National Audit of Dementia

Round 5 local reporting QI webinar

21 November 2023

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | NAD NATIONAL AUDIT OF DEMENTIA

Welcome and housekeeping

- Please use the chat function to comment and ask questions throughout the presentation, we will be monitoring this throughout
- If you are not speaking please mute your microphone
- During the question sessions please use the raise hand function (Participants > raise hand)
- We will note any questions not answered today and get back to you via email
- **This session will be recorded to capture discussions and feedback.**
- NAD QI Webinar - Google Jamboard

Purpose of this webinar:

- Quick recap of the audit and key results
- Maureen McGeorge, QI Consultant, will lead session looking at building actions based on the Model for Improvement
- Groups tasks to discuss selecting your aim, target, change ideas

Overview

1.00	**Welcome/Housekeeping**
1.05	NAD R5 - summary key metrics results and recommendations
1.20	Group task 1 – setting the scene and feedback
1.55	Group task 2 – statement of aim
2.20	Choosing your Team
2.25	Model for Improvement
2.55	**Break**
3.05	Change Ideas
3.25	Group task 3 – testing change ideas
3.35	Introduction to PDSAs
3.45	Group task 4 – planning your QI project
4.00	Next steps and general Q and A
4.15	**Close**

Audit data collection in Round 5

- Mandatory period casenote audit data collection – identification of a total cohort and submitting data on a sample. Key metrics of delirium screening, pain assessment, discharge planning
- Annual Dementia Statement – organisational information and inclusion of key metrics and carer scores
- Carer feedback – carers for people with dementia admitted to hospital in the main casenote data collection period
- Patient feedback – new tool developed, 3-5 patients per month, ongoing

unknown-ORG1 Annual Dementia Statement

This poster demonstrates progress our hospital has made in its work to achieve good quality care for people with Dementia.

See NOTES for information on National Audit of Dementia

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | NAD NATIONAL AUDIT OF DEMENTIA

Annual Dementia Statement
May-June

Feedback We Collect

Our carer rating for quality of care
24
score out of 100

Our carer rating for communication
23
score out of 100

We do not collect feedback on our quality of care from patients with dementia

Nutrition & Environment

90% of our patients with dementia have the personal information document

"Dave"
*based on a bedside check

Out of **10** Adult Wards

80% have finger foods available

70% have snack foods available

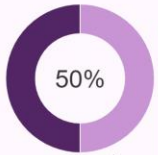
A review of hospital environment for Dementia-friendly criteria has **taken place throughout the hospital**

Changes to improve the environment based on the review are **underway**

3,000

admissions in the past year

Admissions



were people with dementia

Our estimated proportion of people with dementia admitted unknown to us **less than 5%**

Assessments

for people with dementia

Delirium

76% screened for delirium

23% of those were screened within 24 hours of admission

87.1% National screened for delirium	80.9% National screened within 24 hours

Pain

100% assessed for pain

100% of those were assessed within 24 hours of admission

91.6% National assessed for pain	85.1% National assessed within 24 hours

Discharge

Median length of stay

National median length of stay	10 Days

100% discharges planned within 24 hours of admission

National planned discharge within 24 hours	83.5%

Monitoring care of people with dementia

Information reviewed and frequency in our Trust/Health board

Falls	Not Presented
Readmission	Presented Bi-Yearly
Delayed Discharge	Presented Bi-Yearly
Pressure Ulcers	Presented Yearly
Violent Incidents	Presented (Not Specified)

We have a Dementia Strategy Group who meets every 3-6 months

We are signed up to John's Campaign

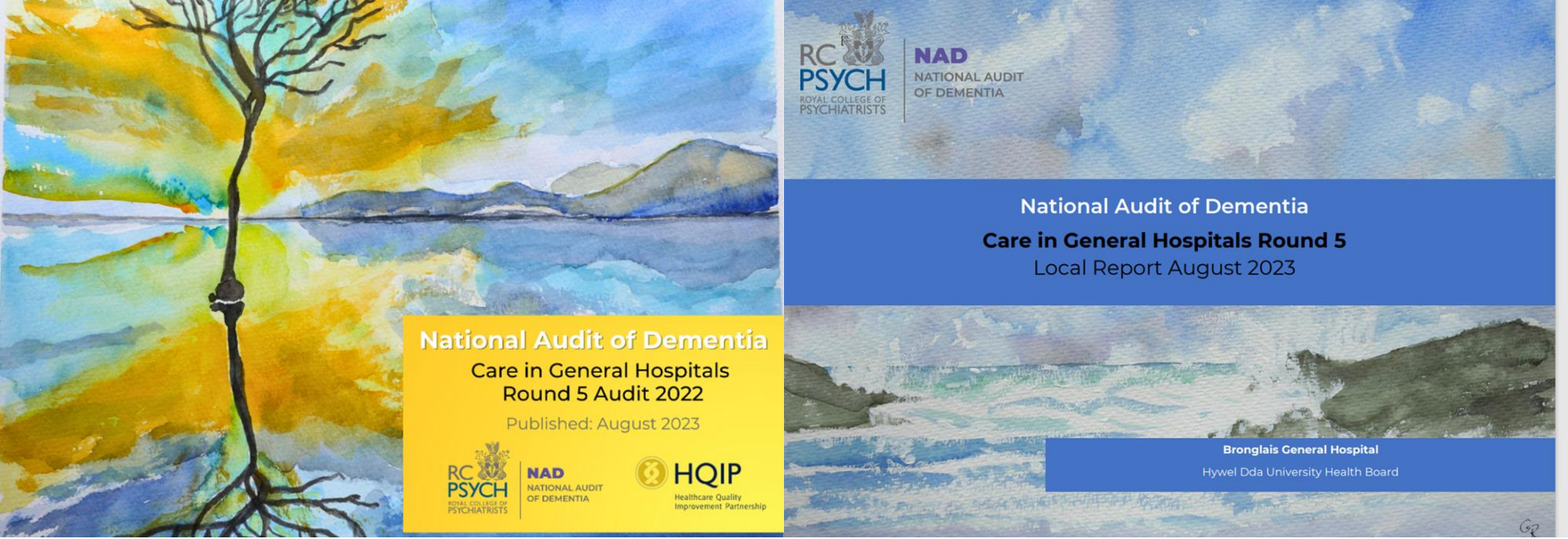
We are signed up to the Dementia Friendly Hospitals Charter

Specialists in our Trust:

2	45	7
Consultant/ Lead Nurses	Consultant Specialists in Dementia	Allied Healthcare Processionals

No Data staff have Tier 1 dementia awareness training at **any level**

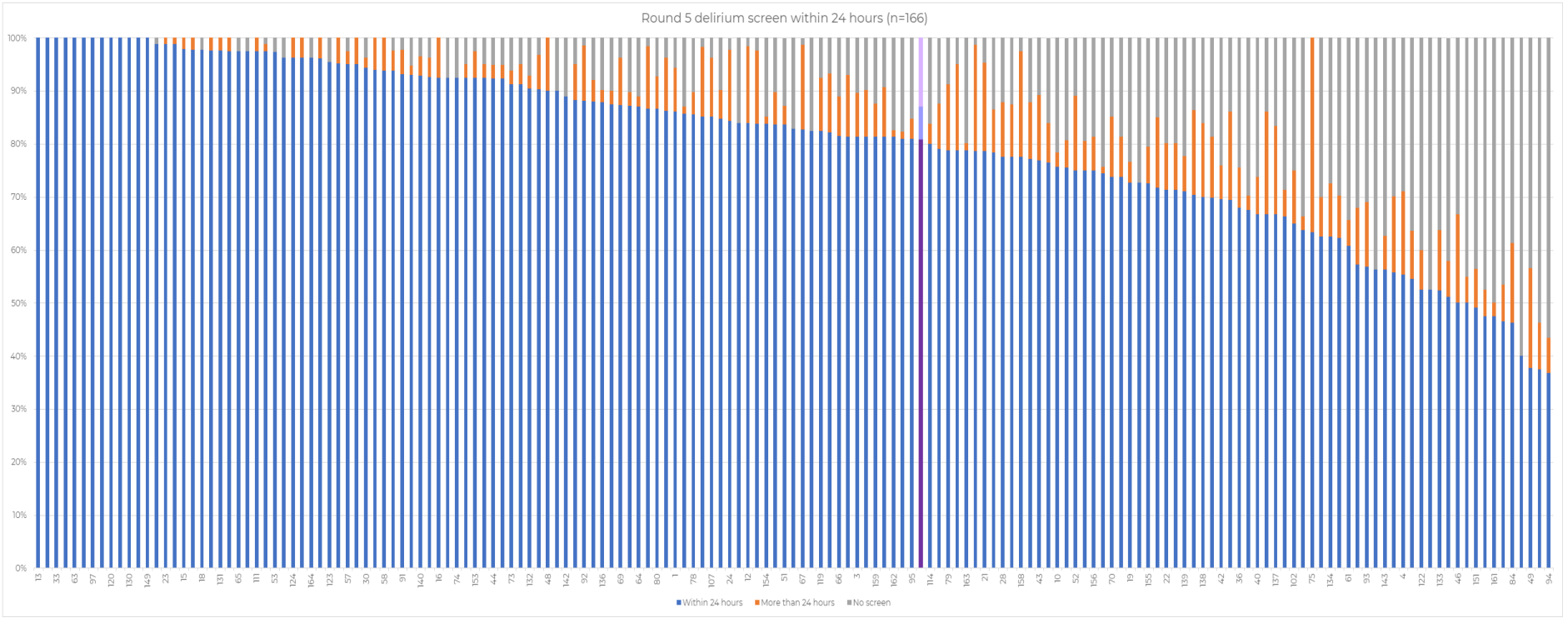
78% staff have Tier 2 dementia training at **Hospital level**



National and Local Reporting August – October

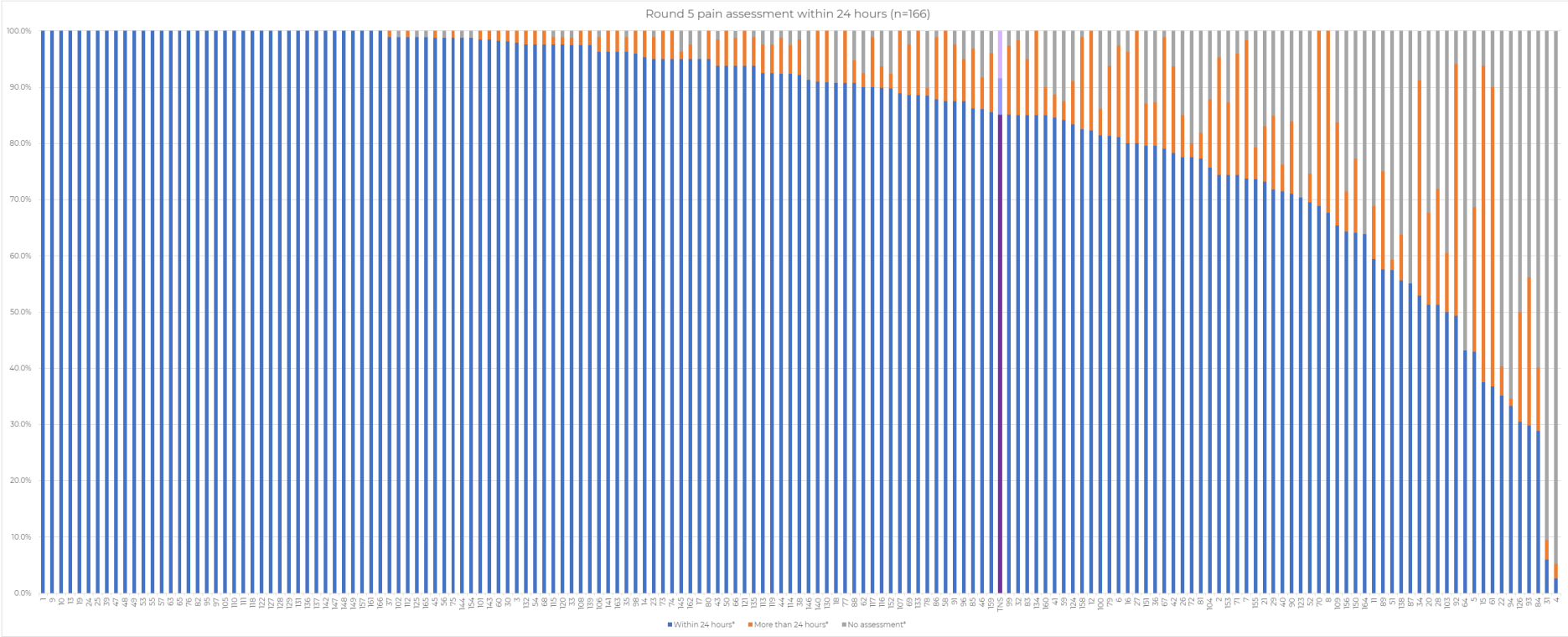
Aggregated site level data available at [Data tables (rcpsych.ac.uk)]

Key metrics reporting – delirium screen



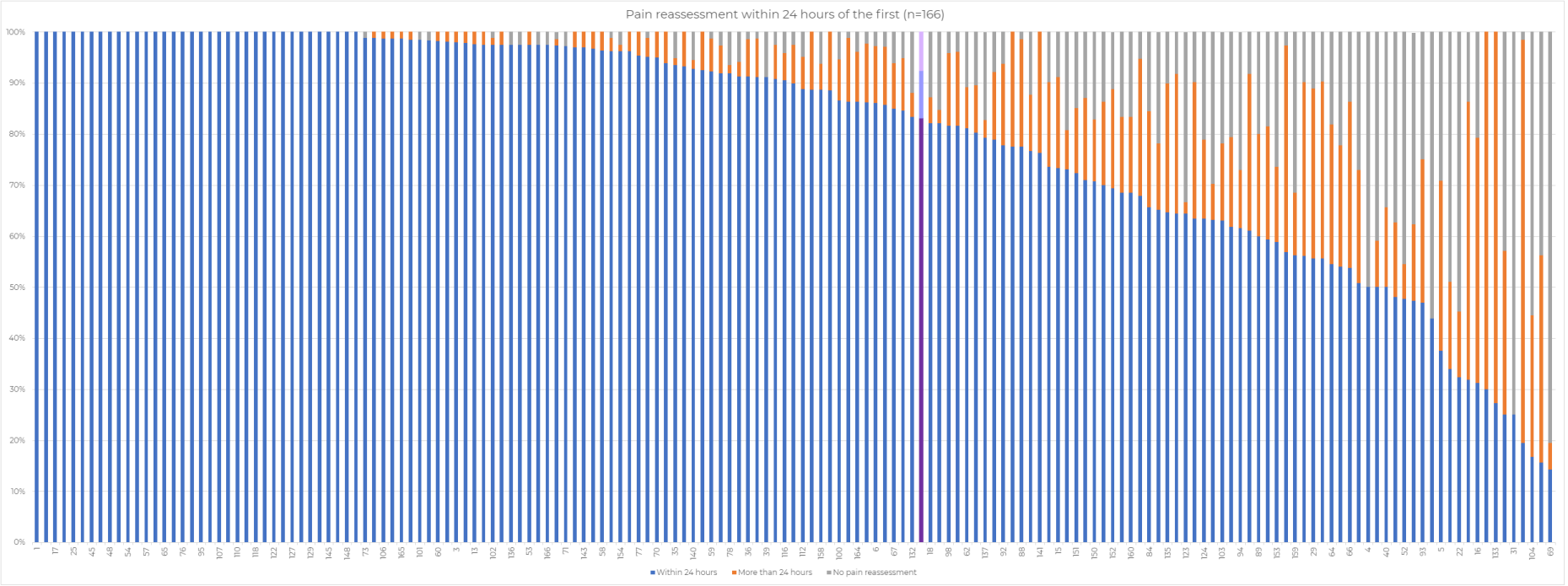
- Range: 37 – 100% (R4 9-100%)
- Average: 87% (R4 58%)

Key metrics reporting – pain assessment



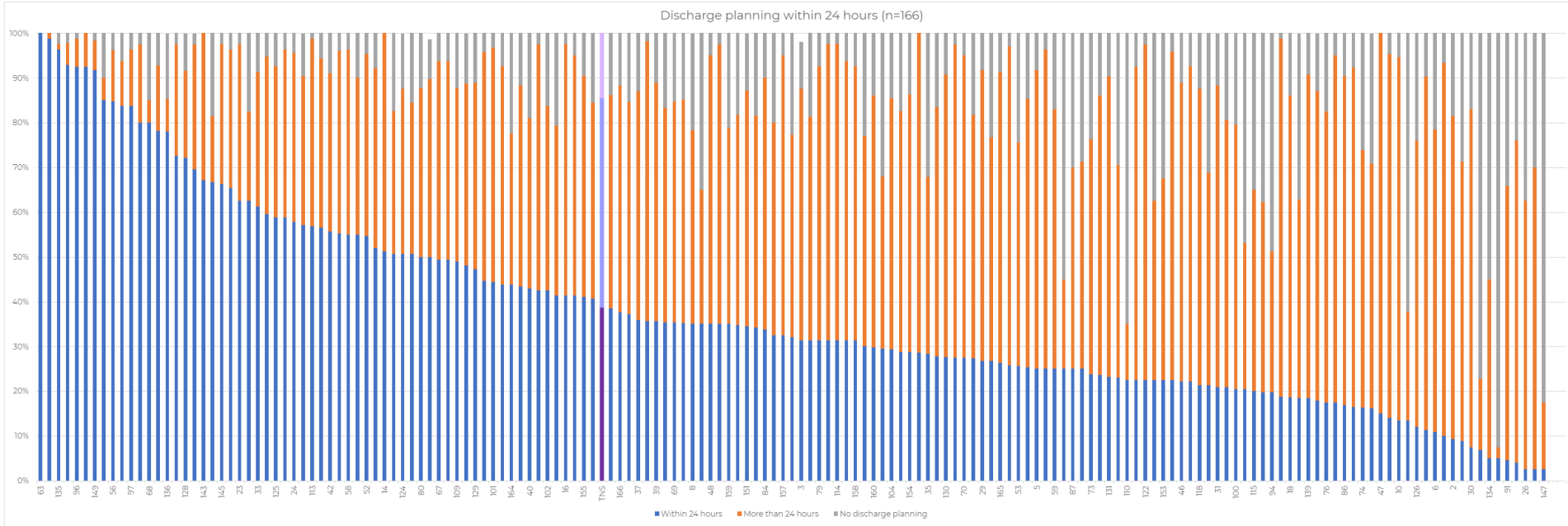
- Range: 5-100% (R4 16-100%)
- Average: 92% (R4 85%)

Key metrics reporting – pain assessment repeated



- Range: 14-100%
- Average: 83%

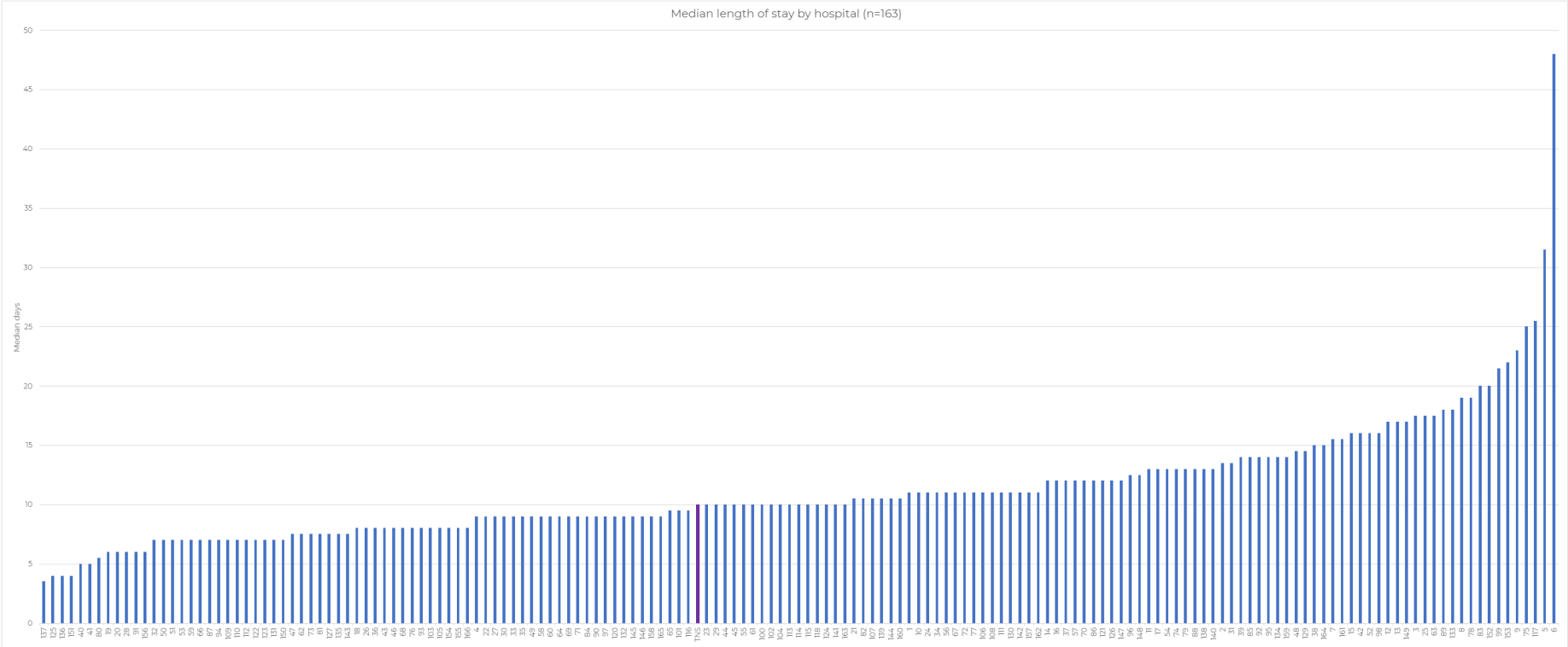
Key metrics reporting – discharge planning within 24 hours



- Range: 3-100%
- Average: 39%

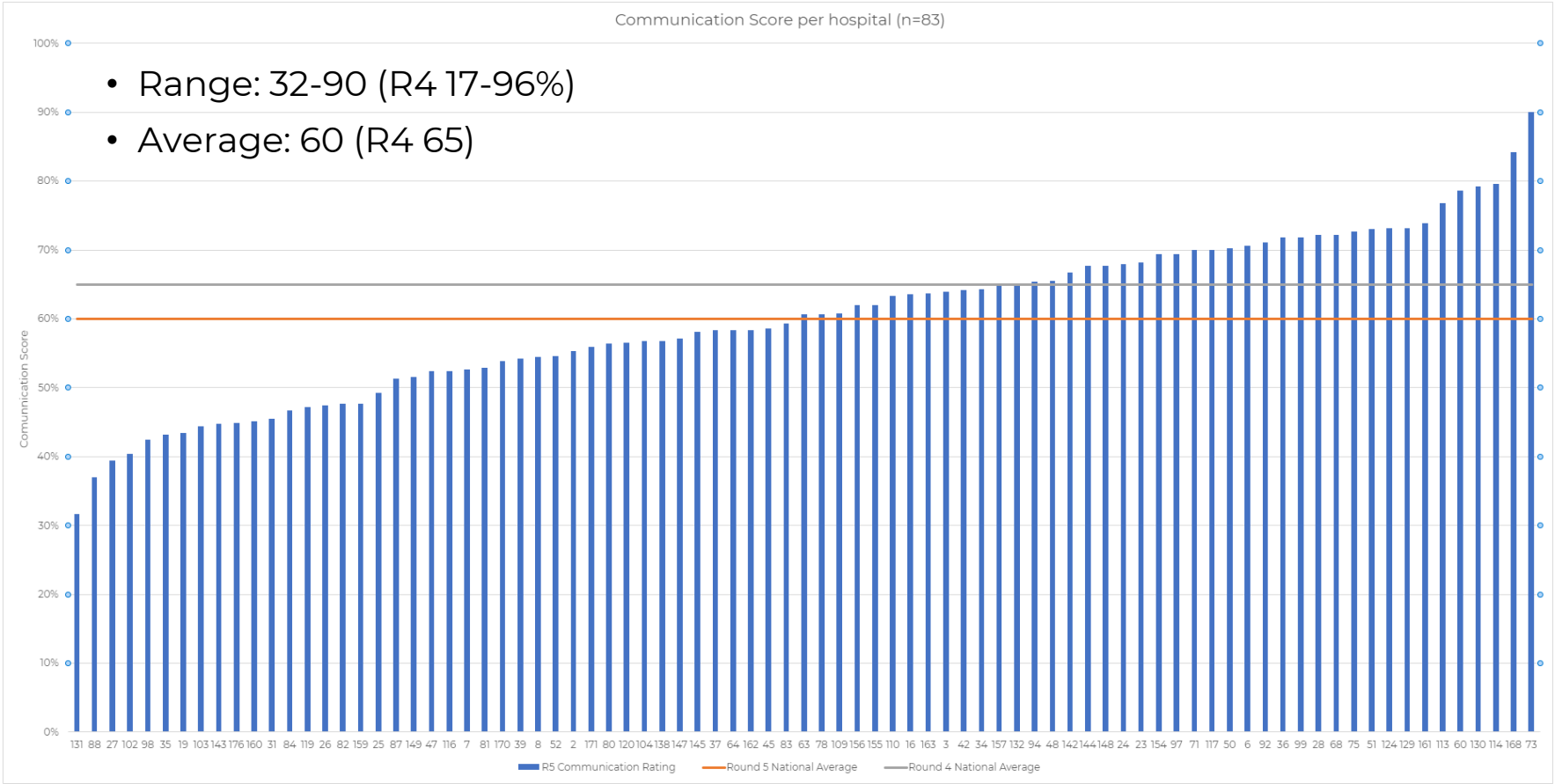
N.B this figure does not take into account reasons leading to cases treated as N/A for outlier analysis

Key metrics reporting – Length of Stay



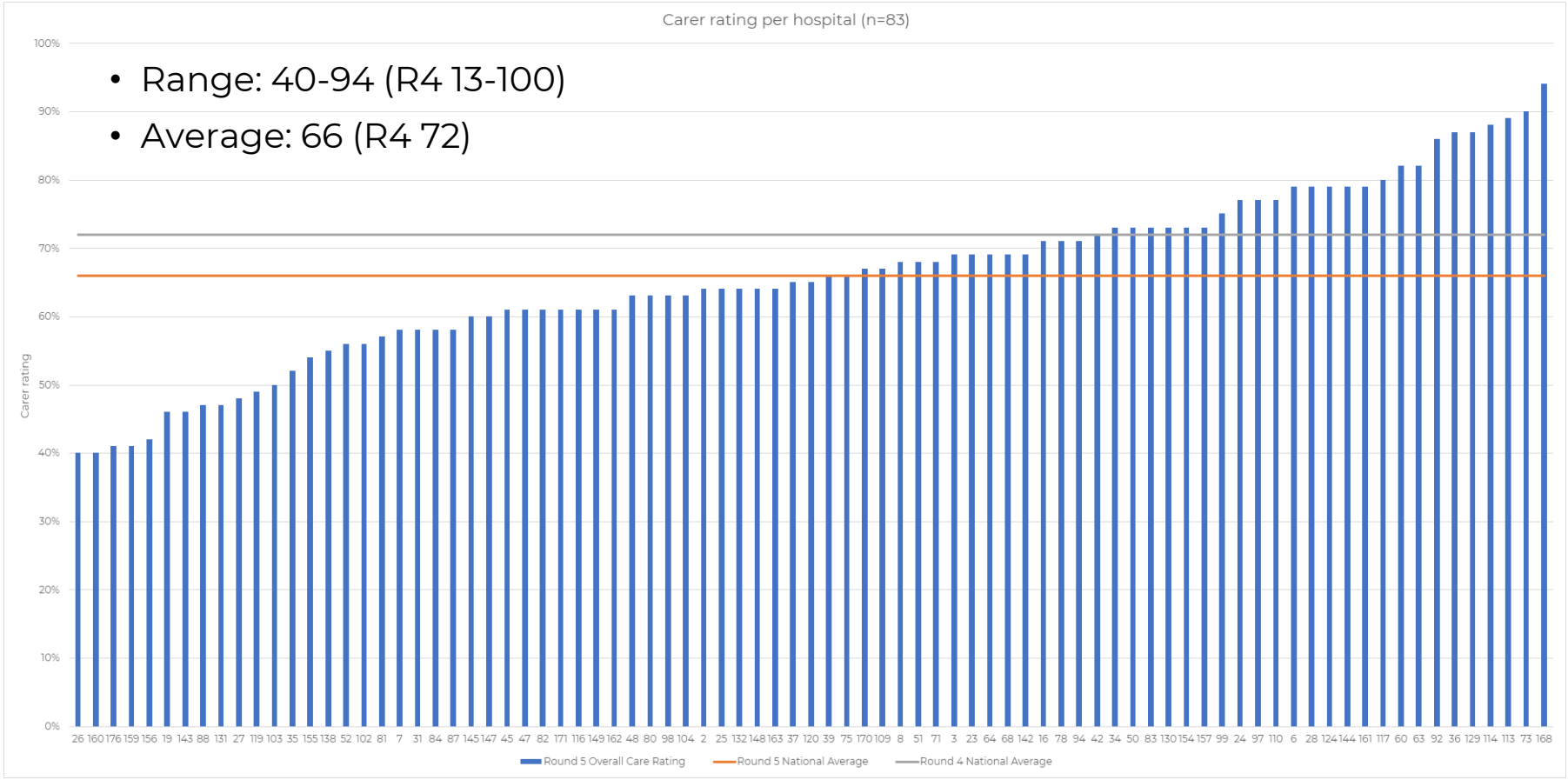
- Median Range: 3.5-48
- Average: 10
- *R4 not compared due to change in methodology*

Key metrics reporting – Carer communication rating



- Range: 32-90 (R4 17-96%)
- Average: 60 (R4 65)

Key metrics reporting – Carer overall rating of care



- Range: 40-94 (R4 13-100)
- Average: 66 (R4 72)

Challenges

- Successes and challenges seen in the data
- Changes in methodology
- Identification for casenote audit, and from hospital's own collated data for ADS
- Access to data

Recommendations

Hospital systems which support care monitoring and delivery

1. The **Chief Executive Officer** should ensure that the Trust/Health Board has a nominated Board member responsible for dementia in addition to the clinical lead, whose responsibilities will include:
   - Establishing and implementing hospital systems capable of 1) identifying people with dementia admitted to the hospital and 2) showing the proportion of people with dementia affected by falls, delayed discharges, readmissions, pressure ulcers and incidents of violence/aggression, so that accurate figures may be supplied to NHS England Emergency Dashboard and other national dashboards.
   - Monitoring the proportion of ward-based staff who have received Tier 2 level training in dementia, and assessing the impact this has on quality of care, as experienced by patients and carers.
   - Scrutinising feedback from patients and carers and reports of the National Audit of Dementia.
   - Tabling the Trust/Board Annual Dementia Statement for review.
   - Providing regular reports to the Integrated Care Board/Welsh Government relating to the appropriate governance and monitoring of care of people with dementia.
   - Developing action plans based on areas identified for improvement in care and patient experience, including ensuring that personal information about their care preferences and needs has been gathered and is available at the bedside; regular review of the environment against "Dementia Friendly" criteria using a standardised tool (e.g. Enhancing the Healing Environment | The King's Fund (kingsfund.org.uk); Patient-Led Assessments of the Care Environment (PLACE) - NHS Digital)

2. **Integrated Care Boards/Welsh Government** should seek assurance from Trusts/Health Boards regarding their actions and progress with the above.

Comprehensive pain assessment

3. The **Medical Director** and **Chief Nurse** should ensure that staff are trained and supported in the use of appropriate tools for comprehensive pain assessment (e.g. e-lfh Pain Management Programme) This should include:
   - Understanding the need for structured pain assessment.
   - How pain interacts with symptoms of dementia, and that people with dementia may not articulate pain.
   - The regular use of an appropriate pain tool for assessing people with dementia on the ward.

What next

- R6 sampling changes and reporting – smaller sample size for smaller hospitals and those with paper records. Timeline brought forward to avoid some of the winter problems – deadline for Part 1 and 2 casenote, ADS and carer approaching fast
- Part 3 deadline is a guillotine deadline – 3 January
- R5 remaining reporting – Regional Report, Report for Wales, further patient feedback, plain version reporting
- National Event – 26 January 2024

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NAD
NATIONAL AUDIT OF DEMENTIA

National Audit of Dementia
QI workshops

Setting the scene: Group task

- Chat about your own experiences of trying to improve something that you wanted to improve e.g. a snack that you like to eat, your skill at doing a game that you enjoy.
  - Was it easy to improve?
  - If not, why not?
- Be ready to share.
- You have 5 minutes.

1.20

Tell us what you talked about

1.25

Setting the scene: what's your problem?

But what happens if …

….. someone else tells us to improve something we think is fine as it is, or …

… we have to rely on other people to help us make the improvement.

Setting the scene: so what are we trying to say?

- Improving things isn't (usually) easy.
- Improvement does not just 'happen'.
- We don't always know that improvement is needed.
- We don't always 'fix' things that are broken.
- We don't always see how much easier things could be … if only we stopped and thought about how to do things diffently.

So you need a 'consistent' way of testing out **different ideas** so you can achieve **better results** and **improve quality**.

Setting the scene: how we deal with complex problems

Trial and error? Chaos

Too much action, not enough thinking

"Just go ahead and do it".

Detailed prior study? Paralysis

Too much thinking, not enough action

"We can't do anything until we know exactly what to do...."

Jeremy Heimens, Henry Timms
New Power: How it's changing the 21st century and why you need to know(2018)

Setting the scene: The Model for Improvement

1. What are you trying to accomplish?

2. How will you know that a change is an improvement?

3. What change can you make that will result in improvement?

Langley G, Nolan K, Nolan T, Norman C, Provost L, (1996), *The improvement guide: a practical approach to enhancing organisational performance*, Jossey Bass Publishers, San Francisco

What's your problem: some examples

- Poor levels of screening for delirium
- Inconsistent availability of finger food
- Poor involvement of patients and carers in decision-making
- Poor assessment of pain
- Poor management of pain

Qu 1: the Model for Improvement

1. What are you trying to accomplish?

2. How will you know that a change is an improvement?

3. What change can you make that will result in improvement?

Understanding the problem and why is keeps happening. Knowing what you're trying to do - clear and desirable aims and objectives.

Langley G, Nolan K, Nolan T, Norman C, Provost L, (1996), *The improvement guide: a practical approach to enhancing organisational performance*, Jossey Bass Publishers, San Francisco

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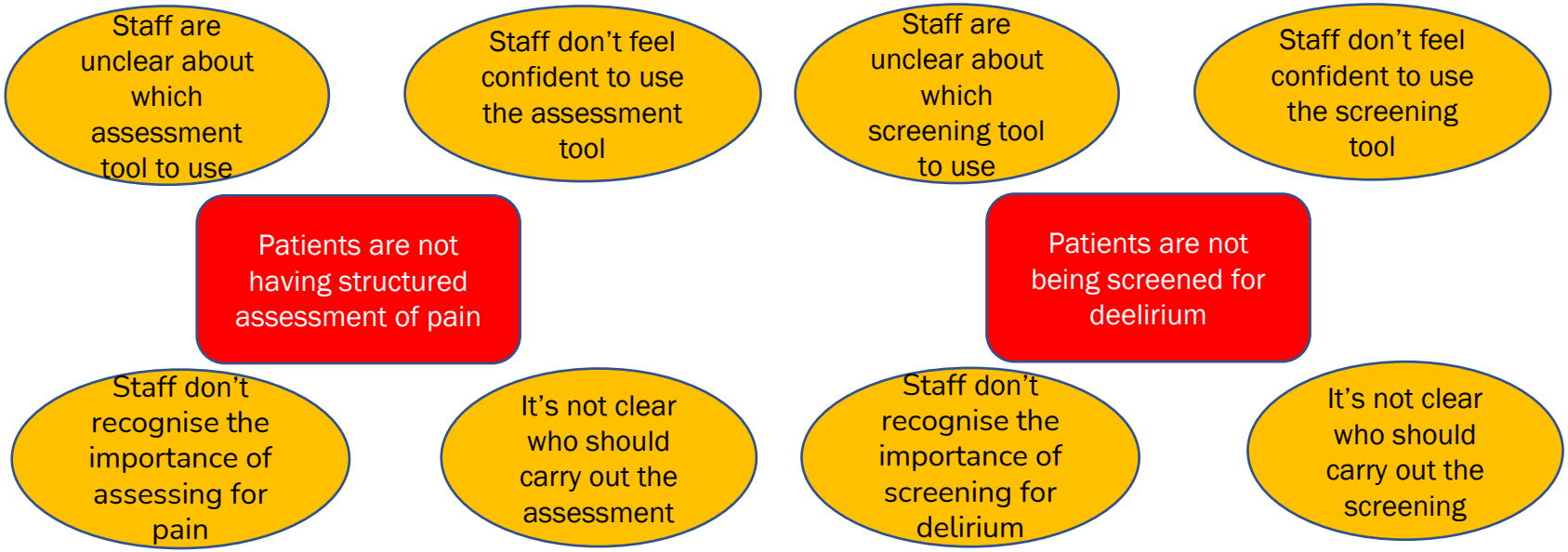
Qu 1: an example of a QI project

Problem 1
Patients are not having a structured assessment of pain.

Problem 2
Patients are not being screened for delirium.

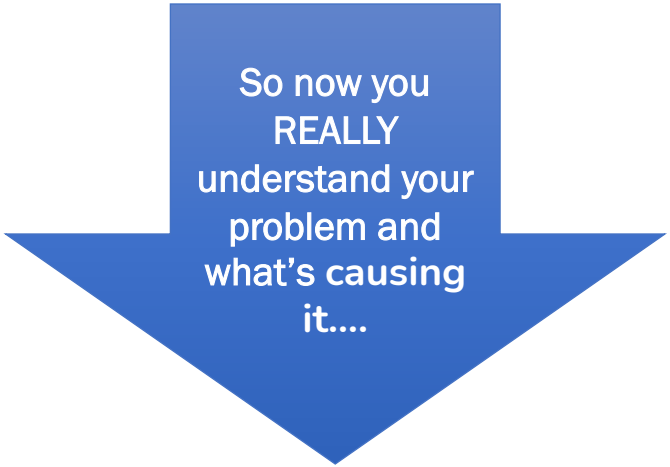
But what is going wrong?

Qu 1: an example of a QI project



Qu 1: what are you trying to accomplish?

What is your problem?
Diagnosis/analysis



What are you going to do about it?

Qu 1: some tools for helping you understand/(diagnose) your problem

Qu 1: look at existing data

- Numbers (quantitative) data that is already being collected: number of patients being assessed for the presence of pain/screened for delirium.
- Information about people's experiences (qualitative data): complaints; service user/carer surveys; local research.

Qu 1: collect some new data/information

- Short survey e.g. ask the healthcare professionals to write down 2 reasons why they think that staff are not assessing for the presence of pain/screening for delirium.

Qu 1: 'the 5 Whys'

We often jump to either the symptom of the problem, OR the solution.

Problem: patients are not having a structured assessment for pain/being screened for delirium

WHY? *Because the team is short staffed*

WHY? *Because there has been a lot of staff sickness*

WHY? *Because staff report that they have not felt able to access advice and leadership*

WHY? *Because there have been a lot of changes in team leadership in recent months.*

WHY? *Because the team manager post has been vacant for several months*

So low staffing levels may be a symptom of a bigger problem … but you need to find out what.

Qu 1: use brainstorming

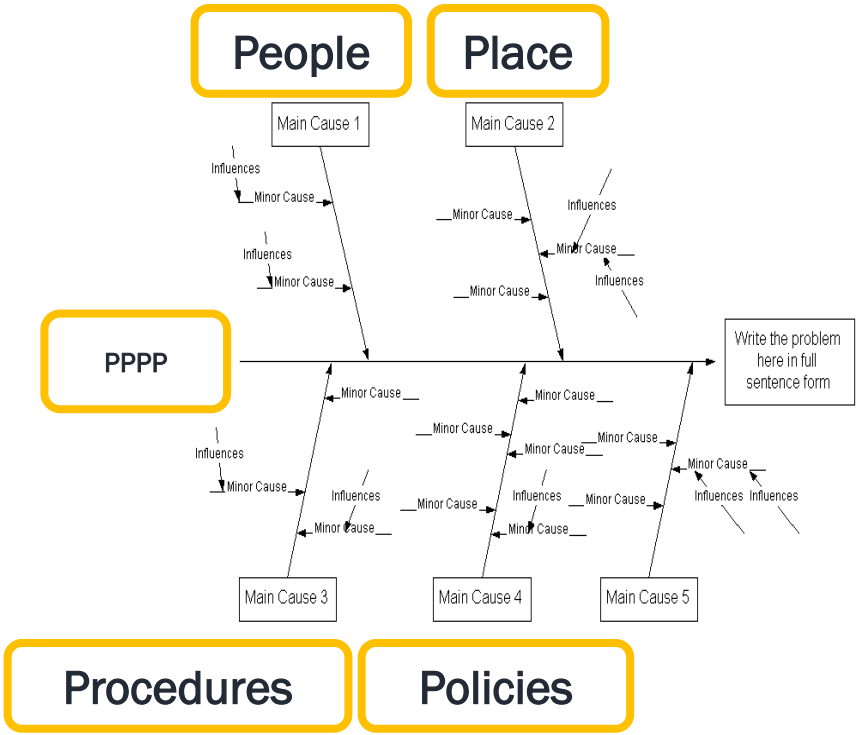
Where team members work together to come up with new ideas for how to solve a problem.

Things to remember:

- Make sure everyone feels comfortable to join in.
- You are not allowed to judge or criticise.
- You could use post-it notes.
- ‘Crazy’ ideas are welcomed.

When you use brainstorming, you can come up with lots of new ideas quickly!

Qu 1: use a Fishbone diagram



You can use this 2 ways:

1. With brainstorming, to help organise your ideas.
2. To organise ideas that you already have into themes.

Qu 1: an example of how these could be used

Problem: *patients are not having a structured assessment of pain/being screened for delirium.*

- **Brainstorm**: talk with your Team about what is happening, and use '5 whys' to move beyond the symptoms.
- **Fishbone diagram**: map out all possible causes into themes.

Qu 1: the importance of contributory factors in improving quality

A '**contributory factor**' is something that helps cause a result.

An example: I cut my finger badly slicing a loaf of bread. What were the contributory factors?

1. It was a new, sharp, knife (equipment).
2. My cat jumped up on the table (distraction).
3. The bread was crusty and hard to cut (difficulty of task).
4. I'm not very good at cutting bread (skills).

Not all contributory factors are amenable to improvement!

Qu 1: how to write a statement of aim

- **What** do you want to improve?
- For whom? – WHICH GROUP? (choose people who are enthusiastic **and** don't be too ambitious).
- By how much? – set a do-able target?
- By when? – be realistic.

Qu 1: different perspectives

Problem: patients are not having a structured assessment of pain/being screened for delirium.

Framed for	Statement of aim	
Trusts leadership team	To ensure the Trust's as 'good' CQC rating is preserved at the next review.	
Service managers	To decrease complaints relating to pain management/delirium screening on Ward 8 by 20% from baseline in 6 months,	
Clinical team	To increase assessment for screening for pain/delirium on Ward 6 by 30% in 5 months.	
Patients	To decrease noise levels on Ward 6 by 30% months in 8 months.	

Qu 1: how to write a statement of aim

- Make sure it is clear so that everyone who hears it will have the same understanding (an 'operational definition').
- Make sure everyone agrees it is important.

AND

- **Remember:** a statement of aim is often most powerful when you write it from the perspective of the service user or staff.

Qu 1: how to write a statement of aim

Problem: patients are not having a structured assessment of pain/being screened for delirium.

- Work in groups. Thinking about the contributory factors we talked about earlier:
  1. agree which you would tackle first, and
  2. write a statement of aim that meets the criteria we have discussed.
  3. When you have finished, write it on the Jam board.
- You have 7 minutes.

1.55

Tell us what you talked about

Qu 1: how to write a statement of aim

The aim used in the case study:

To increase the percentage of patients with dementia that have a structured assessment of pain/are screened for delirium by 20% from baseline in the next 6 months.

Qu 1: key learning points

- When a problem keeps happening, there are lots of different things you can do and people that you can ask to help you understand why so choose carefully so you don't waste time, effort and money.
- Your statement of aim needs to be clear so that everyone understands the same thing.
- You may need to take a slightly different perspective on how you write it to make sure that everyone agrees with it.
- You may need to modify your aim if you reach your goal more quickly than you expected.

Choosing your team: things to think about from the start

Think **systematically** about who needs to be involved.

- What sort of things are you going to need and who can help you get hold of them? e.g. admin support, staff cover?
- Who understands the parts of the system that you are trying to improve so you can work out what is causing the problem?
- Who'll be affected by the changes you are trying to make? Are they likely to stop you?
- Who are the people who like to get involved with new ideas?
- For all of the above: do they need to be involved on a day-to day basis (actively) or kept up to speed (passively)?

2.20

Now think about who you would need in your Team and make notes on the Jam board. You have 5 minutes.

Remember to review your team membership regularly

As your improvement project moves forward, you will need to keep checking who needs to be involved:

- because people's circumstances can change;
- because improvement work can take longer than you expected;
- as your understanding of what is causing your problem deepens, you might need to bring in people with different skills or knowledge.

Qu 1: the Model for Improvement

1.W hat are you trying to accomplish?

2. How will you know that a change is an improvement?

3. What change can you make that will result in improvement?

Measuring processes and ourcomes

Langley G, Nolan K, Nolan T, Norman C, Provost L, (1996), *The improvement guide: a practical approach to enhancing organisational performance*, Jossey Bass Publishers, San Francisco

Qu 2: Why should you measure for improvement?

To know where you are....

... where you are going

... and when you've arrived!

Qu 2: Why should you measure for improvement?

- All improvement involves change. **But** not all change is an improvement!

AND

- Without measurement, it is impossible to know whether you have improved.

Qu 2: Why should you measure for improvement?

“We treat patients using data. We wouldn‘t dream of not using full blood tests and other diagnostic tools. But, somehow, we seem able to intervene in an entire hospital system without data.”

Prof. Charles Vincent

Qu 2: Why should you measure for improvement?

We use measurement all the time in our lives…

To weigh ingredients….

To manage household bills

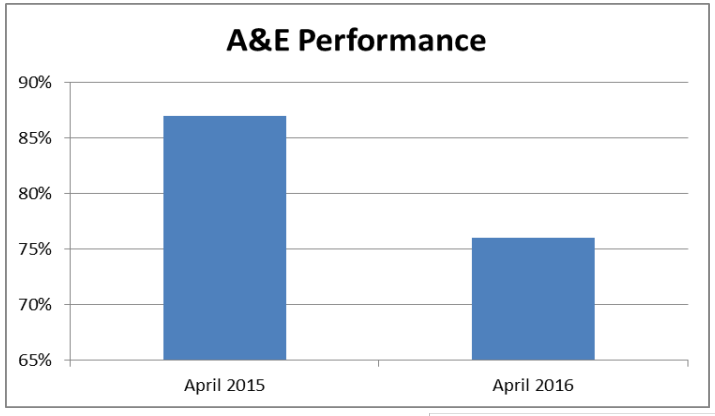
And even to countdown to Christmas!

But ‘measuring for improvement’ can make people scared

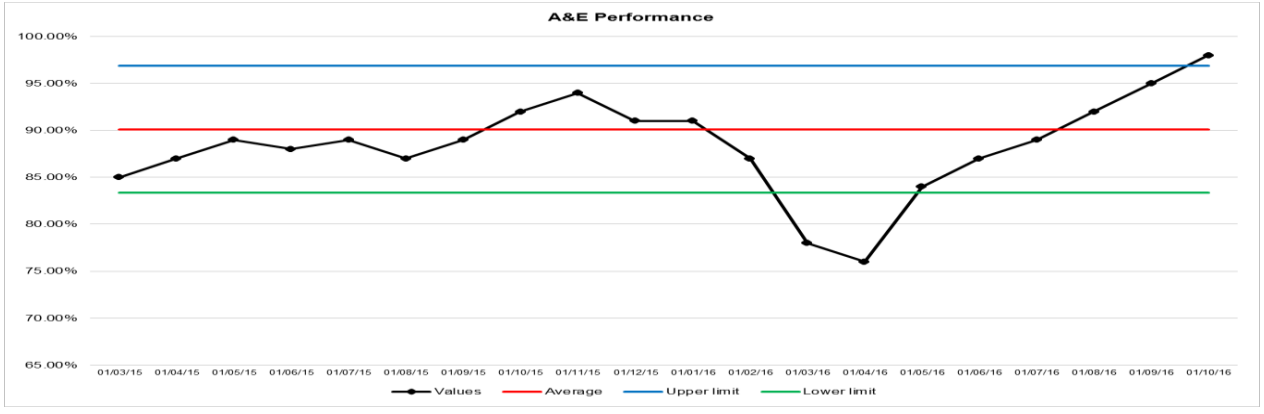
Qu 2: When should you measure for improvement?

- At the beginning of the project (your ‘baseline’): what your current system can deliver.
- Ongoing measurement (ideally): each case/each clinic/each incident/daily/weekly/monthly.

Qu 2: How will you measure for improvement?



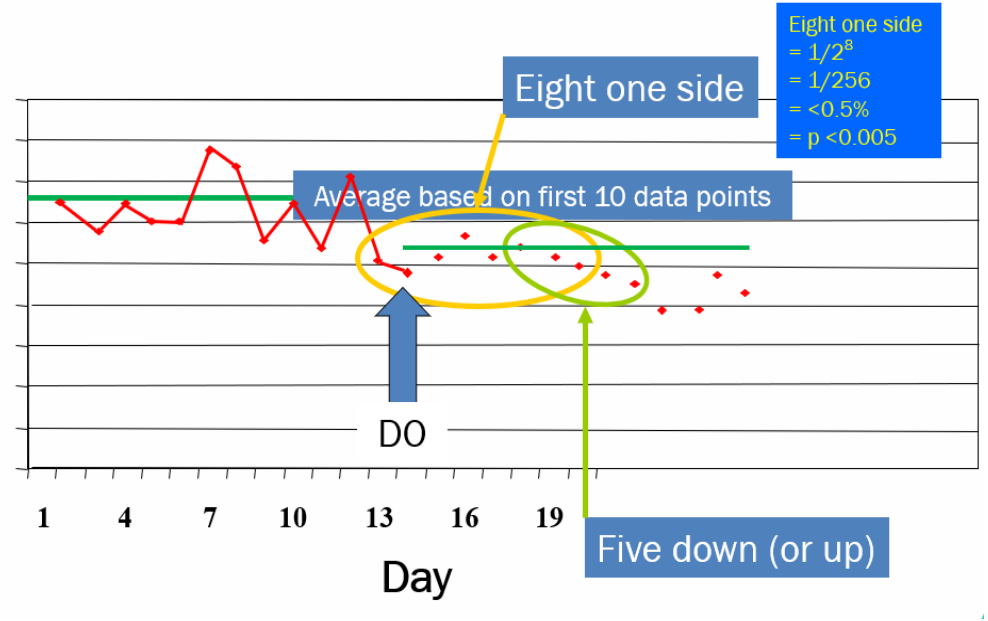
Which presentation would lead you to a better discussion and decision?



Qu 2: How will you measure for improvement?

The Run Chart rules

- Baseline = average of 10 data points
- Significant improvement = 8 data points one side of 10 day average
- OR
- 5 data points that all go either up or down



Qu 2: How will you measure for improvement?

http://qualitysafety.bmj.com/content/20/1/46.abstract

Qu 2: types of QI measures

Outcome measure: definition

Institute for Healthcare Improvement (IHI)

Progress towards the aim of your improvement project

NHS England

'Outcome measures reflect the impact on the patient and show the end result of your improvement work.'

Qu 2: types of QI measures

Our 'real' aim: to reduce unnecessary suffering and premature death for people with dementia in our acute hospitals.

'Clinical' outcome measure: number of premature deaths per week/month.

We could be waiting a l-o-n-g time …so, we often use a 'proxy'.

Aim: To increase the percentage of patients with dementia that have a structured assessment of pain/are screened for delirium by 20% from baseline in the next 6 months.

Outcome measure: The percentage of patients that had a structured pain assessment/were screened for delirium

Qu 2: types of QI measures – outcome measures

- **Baseline outcome measure** (before you test out any changes): the percentage of patients with dementia that had a structured assessment of pain/were screened for delirium over the last 10 days/weeks/months.
- **Ongoing outcome measure**: the percentage of patients with dementia that are having a structured assessment of pain/were screened for delirium per day/week/month),

Qu 2: types of QI measures – process measures

A **process measure** looks at the parts or steps in a process that lead to the outcome:

- Are the processes (parts/steps) in the system working as they should?

  - Often ‘times between’

OR

  - Whether ‘good practice is being followed

Qu 2: types of QI measures – process measures

Aim: To increase the percentage of patients with dementia that have a structured assessment of pain/were screened for deliririum by 20% from baseline in the next 6 months.

One **possible** process measure

- Problem: staff don't feel confident to assess for the presence of pain/screen for delirium
- Process measure: staff confidence levels to assess for the presence of pain/screen for delirium

Qu 2: types of QI measures – balancing measures

- Unintended consequences
- Robbing Peter to pay Paul
- What would you worry about?

Example:

YOU: *"We want to increase the time staff spend managing pain/screening for delirium for our patients with dementia.*

THEM: *"What if the care for our other patients is neglected.*

Qu 2: types of data you can collect

- **Numbers (quantitative data)** e.g. time taken; weight.
- **How often things happen** e.g. number of complaints.
- **How you 'rate' something** e.g. 'How would you rate the helpfulness of the training session? (*'poor', 'fair', 'good', 'very good', 'excellent'*).

Qu 2: Choosing your measures

Do	Don't
use data that is either being collected already OR is easy to collect.	choose too many measures.
choose measures that matter to your team.	choose data that is rare and not sensitive enough to show any improvement.

Qu 2: Key learning points

Try to understand and tackle any restrictions to you collecting the data, because:

- if you don't measure, it is impossible to know whether you have improved;
- to understand what your current system is capable of you need a baseline of how you are doing before you test out any change ideas;
- measures should be collected on an on-going basis so you can see your improvement.

Qu 2: Key learning points

Three types of measures that can be used in Quality Improvement work:

1. **Outcome** – relates back to the aim
2. **Process** – looks at the specific steps in a process that lead to the outcome
3. **Balancing** – unintended consequences

Comfort break

10 minutes

2.55

Qu 3: the Model for Improvement

1. What are you trying to accomplish?

2. How will you know that a change is an improvement?

3. What change can you make that will result in improvement?

What change ideas do you want to test?

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3.05

Qu 3: Change ideas

- What is a ‘change idea’?
- Where do you get them?
- How do you work out which you are going to test first?
- How can you tell whether they are making a difference?

Qu 3: What is a ‘change idea’?

A change idea is a specific idea for how you can do thing differently so that you will get the results that you want.

Qu 3: Where do you get change ideas?

A number of possible places:

- The ‘evidence’
- Other services/people’s experiences
- Anyone can have a great idea
- ‘Steal shamelessly’ (remembering you may have to ‘adapt, not adopt’)

Qu 3: using the example

Aim: To increase the percentage of patients with dementia that have a structured assessed of pain by 20% from baseline in the next 6 months. .

Possible causes … and some ideas for changes.

Possible causes	Change ideas
Staff don't feel confident assessing for pain/screening for delirium	Improve staff confidence to assess for pain/screen for delirium
Staff forget to assess for pain/screen for delirium	Test ways of providing prompt to assess for pain/screen for delirium

Qu 3: How do you work out which change ideas you are going to test first?

Things to think about:

- Which are the team most excited about?
- How much effort would be needed?
- Do you need a ‘quick win’?

Qu 3: How can you tell whether your change ideas are making a difference?

- By measuring.
- How do you choose any extra measures?

  - It's sometimes hard to know when you start your project.

  - Extra measures are linked to your 'change ideas' (so you won't know what they are until you have found out what is causing your problem).

Qu 3: Some examples

Causes	Change idea	Measure
Staff don't feel confident assessing for pain/screening for delirium	Improve staff confidence	Self rating of confidence before and after training

Causes	Change idea	Measure
Staff forget to assess for pain/screen for delirium	Test prompts to remind them	The percentage of patients that receive appropriate assessments for pain/delirium screening

Do you need another measure?

.... an **outcome measure**?

.... a **process measure**?

.... a **balancing measure**?

Remember:

- You can have any mixture of these measures
- Not necessarily all 3 types
- And not too many!

Qu 3/2: testing change ideas and measuring impact

- Work in groups. Thinking about the aim your group agreed earlier:
    1. agree a change idea that you would test first; and
    2. suggest how you would measure its impact.
    3. When you have finished, write your change idea and measure on the Jam board.
- You have 7 minutes.

3.25

Qu 3: Key learning points

- A change idea is a specific idea for how you can do things differently so that you get the results that you want.
- Your team may come up with a lot of ideas, so choose carefully.
- You may need to add an extra measure to show whether you change idea is working.
- Some change ideas work better than others, so choose the best ones.

PDSAs: the Model for Improvement

1. What are you trying to accomplish?

2. How will you know that a change is an improvement?

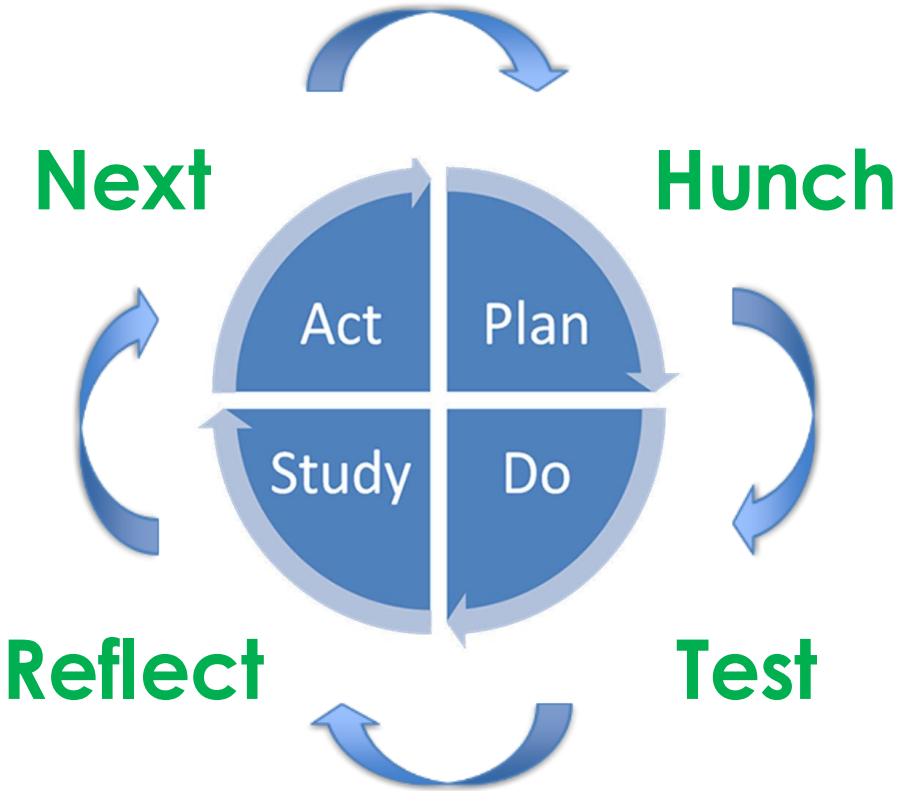
3. What change can you make that will result in improvement?

Rapid small tests of the change idea.

3.35

Langley G, Nolan K, Nolan T, Norman C, Provost L, (1996), *The improvement guide: a practical approach to enhancing organisational performance*, Jossey Bass Publishers, San Francisco

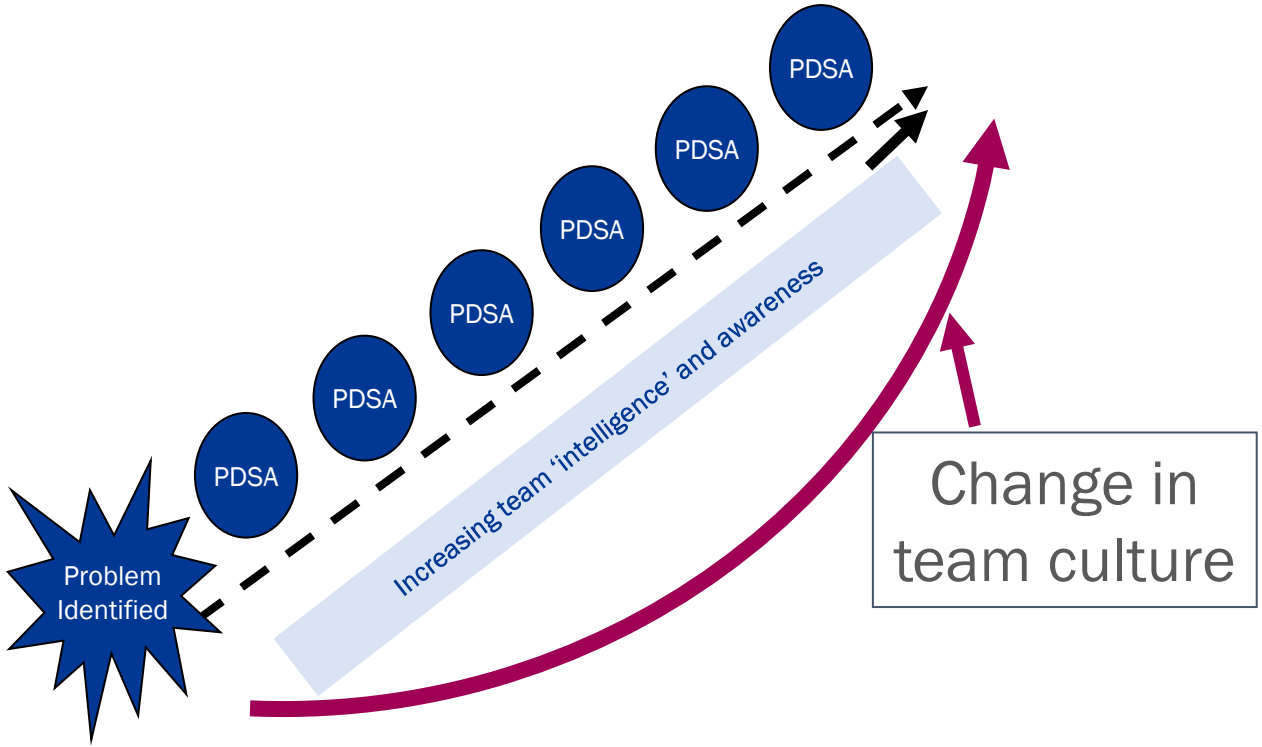
PDSAs



Change ideas and PDSA cycles

Aim: to lose 2 kilos so you can fit into your favourite outfit for a friend's birthday.	
Change Ideas	PDSAs
Eat fewer calories	Try the cabbage diet Stop eating snacks Eat more vegetables … and on
Burn more calories	Go to the gym twice a week Cycle to work Use the stairs instead of the lift … and on
WHAT	HOW

PDSAs: Working together for improvement

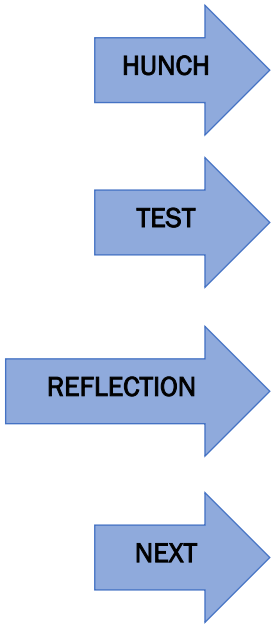


PDSAs: Why use PDSA cycles?

Small rapid tests of what does (or doesn't) work:

- You get less resistance.
- You can find out whether the change will work in the actual environment.
- It's safe and 'low risk' because you are testing and improving the way you do it before being you 'spread' on a broader scale (if at all).
- You keep increasing the rigor of the testing.

PDSAs: a prompt sheet



Team name:	
Who has responsibility for this PDSA cycle?	
What are you hoping to find out?	
Plan (Complete when you are developing your improvement plan for this cycle)	What are you going to do? Who will be involved and how? When will it take place? How will it be done? What will you measure? What are your expectations?
Do (Did) (Complete once you have carried out your improvement idea)	How did you implement the plan? Did you encounter any unexpected problems? Did you achieve any unexpected benefits?
Study (Studied) (Complete once you have reviewed your results)	What results did you achieve? Did they differ from your expectations? How? What have you learnt from this cycle?
Act (Acted) (Complete when you are planning your next improvement cycle)	What action will you now take to either: Refine and re-test your improvement idea? Implement and embed the change? Reject the idea and prepare to test a new one?

PDSAs: Key learning points

- Change ideas are the ‘WHAT’ you want to test.
- PDSA cycles are the ‘HOW’ you want to test your change ideas.
- PDSAs cycles are used for small and rapid testing – *‘What can you do by next Tuesday?’*

Next steps: planning your QI project

- Work in groups.
- Discuss the problem that you plan to tackle. If possible, come up with:
  - an outline of the diagnostic work you need to do;
  - ideas about who needs to be in your team;
- Write these on the Jam board.

3.45

What happens next?

Have a go yourselves!

We have recorded a series of videos to support you and your Team. They are all brief, accessible and repeatable.

1. Agree what you are going to tackle and choose your Team.
2. Work out what's causing your problem.
3. Agree how much improvement you want, and the types of change ideas you might test out.
4. Work out how you'll measure your progress.

The videos are accompanied by a Guide Book.