Improving Behavioral Health through Quality Improvement

Introducing the ELFT Team

Marie
Navina
Auzewell
Paul
John
James
Amar
Mental health services
*Newham, Tower Hamlets, City & Hackney*

Forensic services
*All above & Waltham Forest, Redbridge, Barking & Dagenham, Havering*

Child & Adolescent services, including tier 4 inpatient service

Regional Mother & Baby unit

Community health services
*Newham*

IAPT
*Newham, Richmond and Luton*

Speech & Language
*Barnet*

Challenges and opportunities

- Cultural diversity
- Financial stability and strong assurance systems
- Social deprivation
- Commissioning arrangements
- Geographical diversity
Objectives for today’s learning lab

1. Develop an understanding of how quality improvement can be applied in behavioral health settings

2. Identify change ideas that might help solve complex quality issues in behavioral health care

3. Understand the link between involvement, improvement and recovery

Today’s Agenda

• Introduction to ELFT & setting the context for improvement work to begin

• Overview of our organisational approach

• Increasing service user, carer and family involvement in QI

• Is it making a difference?

• Panel Discussion
Introduction

with  Dr Navina Evans
Consultant child & adolescent psychiatrist
Chief Executive Officer
The old or only way we knew
(Quality Assurance)
Performing well?

<table>
<thead>
<tr>
<th>Key Monitor, National Partners and Local Targets</th>
<th>2019/20 Target</th>
<th>2019/20 Actual</th>
<th>2018/19 Q1</th>
<th>2018/19 Q4</th>
<th>Trust Dec Q4</th>
<th>Contrast</th>
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<tbody>
<tr>
<td>Arrival Targets</td>
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<tr>
<td>Percentage of patients who arrive at the ward within 60 minutes</td>
<td>85.6%</td>
<td>83.6%</td>
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<td>Ratio of patients who arrive at the ward within 120 minutes</td>
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<td>Patients requiring re-admission</td>
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<td>8.0%</td>
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<td>7.9%</td>
<td>9.1%</td>
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<tr>
<td>Percentage of patients who are discharged within 3 days</td>
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<td>61.8%</td>
<td>62.0%</td>
<td>61.9%</td>
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<td>Percentage of patients who are discharged within 5 days</td>
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<td>Percentage of patients who are discharged within 7 days</td>
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<tr>
<td>Other National/Local Targets</td>
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<tr>
<td>Completeness of Documentation – PART ONE, Inpatient Mortality (Mortality)</td>
<td>93.5%</td>
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<td>Compliance with NHS Constitution (Mortality)</td>
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**Mental health**

Three patients die on psychiatric ward

Mark Gould

Tuesday 17 April 2017 13:10 BST

Three patients have died within 12 months on the same ward following warnings from unions about budget cuts.
The culture we want to nurture

A listening and learning organisation  Empowering staff to drive improvement

Increasing transparency and openness  Re-balancing quality control, assurance and improvement

Patients, carers and families at the heart of all we do
Building the case for change

- Sentinel event
- Visits to other organisations
- Trust board bespoke learning sessions
- Early small scale tests
- Developing the strategy through engagement
- Long-term business case approved
- Identify strategic partner
- Assess readiness for change
Clinically Led, Management Partnered, Patient Driven
Contribution to

Better outcomes
Better satisfaction
Value for money
Better population health
We know how to

Focus on recovery
Work with hope
Work with families
Work in systems
Promote resilience
Promote positive behaviour change

Make it feel meaningful
Make it feel possible
Make it feel valued and permanent
Applying QI to three complex areas

with James Innes
(Associate Director for QI)

Dr Amar Shah
(Associate Medical Director for Quality)

Auzewell Chitewe
(Senior Improvement Advisor)

Improving Medicines Safety
Prescribing
(At least 100,000 medicines prescribed annually)

Dispensing
(200,000 medicines dispensed annually)

Administration
(2.02 million doses administered annually)

@ elft.qi@nhs.net  @ELFT_QI  qi.elft.nhs.uk

NHS East London NHS Foundation Trust
2.32 million opportunities for error annually!

Clinical Operations
- TDM
- Medicines Reconciliation
- Clozapine Clinics
- Counselling
- Medication R/V

Responsive System
- Error monitoring
- Medicines Safety Groups

Increasing Awareness
- Medicines Safety Podcasts
- Clinical Alerts & Newsletters
Prescribing
(At least 100,000 medicines prescribed annually)

Dispensing
(200,000 medicines dispensed annually)

Administration
(2.02 million doses administered annually)
To Reduce Checking Errors Leaving the Central Dispensary

Project lead: Yvonne Wilson

Project team: Tracy Wostear, Charity Okoli, Papeya Dasgupta

Project sponsor: Dudley Manns

Background

• Checking errors started to increase leaving the dispensary. (Own error had an impact on confidence)
• Workload had increased by 50% with no extra staff and this bought more distractions in the dispensary.
• To reduce checking errors by 50% by June 2016.
Driver diagram

To reduce checking errors by 50% by June 2016

<table>
<thead>
<tr>
<th>AIM</th>
<th>PRIMARY DRIVERS</th>
<th>SECONDARY DRIVERS</th>
<th>CHANGE IDEAS</th>
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<tr>
<td></td>
<td>Staffing issues</td>
<td>Locum staff</td>
<td>Permanent staff being employed</td>
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<td></td>
<td>Extra band 6 checking support</td>
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<td></td>
<td>Delivery issues</td>
<td></td>
<td>Drivers to wait in reception area until bags are ready</td>
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<td></td>
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<td></td>
<td>Pharmacists to screen right first time</td>
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<td></td>
<td></td>
<td></td>
<td>Eligibility and legality of prescription</td>
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<td>Workload</td>
<td></td>
<td></td>
<td>No phone calls between 1.30 - 3.30pm</td>
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<td></td>
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<td></td>
<td>No talking between 1.30 - 3.30pm</td>
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<tr>
<td>Environment</td>
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Sequence of PDSA’s (1)

Cycle 4: Segregating the unusual prep forms with the aim of reducing selection errors

Cycle 3: Trouble shooter
Change of layout of dispensary to ensure smooth flow of work. And collection of phone call data

Cycle 2: Collection of data changed from monthly to weekly

Cycle 1: No non WORK related talking between 1.30 + 3.30: No unnecessary phone calls between 1.30 + 3.30
No non-related talking extended until 5pm

AIM

Primary Drivers

Secondary Drivers

Change Ideas
Sequence of PDSA’s (2)

**Cycle 8:** Will not having to check Clozapine result help with the amount of calls being made? Will not photo copying a second copy of Discharge liaison form reduce a process for the checker?

**Cycle 7:** Can we reduce a process in the checking procedure?

**Cycle 6:** Can the ward pharmacist or Technician give a copy of the NODF from the ward

**Cycle 5:** To simplify the checking process by removal of a process and abolish of checking logs

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**Percentage of checking errors - P Chart**

- Reduce dispensary distractions
- Sole prescription query trouble-shooter
- Collect accurate error data
- Move unusual drug formulations from main tablet area and simplify checking process

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**NHS East London NHS Foundation Trust**

12/11/2017
Percentage of dispensing errors - P Chart

Prescribing
(At least 100,000 medicines prescribed annually)

Administration
(2.02 million doses administered annually)

Dispensing
(200,000 medicines dispensed annually)

Reduce dispensary distractions
Simplify checking process

No. of Errors / %


0.00%  0.01%  0.02%  0.03%  0.04%  0.05%  0.06%  0.07%  0.08%
What type of administration errors occur?

- Best way to know what type of administration errors are happening
  - Direct observation
  - BUT... limited evidence in mental health...
Gathering evidence

- ... so we did our own study
- Biggest direct observation study ever undertaken in mental health
- **139** errors were detected in **4177** opportunities (**3.3%**)

Gathering evidence

- Missed doses most common error (**40%**)
- Now we knew **missed doses** were the most common error in ELFT
Reducing omitted doses of medication on the Mental Healthcare of Older Peoples’ (MHCOP) Wards

Lead contact: Alan Cottney
Project team: Carmel Stevenson, Peter Bell, Von-de-Viel Nettey, Femi Odugbesan, Andrew Huggard, Natasha Patel, Louise Missen & Tim Pham

Background

• Baseline investigation on 6 MHCOP wards:
  – Missed dose rate = 1.07%
  – Equates to approx. 2900 missed doses a year

• Project aim:
  – To reduce omitted doses of medication to less than 0.5% of total doses due by the end of March 2015
Reducing omitted doses of medication on the MHCOP wards

**AIM**

To ensure that patients receive the right medication at the right time by reducing omitted doses of medication to less than 0.5% by the end of March 2015.

**PRIMARY DRIVERS**

- Reduce unnecessary harm resulting from medication errors
- Improve patients’ physical and mental health
- Give nurses more support in medication administration
- Make medication administration a “high reliability process”

**SECONDARY DRIVERS**

- Improved patient experience
- Reduced inpatient stay
- Decreased morbidity/mortality
- Reduction in polypharmacy
- Improved staff job satisfaction
- Fewer incidents from the administration process
- Increased staff vigilance during administration process
- Better informed staff, greater awareness of medicines management

**CHANGE IDEAS**

- Regular audit of missed doses on wards, with feedback to ward managers
- Nurse survey assessing attitudes to medication rounds & identifying & addressing barriers to safe practice.
- Medicines rationalisation; reviewing drugs and timings
- Allocated a ‘named medication nurse’ role
- Publish a league table showing how the different wards rank in terms of missed doses
- Audit data regularly presented at ward away days and Modern Matron meetings
- Use visual representations to let wards see if missed doses are increasing or decreasing.
- Publically display posters with details of missed doses on each ward.

**Sequence of PDSA’s**

- **Cycle 1:** Issue bulletin highlighting missed doses will be monitored.
- **Cycle 2:** E-mail ward managers informing of the missed dose rate on their wards and asking for action.
- **Cycle 3:** Missed dose league table published fortnightly.
- **Cycle 4:** Individualised ward poster published fortnightly.
Example of league table

Missed Doses of Medication on MHCOP Wards

Date of publication: 19th November (Issue 8)
Time covered by data: 2 weeks

<table>
<thead>
<tr>
<th>Ward</th>
<th>No. doses due</th>
<th>No. doses not signed for</th>
<th>% doses not signed for</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Cedar Lodge</td>
<td>1292</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>2 Columbia</td>
<td>2327</td>
<td>1</td>
<td>0.04%</td>
</tr>
<tr>
<td>3 Ivory</td>
<td>2058</td>
<td>2</td>
<td>0.10%</td>
</tr>
<tr>
<td>4 Larch Lodge</td>
<td>1172</td>
<td>2</td>
<td>0.17%</td>
</tr>
<tr>
<td>5 Thames House</td>
<td>1601</td>
<td>3</td>
<td>0.19%</td>
</tr>
<tr>
<td>6 Leadenhall</td>
<td>2768</td>
<td>19</td>
<td>0.69%</td>
</tr>
<tr>
<td>Total</td>
<td>11,218</td>
<td>27</td>
<td>0.24%</td>
</tr>
</tbody>
</table>

Example of ward poster

Thames House: Missed doses summary

It has now been

3 weeks

since a dose of medication was missed on Thames House Ward

Thames House: Missed medication doses (Week 1-18)
Impact of this project

• Before the project:
  – Missed dose rate during 6-weeks baseline monitoring:
    • 1.07% (2,871 missed doses per year)

• After the project:
  – During the past 6 weeks:
    • 0.06% (154 missed doses per year)
  – 2717 missed doses prevented
Financial data

• Estimate of cost-saving:
  – 2717 medication errors will result in an average of 26 adverse drug events¹
  – One adverse drug event is estimated to cost £1,477²
  – Cost-saving from avoiding 26 adverse drug events per year on 6 MHCOP wards: £38,402

Pareto Chart: incidents reported at ELFT

Incidents resulting in physical violence (Globe ward) - Run Chart

WELCOME TO GLOBE WARD
NOMINATED FOR TEAM OF THE YEAR AWARD 2015
The Attributes of Innovations

1. Relative Advantage
2. Compatibility
3. Complexity/Simplicity
4. Trialability
5. Observability

AIM

To reduce inpatient physical violence

Identification, prediction and responsiveness, working as a team

Openness, transparency and sharing of safety as a priority for the ward community

Primary Drivers

- 1. Objective assessment of risk: mitigates against biases
- 2. Effective MDT working and team communication
- 3. Speed of decision-making and actioning decisions on ward
- 4. Effective transfer of learning from shift to shift
- 5. Staff skills/confidence/attitude to anticipating / predicting needs
- 6. Flattening of hierarchies and stronger MDT working
- 7. Minimising aggravation as a result of unmet needs
- 8. Reducing rigidity of ward environment

Secondary Drivers

- 9. Discussion of violence with SUs and families/carers
- 10. Learning from feedback as a ward community
- 11. Sharing data / information on violence and safety culture

Change Ideas

- Broset Violence Checklist
- Safety Huddles
- Safety Cross
- Safety Discussion in Community Meetings
Violence reduction on acute wards and Psychiatric Intensive Care Units (PICUs)

First stage of successful scale-up
2014-2015

Tower Hamlets
- Brick Lane Ward
- Mill harbour
- Rosebank
- Lea Ward
- Roman Ward
- Globe Ward
- Triage

City and Hackney
- City and Hackney
- Ruth Seifert Ward
- Brett Ward
- Conolly Ward
- Joseph Ward
- Joshua Ward
- Crystal PICU
- Ruby Triage

Newham
- Newham
- Bevon PICU
- Opal Ward
- Emerald Ward
- Topaz Ward
- Jade Ward
- Sapphire Ward
- Ruby Ward

Second stage: Planned experimentation
2016-

Tower Hamlets
- Brick Lane Ward
- Mill harbour
- Rosebank
- Lea Ward
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Violence reduction on acute wards and Psychiatric Intensive Care Units (PICUs) over time:

- Incidents resulting in physical violence (Acute wards only) per 1000 occupied bed days (OBD)
- Incidents resulting in physical violence (PICU wards only) per 1000 OBD

**BASELINE DATA (BEFORE)**

- Learning Set 1: Testing begins 05/10
- Learning Set 6: Time of Day & General Adult wards go smoke free 10/11
- Learning Set 7: Prediction + Safety Huddle 06-Jan-14
- Learning Set 8: Prediction PDSAs + Scale-up prep 12/01
- Learning Set 4
- Learning Set 3
- Learning Set 2
- Learning Set 5: Safety Huddle outcomes + Safewards 13/08
- Learning Set 9: Effective Safety Huddle PDSAs 24/02
- Learning Set 10: Reflecting on why and PDSAs 24/03
- Learning Set 11

**PDSA DATA (AFTER)**

- Learning Set 11

**Graphs and Data:**

- U Chart showing trends over time.
- Data points for UCL and LCL with x-axis dates from 06-Jan-14 to 22-Dec-15.
- No. of Incidents per 1000 OBD

**Wards and Units:**

- Acute wards:
  - Brick Lane Ward
  - Millbank Ward
  - Rosebank Ward
  - Lea Ward
  - Globe Ward
  - Roman Ward
  - Ruth Seifert Ward
  - Brett Ward
  - Joshua Ward
  - Gardner Ward
  - Bevan PICU
  - Mother and Baby Unit

- PICU wards:
  - Conolly Ward
  - Topaz Ward
  - Opal Ward
  - Emerald Ward
  - Sapphire Ward
  - Jade Ward
  - Ruby Ward
  - Triage
  - Crystal PICU

**Other Notes:**

- Gender specific wards
- Shift pattern changes
Lea Ward September Safety Huddle Champion George enjoying his prize

Red Incidents recorded every week on the Safety Cross - C Chart

Acute Wards in City & Hackney
Service users not coming out of their rooms, isolating selves

Relatives worry about the safety of their loved one

Service users don’t want to be on the ward

Upset and emotional

Some staff reluctant to medicate

Very PC – violence is never mentioned

Feel victimised

Higher chance of service user going AWOL as they do not feel safe on the ward or want to be on the ward

Includes verbal aggression as well as physical aggression

Feeling helpless - No point in recording or reporting as nothing happens/changes

Other staff do not know what it feels like to as they only spend short periods of time on the ward

Scary

Staff don’t want to come to work

Staff shortages, Staff sickness, staff depression, low moral

One service users presentation can change the whole atmosphere of the ward.

Therapeutic environment is compromised

Damage to property

Staff expect violence and aggression and new staff should be prepared for this, increase in awareness about what it is really like

Team splitting - team not working together, giving service users different messages and boundaries

Anxiety

Nursing staff don’t feel protected, doctors are protected.

Increase in detention and delayed discharges

Worse impact is on those who are vulnerable

Service users mask symptoms as they do not want to say how they are really feeling as they want to leave the ward sooner

Not all violence/aggression is in response to mental health – some is behavioural

Once a staff member has been assaulted in the past, this has an impact on their engagement with particular service users

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Team splitting - team not working together, giving service users different messages and boundaries

Anxiety

Nursing staff don’t feel protected, doctors are protected.
“I’ve been a nurse here for 20 years and I just thought this was how it was... Now I can see that it doesn’t have to be this way...”

“We’re no longer fire-fighting all the time...”
“I think there is a shift. Before we started this, no one talked about it. Now we are bringing it up, which says 'it is not ok'”
“It is more calm and relaxed”
“I'm just really pleased that it’s permeating out and patients are feeling able to broach the subject”
“It’s been a good few months... we are moving fast now”
“The team feels more confident and are having better discussions around issues that may arise”
“A service user has said she is impressed by the atmosphere...”
“4 months ago I was really scared to come to work, but it’s getting better”
“There’s a better therapeutic environment and patient satisfaction. You can feel the lowered levels of stress for staff and patients”
“Well, what can I say, the team are fantastic! Thank you for helping all the patients here. You save lives and give us a second and third chance”
<table>
<thead>
<tr>
<th>City</th>
<th>Mean Pre</th>
<th>Mean Post</th>
<th>% Reduction</th>
<th>% of Red Incidents Resulting in Resignation</th>
<th>% of Red Incidents Resulting in Sickness</th>
<th>% of Red Incidents Resulting in Relocation</th>
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<td>93%</td>
<td>89%</td>
<td>4%</td>
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<tr>
<td>Cemely</td>
<td>73%</td>
<td>69%</td>
<td>5%</td>
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<td>5%</td>
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<tr>
<td>Gardner</td>
<td>95%</td>
<td>91%</td>
<td>4%</td>
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<td>30%</td>
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<td>24%</td>
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<tr>
<td>Baby Triage</td>
<td>21%</td>
<td>17%</td>
<td>20%</td>
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</tbody>
</table>

Pre and Post mean number of incidents per 1000 OBD – U Chart

(City and Hackney / Newham)
Reducing physical violence on older adult mental health wards

Days between incidents of violence across three wards (T chart)

Incidents of physical violence across East London wards (C chart)

Physical violence to patients (per 100,000 occupied bed days)

Physical violence to staff (per 100,000 occupied bed days)
Average number of physical violent incidents per month

175

175 → 103

Average number of physical violent incidents per month
Reduction physical violence and developing a safety culture across wards in East London

Jan Taylor-Watt, Andy Cruickshank, James Irms, Brian Borne, Ammar Shah

Abstract

The most frequent type of reported safety incidents at East London NHS Foundation Trust, are those involving physical violence. The physical violence against patients is too often referred to as 'patient-related' physical violence. The Trust's concern was that the negative impact of this violence on both patients and staff was not well understood. The Trust's objective was to improve the safety culture of the wards and reduce the number of incidents related to physical violence. The Trust's approach was to develop a multi-disciplinary team of experts working together to create a safer environment for patients and staff. The team consisted of doctors, nurses, social workers, mental health professionals, and management. The team developed a protocol for patients with a history of violent behavior and established a system for recording and reporting incidents. The protocol included a series of steps to reduce the risk of physical violence, such as increasing the availability of staff, implementing a buddy system, and providing additional training to staff. The protocol was evaluated using a combination of qualitative and quantitative methods. The results showed a significant reduction in physical violence and an improvement in the safety culture on the wards.

Improving Joy in Work

Improving Joy in Work
Enjoying Work

Aim: To improve staff satisfaction and wellbeing so that staff are better able to meet the needs of their service users

What staff said matters to them

- Satisfaction 32.2%
- Enjoyment 15.5%
- Thriving 2.2%
- Fulfillment 34.1%
- Other

Other

- Rewarding, helping humanity, spiritual uplifting, learning continuously, being supported at work, seen as a worthwhile work colleague
- Brilliant communication
- No motivation
- Patient satisfaction
- Appreciated
- Work life balance
- Camaraderie
How we will know if staff are enjoying their work

- **Meaning**
  - Quality of work
  - Focus on patients
  - Demeanour (smiling & motivated)
  - Productivity
  - Results of work

- **Teamwork**
  - Team cohesion
  - Behaviours within team

- **Trust**
  - Sickness & Absence
  - Valued
  - Enjoyment
  - Satisfaction

- **Embrace New Ways of Working**
  - Development Opportunities (academic & role)
  - Staff complaints
  - Listened to
  - Communication

Driver Diagram

Change Ideas
Definitions:

“When the literature is further scrutinised, some commonalities begin to emerge, defining and describing the type of leadership that fosters enhanced quality or performance. These suggest that leadership for improvement is:

- Inclusive: it is linked less with striving to know all the answers and more with engaging others to make their personal contribution.

- Team-Based: it has a direct impact on teams and their ability to improve the quality of what they do.

- Collective: to become embedded in the culture, the focus is on groups of individuals creating collective effort.

- Personal: the significance of personal style, preference and behaviour has an undeniable impact.

- Culturally-Sensitive: culture plays an important role in quality improvement and leadership and culture are inter-dependent.

Involvement, improvement and recovery

with Paul Binfield
(Head of People Participation)

John Kauzeni
(People participation lead)
The PRIDE Project

- PRIDE = Participation; Recovery; Involvement; Development; Experience.

- Funded by the Centre for Public Engagement, Queen Mary University of London, based at East London Foundation Trust.

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PRIDE Qualitative Study Research Findings

Why did participants join People Participation activities?

To give back to the service

"I felt a sort of passion in wanting to help improve things. I felt sort of like a need to pay back some of the really great sort of professionals I met across the years who’d helped me out”.

To influence changes for the better within services

"I think the move towards greater patient engagement, if you like, with their own treatment and the way that they are dealt with by the NHS, I think participation is a huge step towards that…".

"I’ve had quite a few staff remark to me that I’ve changed their attitude of service users and service user involvement in peer support and that sort of thing. So I think I’ve changed some attitude there”.

Curiosity

"So really it was the PPL lead… and she came along and, I’m not even sure how it happened, but I got involved and I started enjoying it. It was hard at first, especially talking to many people. Very scary and very shaky, but she kind of made it a lot better. She’s really good at her job. She really looked after you, you know, and I feel there’s been progress since I first started.”

Social aspect – meeting like-minded people

"I come to the meetings and I look forward to coming… because it’s a change from that routine of hanging around with people (and) doing things that are not going to help them in their mental state.”

Social aspect – meeting like-minded people (cont.)

"I needed to be involved in getting to know some other people.”

Having structure to their day and keeping occupied

"People Participation has turned my life around in the last 2 years I have been doing it. It gives me something to do. It involves me in aspects of other people’s illnesses, understanding other people’s illnesses.”

"I feel that I am happy…mental state as well because I feel more happier when doing participation.”

What were the benefits and experiences (positive or negative) for recovery by being involved in People Participation?

Sharing experiences with like minded people

"Be able to express my views, meet like-minded people who have gone through the same thing.”

“You get to connect with people and it’s so lovely when people come up to you and say “I love coming here because you are here as well” and, you know, that sort of thing. Just to be you.”
PRIDE Qualitative Study Research Findings

What were the benefits and experiences (positive or negative) for recovery by being involved in People Participation? (cont.)

Improvement in self-confidence and motivation

“I have learnt how to… be more assertive, be more confident, be more not confrontational…”

“My self-worth is probably the biggest improvement.”

“It helped me achieve a sense of well-being, it’s educated me, it’s made me more self-aware, it’s helped me just become a person that could, a normal person, normal as in the sense that like a person that can be in the community and have a mental health problem but still carry on and live a normal life…”

Better understanding of services

“How do I relate to services, it’s more of a positive thing…”

“When going inside the service that I did stay in it was kind of nice to see the day-to-day running so I guess that kind of give me another dimension to what I knew about that service…”

“It’s changed my views of services in ELFT and it’s changed my view that services are changing towards a more patient focused and listening more to the service users. I think, I mean in the past with psychiatric services, there wasn’t such a focus on recovery. It was more a focus on containment”

Facing and overcoming fears, independence

“It is always good to learn about things that you actually fear.”

“One of my things is the fear of… being discharged and being left on your own. But now I don’t fear that because I know there’s always access to everything, you know, and if you are having problems, you talk.”

Sense of achievement, feeling valued

“You are important actually… You do learn if you’re given a question your answer is important.”

“So it opens doors. You meet people you normally wouldn’t have met. You know, when you give yourself to something, it is not about rising to this or being big at this or doing, earning x amount of money. For me it was, you know, just one step at a time and I enjoy it now.”

Giving back feels good

“I’ve always felt the value in everything I’ve done.”

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PRIDE Qualitative Study Research Findings

What were the benefits and experiences (positive or negative) for recovery by being involved in People Participation? (cont.)

Giving back feels good

“It’s helped with my recovery greatly. Sort of helping other people and feeling productive and putting a positive end to a negative set of experiences. It’s all, sort of, been great.”

Having a voice and improving services

“It made me more empowered because I was sitting on panels and I was having a say of who comes in and who doesn’t come in”

“Getting involved… taking part, having a say, being listed to, being educated…”

Better coping mechanisms

“I ain’t had drugs, drunk alcohol for 17 years, I haven’t smoked cigarettes for 12 years… it’s made me more self-aware of how you can end up back in hospital again or in trouble with the law if you don’t do things that are positive rather than negative.”

Better coping mechanisms

“It’s helped me because it’s made me think about what are the good things in life and what are the bad things in life and what’s going to keep me well and safe and keep me from going back to hospital again.”

What skills were refreshed or gained by taking part in PP activities?

Listening skills/interpersonal skills

“I’ve learnt so much from going to the meetings, you know, talking and listening to other people, so I’ve learnt a lot, and I’ve got sort of self-respect and my say back, which I didn’t have before”

General communication skills.

“It trains you to develop your skills set. That was very attractive to me.”
What skills were refreshed or gained by taking part in People Participation activities?

Public speaking skills - giving training to staff
“I think being able to express yourself, especially when I do talks with new nurses or new social therapists, they really want to hear the service user’s view and see the other side. Not just the things they are trained in. Not just the things that are passed down, but the service user’s view is the reality. The fact that I was a patient made my views more important.”
“I’ve had quite a few staff remark to me that I’ve changed their attitude of service users and service user involvement in peer support and that sort of thing. So I think I’ve changed some attitude there.”

Creative skills (poetry)

Avoiding conflict/ dealing better with conflict

What were the participants’ experience of the support provided?

Trust/Availability
“Yes, she has been really good. I’ve needed to lean on her quite a bit. Especially when writing any script or doing any talk, the fact that she’s there makes it much easier. I can get all the information that I need and she really supports me. She does a wonderful job. She has great qualities, you know. So I wouldn’t be able to do the stuff I’ve done without her.”
“Our People Participation Lead is probably the best one and I wouldn’t want anyone else. I can talk to her about anything. She is down to earth, human. She’s a lovely lady and I can go to her whenever I like.”

Being a companion

Facing fears - pushing personal boundaries
“I set myself boundaries because I guess we all live in our own safety nets when you have mental illness. She actually makes me go to the edge and sometimes over. And when I do that, I feel, you know, like, ‘wow, I’m so glad I did that. Can I do that? I can really do that’ you know.”

Keeping updated on training, events and opportunities

Support with personal issues
PRIDE Qualitative Study Research Findings

What were the participants’ experience of the support provided? (cont.)

Genuinely caring – seeing service users as people and not just a job
“People Participation Leads should be on ward rounds. You can talk to People Participation Leads about things you wouldn’t talk to a doctor about.”

What aspects of this initiative could be improved/suggestions for improvement?

More involvement from young people
Change in staff attitudes – especially on interview panels not seeing service user involvement as valid
Better financial incentive
Better payment system – getting paid on time, less form filling
Financial recognition of travel time involved for service users from Luton and Beds who attend events in London, recognition of childcare issues and that some service users are parents
Moving-on support system like careers advice
Having a People Participation web page with info on events, training, different mental health conditions, common medication side-effects, sign-posting to other support services, etc
Does not need improving!

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PRIDE Qualitative Study Research Findings

What aspects of this initiative could be improved/suggestions for improvement? (cont.)

“Whoever is listening to this, just know one thing – People Participation has pulled me out of a very big hole which is now filled with cement and I don’t go back there now… I’m moving forward. I feel like a human being now, not an animal.”

“As far as this Trust is concerned, we seem to have pretty well nailed People Participation, I think. I don’t know where we stand nationally in terms of participation, but we are damn good at it and I think we could teach those other Trusts.”

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Break Time

Some time to reflect at your tables

• What are your biggest opportunities and challenges in behavioral health?

• Have you heard anything today that you’d like to try back in your organization?

• How might you get started with using QI in behavioral health and involving patients and families within your improvement work?
Panel Discussion

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Steven
Auzewell
Paul
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