact with someone with QI training, or a QI sponsor, seemed to have more confidence and energy to bounce back from setbacks in their projects. Interviewees also reported the benefits of having central QI team input, particularly because this helped motivate project teams to make progress, rather than relying on traditional management structures.

Training

Training has had a positive impact on those who have attended, as well as the volume and progress of projects. However, there are significant issues around its accessibility.

The Trust is aiming to build capability around QI in the organisation at both scale and pace. In total, 365 staff, patients and external partners have undertaken the six-month Improvement Science in Action (ISIA) training course in just over a year. Both qualitative and quantitative analysis indicates that the first three waves of training have had a positive impact.

One positive impact has been an increase in self-reported staff capability and confidence in using the QI methodology. Feedback about ISIA was generally positive, with both content and structure considered to be helpful. Pre and post training surveys suggested the course increased the perceived capability of those who attended, with all aspects of the training measured showing movement to an increased level of competency. This also appears to have been reflected in the Trust-wide capability survey, which demonstrated a shift along the spectrum of perceived capability from 2014 to 2015.

The second positive impact has been on QI project activity. Training was associated with an increase in the number of registered QI projects, but also in the progress that these projects were making. In particular, there were far fewer projects identified as 'stalled' and far more projects identified as actively testing change ideas.

Despite these positive impacts, lack of access to training is a significant issue for many staff. There was a feeling that no training meant that no QI project work could happen. Moreover, for some, not being invited to QI training resulted in a sense of being abandoned from the QI journey.

Issues around accessibility could be grouped into the following issues:

- Concerns that those delegates trained to date were a selective group of senior staff and this seemed to fly in the face of what the programme was being described as: a 'bottom up' initiative. Analysis of those who have been trained does uphold elements of this assertion: many of those trained to date are in management roles.

- The training on offer may not be flexible enough for the needs of different groups and this was a barrier to the spread of QI. In some cases the length of training was cited as a major issue (length of individual learning sessions as well as total course duration), in others the fact that training was incompatible with people's work schedules.

- Whilst other learning resources were available (IHI Open School and the QI microsite), there appeared to be little awareness about these in comparison to the ISIA course. It was generally perceived that the six-month ISIA course was associated with QI work in the Trust.

Time and resources

Time and other resources are critical issues for those attempting to use QI to improve quality. Many interview and survey responses centred on the time and resource required to undertake QI training, or the time and resource it took to undertake QI work itself.

As discussed above, many considered the existing training options (IHI Open School and ISIA) to be too comprehensive and lengthy. There were concerns raised around the feasibility of sending clinical staff for lengthy training and also fitting this into people's busy schedules.

There was also a belief that QI is time consuming. Many responses focused on a need to help staff with their workload, so that 'extra' things such as QI could be fitted in. This perceived lack of support around time and resource was felt to impede multidisciplinary QI work.

Communication

While numerous communication channels are being utilised by the QI Programme, there are still communication needs that are not being met.

The Trust has undertaken a large and multi-faceted communication campaign to raise awareness about the QI Programme. This has included face-to-face engagement through a series of launch events, roadshows and conferences, the creation of a bespoke QI microsite that has seen in excess of 60,000 page views in one year and regular digital and paper based newsletters, both inside the Trust and beyond. The Trust has also used social media to raise awareness about the Programme.

Despite this, it was evident that communication could be improved in certain areas. Particular communications needs included:

- The Trust could focus on reporting more QI project related outcomes rather than general project-related activity. Showing that change is happening may help dispel some doubts about the validity and effectiveness of the QI process.

- The Trust could try to create more awareness about existing QI projects. This would enable other teams to share learning and harvest new ideas.

- The Trust could try to improve communication around how to access different types of QI training.

- The Trust could communicate how the QI Programme 'fits in' with other improvement work, in particular acknowledging improvement work that has happened before.

Service users

One of the key ambitions of the QI Programme is to nurture a culture where service users, their carers and families are at the heart of everything that the Trust does. A critical enabler to develop this culture is service user input into QI work. During the course of the evaluation, surprisingly little qualitative information was generated about service user input. In total, one third of QI projects feature service user input so there is room to engage further (35%).

A range of activity is underway with the aim of increasing service user input into QI projects. From interviews with service users, however, it was apparent that some service users were unaware of the QI Programme and therefore unable to comment on how well they thought it was progressing. This suggests that further work is required to engage more service users around QI and how they could get involved.

Recommendations

The following recommendations are made based on the lessons learnt from the evaluation:

1. **Support structures around QI projects need to be strengthened**. High priority areas for the Trust will continue to be supported by the use of collaborative learning systems, but directorate leaders need to create a clear support structure for QI so that this work becomes an integrated part of business as usual and not an add on.

2. **Directorate leaders and QI sponsors should look at what work could be done differently**, or not all, to make space for tackling complex issues through QI.

3. **More QI training options should be available**, of varying lengths and depths, to make training more accessible for a diverse group of service users, carers and staff.

4. **QI related communications should include more reporting on QI project outcomes** and also help staff to understand how the QI Programme integrates with existing improvement work that has been undertaken previously. More could also be done to increase access to information on existing QI projects so that other teams can harvest ideas.

5. **More needs to be done to engage a broader group of service users and carers**. This may involve wider communication and ensuring that processes around ensuring service involvement are strengthened.

Ongoing monitoring

This evaluation was conducted 12-18 months after the launch of the Trust's QI Programme. The evaluation team considered the frequency and method of evaluation that might be most helpful and practical going forwards.

Frequency of evaluation

It is recommended that the Trust undertake an evaluation of the QI Programme on an annual basis. This would allow the Trust to reflect on progress and learn from driving and hindering factors in the ongoing delivery of the QI Programme. In order to make the evaluation data meaningful, it will require several months to collect data from a range of stakeholders, making an annual process more pragmatic. Data collection could start immediately following the financial year-end, with a final report due in July of each year.

Method of evaluation

It is recommended that a similar mixed methods evaluation is undertaken as described herein. Table 6 outlines the recommended evaluation strategy for subsequent years. Using the same surveys and questions would allow progress to be tracked over time.

Evaluation team

Team members outside the central QI team were heavily involved in this evaluation. For subsequent years, as the strategy and tools for the evaluation are in place, the evaluation should take less time and could be led by the QI team, with interviews undertaken by members of the Quality Department not directly involved in the QI Programme and service user auditors.

The evaluation has been useful for compiling information about the programme's successes, identifying areas for further development and building further research and analysis skills within the team. The evaluation process itself has been a test of change and the evaluation team hope that the Trust will use the findings to continue to strengthen the Programme for the benefit of service users and staff.

Table 6: Proposed evaluation strategy for future years

Focus	Evaluation question	Measurement method
Building will	How effectively are we engaging and inspiring staff, service users and other key stakeholders in our QI work?	Data on number of people involved in QI projects (staff and service users) Survey data from all staff (using the Safety Climate survey as for this evaluation) and a sample of service users across all teams (using the Patient Safety Climate tool)
Building capability	How effectively are we building capability and capacity for our QI work?	Data on number of people trained at different levels of the organisation Before and after survey with participants of the training programmes Survey of all staff involved in training (using the IHI Science of Improvement self-assessment as for this evaluation) Interviews with sample of staff involved in training (at least 30)

Focus	Evaluation question	Measurement method
Alignment	How effectively are we integrating quality improvement into our operational structures and systems?	Survey of all clinical and service leaders (using the IHI Improvement Capability survey as for this evaluation) Interviews with sample of clinical and service leaders (approx. 5)
	How effectively are we involving service users and carers in our QI work?	Interviews with service users and carers from a sample of teams involved in QI work (at least 20)
	Are our systems supporting or hindering our QI work?	Survey of all staff and Board members (using the IHI Improvement Capability survey for staff and the IHI Board survey as for this evaluation)
Projects, and outcome of projects	How are our QI projects progressing over time?	Data on progression of QI projects over the year (number and stage of progress)
	Are our QI projects aligned with our strategic improvement priorities?	Data on alignment of projects with priority areas
	What has been the impact of our QI projects on our strategic aims and priority areas of work?	Outcome measures for our strategic aims and priority areas of work (using data over time, and comparing participating versus non-participating units)
	What has been the economic impact of our QI Programme?	Financial data on costs and savings related to QI projects for our priority areas of work (using cost calculators and economic evaluations being developed by the finance team for the four priority areas of QI work)