A step-by-step plan to build your improvement system
Nothing to Disclose

Paul Binfield, Paul Gilluley, James Innes, Amar Shah, Navina Evans, Tim Gill, Hannah Mellor, Mohit Venkataram, Forid Alom, and Auzewell Chitewe have no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
Introducing the ELFT Team

Navina  Paul  Amar  Auz  Paul

Forid  James  Mohit  Tim  Hannah
Mental health services
Newham, Tower Hamlets, City & Hackney, Luton and Bedfordshire

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, Tower Hamlets & Bedfordshire

Primary care psychological services
Newham, Richmond, Tower Hamlets and Bedfordshire
Challenges and opportunities

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

1. Create a bespoke plan for developing a culture of continuous improvement in your organisation

2. Identify the high-impact components necessary to build an improvement system at scale

3. Develop actionable ideas that can be tested in your organisation in order to further develop your approach to improvement

elft.qi@nhs.net  https://qi.elft.nhs.uk  @ELFT_QI
Today’s agenda

- Key principles for large-scale change
- The ELFT journey of continuous improvement
- Executive leadership for improvement
- Infrastructure for improvement at scale
- World café to dive into four topics:
  - Involving patients, service users, carers and families in quality improvement
  - Engaging, involving and inspiring people
  - Building improvement skills
  - Embedding QI into daily work
- Facilitated self-assessment and action planning
- Q&A with the ELFT panel

qi@elft.nhs.uk
https://qi.elft.nhs.uk
@ELFT_QI
hope & fear
<p>| | | | | |</p>
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<td>2</td>
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<td>14</td>
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<td>60</td>
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<td>70</td>
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</tbody>
</table>
Key principles for large-scale change

with Dr Amar Shah
(Chief Quality Officer)
First, let’s define what we mean by...

Quality improvement
improving quality $\neq$ quality improvement
Arguably the most important competency for dealing with complexity is systems thinking.

The three characteristics of systems thinking include:

1. A consistent and strong commitment to learning
2. A willingness to challenge your own mental model
3. Always including multiple perspectives when looking at a phenomenon
Social Movements For Good
“a voluntary collective of individuals committed to promoting or resisting change through co-ordinated activity”

Seven common characteristics of social movements:

- Energy
- Mass
- Passion
- Commitment
- Pace and momentum
- Spread
- Longevity

Bate, Bevan & Robert, 2004
<table>
<thead>
<tr>
<th>Current prevailing beliefs about change</th>
<th>A movement perspective of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Change starts at the top</td>
<td>• Change builds from bottom-up action</td>
</tr>
<tr>
<td>• It takes a crisis to provoke a change</td>
<td>• Change can be driven by passion to improve</td>
</tr>
<tr>
<td>• Only a strong leader can change a large institution</td>
<td>• Change comes from the collective action of individuals</td>
</tr>
<tr>
<td>• To lead change you need a clear agenda</td>
<td>• You need to have a clear cause but can be uncertain about how you will achieve it</td>
</tr>
<tr>
<td>• Most people are against change</td>
<td>• People have an inner desire to make things better</td>
</tr>
<tr>
<td>• Change management is a disciplined process</td>
<td>• Change is opportunistic and spontaneous</td>
</tr>
</tbody>
</table>
THINK BIG

LEARN FAST
(It’s All about Cycle Time!)

START SMALL
(Critical)
It's a marathon

...not a sprint.
Our journey…

with Dr Navina Evans
(Chief Executive Officer)
10 YEARS AGO
The old or only way we knew (Quality Assurance)

- Better
- Quality
- Worse

No action taken here

Reject defectives

Requirement, Specification or Threshold
### Trust Board Scorecard Q4 2009/10

<table>
<thead>
<tr>
<th>Key Monitor, National, Partner and Local Targets</th>
<th>2009/10 Target</th>
<th>2008/09 Actual</th>
<th>2009/10 Q3</th>
<th>2009/10 Q4</th>
<th>Trend Q3-Q4</th>
<th>Comment</th>
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<tr>
<td>Monitor Targets</td>
<td></td>
<td></td>
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<td>Annual number of MRSA bloodstream infections</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td></td>
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<tr>
<td>reported</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Reduction in C. Diff</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>CPA inpatient discharges followed up within 7</td>
<td>95.0%</td>
<td>99.5%</td>
<td>99.0%</td>
<td>99.1%</td>
<td></td>
<td></td>
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<tr>
<td>days (face to face and telephone)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Patients occupying beds with delayed transfer</td>
<td>7.5%</td>
<td>3.5%</td>
<td>1.8%</td>
<td>1.8%</td>
<td></td>
<td></td>
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<tr>
<td>of care</td>
<td></td>
<td></td>
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<tr>
<td>Admissions made via Crisis Resolution Teams (end</td>
<td>90.0%</td>
<td>98.3%</td>
<td>99.0%</td>
<td>96.7%</td>
<td></td>
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<tr>
<td>of period</td>
<td></td>
<td></td>
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<tr>
<td>Number of Crisis Resolution Teams</td>
<td>7.1</td>
<td>7.3</td>
<td>7.3</td>
<td>7.3</td>
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<tr>
<td>Other National/CQC Targets</td>
<td></td>
<td></td>
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<tr>
<td>Completeness of Ethnicity Coding – PART ONE:</td>
<td>85%</td>
<td>98.1%</td>
<td>97.3%</td>
<td>97.3%</td>
<td></td>
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<tr>
<td>Inpatient in MHMDS (Year to date)</td>
<td></td>
<td></td>
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<tr>
<td>Completeness of Mental Health Minimum data set</td>
<td>99%</td>
<td>97.6%</td>
<td>99.4%</td>
<td>99.4%</td>
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<tr>
<td>– PART ONE (As per 2009/9)</td>
<td></td>
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<tr>
<td>Completeness of Mental Health Minimum data set</td>
<td>TBA</td>
<td>Not Used</td>
<td>45.0%</td>
<td>45.0%</td>
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<tr>
<td>– PART TWO (New – confirmed 22/12/2009)</td>
<td></td>
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<tr>
<td>Patterns of Care – assignment of Care Co-</td>
<td>80%</td>
<td>99.6%</td>
<td>93.2%</td>
<td>93.2%</td>
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<tr>
<td>ordinator within Mental Health Minimum data set</td>
<td></td>
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<tr>
<td>CAMHS - National Priorities - Six targets graded</td>
<td>24</td>
<td>22</td>
<td>22</td>
<td>24</td>
<td></td>
<td></td>
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<tr>
<td>1 (lowest) to 4 (best)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Annual Staff Survey (Job Satisfaction)</td>
<td>Benchmarked</td>
<td>Satisfactory</td>
<td>N/A</td>
<td>TBC</td>
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<tr>
<td>Drug Misusers in effective Treatment</td>
<td>90.0%</td>
<td>95.5%</td>
<td>92.9%</td>
<td>92.9%</td>
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<td>Access to healthcare for people with a learning</td>
<td>Yes</td>
<td>Not Used</td>
<td>N/A</td>
<td>Yes</td>
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<td>disability – report compliance to CQC</td>
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<td>Best practice in mental health services for</td>
<td>48</td>
<td>4044</td>
<td>42</td>
<td>46</td>
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<td>people with a learning disability – Green Light</td>
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<td>Toolkit Score</td>
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<td></td>
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<tr>
<td>Maximum waiting time of four hours in A&amp;E from</td>
<td>98.0%</td>
<td>97.5%</td>
<td>98.3%</td>
<td>98.3%</td>
<td></td>
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<tr>
<td>arrival to admission, transfer or discharge</td>
<td></td>
<td></td>
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<td>PCT Contract and Mandatory Targets</td>
<td></td>
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<td>Number of Early Intervention Services Teams</td>
<td>3</td>
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<td>Early Intervention Services Caseload</td>
<td>511</td>
<td>569</td>
<td>534</td>
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<td>Newly diagnosed cases of first episode psychosis</td>
<td>176</td>
<td>243</td>
<td>199</td>
<td>248</td>
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<tr>
<td>receiving Early intervention Services</td>
<td></td>
<td></td>
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<tr>
<td>Number of patients receiving Adult Crisis</td>
<td>2280</td>
<td>2,346</td>
<td>1,874</td>
<td>2,552</td>
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<tr>
<td>Resolution Services (Episodes for Year to date)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Specialist Addictions – % of discharges retained</td>
<td>85.0%</td>
<td>96.1%</td>
<td>92.9%</td>
<td>92.9%</td>
<td></td>
<td></td>
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<tr>
<td>12 weeks or more</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Specialist Addictions - Number of drug</td>
<td>678</td>
<td>710</td>
<td>780</td>
<td>770</td>
<td></td>
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<tr>
<td>misusers in treatment (snapshot at period end)</td>
<td></td>
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<td>CAMHS Service protocols</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
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<td>Mixed Sex accommodation breaches</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
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<tr>
<td>Patient Experience - Community</td>
<td>95%</td>
<td>Not Used</td>
<td>88.2%</td>
<td>92.9%</td>
<td></td>
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<tr>
<td>Assessment within 28 days of referral</td>
<td></td>
<td></td>
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<tr>
<td>CPA patients - care plans in date</td>
<td>95%</td>
<td>93.1%</td>
<td>93.3%</td>
<td>94.2%</td>
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<tr>
<td>Patient Experience - Inpatients</td>
<td></td>
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<tr>
<td>Adult Acute Inpatient Bed Occupancy Year to Date</td>
<td>95%</td>
<td>95.3%</td>
<td>98.3%</td>
<td>97.3%</td>
<td></td>
<td></td>
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<tr>
<td>(excluding home leave)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Information Governance/Accuracy</td>
<td>90.0%</td>
<td>87.0%</td>
<td>87.0%</td>
<td>90.9%</td>
<td></td>
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<tr>
<td>Information Governance Toolkit score</td>
<td></td>
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</tbody>
</table>
Mental health

Three patients die on psychiatric ward

Three patients have died within 12 months on the same ward following warnings from unions about budget cuts

Mark Gould

Tuesday 12 April 2011
13.10 BST

This article is 4 years old

Save for later

Most popular

Star architect Zaha Hadid dies aged 65 from heart attack
The culture we want to nurture

A listening and learning organisation

Empowering staff to drive improvement

Patients, carers and families at the heart of all we do

Increasing transparency and openness

Re-balancing quality control, assurance and improvement
YEARS AGO
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
Mental health’s revolving door

You see them on the streets, sometimes with shabby clothes, unkempt appearance, talking to themselves. Others live lives of desperation, away from the public eye. They are the mentally ill and are victims of a bungled experiment called community care.

James Hollings reports.

The depressing state of mental health

John Ballantyne was just 15 when he took his life last May. He was found on the grounds of St. Joseph's in April and April.

Men behaving sadly

As Kiwi's explored their way into the new Millennium on December 31, a 100-year-old man took his own life, becoming the city's 39th suicide statistic for 1999. At the close of Mental Health Awareness week, Cate Brett asks whether our disinterest over youth suicide is blinding us to a bigger — and potentially preventable — problem of men behaving sadly.

A service's nose taps the scent of men behaving sadly.

The funding and efficiency gap

There are significant challenges of mental health in the country, including how to make mental health services more accessible and effective. Mental health services are seen as a priority, but there is a need to address funding and efficiency gaps. The Five Year Forward View sets out a plan for improving mental health services in England.
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
Leadership for Improvement: The Executive Perspective

with Dr Paul Gilluley
(Chief Medical Officer)
Leadership for Improvement: The Executive Perspective

with Dr Mohit Venkataram
(Director of Commercial Development)
Building an Infrastructure for Improvement

with James Innes
(Associate Director of QI)
Strategic quality improvement
An action learning approach

Author
Vijaya Nath
May 2016

Building the foundations for improvement
How five UK trusts built quality improvement capability at scale within their organisations
Bryan Jones and Tricia Woodford

Learning report
February 2015

The Model for Understanding Success in Quality (MUSIQ): building a theory of context in healthcare quality improvement
Hether C. Kaplan, Lloyd P. Provost, Craig M. Fordham, Peter A. Margolin

ABSTRACT
Background. Quality improvement (QI) efforts have become ubiquitous in healthcare. However, the basis for understanding which QI contexts contribute to successful improvement is not well understood. Understanding the context of QI efforts is essential to the design and implementation of improvement initiatives and to the dissemination of effective quality improvement strategies. This study examines the nature of the context of QI efforts and the extent to which these contexts are similar across healthcare settings. An exploratory mixed-methods study of QI efforts across 11 healthcare organisations was conducted. The study included 56 in-depth interviews with leaders and staff who were involved in QI efforts at each organisation. The study findings are synthesised in a conceptual model of QI efforts and the contexts in which they occur.

Methods. QI efforts were guided by the Triple Aim and were classified using a conceptual model of context to identify five types of context: healthcare setting, culture, leadership, team, and environment. A qualitative content analysis approach was used to analyse the interview data. A mixed-methods approach was used to validate and refine the model. An expert panel was used to review the model and provide feedback on its validity and usefulness.

Results. The model identifies five types of context: healthcare setting, culture, leadership, team, and environment. The model highlights the interrelatedness of these contexts and the complexity of QI efforts. The model also identifies key factors that influence the success of QI efforts. These factors include the alignment of QI efforts with organisational goals, the involvement of key stakeholders, the use of evidence-based practices, and the availability of resources.

Conclusion. The MUSIQ framework provides a conceptual model of context in QI efforts and highlights the complexity of QI efforts. The framework can be used to guide the design and implementation of QI efforts and to facilitate the dissemination of effective QI strategies. The framework can also be used to train leaders and staff in QI skills and to support the development of QI competencies. The framework can also be used to support the evaluation of QI efforts and to assess the extent to which QI efforts are aligned with organisational goals.

Transformation of healthcare—quality improvement

M.Q. in healthcare quality improvement: a qualitative study of the barriers and facilitators to QI efforts. A mixed-methods study of QI efforts across 11 healthcare organisations was conducted. The study included 56 in-depth interviews with leaders and staff who were involved in QI efforts at each organisation. The study findings are synthesised in a conceptual model of QI efforts and the contexts in which they occur.

What is "quality improvement" and how can it transform healthcare?
Neil B. Anderson, Frank Swick

Table 1: Illustrative tools and methods in improvement

<table>
<thead>
<tr>
<th>Tool/Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fishbone Diagram</td>
<td>A visual tool for identifying the root causes of a problem</td>
</tr>
<tr>
<td>Pareto Chart</td>
<td>A chart that shows the frequency of occurrences of defects or problems</td>
</tr>
<tr>
<td>Scatter Diagram</td>
<td>A graph that shows the relationship between two variables</td>
</tr>
<tr>
<td>Flowchart</td>
<td>A diagram that shows a process</td>
</tr>
</tbody>
</table>

Improving Patient Care
Creating the Evidence Base for Quality Improvement Collaboratives

Ten challenges in improving quality in healthcare: lessons from the Health Foundation’s programme evaluations and relevant literature
Mary Quinn, Sally Coates, Elizabeth Stirling

Institute for Healthcare Improvement
Building capacity and capability for improvement: embedding quality improvement skills in NHS providers
Joni Jabbar

November 2017
**AIM**
To Improve the Quality of Life for all we serve

**Engaging, encouraging & inspiring**
- Developing improvement skills
  1. Targeting / segmenting communication for different groups (community-based staff, Bedfordshire & Luton staff)
  2. Sharing stories – newsletters, microsite, presenting internally
  3. Celebration – awards, conferences, publications, internal presentations
  4. Share externally – social media, Open mornings, visits, microsite
  5. Work upstream – trainees, regional partners, key national and international influencers

**Developing improvement skills**
- Embedding into daily work
  1. Pocket QI for anyone interested, extended to Beds & Luton
  2. Refresher training for all ISIA graduates
  3. Improvement Science in Action waves
  4. Online learning options
  5. Develop cohort and pipeline of improvement coaches
  6. Leadership and scale-up workshops for sponsors
  7. Bespoke learning, including Board sessions & commissioners

**Embedding into daily work**
- QI Projects
  1. Learning system: QI Life, quality dashboards, microsite
  2. Standard work as part of a holistic quality system
  3. Job descriptions, recruitment process, appraisal process
  4. Annual cycle of improvement: planning, prioritising, design and resourcing projects
  5. Support staff to find time and space to improve things
  6. Support deeper service user and carer involvement

**QI Projects**

**Directorate-level priorities**
- Defined through annual cycle of planning
- Most local projects aligned to directorate priorities

**Trust-wide strategic priorities**
1. Reducing inpatient physical violence
2. Improving access to community services
3. Enjoying work
4. Shaping recover in the community
5. Value for money
AIM
To improve the Quality of Life for all we serve

Engaging, encouraging & inspiring

- Developing improvement skills
- Embedding into daily work

QI Projects

1. Targeting / segmenting communication for different groups (community-based staff, Bedfordshire & Luton staff)
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3. Celebration – awards, conferences, publications, internal presentations
4. Share externally – social media, Open mornings, visits, microsite
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Directorate-level priorities
- Defined through annual cycle of planning
- Most local projects aligned to directorate priorities

Trust-wide strategic priorities
1. Reducing inpatient physical violence
2. Improving access to community services
3. Enjoying work
4. Shaping recover in the community
5. Value for money
“Effective communication is critical to successful large-scale change. Yet, in our experience, communication strategies are not formally incorporated into quality improvement (QI) frameworks”
Five Key Steps...

1. Plan for success (have a communications team, identify and prioritise audience, have a strategy)

2. Getting started: creating messages, communications channels and communications plan

3. Sustain interest: Keep audience on board, power of story telling, evaluate communications

4. Spread learning from your work

The #QiComms Charter

1. We will use #QiComms to accelerate our improvement work for the benefit of patients and everyone we serve

We believe that everyone should benefit from improvements in treatment and care, as quickly as possible. We will use #QiComms to make sure everyone across our organisation is inspired and motivated to engage in quality and safety improvement work and deliver better and safer treatment and care.

2. We will plan our #QiComms from the start

We build communications into our planning process from the beginning and review our communications against measurable goals at the end, so that it supports us in achieving our quality and safety improvement goals every step of the way.

3. We will give #QiComms support at the highest level

Our leaders and senior managers recognise the value of #QiComms and ensure improvement teams have the expertise, skills and resources they need to integrate #QiComms into their work effectively.

4. We will take a strategic approach to #QiComms

We understand our audiences, so we can design strategies and tactics to reach them with a clear and consistent set of messages to meet our improvement goals.

5. We will make our #QiComms evidence-based

We support our #QiComms work with sound theory and evidence, contributing to what we know about the impact and effectiveness of communications methods, tools and approaches by undertaking research and sharing our work.

6. We will continuously improve our #QiComms

We will develop indicators, collect data and monitor and evaluate our communications work so we can continuously improve, increase our impact and deliver greater value to our organisation’s quality improvement efforts.

7. We will put people at the centre of our #QiComms work

We will speak to the hearts, as well as minds, of all those delivering and supporting quality and safety improvement. We focus on people and find ways to engage with them to motivate and inspire them to work with us to achieve our improvement goals.

Signed

Role

Organisation

Date
Can you create a compelling narrative to engage your stakeholders?
The power of multiple approaches

Publications

Build & leverage champions and experts

Face to face interaction

Credibility and Celebration

Formal communication channels

Social media and internet
AIM

To improve the quality of life for all we serve

Engaging, encouraging & inspiring

Developing improvement skills

Embedding into daily work

QI Projects

1. Targeting / segmenting communication for different groups (community-based staff, Bedfordshire & Luton staff)
2. Sharing stories – newsletters, microsite, presenting internally
3. Celebration – awards, conferences, publications, internal presentations
4. Share externally – social media, Open mornings, visits, microsite
5. Work upstream – trainees, regional partners, key national and international influencers

1. Pocket QI for anyone interested, extended to Beds & Luton
2. Refresher training for all ISIA graduates
3. Improvement Science in Action waves
4. Online learning options
5. Develop cohort and pipeline of improvement coaches
6. Leadership and scale-up workshops for sponsors
7. Bespoke learning, including Board sessions & commissioners

1. Learning system: QI Life, quality dashboards, microsite
2. Standard work as part of a holistic quality system
3. Job descriptions, recruitment process, appraisal process
4. Annual cycle of improvement: planning, prioritising, design and resourcing projects
5. Support staff to find time and space to improve things
6. Support deeper service user and carer involvement

Directorate-level priorities
- Defined through annual cycle of planning
- Most local projects aligned to directorate priorities

Trust-wide strategic priorities
1. Reducing inpatient physical violence
2. Improving access to community services
3. Enjoying work
4. Shaping recover in the community
5. Value for money
“While organisations are initiating a number of strategies to improve care, many clinicians practicing in them have not received training on quality and safety as a part of their formal education.”
### Dosing the Science of Improvement to Select Groups in an Organization

<table>
<thead>
<tr>
<th>Science of Improvement Topic</th>
<th>Board</th>
<th>Sr. Mgmt.</th>
<th>Sr. Clinicians</th>
<th>Nurse Mgrs.</th>
<th>Admin Mgrs.</th>
<th>QI Team Ldrs.</th>
<th>QI Experts</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of QI</td>
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<td>Profound Knowledge</td>
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<tr>
<td>Quality as a Business Strategy</td>
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<td>Model for Improvement</td>
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<td>PDSA Testing</td>
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<tr>
<td>Understanding Variation</td>
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<tr>
<td>Scale-up and Spread</td>
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<tr>
<td>Construction of Control Charts</td>
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</table>

Note that the intensity of the color reflects the "dose" of the science of improvement knowledge and skills that would be administered to each respective group. The mechanisms for administering the allocated dose would range from the IHI Open School to the Improvement Advisor Professional Development Program.

Experts by experience

All staff

Staff involved in or leading QI projects

QI coaches

Sponsors

Internal experts (IAs)

Board

817 completed Pocket QI so far. All staff receive intro to QI at induction

Estimated number needed to train = 5500

Needs = introduction to QI & systems thinking, identifying problems, how to get involved


Estimated number needed to train = 1000

Needs = Model for improvement, PDSA, measurement and using data, leading teams

87 QI coaches trained so far, with 33 currently active. Cohort 4 currently underway

Estimated number needed = 60

Needs = deep understanding of method & tools, understanding variation, coaching teams

58 current sponsors. All completed ISIA.

Needs = Model for improvement, PDSA, measurement & variation, scale-up and spread, leadership for improvement

Currently have 9 Improvement Advisors (IAs), with 2 further IAs to be trained 2018/2019

Estimated number needed to train = 11

Needs = deep statistical process control, deep improvement methods, effective plans for implementation & spread

All Executives have completed ILP. Annual Board session with IHI & regular Board development

Needs = setting direction and big goals, executive leadership, oversight of improvement, understanding variation

Bespoke QI learning sessions for service users and carers. Over 95 attended so far. Build into recovery college syllabus

Needs = introduction to QI, how to get involved in improving a service, practical skills in confidence-building, presentation, contributing ideas

Psychology trainees – Pocket QI, embedded into QI project teams with 4 bespoke learning sessions

Nursing students – Intro to QI delivered within undergraduate and postgrad syllabus, embedded into QI project teams during student placements

Working upstream
Building Capability at Pace and Scale

Single methodology

Identify and realign existing resources and assets

Plan to build capability across all levels and disciplines

Be prepared to invest
AIM
To improve the quality of life for all we serve

Engaging, encouraging & inspiring

Developing improvement skills

Embedding into daily work

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The Typical Approach...

Conference Room

DESIGN → DESIGN → DESIGN → DESIGN → APPROVE

Real World

IMPLEMENT
“Every system is perfectly designed to get the results it gets...”
So how do we make it easy for staff to get involved in QI?
Change in leadership behaviours

Use of data to guide decision-making

“Go see” “Gemba” Executive WalkRounds

Stop solving problems at the top

Give people time and space to solve complex problems

Paying personal attention

Manage the expectations

Role Modelling
Tips for embedding QI into daily work

1. Start at the top
2. Ensure patients & carers are integral
3. Create a support structure for every QI project
4. Create organizational learning system utilizing time series analysis
5. Create capacity for QI
AIM
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Bottom Up

Top Down
WHAT MATTERS MOST
Trust-wide priority areas

- Triple Aim
- Improving Access & Flow in the community
- Enjoying work
- Reshaping Community Services
Number of QI projects $\propto$ Size of support infrastructure
Break Time
World Café Session

The ELFT infrastructure for Improvement
Lunch Time
Leadership for improvement

Assessment & action-planning

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Engage Across Boundaries

Create Vision and Build Will

Driven by Persons & Community

Develop Capability

Deliver Results

Shape Culture


http://www.ihi.org/resources/pages/ihiwhitepapers/highimpactleadership
### High Impact Leadership Behaviours

<table>
<thead>
<tr>
<th>1. Person-centeredness</th>
<th>Be consistently person-centered in word and deed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Front Line Engagement</td>
<td>Be a regular authentic presence at the front line and a visible champion of improvement</td>
</tr>
<tr>
<td>3. Relentless Focus</td>
<td>Remain focused on the vision and strategy</td>
</tr>
<tr>
<td>4. Transparency</td>
<td>Require transparency about results, progress, aims, and defects</td>
</tr>
<tr>
<td>5. Boundarilessness</td>
<td>Encourage and practice systems thinking and collaboration across boundaries</td>
</tr>
</tbody>
</table>
High Impact Leadership Behaviours

• Fill out the assessment tool (both for you, and for your senior leadership team)

• Start developing some ideas of how to strengthen your own high-impact leadership behaviours, and how to influence your senior leadership team to strengthen theirs
## A. Person-centredness: Be consistently person-centered in word and deed

<table>
<thead>
<tr>
<th></th>
<th>YOU</th>
<th>YOUR SENIOR LEADERSHIP TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What could you do to strengthen your person-centredness?</strong></td>
<td>Never</td>
<td>Quarterly</td>
</tr>
<tr>
<td>How frequently do you talk with patients and service users about their care experience and what matters to them?</td>
<td>Never</td>
<td>Quarterly</td>
</tr>
<tr>
<td>How frequently do you include patients and service users as members of improvement teams?</td>
<td>Never</td>
<td>Quarterly</td>
</tr>
<tr>
<td>How frequently do you review feedback and information from patients and service users?</td>
<td>Never</td>
<td>Quarterly</td>
</tr>
<tr>
<td>How frequently do you use stories and experiences from patients, service users and families to build will or shape culture with those you lead?</td>
<td>Never</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

**Note:** The table above outlines various aspects of person-centred leadership behaviors and asks about the frequency and actions that can be taken to strengthen these behaviors.
### B. Front-line Engagement: Be a regular authentic presence at the front line and a visible champion of improvement

<table>
<thead>
<tr>
<th>You</th>
<th>Your Senior Leadership Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Never</strong></td>
<td><strong>Quarterly</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>How frequently do you visit front line staff to hear about their experience at work?</td>
<td></td>
</tr>
<tr>
<td>How frequently do you review with front line team members their improvement projects?</td>
<td></td>
</tr>
<tr>
<td>How frequently do you demonstrate improvement theory and methods to those you lead?</td>
<td></td>
</tr>
<tr>
<td>How frequently do you review and reprioritise a list of needed improvement priorities and projects?</td>
<td></td>
</tr>
<tr>
<td>How frequently do you actively participate, lead or sponsor improvement projects?</td>
<td></td>
</tr>
</tbody>
</table>
## C. Relentless Focus: Remain focused on the vision and strategy

What could you do to strengthen your relentless focus?

<table>
<thead>
<tr>
<th>YOU</th>
<th>YOUR SENIOR LEADERSHIP TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>Strongly disagree</td>
</tr>
<tr>
<td>Somewhat disagree</td>
<td>Somewhat disagree</td>
</tr>
<tr>
<td>Neutral</td>
<td>Neutral</td>
</tr>
<tr>
<td>Somewhat agree</td>
<td>Somewhat agree</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>Strongly agree</td>
</tr>
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</table>

### I can articulate a clear vision of the future for my department and organization

### I have a clear and executable strategy for achieving the vision and have created a focus on delivering results

### The measurement system I use to monitor performance and quality is aligned with the vision and strategy

### I routinely talk about the vision and strategy at team meetings, and as a result, all team members understand the strategy and how progress and success will be measured.

### I have prioritized and aligned improvement efforts with the strategy and have provided adequate resources to accomplish the goals
## D. Transparency: Require transparency about results, progress, aims and harm

<table>
<thead>
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<th>YOU</th>
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</tr>
</thead>
<tbody>
<tr>
<td>What could you do to strengthen your transparency?</td>
<td>How could you influence your senior leadership team to strengthen their transparency?</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>Somewhat disagree</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>I have ensured that key quality, safety and performance measures are available to all team members on a real time basis</td>
<td></td>
</tr>
<tr>
<td>When visiting a team, I look for visible displays of quality and performance measures, and ask the team to talk about these</td>
<td></td>
</tr>
<tr>
<td>I ensure that quality, safety and performance data is available to patients, service users, families and local citizens</td>
<td></td>
</tr>
<tr>
<td>When a safety incident occurs, I ensure that the service user and any relevant family members are fully informed</td>
<td></td>
</tr>
<tr>
<td>I regularly encourage those I lead to talk about things that have gone wrong and encourage learning from these</td>
<td></td>
</tr>
</tbody>
</table>
### E. Boundarilessness: Encourage and practice system thinking and collaboration across boundaries

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<tr>
<td>Strongly agree</td>
<td>Strongly agree</td>
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</tbody>
</table>

**What could you do to strengthen your boundarilessness?**

- The service redesign and improvement efforts I lead/sponsor cross multiple departmental, organizational and professional boundaries.
- I arrange or foster participation and collaboration with others beyond my direct management control.
- Clinical and service information flows easily across organizational, provider and other boundaries.
- I am generous with power, sharing leadership of population health improvement with others in the community and across organizational boundaries.

**How could you influence your senior leadership team to strengthen their boundarilessness?**
Infrastructure for Improvement

Assessment & action-planning

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### A. Engaging, Encouraging & Inspiring:

<table>
<thead>
<tr>
<th>Notes on your current position.</th>
<th>Where are the opportunities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of your stakeholders &amp; stakeholder map. Where are the bright spots?</td>
<td></td>
</tr>
<tr>
<td>Engagement strategies and mechanisms for interacting with stakeholders</td>
<td></td>
</tr>
<tr>
<td>Story telling. Is there a compelling narrative around this work?</td>
<td></td>
</tr>
<tr>
<td>How are you engaging both hearts &amp; minds?</td>
<td></td>
</tr>
</tbody>
</table>
### B. Building Capability:

<table>
<thead>
<tr>
<th>Notes on your current position</th>
<th>Where are the opportunities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of improvement capability that already resides in your organisation. Can you realign existing resources?</td>
<td></td>
</tr>
<tr>
<td>Do you have an organisational plan for how you will build capability?</td>
<td></td>
</tr>
<tr>
<td>How will you build capability at different levels inside/outside of your organisation?</td>
<td></td>
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</tbody>
</table>
## C. Embedding into Daily Work

<table>
<thead>
<tr>
<th>Your current position</th>
<th>Where are the opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational learning system utilising time series analysis</td>
<td></td>
</tr>
<tr>
<td>Structures in place to support QI projects in organisation</td>
<td></td>
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<tr>
<td>Time and space for project teams to undertake QI projects</td>
<td></td>
</tr>
</tbody>
</table>
## D. Developing a Portfolio of QI Projects

<table>
<thead>
<tr>
<th>Your Current Position</th>
<th>Where are the opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portfolio contains top down projects, bottom up projects or a mixture of both</td>
<td></td>
</tr>
<tr>
<td>How do projects align with organisational aims?</td>
<td></td>
</tr>
<tr>
<td>Projects represent diversity of sites/services in your organisation</td>
<td></td>
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</tbody>
</table>
People Participation

Assessment & action-planning

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## People Participation

<table>
<thead>
<tr>
<th></th>
<th>Your Strength</th>
<th>Your Weakness</th>
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</thead>
<tbody>
<tr>
<td>Executive/Leadership Buy In</td>
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<tr>
<td>Staff (dedicated staff)</td>
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<tr>
<td>Patient Engagement</td>
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<tr>
<td>Structure that facilitates/allows participation</td>
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<tr>
<td>Current activity</td>
<td></td>
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<tr>
<td>Quality Improvement )Big I)</td>
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<td></td>
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<tr>
<td>Co-production/Co-Design</td>
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</table>
Break Time