Demand, Capacity & Flow QI Collaborative

Learning Set 2
Tuesday 4 July 2023

Demand, Capacity & Flow
Quality Improvement Collaborative

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Housekeeping

- No fire alarm tests are planned for today.
- Toilets are located to the right of the lifts on level 1 and the ground floor.
- Lunch will be from 12.30-1.15pm and will be served at the back of the main auditorium.
- **Room 1.1** is also available if anyone needs to take a break at any point or needs some space on their own.
- If you need to take a phone call or attend to an email during a presentation, please kindly leave the room.

Twitter

- We will be live tweeting this event so you may see the QI coaches on their phones during some sessions. Please also find and follow us **@NCCMentalHealth** or search for **#DCFQI**.
- We encourage use of Twitter and social media to share the work that you are doing throughout the collaborative.
- However, we kindly ask you not to tweet people's names, photographs of people's faces or their talks without their permission.

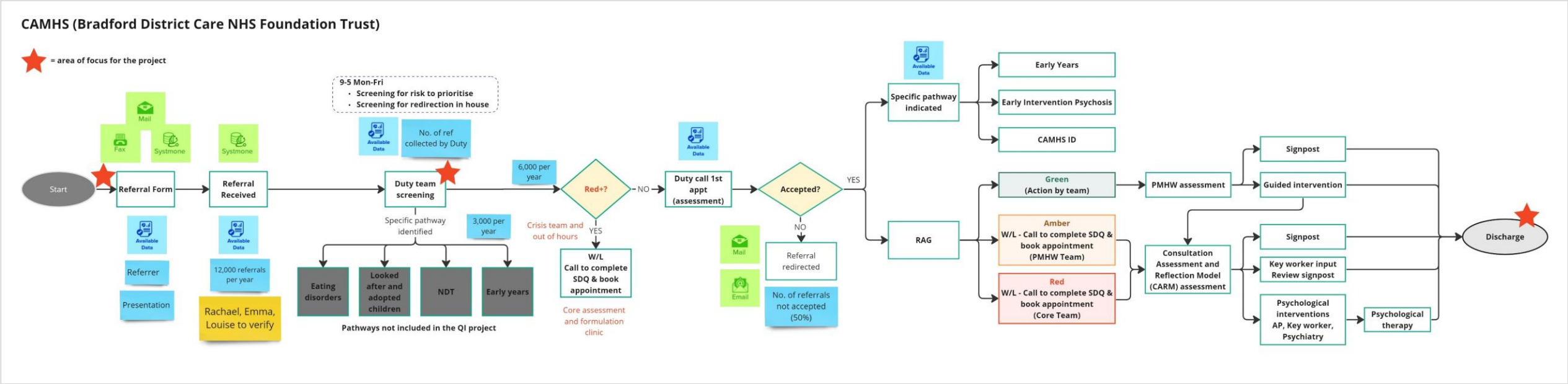
Thank you!!

Agenda

Time	Item	Speaker
10:30-10.40	Welcome and housekeeping	Emily Cannon, Head of Quality Improvement, NCCMH
10.40-10.50	Networking	All
10.50-11.55	Three DCF teams share their progress and learning so far	• Improving Access to Psychological Therapies (West London NHS Trust) • Adult Community Mental Health Team (Kent and Medway NHS and Social Care Partnership Trust) • Autism Spectrum Service (Cambridge and Peterborough NHS Foundation Trust)
11.55-12.30	Review driver diagrams and generate change ideas	All
12.30-13.15	LUNCH	
13.15-14.00	Plan-Do-Study-Act (PDSA) cycles in action	Renata Souza and Aarti Gandesha, QI Coaches, NCCMH
14:00–14.50	Co-production workshop	Sarah Markham and Ben, Patient/Carer representatives, NCCMH
14.50-15.00	Close	Saiqa Akhtar, Senior Quality Improvement Advisor, NCCMH

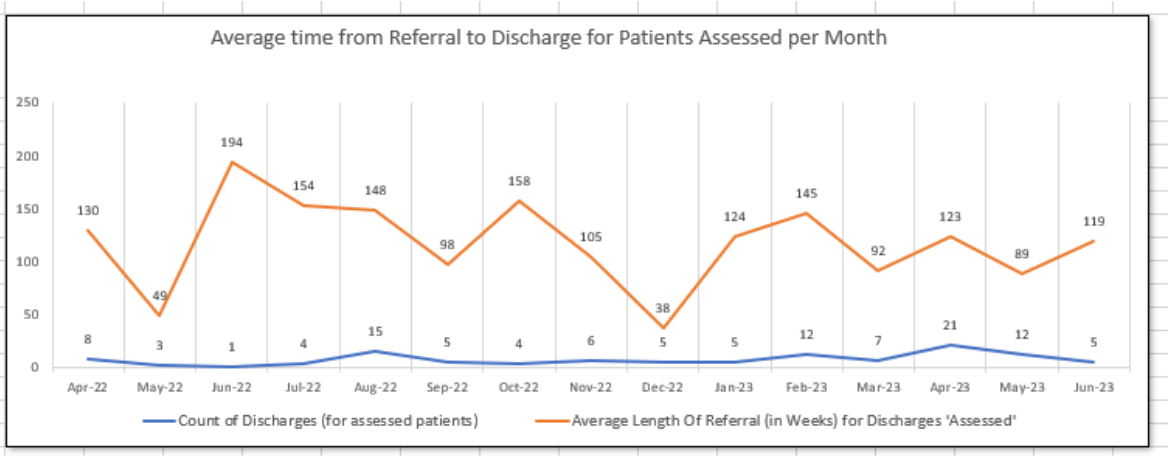
Since the last learning set (April)…

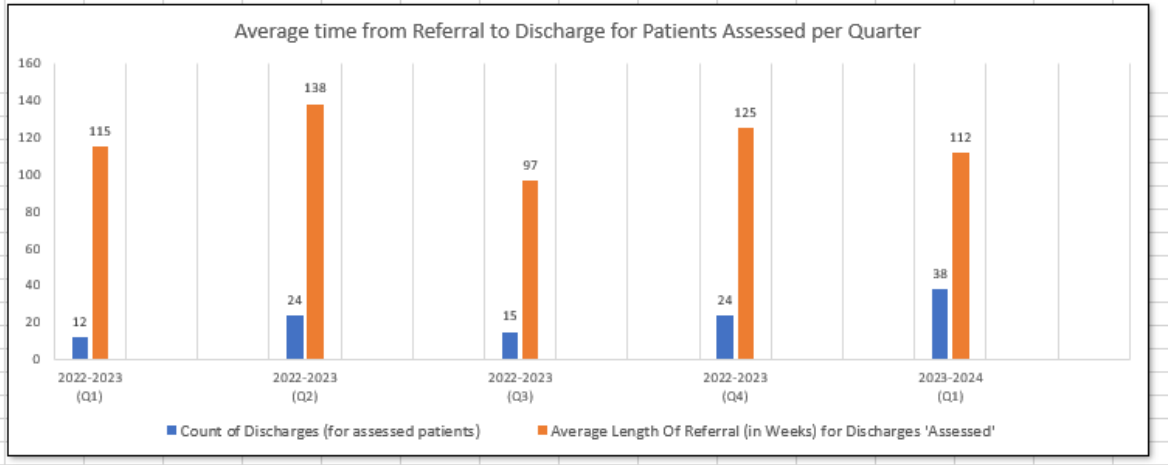
Teams have finalised their flow charts…



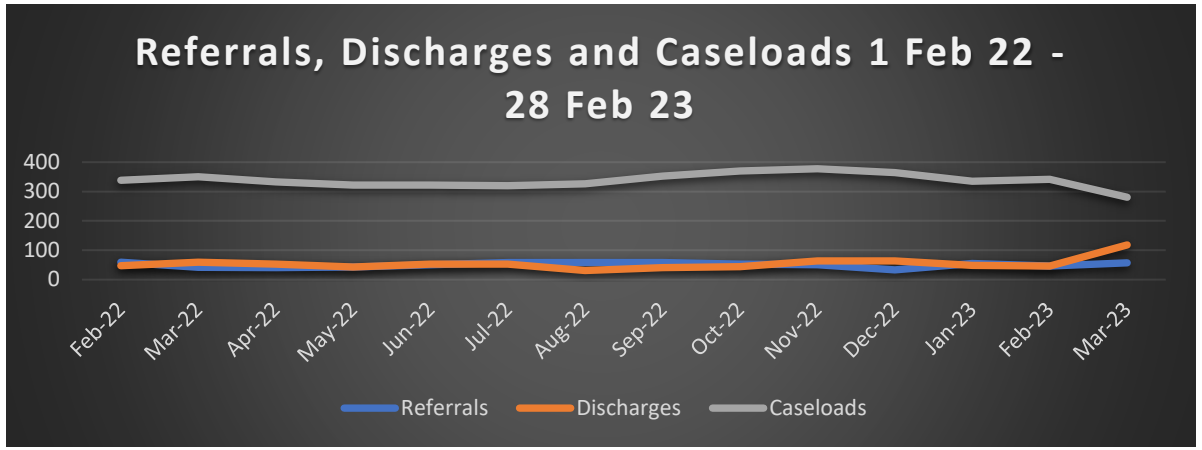
Have been reviewing data to better understand demand and capacity...

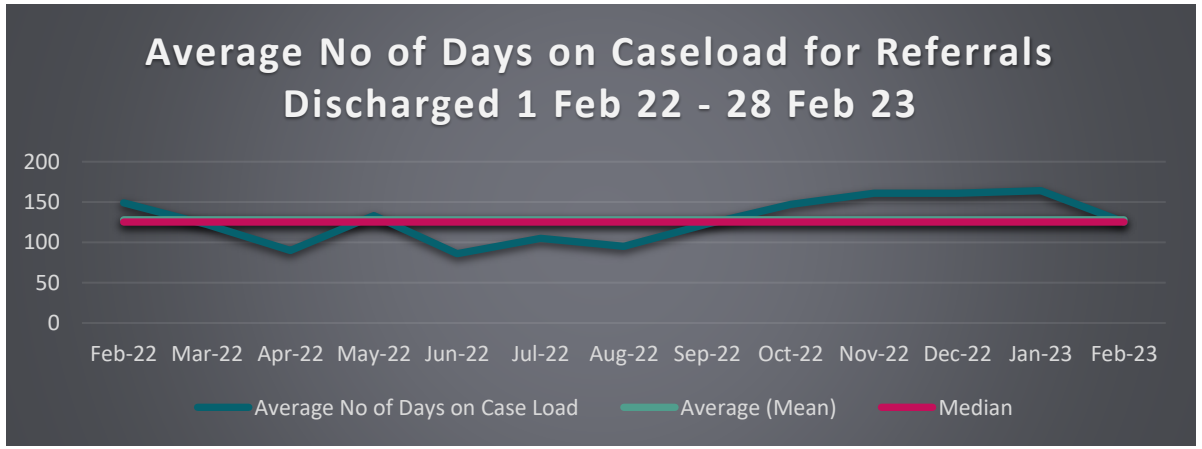
Adult Autism Team (North-East London NHS Foundation Trust)





North and West Older Adults CMHT (Oxford Health NHS Foundation Trust)





Are finalising their project aims...

100% of routine referrals an assessment within 6 weeks and 100% of urgent referrals to have an assessment within 48 hours by July 2024.

Havering Mental Health and Wellness Team (North-East London Foundation Trust)

Ensure 95% of referrals have an outcome within 7 working days

Hounslow IAPT (West London NHS Trust)

AIM STATEMENTS

To reduce the average time patients are on the caseload by 10%, by April 2024

North and West Older Adults CMHT (Oxford Health NHS Foundation Trust)

To reduce waiting times from referral to diagnosis by 35% by July 2024

Memory Assessment Service (Bradford District Care NHS Foundation Trust)

Reduce the time taken that patients are waiting from referral to assessment by 50% by January 2024

Wellbeing Team (Coventry and Warwickshire Partnership NHS Trust)

To reduce the average waiting times from referral to assessment for patients waiting longer than 52 weeks, by X% by June 2024.

Adult Autism Team (North-East London Foundation Trust)

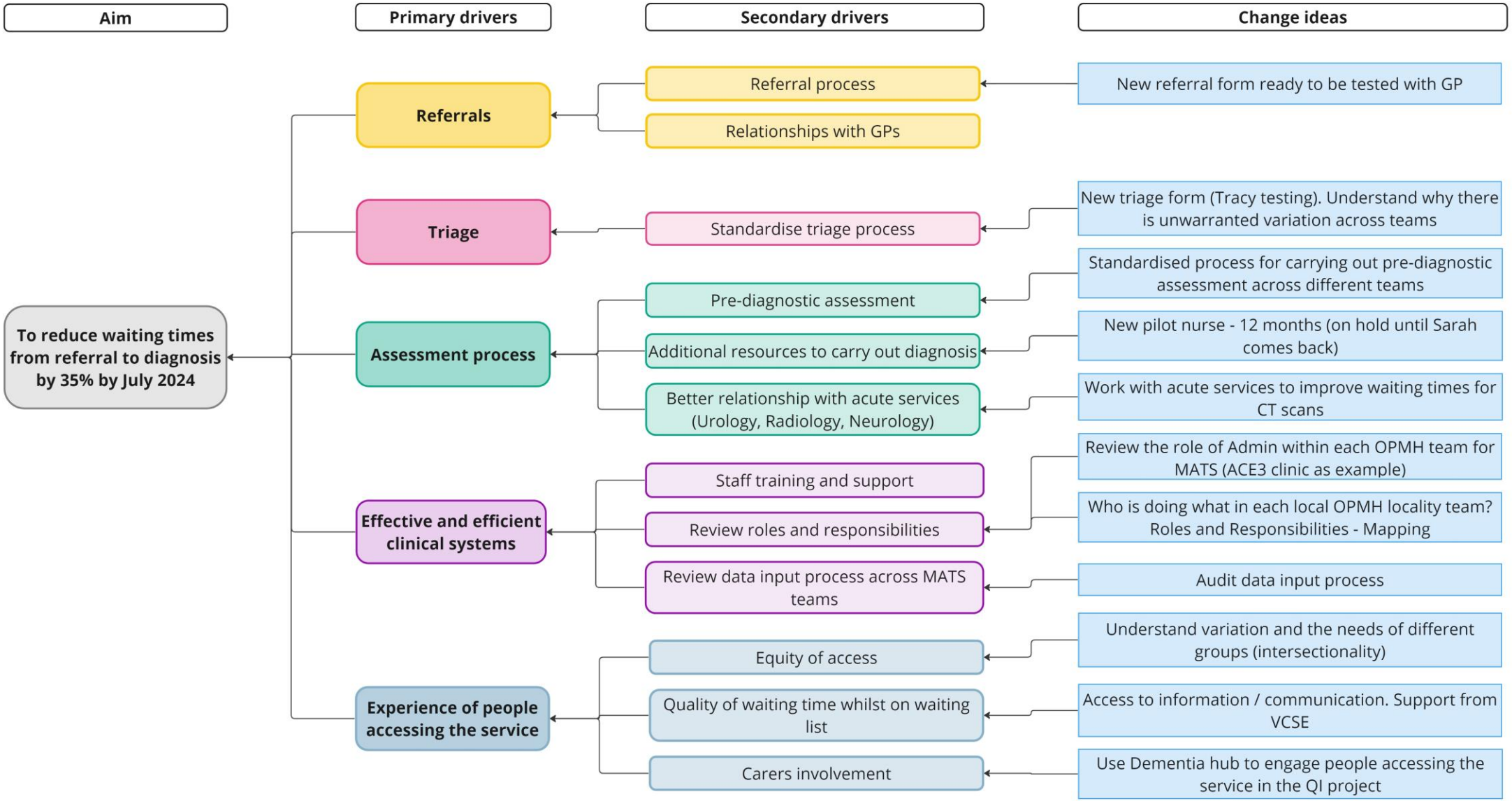
And developing their driver diagrams...

CHESHIRE AND WIRRAL - COMPLEX NEEDS SERVICE (CNS)

Aim, driver diagram and measured based on West CNS, with view to apply to learning and good practice to Wirral and East

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
Increase access to the complex needs service, including access to intervention and support to wider system, by X% by June 2024.	**Manage demand and support the wider system**	Primary care interface meeting	Joint assessments to ensure patients are on the right pathway
		Upskill external staff	Training offer
		Promote and increase consultation offer	'Champions' to become experts in offer of CNS
		Support CMHT staff to deliver SCM	Monitor length of time to do consultations - impact on staff capacity
		Utilise link workers to communicate service offer and manage expectations	1 hr drop in sessions for new staff to give overview of service offer
	Improve patient flow and experience from referral to treatment	Reduce waiting time from referral to assessment	Stagger assessments to improve patient flow
		Reduce waiting time from assessment to treatment	Information pathway
		Patient engagement throughout referral process	Map out local support / signposting for patients and carers
		Information and support for patients and carers	Review of reasonable adjustments that service offers
	Deliver more interventions	Increase staff capacity	Use assessment slots as treatment slots
		Staff wellbeing / retaining staff	Link in with trust wide people plan re retainment of staff

Memory Assessment and Treatment Service (Bradford District Care NHS Foundation Trust)

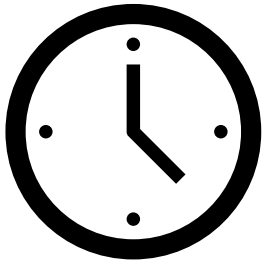


NORTH EAST LONDON FOUNDATION TRUST - HAVERING CAMHS

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS
Increase the number of discharges from Havering CAMHS by 25% in July 2024.	**Clear discharge processes and oversight of discharge**	Embed 'I Thrive Model'
		Clear discharge pathway
		Embed readmittance procedure
		Staff confidence
	Care planning	Embed 'I Thrive Model'
		Work with external agencies (e.g. GPs)
		Care plans developed with 'I statements' (patient centred)
		Oversight of intervention pathways
	Improve patient flow in the intervention pathway	Embed 'I Thrive Model'
		Work with external agencies (e.g. GPs)
		Transfer of cases
		Management of caseloads
	Improve patient/carer information and support	Embed 'I Thrive Model'
		Consistent and ongoing communication about discharge
		Patient supported to be independent and feel safe and confident on discharge
		Clear communication about CAMHS service offer and post-discharge support

Networking

- **Form a group of 3/4 people that you don't know**
- **Share something that you've achieved/are proud of in your DCF project, since the last learning set (April)**



10 minutes

Three DCF teams share their progress and learning so far

Saiqa Akhtar
Senior Quality Improvement Advisor, NCCMH

Three DCF teams share their progress and learning so far

- **30 minutes (10:50-11:20):** First team of choice
- **5 minutes (11:20-11:25):** Move to your next team / room
- **30 minutes (11:25-11:55):** Second team of choice

Team presenting	Room
Improving Access to Psychological Therapies (West London NHS Trust)	**1.2-4**
Adult Community Mental Health Team (Kent and Medway NHS and Social Care Partnership Trust)	**1.1**
Autism Spectrum Service (Cambridge and Peterborough NHS Foundation Trust)	**1.7**

Promoting hope and wellbeing together

West London NHS Trust

Hounslow IAPT

Improving access to psychological therapies in Hounslow

Annabelle Norman, Lena Paul, Vanessa Papas, Rose Baverstock, Jake Domingo, Zach Glaser, Sam Pye, Hannah Spencer, Sue Lewis

NHS West London NHS Trust

About Our Service

- Primary care psychological therapies service offering brief intervention for mild to moderate mental health difficulties
- Types of difficulties: Depression, Generalised Anxiety, Social Anxiety, Health Anxiety, Panic Disorder, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder, Specific Phobias, Body Dysmorphic Disorder
- We cover the whole borough of Hounslow (approx. 293,000 residents)
- **Key targets:** ***Access:*** 583 new Ax/month and ***Recovery rate:*** 50% of people need to recover/sub-clinical on self report measures for anxiety and depression at discharge. ***Waiting times-*** 75% of people referred to IAPT services should start treatment within 6 weeks of referral, and 95% should start treatment within 18 weeks of referral.
- **Referral routes:** majority self-referral but also GP, secondary care, perinatal services, social services, physical health care services.

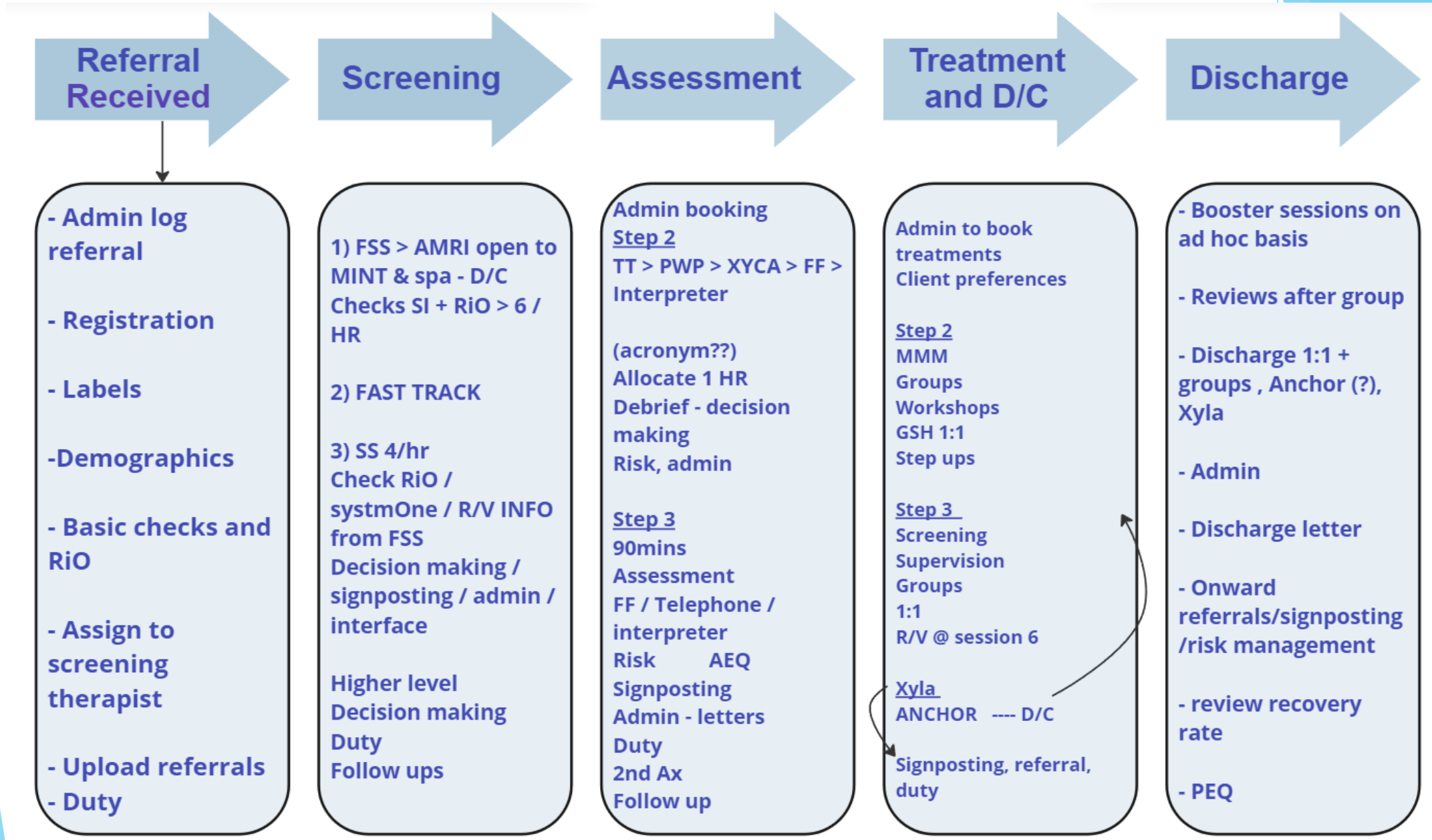
Our QI project team

- Range of clinical professionals and expert by experience

Clinical leads, Deputy clinical lead, Senior CBT therapist, CBT Therapist, Lead PWP, PWP, Assistant Psychologist

- Having a range of experience has helped gather different viewpoints and ideas

- The team meets for 1-2 hours every 2 weeks to build on the project between the learning sets.


Referral Received
Screening
Assessment
Treatment and D/C
Discharge
- Admin log referral
- Registration
- Labels
-Demographics
- Basic checks and RiO
- Assign to screening therapist
- Upload referrals
- Duty
1) FSS > AMRI open to MINT & spa - D/C Checks SI + RiO > 6 / HR
2) FAST TRACK
3) SS 4/hr
Check RiO / systmOne / R/V INFO from FSS
Decision making / signposting / admin / interface
Higher level Decision making
Duty
Follow ups
Admin booking
Step 2
TT > PWP > XYCA > FF > Interpreter
(acronym??)
Allocate 1 HR
Debrief - decision making
Risk, admin
Step 3
90mins
Assessment
FF / Telephone / interpreter
Risk AEQ
Signposting
Admin - letters
Duty
2nd Ax
Follow up
Admin to book treatments
Client preferences
Step 2
MMM
Groups
Workshops
GSH 1:1
Step ups
Step 3
Screening
Supervision
Groups
1:1
R/V @ session 6
Xyla
ANCHOR ---- D/C
Signposting, referral, duty
- Booster sessions on ad hoc basis
- Reviews after group
- Discharge 1:1 + groups , Anchor (?), Xyla
- Admin
- Discharge letter
- Onward referrals/signposting /risk management
- review recovery rate
- PEQ

Areas of focus- Screening

- Long backlog at Standard Screening, up to 155 in April 2023
- Disparity between referrals, some service users waiting longer than others for screening outcomes
- Feedback from Step 3 clinicians that standard screening often takes longer than time allocated
- Awaiting Missing Risk Information (AMRI) stage causing delays and requires staff (on a rota system) to monitor this stage
- Desire to improve service user experience of referral process

Disparities in screening

- In total, over this 6-month period (Jan – June), 79.6% of referrals were screened within 7 working days.
- When comparing how many referrals are screened into either a step 2 assessment or a step 3 assessment in 7 working days:

Step 2 assessment	Step 3 assessment
↓	↓
93.2%	37%

- This means individuals requiring a step 3 assessment will tend to wait longer before a screening decision is made

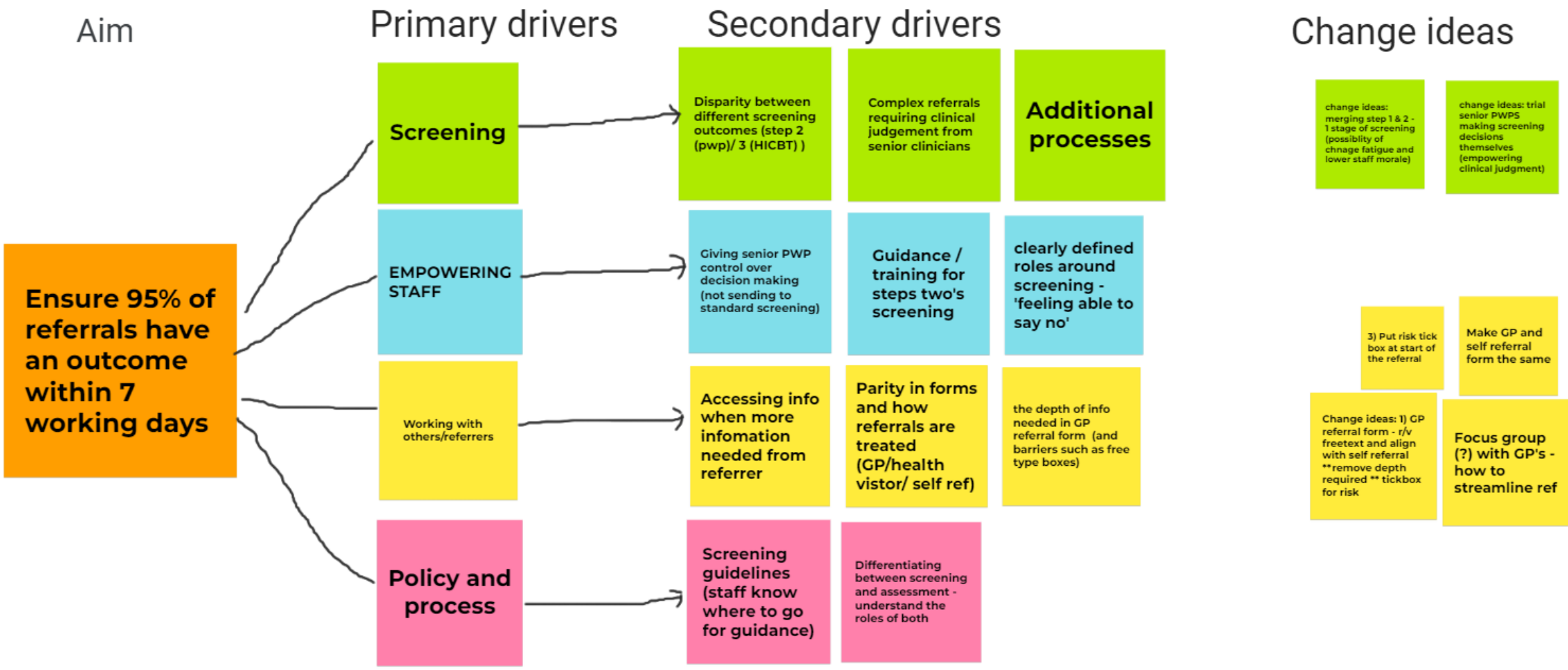
Project Aim Statement

- **What?** Reduce the length of time service users wait from referral received to having an outcome e.g. discharge or entering WL for assessment at S2, S3 and counselling

- **How good?** Have 95% of referrals screened within 7 working days

- **By when?** By November 2023 (6 months)

Driver diagram



Change Ideas- brainstorming

Removal of AMRI stage	To cut down number of screening stages to just 1	If AMRI eliminated, have a clear guidelines on what happens when essential info is missing
Removal of AMRI and then updating referral form to say if there's missing info then the referral will be rejected)	Having senior people being able to debrief or supervise screening decisions	Having clear ineligibility criteria for assessments (who would we not accept)
GP referral form - have a 'what is reason for the referral' - then select from presenting problems that IAPT support including 'other'	Tighten up process and polices around safeguarding (including perpetrators)	If stages are merged, have training for first stage screeners so they don't feel thrown into it
Create a pathway amongst more experienced PWPs to be trained in standard screening	stream line screening policy to reduce confusion	If stages of screening stay the same, more time allocated for first stage screening
First stage screener being able to make a decision about step three as without having to move to standard screening	having a daily screening debrief	Communication to all GP surgeries in borough to put IAPT on website and raise awareness of self referrals
Software to send referrals to certain stage automatically	improve letter templates for discharge when screening is rejected - worded in softer and more informative way	Refresher training for staff (even half an hour) around screening
To empower step 1 and 2 - increase supervision on a short term basis	Make GP referral form the same as all the other referral forms	Screeners checklist - checklist screening system to replace a flowchart.
	No free text on referral forms	New roles: Mental Health Practitioner role to replace Duty, Debrief Screening.
	Put the risk questions somewhere prominant on form and make it clear if not answered it is rejected	New role: Band 6 PWP care co-ordinator role (Screening role)

Key achievements and learning so far

- Establishing a committed QI team
- Understanding the service stages in more depth through process mapping- helped to consider all areas which could impact flow
- Data analysis – baseline data evidencing the extent of the disparity between Stage 1 and Stage 2 Screening stages
- Recognising the efficiency of Stage 1 screening (i.e. 93% of referrals have an outcome within 7 working days)
- Identifying change ideas that will improve client and staff experience
- Service wide involvement where possible

Any questions for participants to help you progress your work?

This can relate to service user involvement, areas of focus identified for the project, change ideas, barriers to progressing the work, etc

What have you done to engage the wider team?

Are there any platforms or tools you would recommend?

What is the process for screening referrals in your service?

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Kent and Medway NHS and Social Care Partnership Trust

Dartford, Gravesend and Swanley Community Mental Health Team

Presenters:

Dr K Valsraj - Deputy Chief Medical Officer for Quality and Safety and Consultant Psychiatrist

Albert Kemp – Quality Improvement Advanced Practitioner

Keri David-Valentine – General Manager North Directorate

Brilliant care through brilliant people

Our QI project team

- Dr K Valsraj – Deputy Chief Medical Officer for Quality and Safety and Consultant Psychiatrist
- Keri David Valentine – General Manager North Kent Directorate
- Albert Kemp – Quality Improvement Advanced Practitioner
- Cally Henderson – Business Intelligence Partner North Kent Directorate
- Jess Hufflett – Occupational Therapist
- Alison Hall – Interim Consultant Psychotherapist and Service Lead
- Jess Delo – Clinical Associate Psychologist
- Rupy Thind – Business Admin Coordinator
- Gordon McKay – Service Manager CMHT, Older Adults and Rough Sleepers
- Renata Souza – Quality Improvement Coach (RCPsych)

Why we joined the collaborative

- There is a need to think of creative ways to improve capacity with the resources available.
- Where we are not hiring new people but are for example, improving the current processes.
- There is the potential to do things better, for example by **identifying bottlenecks** and **saving time**, therefore **increasing capacity** by utilising existing resources.

Our service

- Provision of service for all adults of working age - approx. 250,000 people
- Case load of approx. 1,200
- On average, the team have 25-50 referrals a week
- Referrals come from GP, other primary care, self-referral
- There are 3 separate localities that work as one team

MDT team

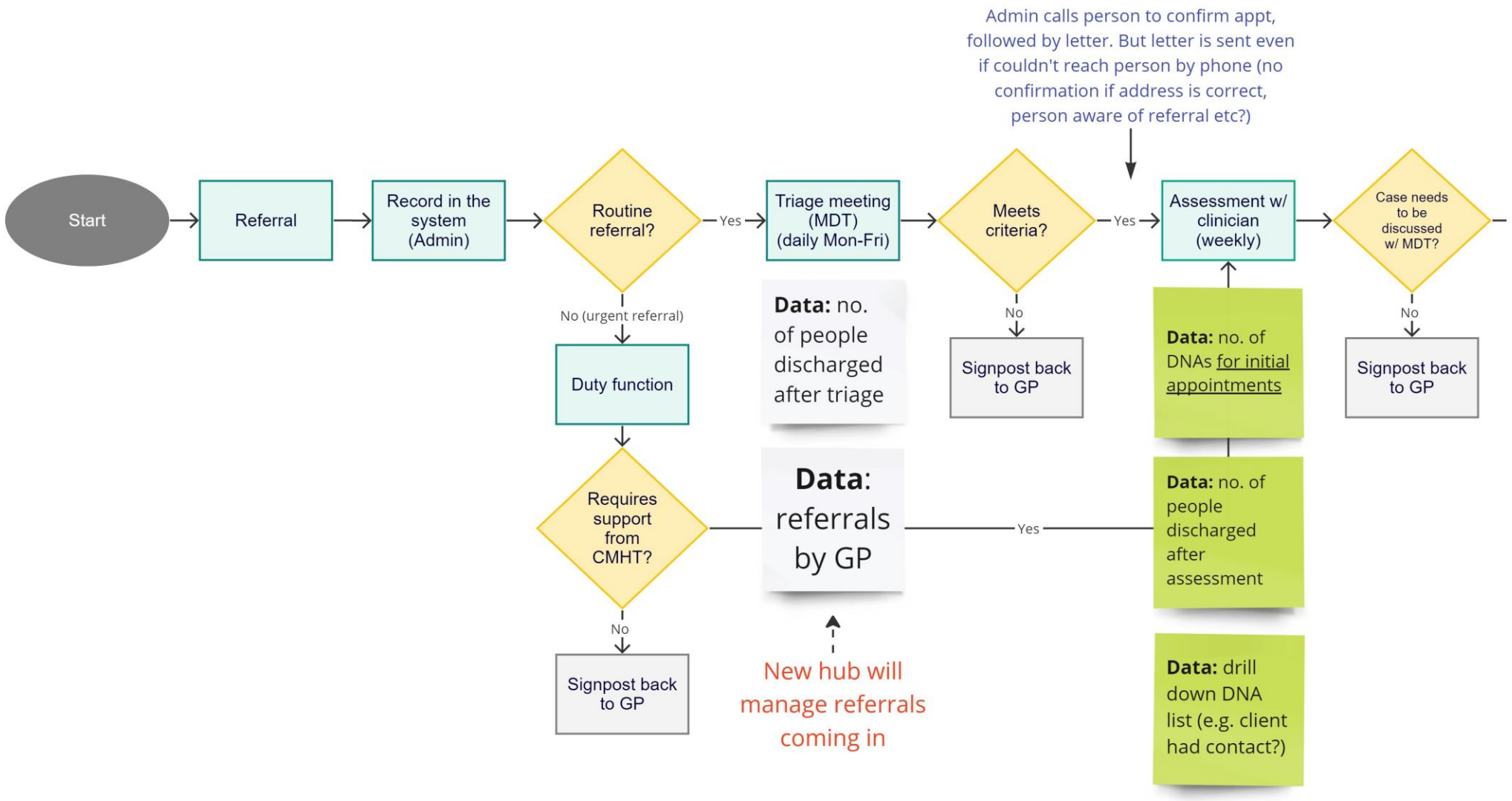
- 3 Consultants
- 2 Team Leader & Team Manager
- 10 Community Mental Health Nurses
- 1 Occupational Therapist
- 5 Mental Health Nurses & Mental Health Well-being Practitioners
- 5 Psychologists
- 4 Care Support Workers
- 1 Peer Support Worker

Flow chart of the patient journey through the Community Mental Health pathway

Brilliant care through brilliant people

RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

= area of focus for the project



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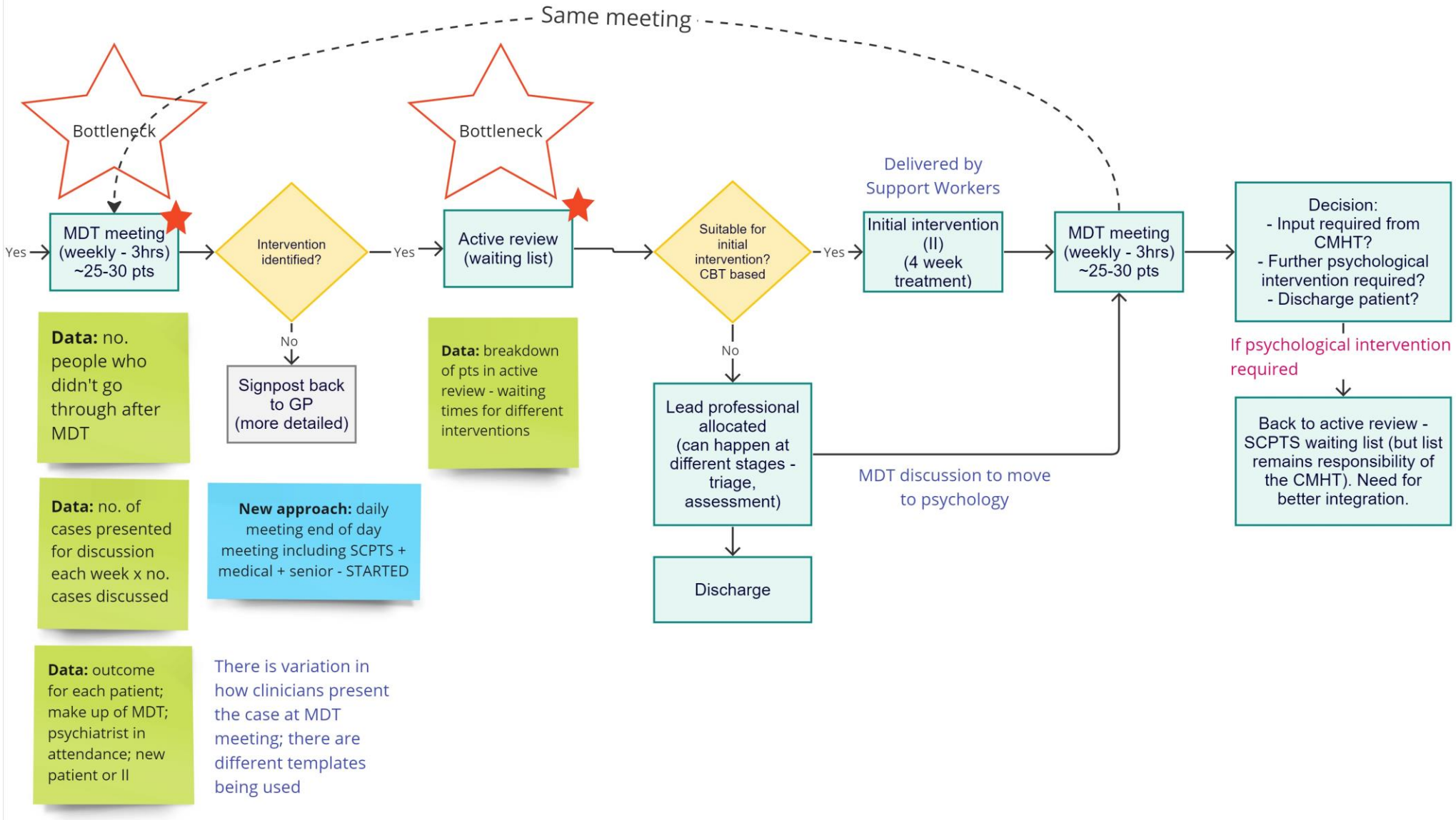
RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE



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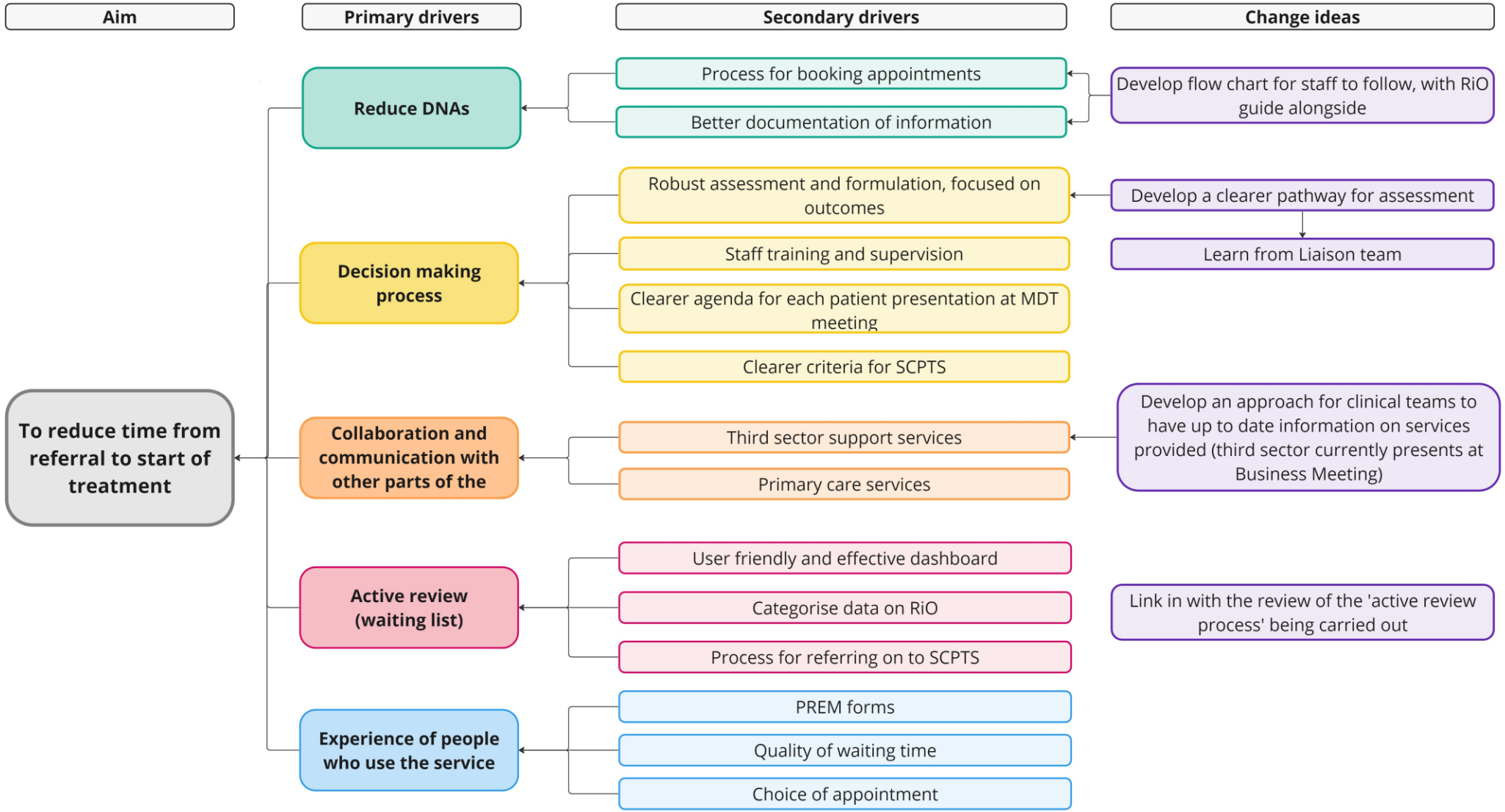
RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Key bottlenecks

Multi-disciplinary (MDT) meeting	We have determined that only **50%** of planned patients are discussed in the MDT meeting. This creates delays for those patients.
Waiting list (active review)	There are currently **300 patients** on the team waiting list (active review).
DNA (did not attend) numbers	DNA numbers (on 2 or more occasions) are **high.** For example, of the 6057 referrals, there were 1408 DNAs, which converts to a **23.25% DNA rate**.

Driver Diagram



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RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Challenges

- We are still working to make the aim SMART, as the data is not very accurate.

For example, the way the data is recorded does not reflect the reality. Treatment starts at a certain point, but the system classifies 'treatment' when it is for a session greater than 30 mins. Therefore, the picture that the system is showing is inaccurate, representing shorter waiting times than is present in reality. **We estimate that it is 3-6 months and approximately 300 people are waiting on "active review"** (waiting list)

- We are struggling to identify a service user to engage in the project.

- The team is changing - members of the project team are changing roles and there is a lack of consistency.

Key achievements and learning so far

- The project has enabled different disciplines within the team (e.g. Psychology, Nursing, Admin, Occupational Therapy, Medical, Business Intelligence) to take the time to work together and use their individual skills and expertise.

- Bringing the data into the day-to-day work has been insightful and has allowed the team to work closer with data colleagues in order to better understand and improve the service, so the work is informed by data and is not guess work.

- Improving the MDT meeting has already been identified as a key area for improvement within this project.

Questions and discussion

Cambridgeshire & Peterborough NHS Foundation Trust

Cambridgeshire Lifespan Autism Spectrum Service (CLASS)

Janine Robinson

Kailash Ludhor

Andrea Woods

Susanna Snell

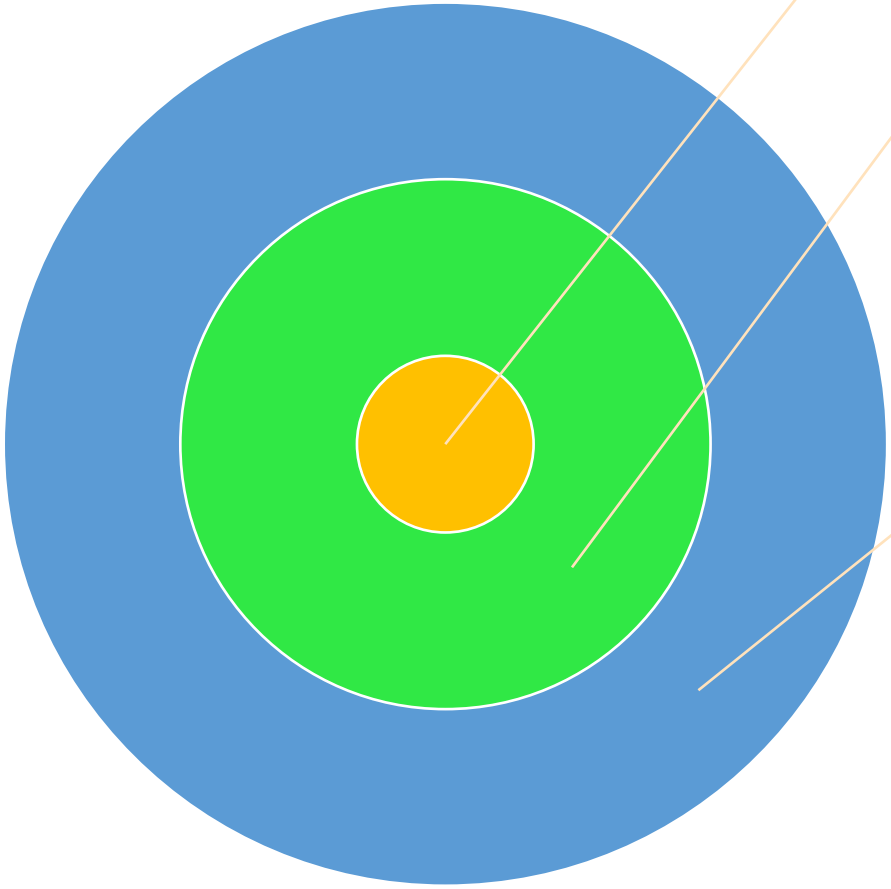
Irene James

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Our service

Specialist service	• Well-established service evolved from a charitably funded national service model (1999) • Commissioned to assess autism in adults 18+ years (without a LD diagnosis) • Serving people in C&P area, provided GP falls within commissioning region • Expanded commissioning to include time-limited, focused period of psychoeducation
Referral criteria/processes	• No self-referrals • GP referral processed by Primary Care Mental Health Service • Internal CPFT referrals from other CPFT mental health services, Staff mental health/occupational health • Right to choose
Commissioned to assess 300 people per year	• Referral rate increased over past 2 years • Demand exceed capacity • Training/liaison/capacity building
Multidisciplinary team	• Nursing, occupational therapy, psychology, psychiatry supported by administrative team • Trainees/students • Research support • Current vacancies – new posts to be advertised: OT and speech and language therapy • PPI group • Volunteer –Overseeing our Library

Our QI project team



Core CLASS project team:

Project Lead: KL

Administration: IF

Clinical & project support: KT & IJ

Clinical Lead Referral/Screening Triage: AW

Clinical Lead Assessment: JR

Clinical Leads Post diagnostic support: AW&SS

Lived Experience representative: AH

Fortnightly wider CLASS team meetings:

Management support & input

Clinical review and input

RCPsych input & Support

CPFT QI Advisor

Lived experience

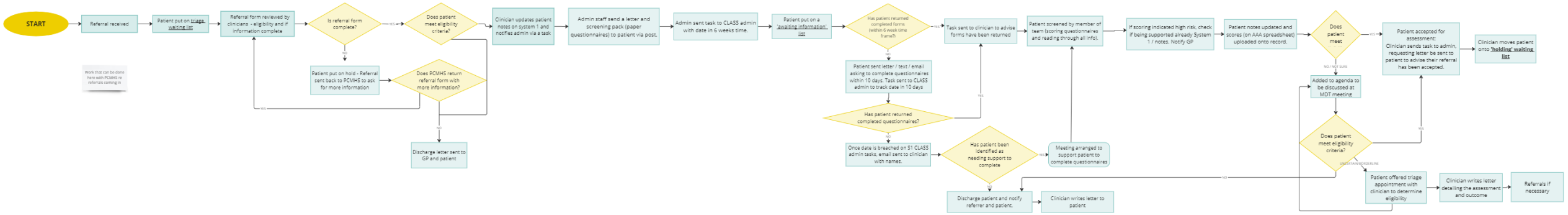
Wider networks & stakeholders:

Lived experience

Quarterly Learning Sets

Flow chart of CLASS pathway

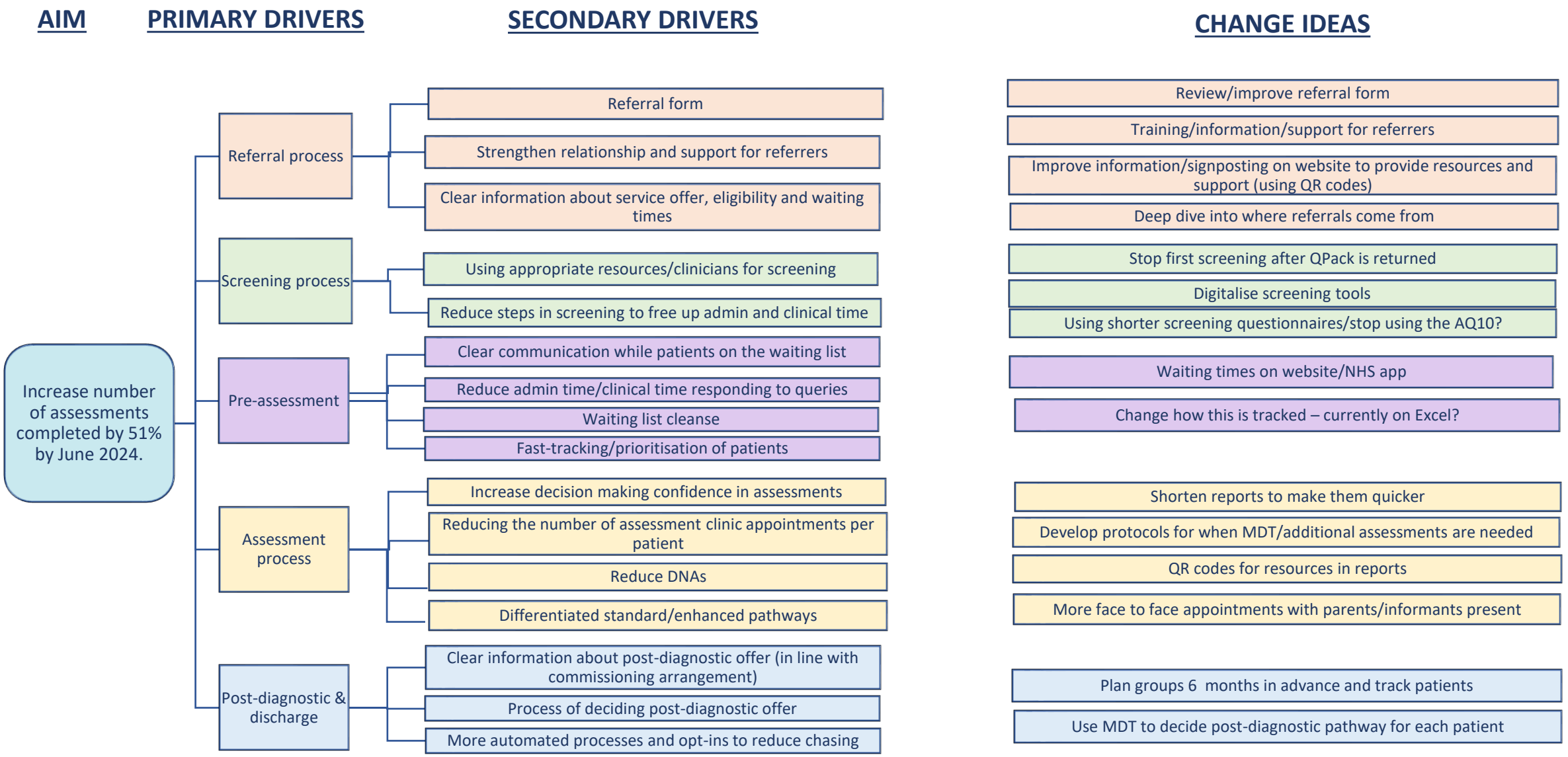
Mapped from referral > screening > waiting list > assessment > post diagnostic > discharge



Areas of focus: challenges/bottlenecks/data

Stage1	Stage 2	Stage 3	Stage 4	Stage 5
Identification & referral	**Screening & Triage**	**Pre-assessment**	**Assessment**	**Post-assessment/diagnosis**
Increase in referrals+++ 2019-2020 = 430 2022-2023 = 887 106% increase	2-stage screening time intensive	Long waits	Complete change in assessment processes since pandemic Conversion rates: 2019 80% 2023 79%	Reports lengthy/variable and take long Reports can be late owing to caseload and gaps for report writing Expectations/value of reports for whom
Increase in complexity	New process of triage – extra work or valuable/necessary	More people in crisis	More choice for people but impact on service is clear	Commissioned for psychoeducation Also offer sensory assessments, sensory group, vocational support, etc.,
Poor quality referrals	Backlog & new referrals – need dedicated time of several people to keep on top of task	Requests to expedite+++ Results in MDT decisions and admin	More DNAs More time More difficult to get information	Evaluation not yet completed Too much choice might be overwhelming/limits offer for everyone
Change in process – no longer PCMH screening Possibly more inappropriate referrals Chasing information • Admin time • Delays for patient	Reflect on purpose of screening and triage If most get a Dx then should we accept everyone? Is screening/triage useful for certain purposes, e.g., discharge or planning assessment? If spend 1 hour with patient and Dx is highly likely why not Dx then? Duplication/Paperwork administration	Extends waiting time for others Whose responsibility to support? How much information to give, when and in what format? Texts/QR codes/letters? Keeping track of addresses/contact details, moving out of area/temporary addresses	A factor of pandemic Length of period on waiting list and increase in anxiety? Greater expectations of service New way of working – untested and less confident Easier to offer additional clinic slots online if unsure Not sure when is enough information Need to examine if conversion rates are lower	Chasing to get people signed up Extended periods before discharge from service More involved with people the greater the unmet need is in evidence CLASS takes on the work as others close their doors Model not sustainable given numbers/pressure for assessment/diagnostic clinicians' time

Our project driver diagram



Key achievements and learning so far

- Deep dive into process from start to finish -
  - Created an opportunity to map out the pathway / visual representation of complexity
  - Generated thought-provoking conversation
  - Whole team approach - new and experienced staff.
- Viewing process from all perspectives, including service user involvement
- Willingness to be bold in piloting change provided ethical and safe
- Drilling down into what is measurable and what will constitute improvement
- Acknowledgement of complexity of change in service (expansion of team, delivery objectives, delivery models) and context of commissioning changes and pandemic-associated changes to service delivery (online)
- Reflection on past and present system and confidence to work differently

Thank you! Questions for you…

- As part of your QI process are you planning to streamline any referral (front door) process, or the evaluation / assessment process ? Have you found any non-value adding steps within your process?

- Is there any part of the process that can be automated (AI)?

- Looking back at the current process and demand on the service (post Covid) tell us one thing you will stop doing / review to optimise quality and enhance patient experience.

Review driver diagrams and generate change ideas

Amar Shah
National Improvement Lead, NCCMH

Demand, Capacity & Flow
Quality Improvement Collaborative

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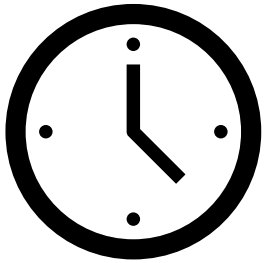
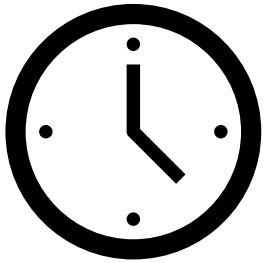
- **Review/continue working on your driver diagram**
- **Start to generate and prioritise your change ideas**



20 minutes

- **Speak to other teams and learn more about each other's projects**

At least one team member stays at the table to discuss your project



20 minutes

Lunch

12.30-13.15

Plan-Do-Study-Act (PDSA) cycles in action

Renata Souza and Aarti Gandesha

Quality Improvement Coaches, NCCMH

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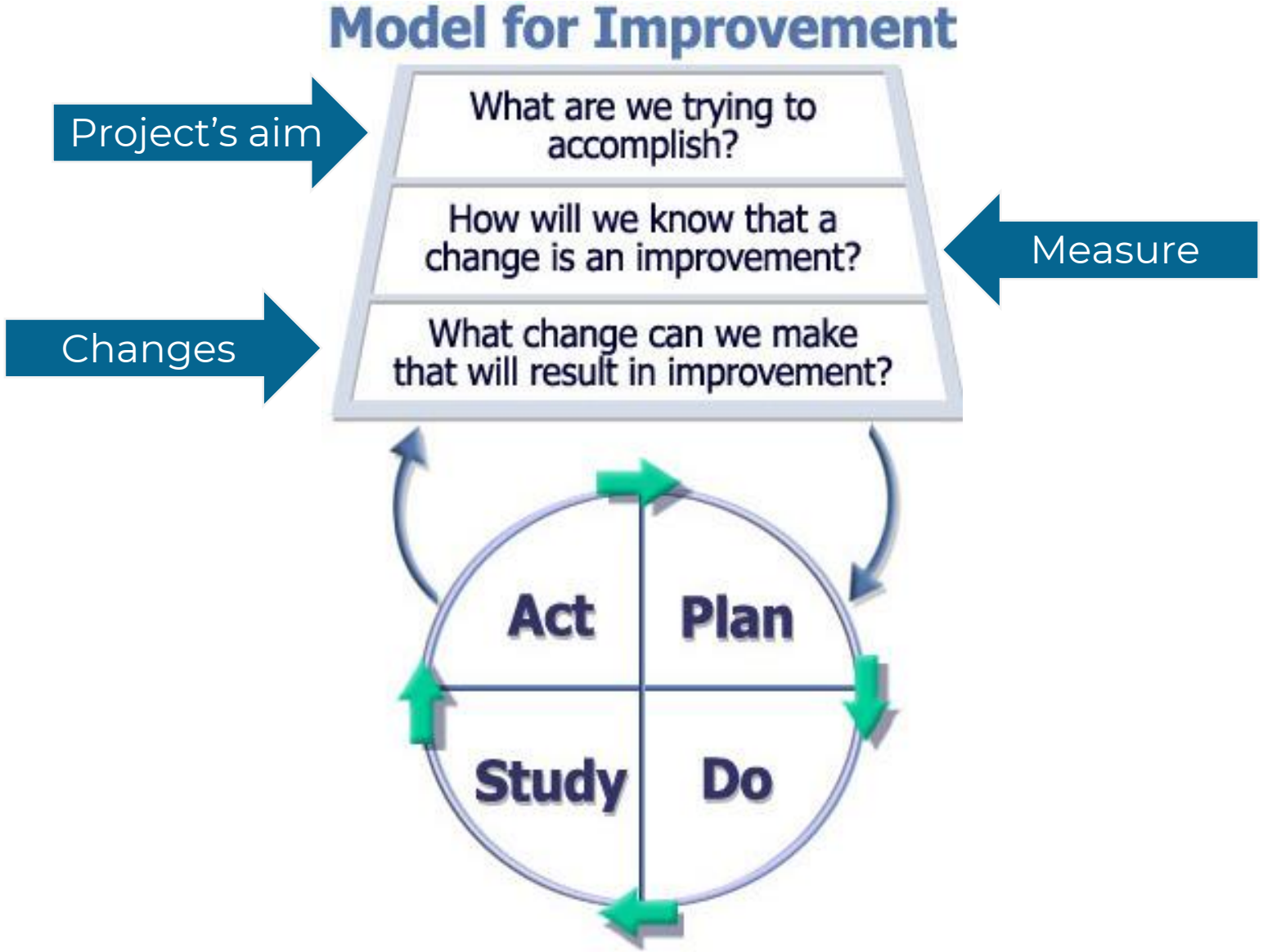
Model for Improvement



PDSA cycle

What's next?

What might happen if we try something different?

Let's try it!

Did it work?

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PDSA Worksheet Template

The Plan-Do-Study-Act (PDSA) cycle is a useful tool for documenting a test of change. Running a PDSA cycle is a way to test change ideas — you develop a plan to test the change (Plan), carry out the test (Do), observe, analyse, and learn from the test (Study), and determine what modifications, if any, to make for the next cycle (Act).

In most improvement projects, teams will test several different changes, and each change may go through several PDSA cycles as you continue to learn. Keep a file of all PDSA cycles for all the changes your team tests. Fill out one PDSA worksheet for each change you test.

Instructions

1. **Plan:** Plan the test, including a plan for collecting data
   - State the question you want to answer and make a prediction about what you think will happen
   - Develop a plan to test the change. (Who? What? When? Where?)
   - Identify what data you will need to collect and how you will collect it

2. **Do:** Run the test on a small scale.
   - Carry out the test.
   - Document problems and unexpected observations.
   - Collect and begin to analyse the data.

3. **Study:** Analyse the results and compare them to your predictions.
   - Complete, as a team, your analysis of the data.
   - Compare the data to your prediction.
   - Summarise and reflect on what you learned.

4. **Act:** Based on what you learned from the test, make a plan for your next step
   - Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don't do another test on this change idea).
   - Prepare a plan for the next PDSA

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PDSA Worksheet Template

Objective:

1. Plan: Plan the test, including a plan for collecting data

Questions:

Predictions:

Who, what, where, when:

Plan for collecting data:

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2. **Do:** Run the test on a small scale

Describe what happened. What data did you collect? What observations did you make?

3. **Study:** Analyse the results and compare them to your predictions

Summarise and reflect on what you learned:

4. **Act:** Based on what you learnt from the test, make a plan for your next step:

Determine what modifications you should make – adapt, adopt or abandon:

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A PDSA in Practice

What you need:

- A table of at least six people
- A ball pit ball on your table
- A ‘PDSA in Practice’ worksheet (one per team)
- Assign one person on your table/team to be the timekeeper.

A PDSA in Practice

What you're going to do:

- Complete task on next slide as fast as possible
- Timekeeper to record how long it took to complete task on worksheet against PDSA cycle 1
- When all teams have finished cycle 1, you'll have some time to reflect on the attempt and plan for cycle 2
- If you try something different, record what the plan was on your worksheet (only make ONE change per round)
- We'll aim for at least three rounds.

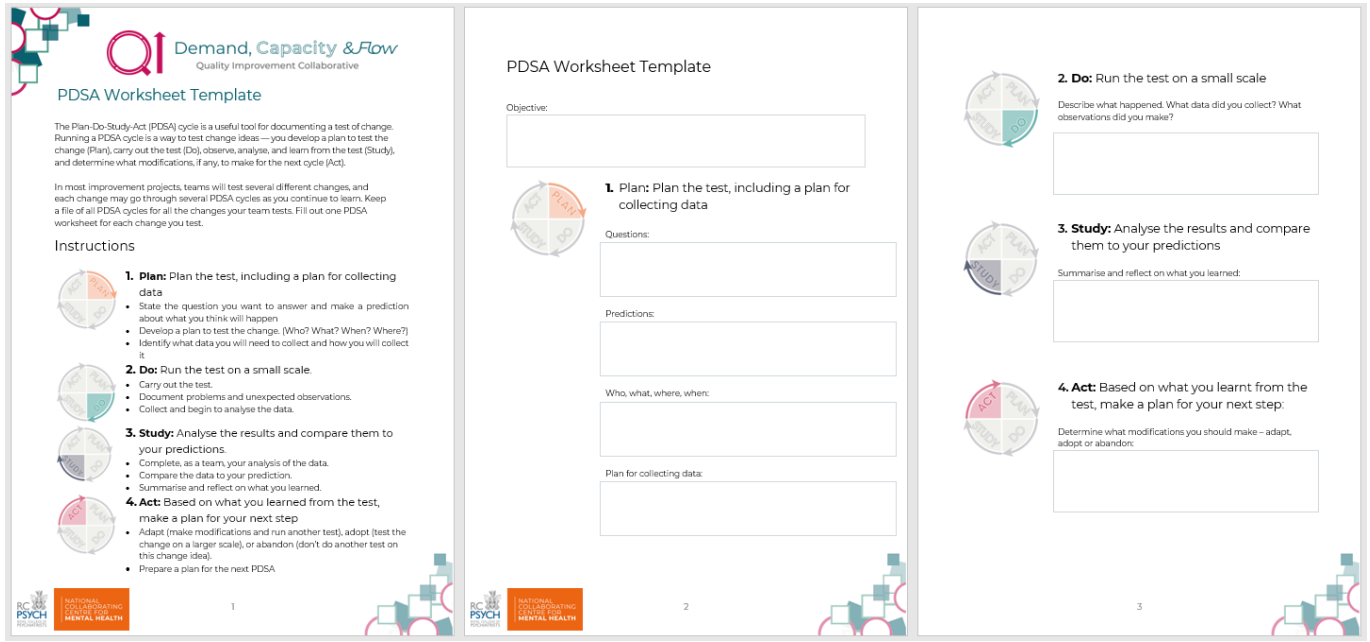
All team members (excluding timekeeper) to touch the ball on your table in chronological order of date and month of your birthdays

Tips from the team

- Make sure the change idea you are testing is specific and tangible, and start testing on a small scale.
- Do not underestimate the importance of planning each PDSA cycle …
- But don’t get stuck trying to create the ‘perfect’ plan, it just needs to be good enough to try the idea out.
- Try to make one tweak to the test per PDSA cycle, otherwise you won’t know what change had an effect.
- It’s ok to abandon some ideas after testing them. You’ll probably still have learned something, and it might inform other tests of change.

Planning a PSDA cycle

- Pick one of your change ideas
- Start to complete the ‘Plan’ section of the PDSA worksheet.
- Remember…a change idea is specific, tangible and a clear action!



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   - Prepare a plan for the next PDSA

1

PDSA Worksheet Template

Objective:

1. **Plan:** Plan the test, including a plan for collecting data

Questions:

Predictions:

Who, what, where, when:

Plan for collecting data:

2

2. **Do:** Run the test on a small scale

Describe what happened. What data did you collect? What observations did you make?

3. **Study:** Analyse the results and compare them to your predictions

Summarise and reflect on what you learned:

4. **Act:** Based on what you learnt from the test, make a plan for your next step:

Determine what modifications you should make – adapt, adopt or abandon:

3

Co-production workshop: Following-up from Learning Set 1

Sarah Markham and Ben
DCF Patient and Carer Representatives, NCCMH

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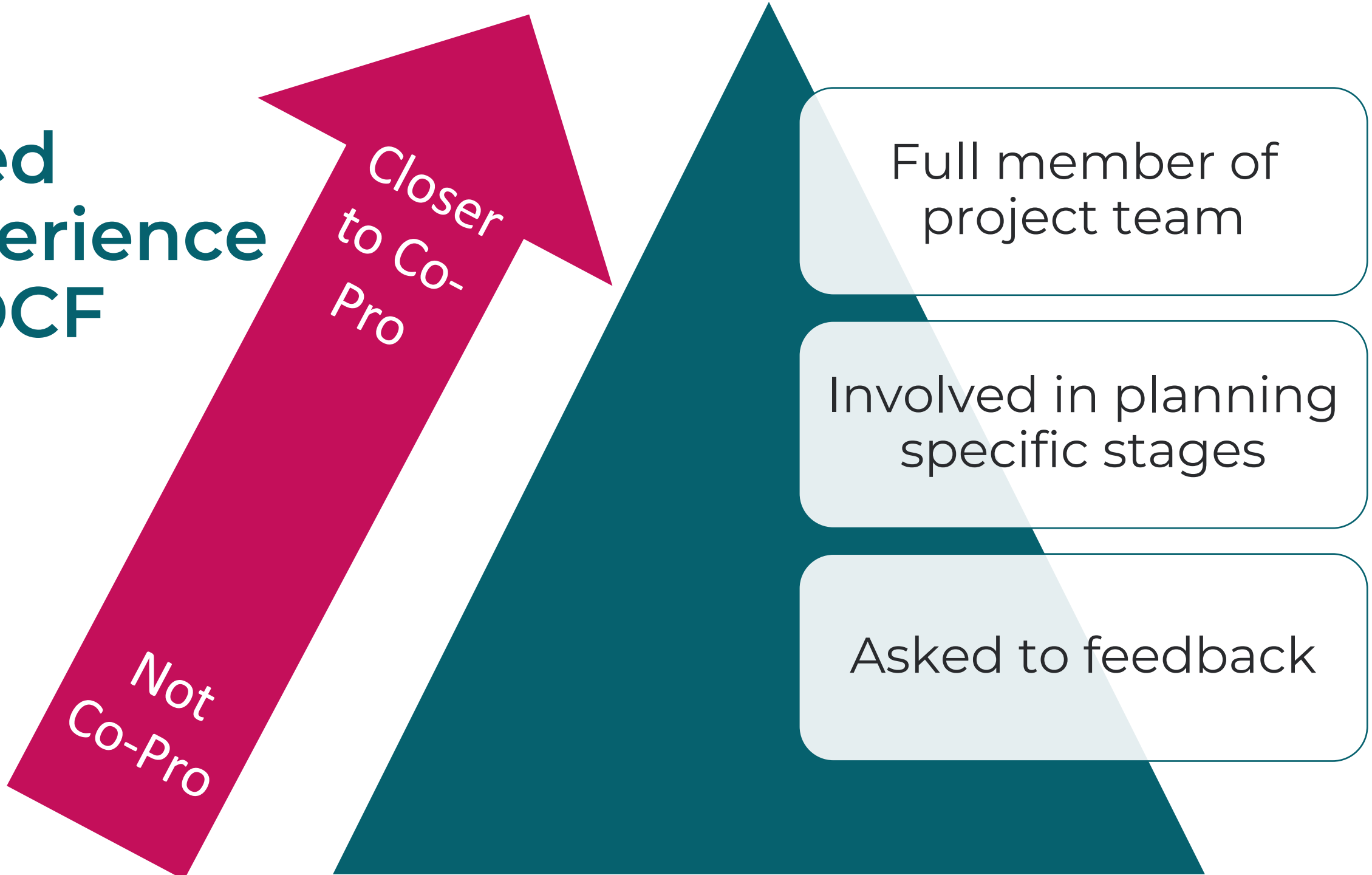
Checking in on progress

Lived experience in DCF



Group discussion 1 (Previous Learning Set)

What can a person in a lived experience role add to Project Teams?

Ensuring quality and meaningful interventions are provided from our services

Remind us what it's like to try access services

Ensuring quality and meaningful interventions are provided from our services

Gives valuable multiple perspectives

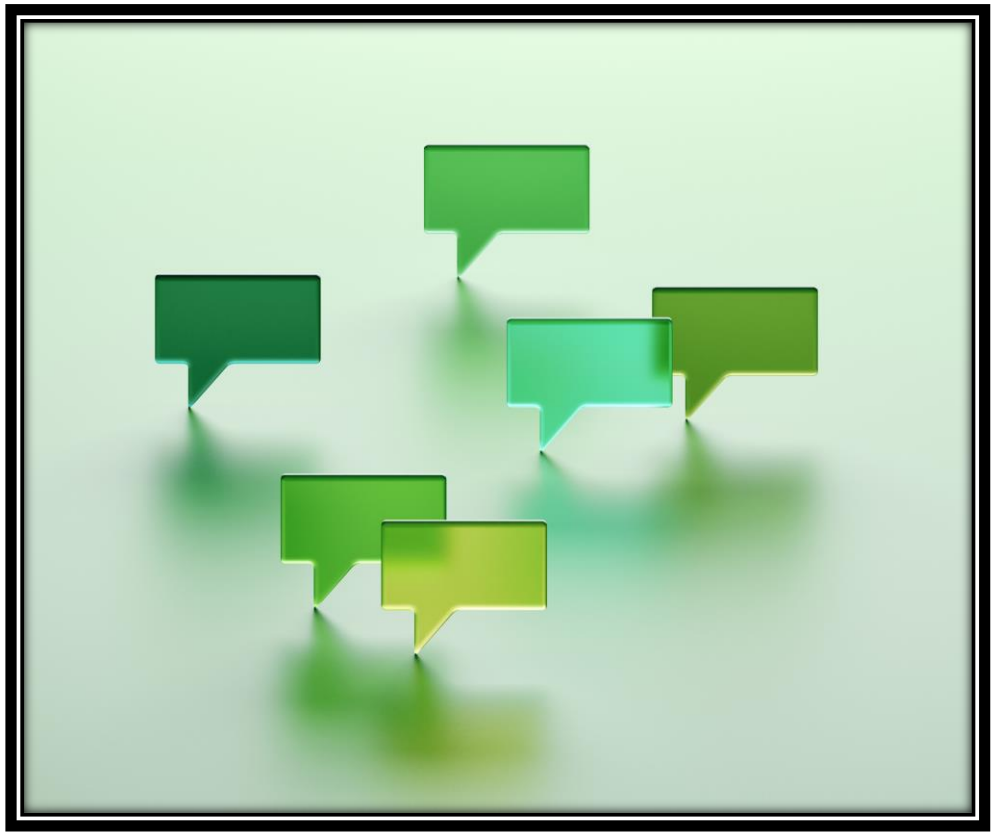
Their own unique experience and perspective

No production like co-production

Able to have the knowledge and experience of using the service and

The real journey of a patient's journey through the system

Making patients feel less judged and like they're not alone in their experiences



Themes

- The “human side”, “what it feels like” as a patient
- “Concrete examples” of improvements we might not be able to see
- Generally, “knowledge, experience, insight”

Group discussion 2

What are the issues, attitudes and behaviours that would get in the way of achieving all those benefits?

Thinking it will be too traumatic for the service user, they won't be able to cope

Disrespectful, patronising, lots of

Inaccessible jargon, tokenistic. Selection of unrepresentative experts by experience. Avoiding disruption. Lack of pre-meeting support. Not opening up agenda. Not providing practical support

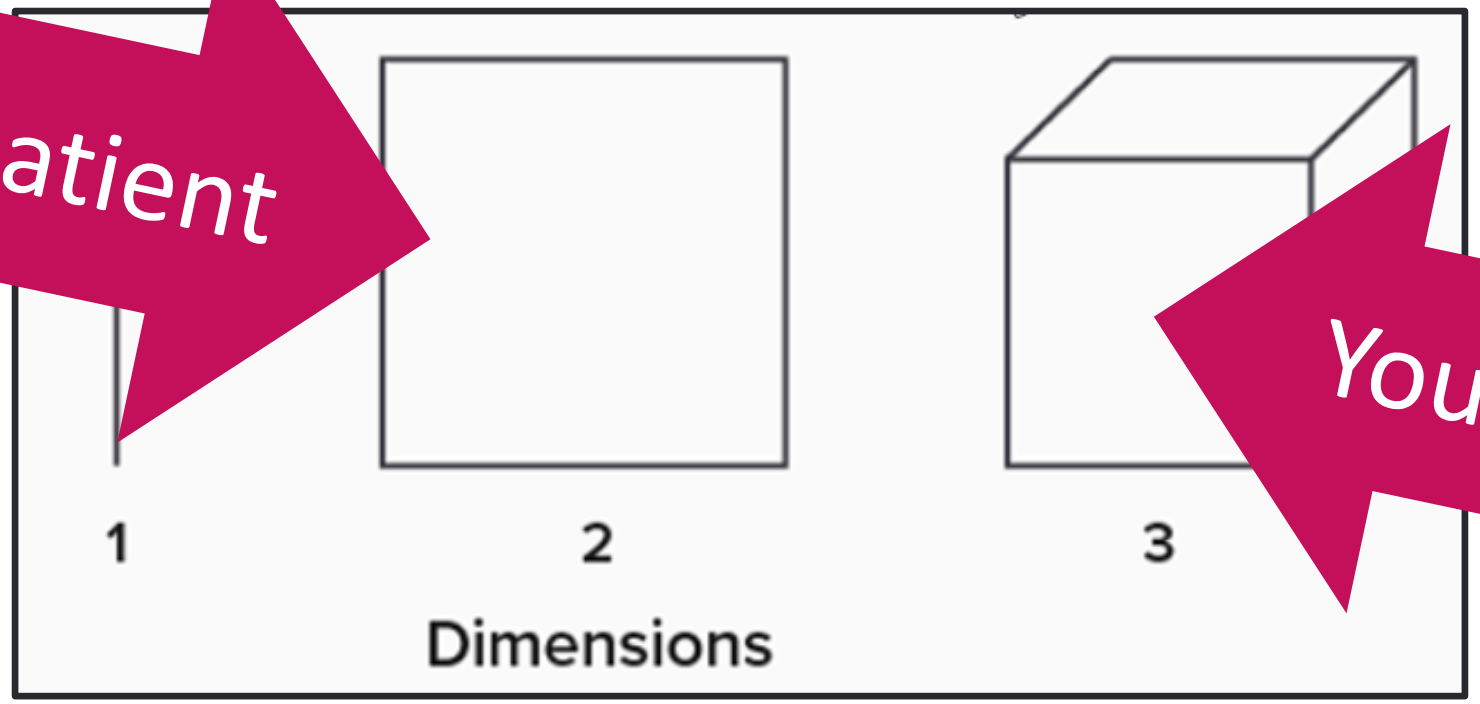
Recruit them but don't invite to any meetings and then let them know the outcome....or not!

Having hierarchy

Themes

Lack of power
Lack of respect
Time not valued

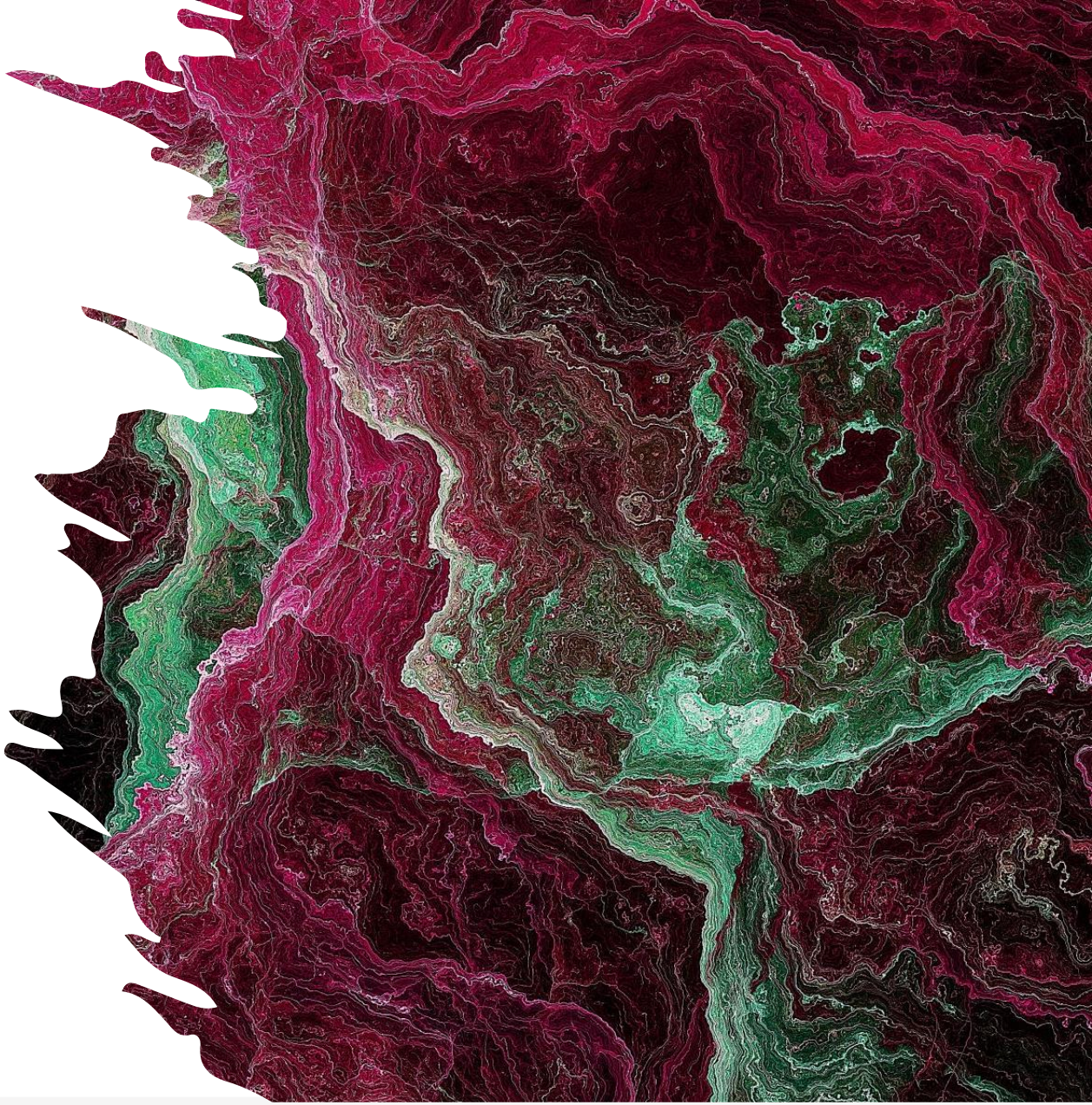
You the patient



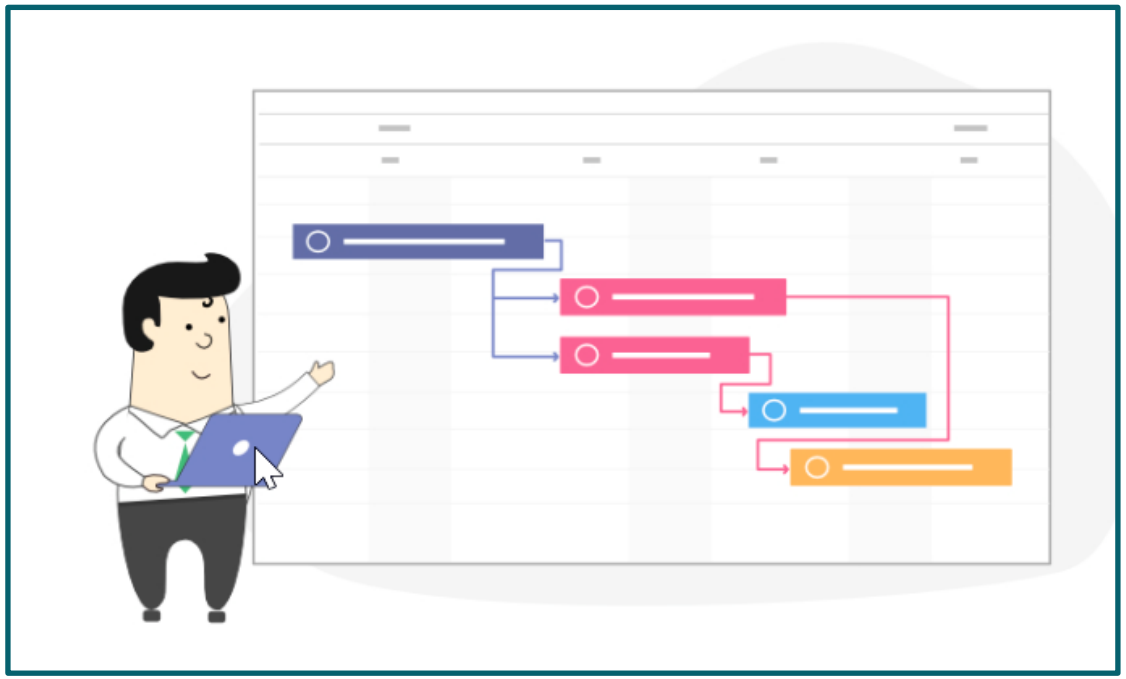
You the you!

Team Progression

- CAMHS team
- What about your Team?
- Motivational Devices and Incentives



When's the ‘right time' to involve someone?



A. Now & work through uncertainty together…

Who is the 'right person'?

OR…?

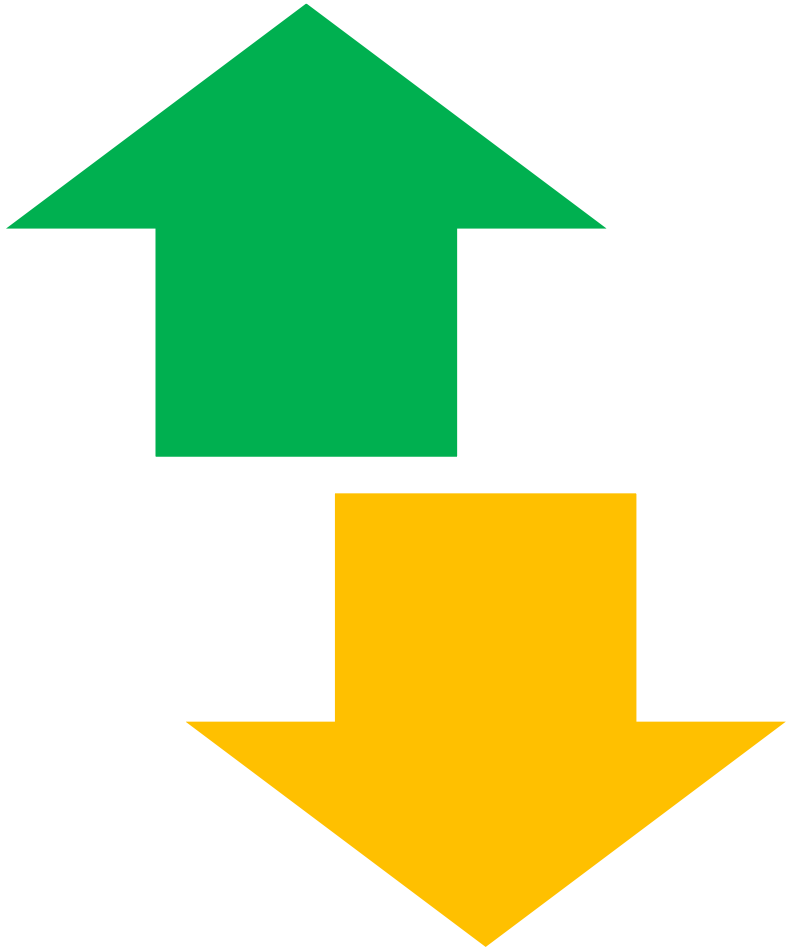
Who can bring "diversity of thought" to the team?

(attendee last Learning Set)

However, give weight to…

- **Current/recent experience of your service**
- **Lived experience of inequalities in healthcare**
- **Desire to apply own experiences to help others**

Where to find 'them'?



Who is out there in our community? Let's get creative

Only work to the organisation's 'model' of lived experience

National picture: daily rate for roles requiring lived experience

£35-£70

Minimum wage

£140

RCPsych standard rate

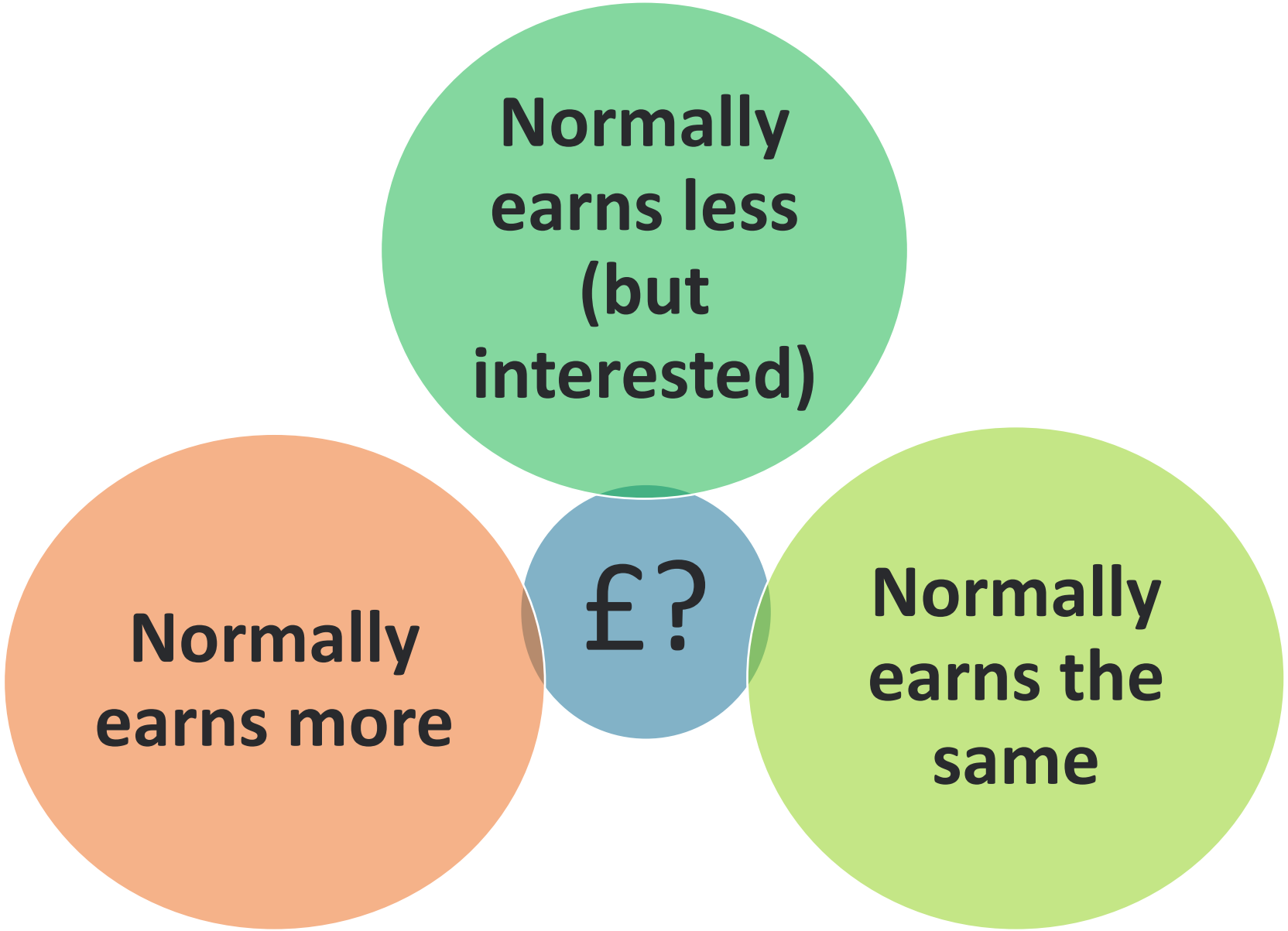
£280

RCPsych higher rate

£500

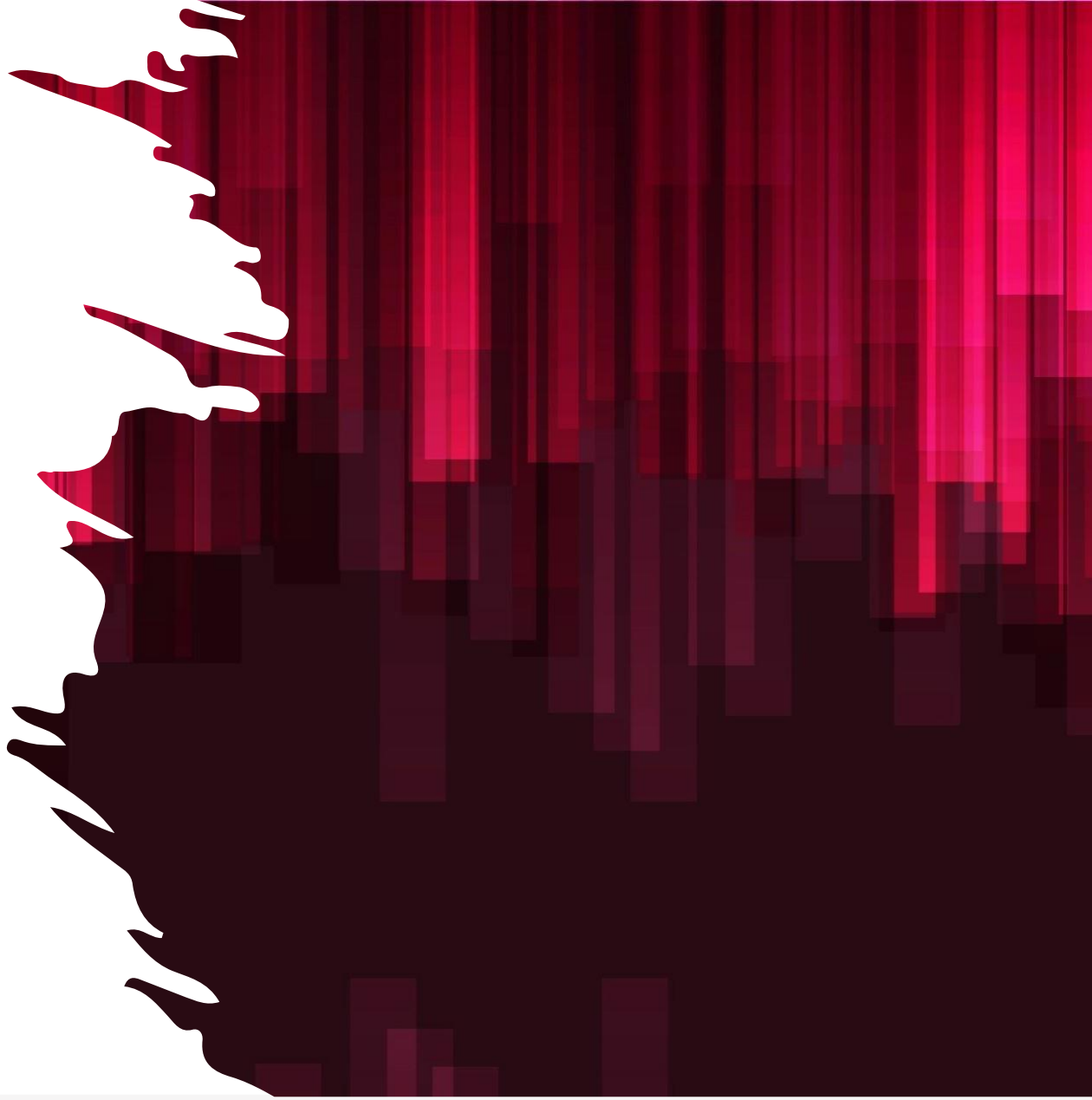
Highest profile work

Pay to attract a wide range of people



QI Collaborative – Next Steps

- What will you take from today?
- How do you plan to use it?
- Next steps …



Final Reflections

- Developments from today
- Projections from next time
- Thoughts?

Close

Saiqa Akhtar

Senior Quality Improvement Advisor, NCCMH

Optional drop-in sessions

Time	Item	Facilitators
From 3pm	Time with QI coach	DCF QI Coaches

- We value your feedback as this helps us to continue to improve these events and ensure topics covered are meaningful and relevant to you.

- Please use the QR displayed here, or the paper copies on your tables.