NHS Confederation

Mental Health and Acute ED Interface Improvement Collaborative:

Session 2: Measurement and scoping ideas

23rd July 2025

Welcome to the collaborative

House keeping

 Recorded	 Timing	 Behaviours	 Group work	 Questions	 Be present	 Breaks

Our aim

To help support partnership working across acute and mental health services to *start to* improve cross system working by supporting practical, real-time testing of improvement ideas across these boundaries.

Expectations

For us

- We are facilitators supporting your learning
- Support culture, improvement & connections
- Keep teams on track & ask curious questions

For you

- You are the experts with the answers
- Listen, reflect and contribute
- What you put in is what you get out: be committed

Session 1: 21st May 2025, 10-12:30pm	Session 2: 23rd July 2025, 1:30-4pm	Session 3: 24th Sept 2025, 10-12:30pm	Session 4: 26th Nov 2025, 1:30-4pm	Session 5: 28th Jan 2026, 10-12:30pm	Session 6: 29th Apr 2026, 1:30-4pm
Understanding the problem	**Measurement, and scoping out ideas**	**Human factors and behavioural change**	**Testing out improvement ideas**	**On-going testing & sustainability**	**Recognition, spread & sharing**
• Defining your aim, purpose and “why” • Tools to use to scope out problem further • How to evidence the problem • Who needs to be involved – stakeholders • Patient first focus – not just targets, patients lives and experience • Addressing Mental Health Stigma	• Measurement for improvement • Data collection • Understanding and presenting data • Driver diagram • Tools to identify change ideas • Examples of change ideas • Understanding unintended consequences along the pathway	• Creating a change culture • Managing pressure/stresses • Behaviour and mindset change • Human factors • Dealing with resistance to change • Leadership styles to help change flourish • Addressing Mental Health Stigma	• Small scale testing • Improvement models • Plan-Do-Study-Act • Ongoing measurement	• Change ideas evaluation • Reflections and learning • Sustainability factors • Ongoing innovations and data for improvement	• Recognition of your progress – sharing learning • Critical reflection and analysis • Creating your spread plan • Revisit sustainability factors
Action learning period 1: Scope out your problem in your local setting ***Webinar 1: Understanding Health Inequalities 18th June 2025, 11-12:30pm***	**Action learning period 2:** Understand your data and gather as many change ideas as possible ***Buddy team check-in***	**Action learning period 3:** Test out ideas in practice and experiment changes ***Webinar 2: Leading through change 22nd Oct 2025, 11-12:30pm***	**Action learning period 4:** Discuss, share and learn about how behaviours are key to making change stick ***Buddy team check-in***	**Action learning period 5:** Continue to test and understand your assurance systems ***Webinar 3: People's Choice 25th Mar 2026, 11-12:30pm***	**Action learning period 6:** Commit to the on-going journey and how to spread wider ***Celebration event***

Today's agenda

Time	Item	
13:30 - 13:40	Welcome and recap	Alex Stewart & Emma Fulton
13:40 – 13:50	Confed expo session debrief	Paul Hopely & Ian Callaghan
13:50 - 13:55	Policy Update – 10 Year Plan	Mary Docherty
13:55 - 14:20	The perfect pitch – Working with your buddy team (breakout)	All
14:20 - 14:30	An introduction into measurement for improvement	Emma Fulton
14:30 - 15:00	Making data count	Guest speaker: Sam Riley, Director of Making Data Count, NHSE
15:00 - 15:10	**BREAK**	
15:10 – 15:20	Data packs	Nick Gitsham, NHSE MHIST
15:20 - 15:45	Creating your measurement plan (breakout)	
15:45 - 15:55	Driver Diagrams	Emma Fulton
15:55 - 16:00	Next steps and homework before next session: Human Factors and Behavioural Change – 24th September	Alex Stewart

Recap

Behaviors and culture
- Your behaviors and approach in improvement work
- Listen, hear respected
- Biases and critical reflection
- Common pitfalls in understanding things

Understanding the problem
- Finding your purpose – why
- What tools to use to understand it further
- How to create a SMART aim
- Systems thinking view on problem

Key stakeholders
- Stakeholder mapping
- Patient engagement and involvement
- Your project team

Outcome measures
- How to find your outcome measures
- Some common challenges of data collection at a system level
- What a measurement plan is

Programme engagement
- To get the most out of the programme, please ensure you are meeting with your dedicated Facilitator **at least once in between learning sessions.** It is essential for you to connect with them so we can have a collective view of how all teams are doing.
- Please remember the post course actions are an important part of the programme and its essential to send to your facilitator ahead of each learning session. We will share these with all teams to learn from each other throughout.
- We are still exploring a teams channel for everyone, however we know that some NHS organisations do not allow external teams channels – we are trying to find a way to work through this and will share more with you soon.

Progress check-in: Teams Poll

On a scale of 1 – 5 (5 being high/positive):

Q1: Since the first session, how much progress do you feel like you've made as a team?

Q2: Is the offer of the handouts and facilitator's support helpful?

Q3: How much has your confidence/belief/knowledge in carrying out improvement grown?

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Confed expo session:
Improving interface working across mental health and acute A&E services

Ian Callaghan,
Programme Ambassador

Confed Expo

NHS

Table discussions:

- What are the barriers and gaps needed to overcome to achieve what good looks like?
- How and where have you seen this done well?
- What can we learn from other pathways and services?

Results from Table Discussion: What would good look like?

- Environment matters: Quiet, safe, and suitable spaces for patients and staff are essential to reduce distress and support effective care. This includes avoiding corridor care and ensuring spaces are age-appropriate and non-clinical where possible.
- Timely access: People should not face long waits. Quick, responsive triage and onward referral are key, with 24/7 availability where needed.
- Right place, right care: Mental health-specific alternatives to A&E should be available and clearly signposted, with physical A&E attendance only where clinically necessary.
- Integrated expertise: A&E staff need training and confidence to respond to mental health crises, supported by embedded or on-call MH professionals.
- Clear pathways: Service users and families should know what to expect, with mapped and communicated next steps.

Results from Table Discussion: What would good look like?

- Whole-family support: Families need connection points and ongoing support during and after the crisis, not just during hospital attendance.
- Reduce stigma: Improve staff culture and attitudes through training and supervision, tackling unconscious bias and promoting parity of esteem.
- Joined-up system response: Strong community crisis services and clear system-level coordination are key to reducing inappropriate attendances and improving patient flow.
- Avoid criminalisation: Police should not be default responders or left waiting. Handovers must be streamlined.
- Avoid medicalisation: Address wider social determinants and ensure support isn't overly clinical in nature.

Results from Table Discussion: What are the barriers and gaps needed to overcome to achieve?

- System culture and collaboration: Services often operate in silos; there is a need for stronger, system-wide ownership, with better communication and shared goals.
- Premises and estate pressures: Lack of suitable spaces and capital funding hampers the development of quiet, co-located, and fit-for-purpose environments.
- Funding models: Short-term or inflexible funding contracts don't support long-term planning or sustainable change (e.g. leases, recruitment).
- Workforce challenges: Gaps in MH expertise, crisis cover, AMHP provision, and training (especially out of hours) lead to inconsistent care.
- Access and availability: Community crisis alternatives are not always available 24/7 or well-known to professionals and the public.
- Inpatient flow: Lack of inpatient capacity, step-up/step-down models, and fully functioning CMHTs creates bottlenecks.

Results from Table Discussion: What are the barriers and gaps needed to overcome to achieve?

- Risk and accountability: Confusion over who holds clinical and operational risk can lead to delays or poor handover. Clearer governance and risk-sharing needed.
- Information and awareness gaps: Staff and partners are not always aware of what services exist or how to access them, leading to missed opportunities for diversion or early support.
- Capacity to lead change: Frontline teams lack time and space to collaborate on solutions, despite recognising what needs to improve.

Results from Table Discussion: How and where have you seen this done well?

- Voluntary sector partnerships work: Organisations like Mental Health Matters, Richmond Fellowship, and others show the value of more agile, responsive VCSE involvement in crisis pathways.
- Skill-mixing models: Blending clinical and non-clinical roles, including peer support, increases flexibility and effectiveness.
- Examples to learn from:
- Kent and Medway: Effective VCSE partnerships
- Mansfield and Lincolnshire: Streamlined, effective A&E diversion models
- Crisis Houses: Show how step-down or alternative crisis care can work in practice

Confed Expo

NHS

Thank you

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UEC Policy Update

Mary Docherty,
Programme Ambassador

25 mins

The perfect pitch!

3 minutes: you need to pitch your problem area description, project aim and key stakeholders to your buddy team

Your buddy team then has around 8 minutes to talk to you about your pitch: Did it make sense to them? Is there anything missing? Does it sound SMART? Is there anything interesting about it? Can they offer advice?

Then swap roles as teams and listen to the other team pitch and the other team provide feedback

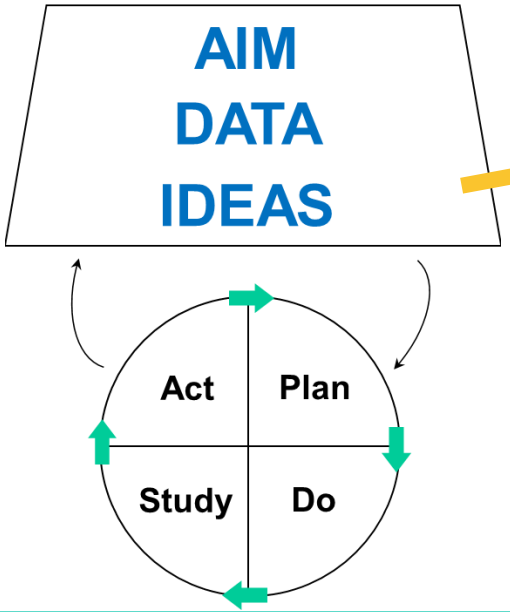
Measurement for improvement

Emma Fulton
NHS Confederation

System of Profound Knowledge

The system of profound knowledge provides a lens. It provides a new map of theory by which to understand and optimize our organisations

- Deming, Out of the Crisis



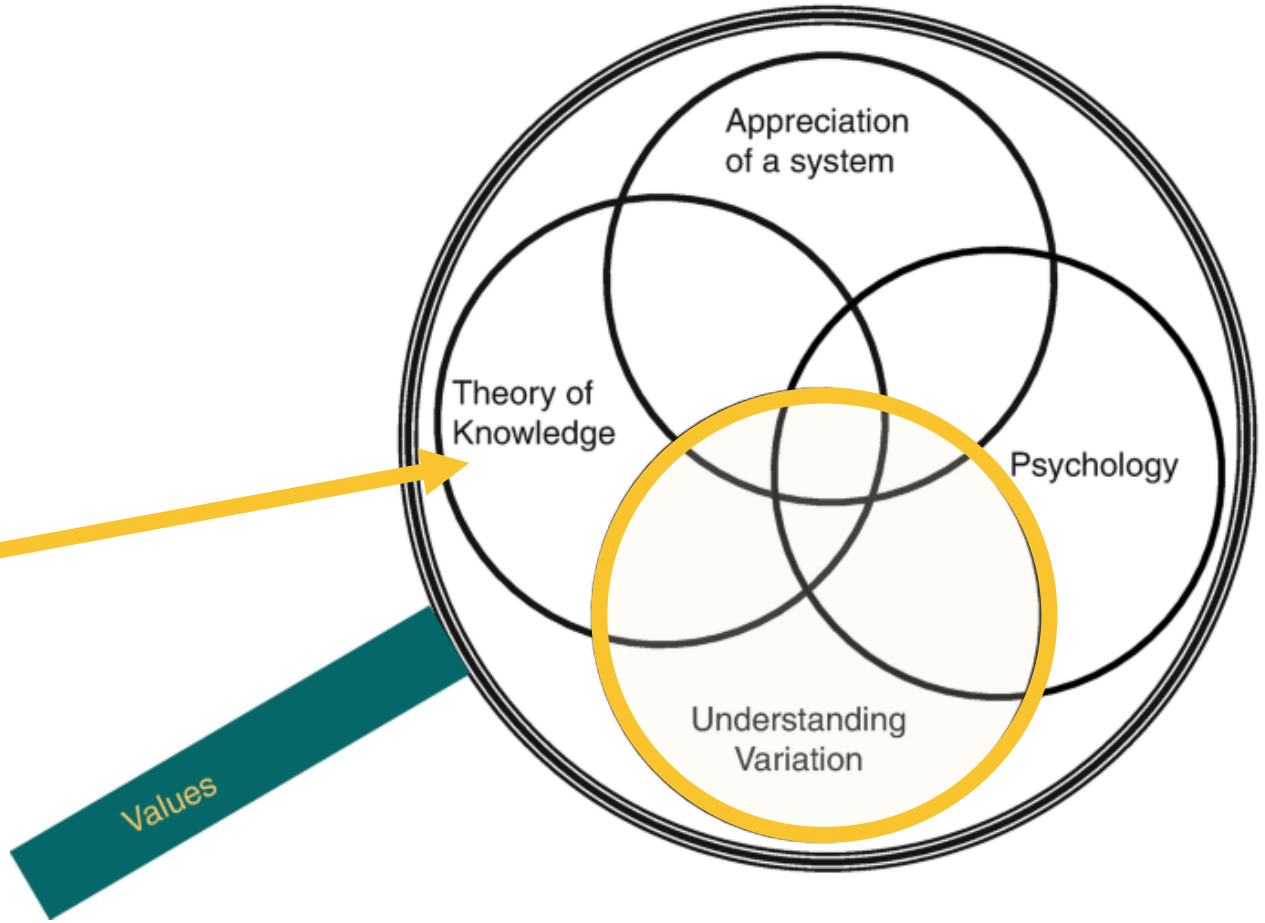


Image from Shah, R.K., Godambe, S.A. (eds) Patient Safety and Quality Improvement in Healthcare. 2021

Source Langley, Gerald J, Ronald D Moen, Kevin M Nolan, Thomas W Nolan, Clifford L Norman, and Lloyd P Provost. The Improvement Guide: A Practical Approach to Enhancing Organizational. San Francisco, USA: Jossey-Bass Publishers, 2009.

Different approaches to measurement

Characteristic	Judgement	Research	Improvement
Aim	Achievement of target or standard; Assurance	New knowledge	Improvement of service
Testing strategy	No tests	One large, blind test	Sequential, observable tests
Sample size	Obtain 100% of available, relevant data	"Just in case" data	"Just enough" data; small, sequential samples
Hypothesis	No hypothesis	Fixed hypothesis	Hypothesis flexible; changes as learning takes place
Variation	Adjust measures to reduce variation	Design to eliminate unwanted variation	Accept consistent variation
Determining if change is an improvement	No change focus	Statistical tests (t-test, F-test, chi square, p-values)	Run charts or statistical process control (SPC) charts

Healthcare
Performance
Targets
Audits

Academia /Papers
Publications
Education
RCT

Not seen enough!

Adapted from: Solberg LI, Mosser G & McDonald S (1997). "The Three Faces of Performance Measurement: Improvement, Accountability and Research" Journal on Quality Improvement ***23(3):*** *135-147.*

Collecting Data: Measures

Process: These are the practical steps (processes) taken to deliver the outcome e.g. Number of crisp packets I eat, how much steps I take in a day or how many calories I eat in a day – all process measures to achieve outcome of losing weight

Balancing: If changes are done to one part of the system, could they impact another part of the system? Are there any unintended consequences that we need to keep an eye on? E.g. I could become depressed due to extreme dieting – measuring mood is a balancing measure

Outcome: What is the end impact you want to see? What is the outcome you need to show to prove you have made an improvement to the core problem? E.g. % of weight loss, improvement in energy levels

Top Tips for Collecting Data

Process measures might increase based on your change ideas so be fluid in your measurement plan

6-8 measures in total are enough – you don't need lots, you are not trying to improve data itself

Collect baseline outcome measures to know where you are currently at (before improvement starts) & can then compare

Don't forget qualitative data as a less regular measure to collect (before, during, after improvement)

Make sure everyone understands the definitions for your measures and why you are collecting them

Make the data relevant – national level data is not specific enough – there is too much variation in it. You need data closer to the improvement

What data

Safety incidents	Patient survey results	Audits
Complaints	Staff survey	Patient feedback
Waiting times	Observations	Interviews
Targets	Performance statistics	Create your own tally
Activity levels	Characteristic factors	Financial
Patient clinical outcomes	Death/serious harm rates	What else?

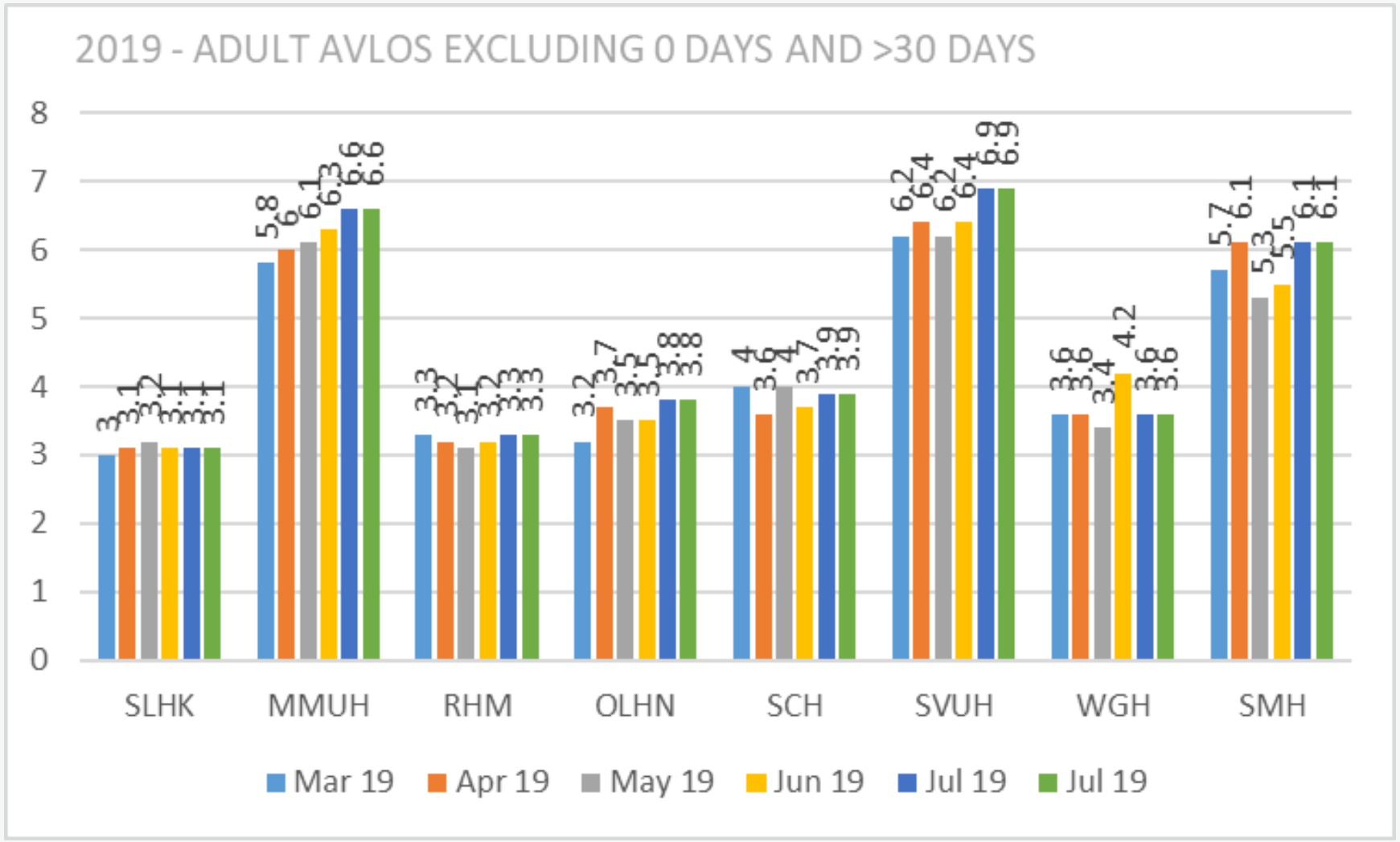
Measurement plan example of a starting point

Measure Definition What is the data you want to collect – define it	Type of measure Outcome/ Process/ Balancing	Concept Why Measure it?	Frequency How often will it be collected? Will it be all occurrences?	Data Collection How will the data be collected? Is there a system? Will it be done manually?	Person Who will be the person responsible for collecting it?
Reduction in surgical procedures cancellation or pauses due to failed pre op (any specific reason?)	Outcome	Identify baseline position and to understand if the changes we put in place lead to a reduction in cancellations for patients	Weekly	eCAMIS – digital system at pre-op stage	Joe Blogs
Reduce the number of discharges of patients due to being medically unfit for surgery	Outcome	We want to improve the pre op process so if this is picked up earlier it can mean patients can be supported to become “fit” for surgery hence reduce discharge rate	Weekly	eCAMIS – digital system –monitor at clinic apt stage	Joe Bloggs
Increase referral/support and uptake of public health support for patients to “keep well” for surgery	Process	We want to improve patient’s care/outcomes and part of that means educating them on how to keep well while they wait	Monthly	Number of appointments/interactions with public health care colleagues e.g. link worker or health coach	Joe Bloggs
Reduce the number of tasks sent to primary care (GP) to manage patient’s pre-op needs	Outcome	We want to reduce the number of tasks passed between providers and try to address them within current pathway	Monthly	Number of letters/messages/correspondence sent to primary care requiring action for patient’s pre op needs (spot audit before, during after project)	Joe Bloggs
Monitor post op surgical readmission rate (7 days) to ensure it does not increase	Balancing	To ensure the changes we put in place do not have an unintended consequence on readmission rates post surgery	Monthly	Patient Administration System PAS	Joe Bloggs

Making Data Count

An Introduction

Presented by:
Samantha Riley, Director of Making Data Count
23 July 2025


2019 - ADULT AVLOS EXCLUDING 0 DAYS AND >30 DAYS
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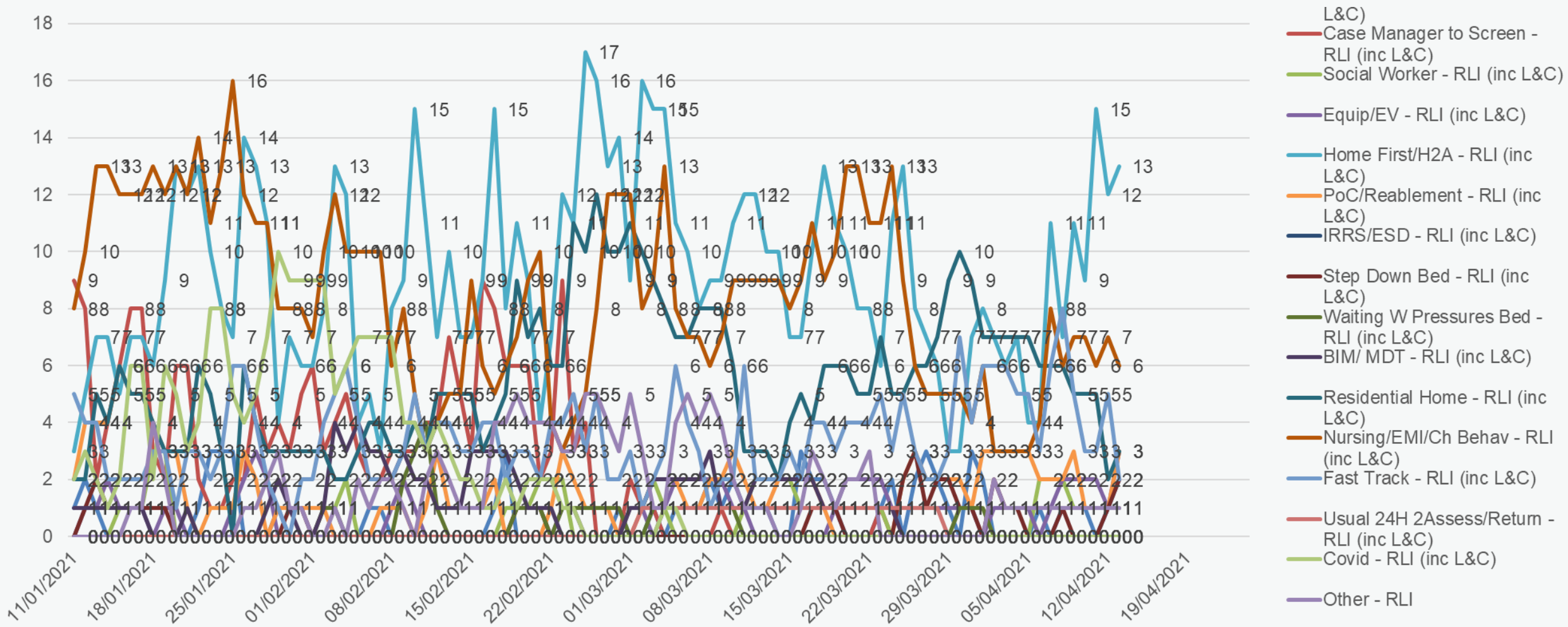
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L&C)
Case Manager to Screen - RLI (inc L&C)
Social Worker - RLI (inc L&C)
Equip/EV - RLI (inc L&C)
Home First/H2A - RLI (inc L&C)
PoC/Reablement - RLI (inc L&C)
IRRS/ESD - RLI (inc L&C)
Step Down Bed - RLI (inc L&C)
Waiting W Pressures Bed - RLI (inc L&C)
BIM/ MDT - RLI (inc L&C)
Residential Home - RLI (inc L&C)
Nursing/EMI/Ch Behav - RLI (inc L&C)
Fast Track - RLI (inc L&C)
Usual 24H 2Assess/Return - RLI (inc L&C)
Covid - RLI (inc L&C)
Other - RLI

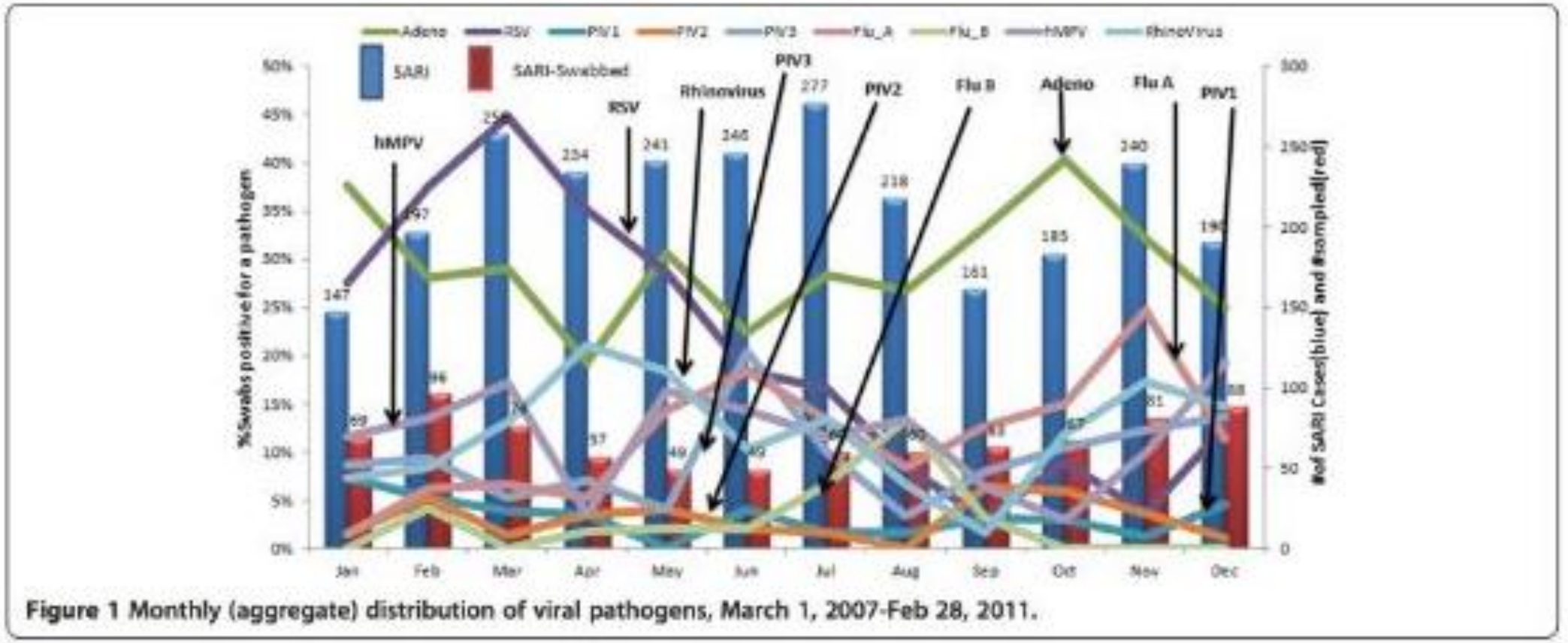
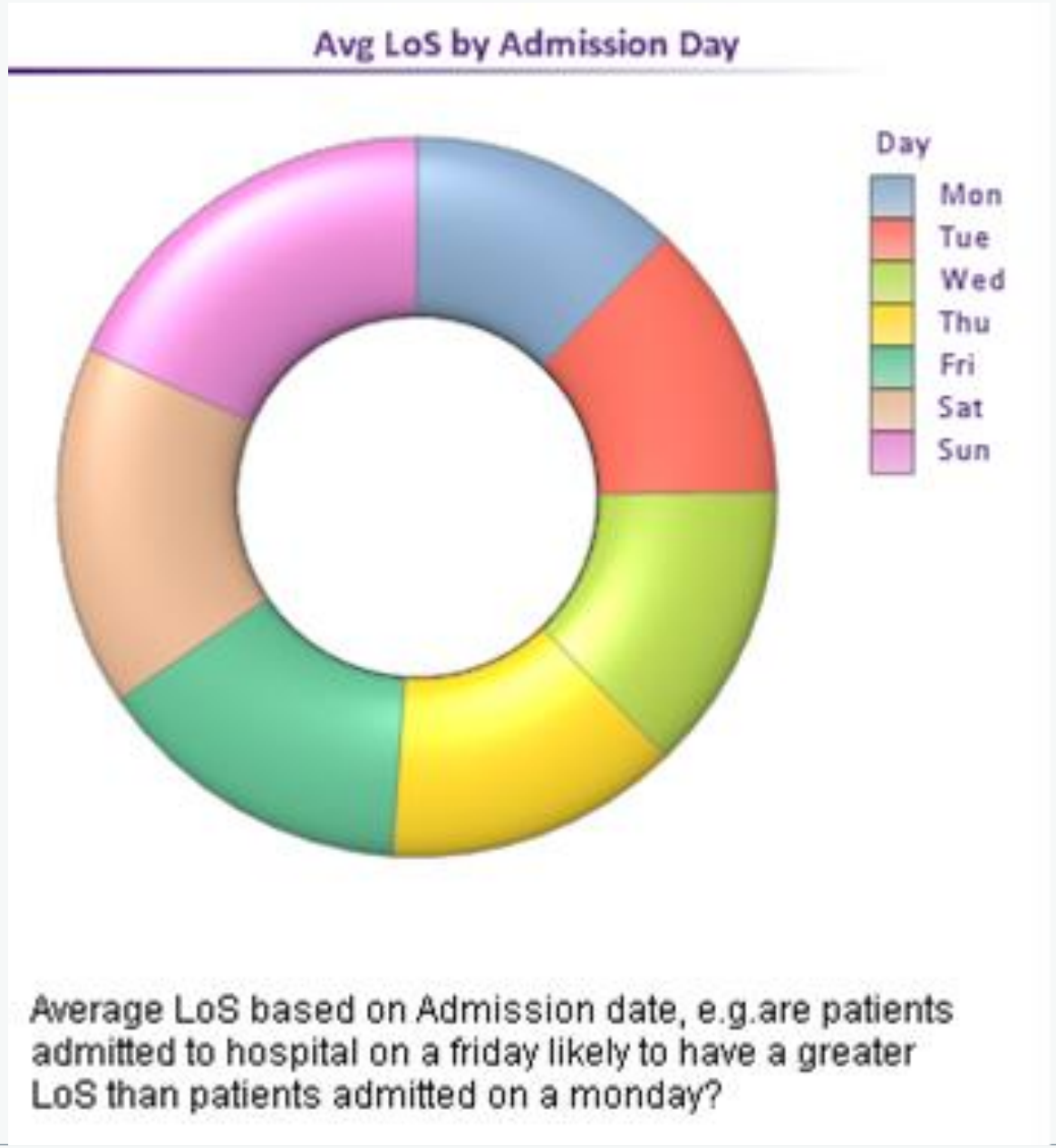


Figure 1 Monthly (aggregate) distribution of viral pathogens, March 1, 2007-Feb 28, 2011.



Average LoS based on Admission date, e.g.are patients admitted to hospital on a friday likely to have a greater LoS than patients admitted on a monday?

Understanding performance

Specialty RTT Performance

Specialty Performance	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend	Trend
Cardiology	94.7%	92.0%	92.3%					93.7%	94.4%	↑	0.7%
Dermatology	98.4%	98.1%	98.2%					90.8%	92.1%	↑	1.3%
Ear, Nose & Throat	92.0%	92.9%	92					4%	87.0%	↓	-1.4%
Gastroenterology	86.5%	87.7%						%	86.1%	↑	0.6%
General Medicine	100.0%	100.0%							100.0%		0.0%
General Surgery	75.5%	78.5%							87.9%	↓	-0.9%
Geriatric Medicine	98.9%	98.9%							98.6%	↓	-0.5%
Gynaecology	87.0%	87.8%							85.3%	↓	-1.8%
Neurology	92.1%	92.1%							86.7%	↓	-0.9%
Ophthalmology	81.2%	84.5%							87.6%	↓	-2.4%
Oral Surgery	78.8%	81.8%							83.5%	↓	-2.2%
Orthopaedics	88.6%	92.0%						%	83.2%	↓	-0.4%
Other	87.9%	88.4%	90.					1.5%	90.4%	↓	-1.1%
Plastic Surgery	82.2%	84.7%	87.6%					87.9%	84.7%	↓	-3.2%
Respiratory Medicine	79.3%	83.4%	87.5%					92.2%	86.1%	↓	-6.1%
Rheumatology	79.4%	81.5%	79.9%	76.0%			74.9%	75.7%	75.6%	↓	-0.1%
Urology	85.4%	87.5%	88.7%	89.9%	91.5%	91.4%	92.0%	92.2%	90.6%	↓	-1.6%
TRUST	86.1%	87.7%	88.7%	88.7%	88.3%	87.9%	88.7%	88.7%	87.4%	↓	-1.3%

Describing performance

a slight decrease fro 23%

slightly deteriorated fro 64.60% in July.

deteriorate 1.14% in July.

deteriorated from 4 July.

performance deteri 4.67% in June to 81.12% in July.

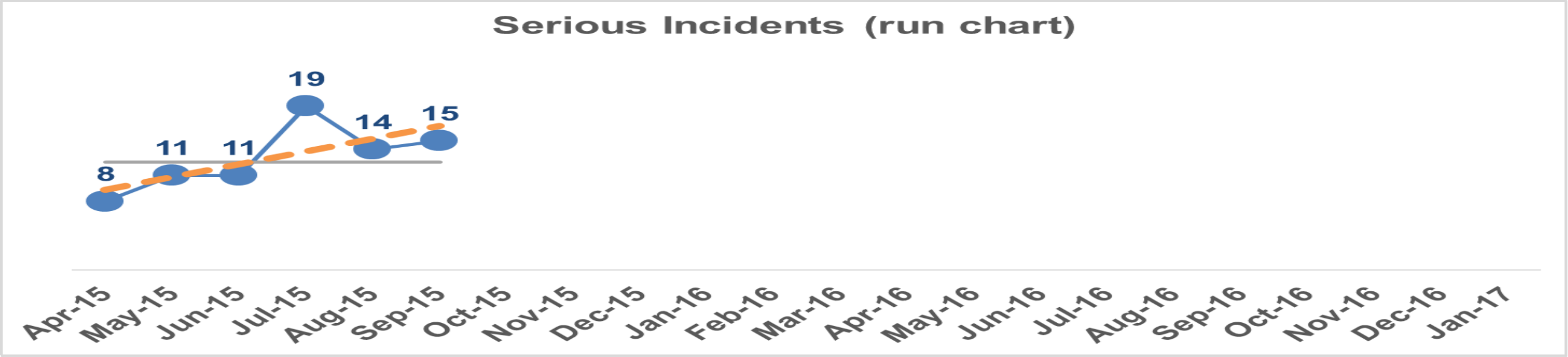

5
J
Q
K
?

Scenario

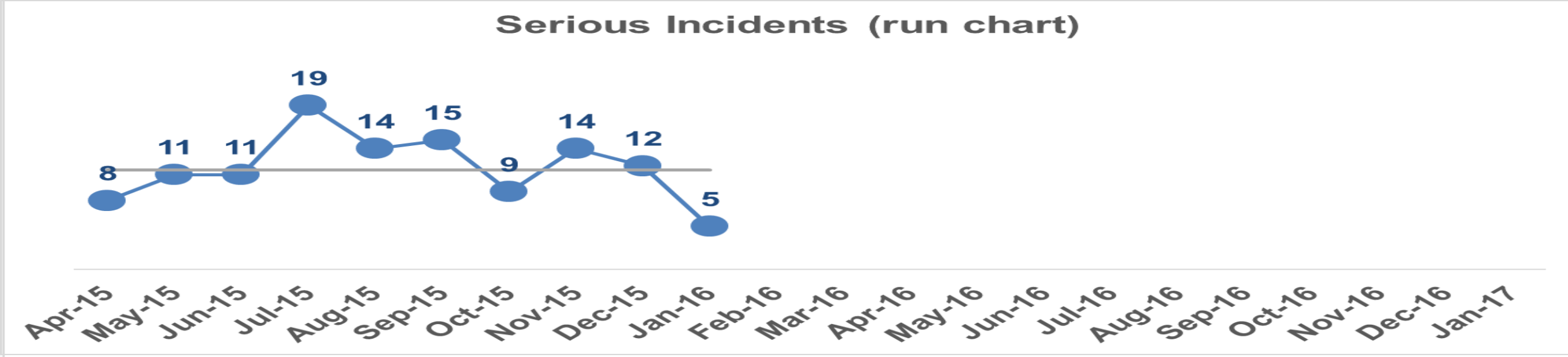
We’re going to simulate some **real data** in a healthcare setting

We’ll be thinking about **how people react to patterns and trends** in data.

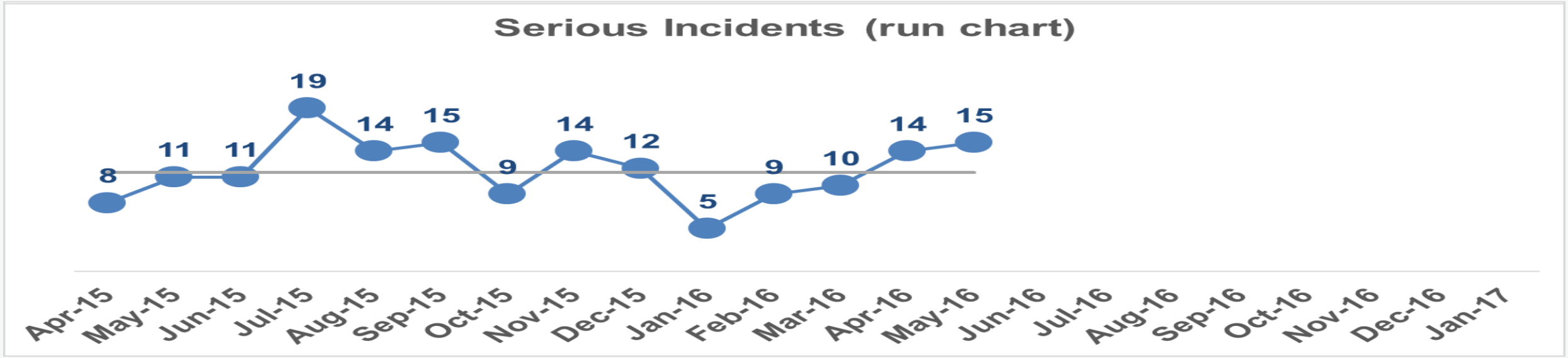
Can you spot an **improvement or decline** when it occurs?



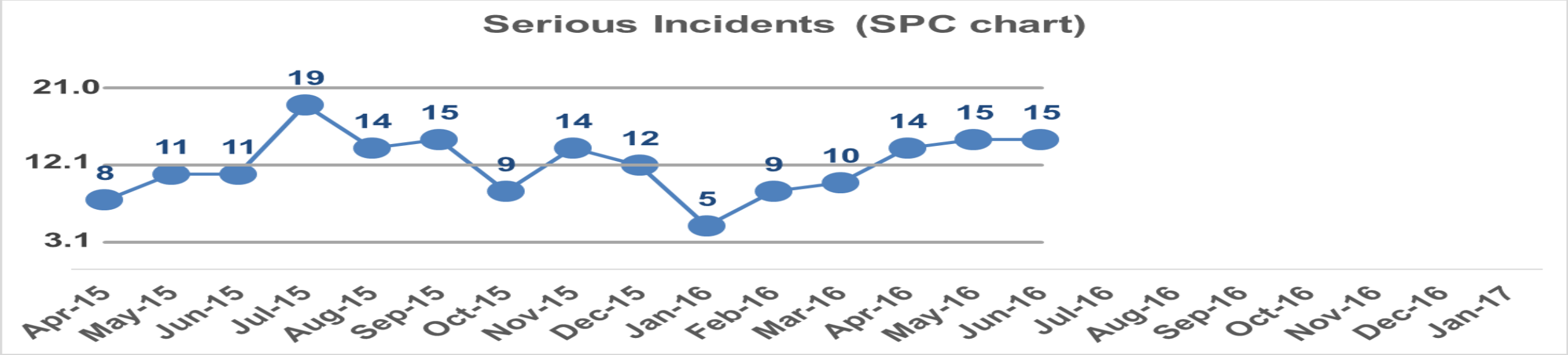
What might a linear trend line show?
What's your impression – increase, decline or no change?



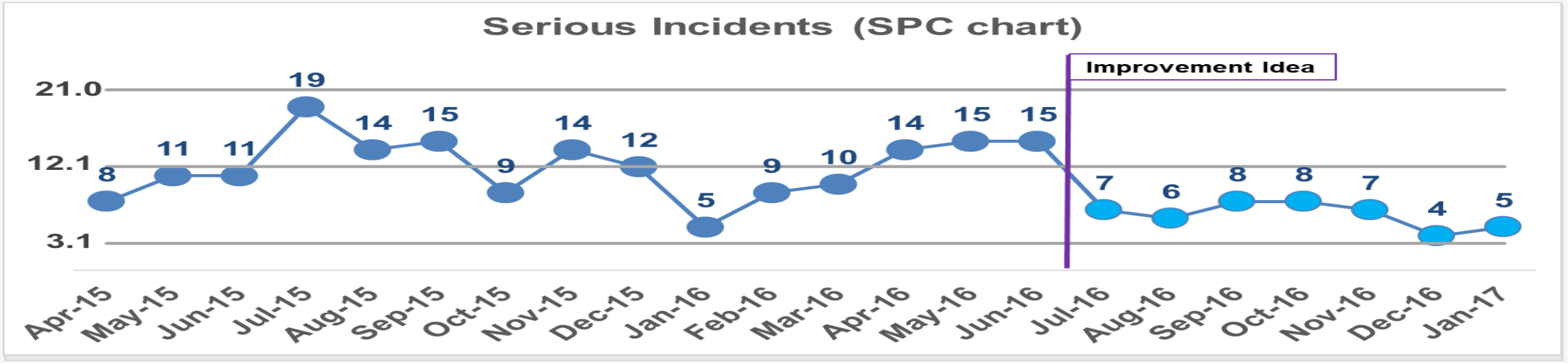
Lowest recorded value.
Has something good happened?



Negative trend of four
Has something bad happened?



An improvement idea is now implemented.
At what point, if ever, are you confident it has succeeded?

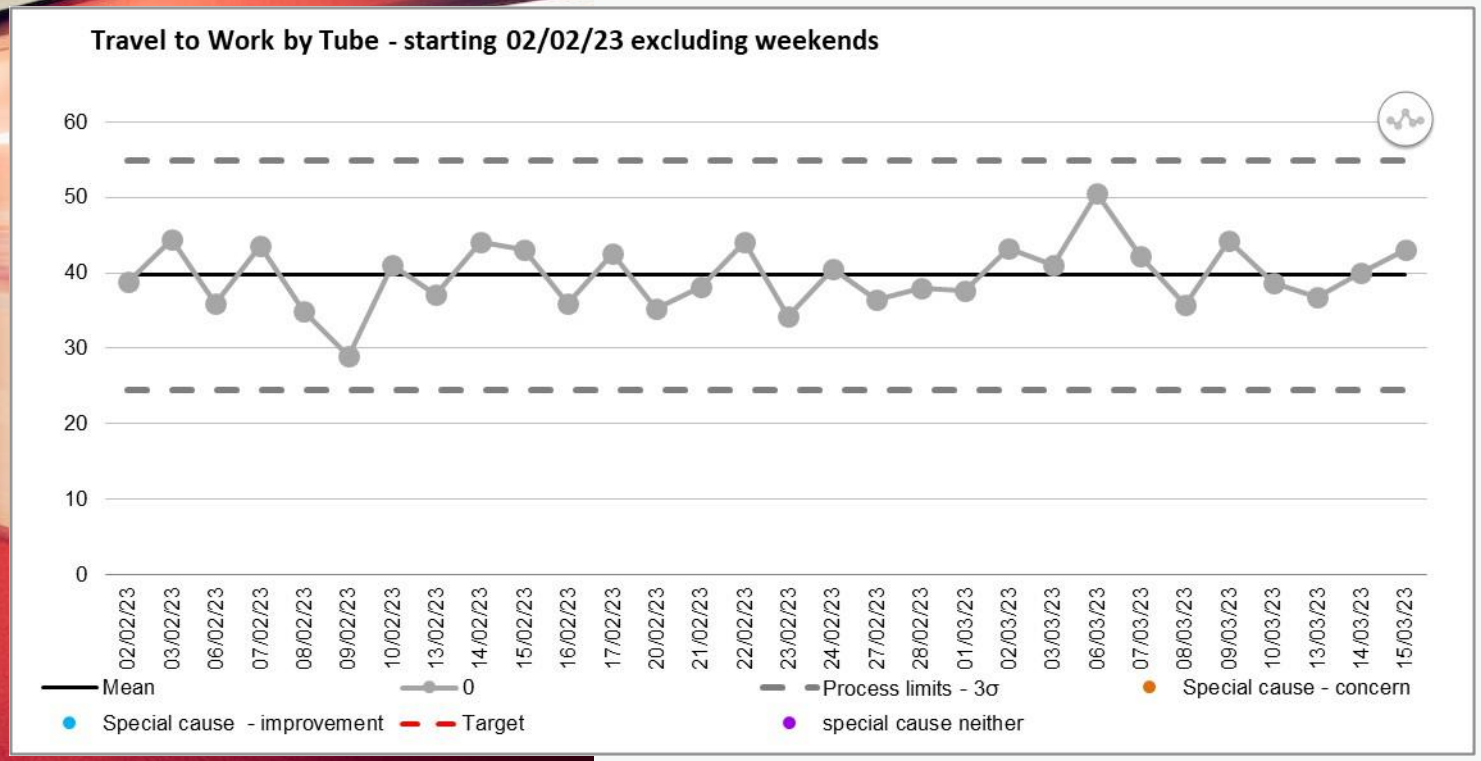


Seven months of success?

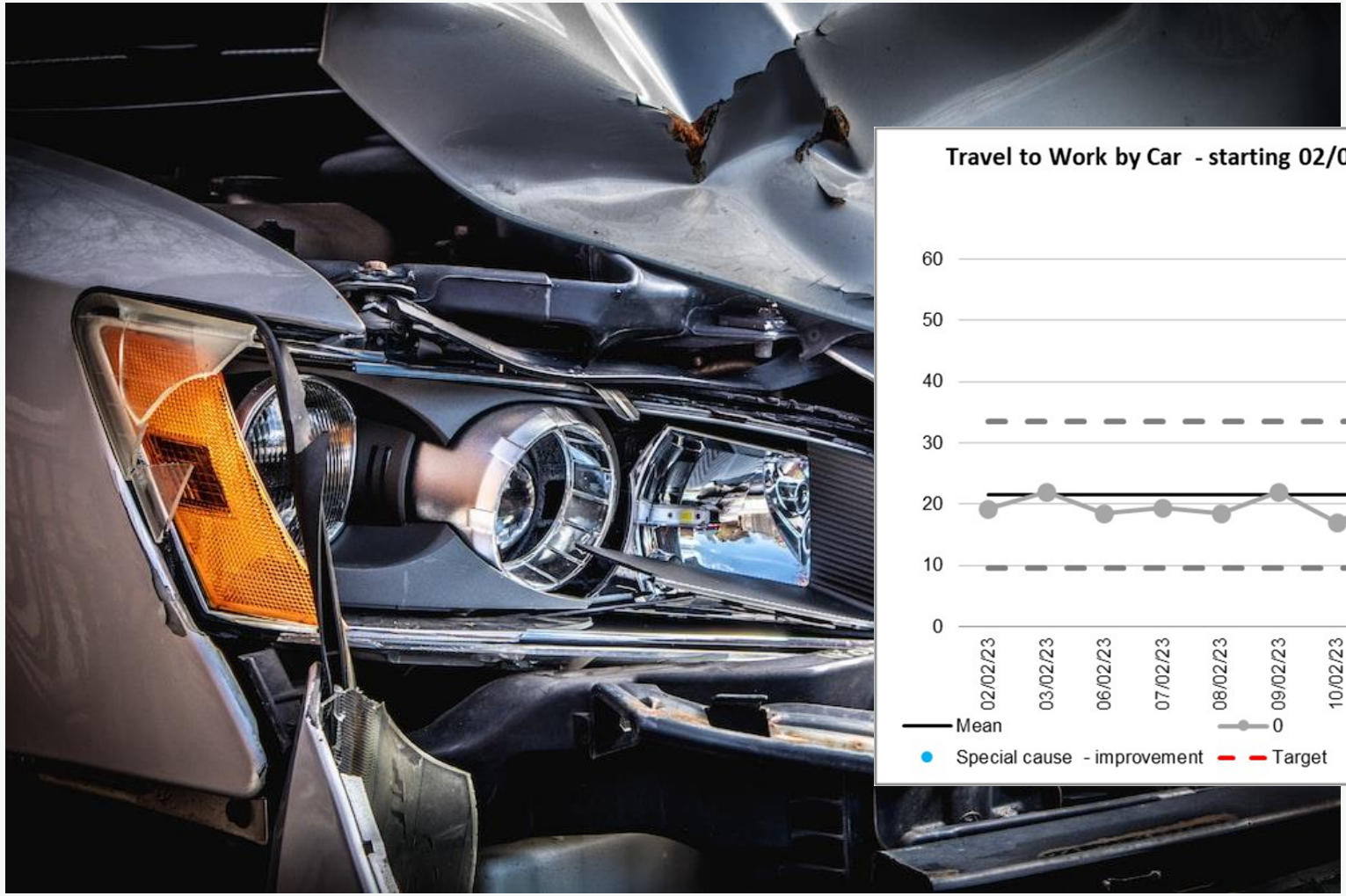
What was the data set?

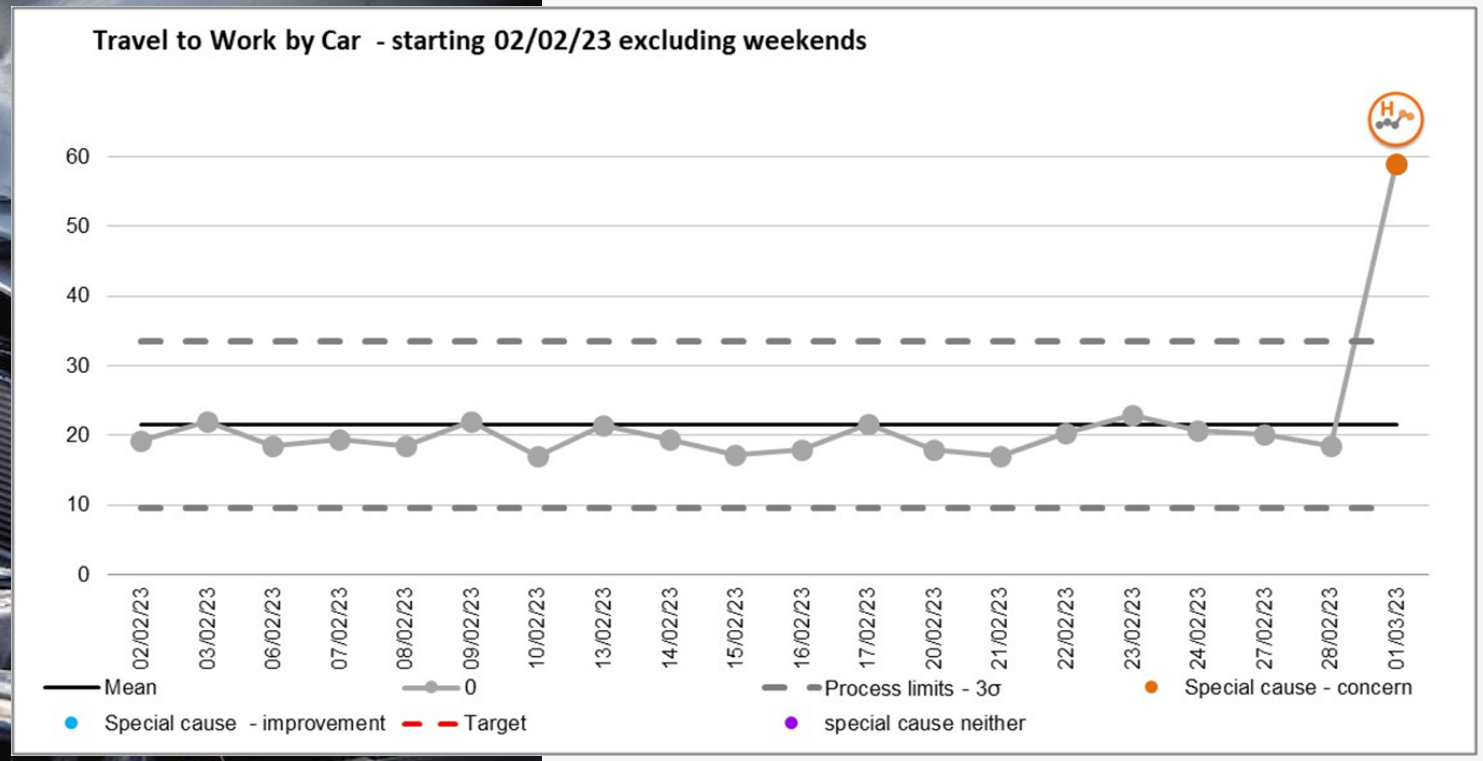
SPC tells us when patterns are statistically significant

Variation matters : expected (common cause)

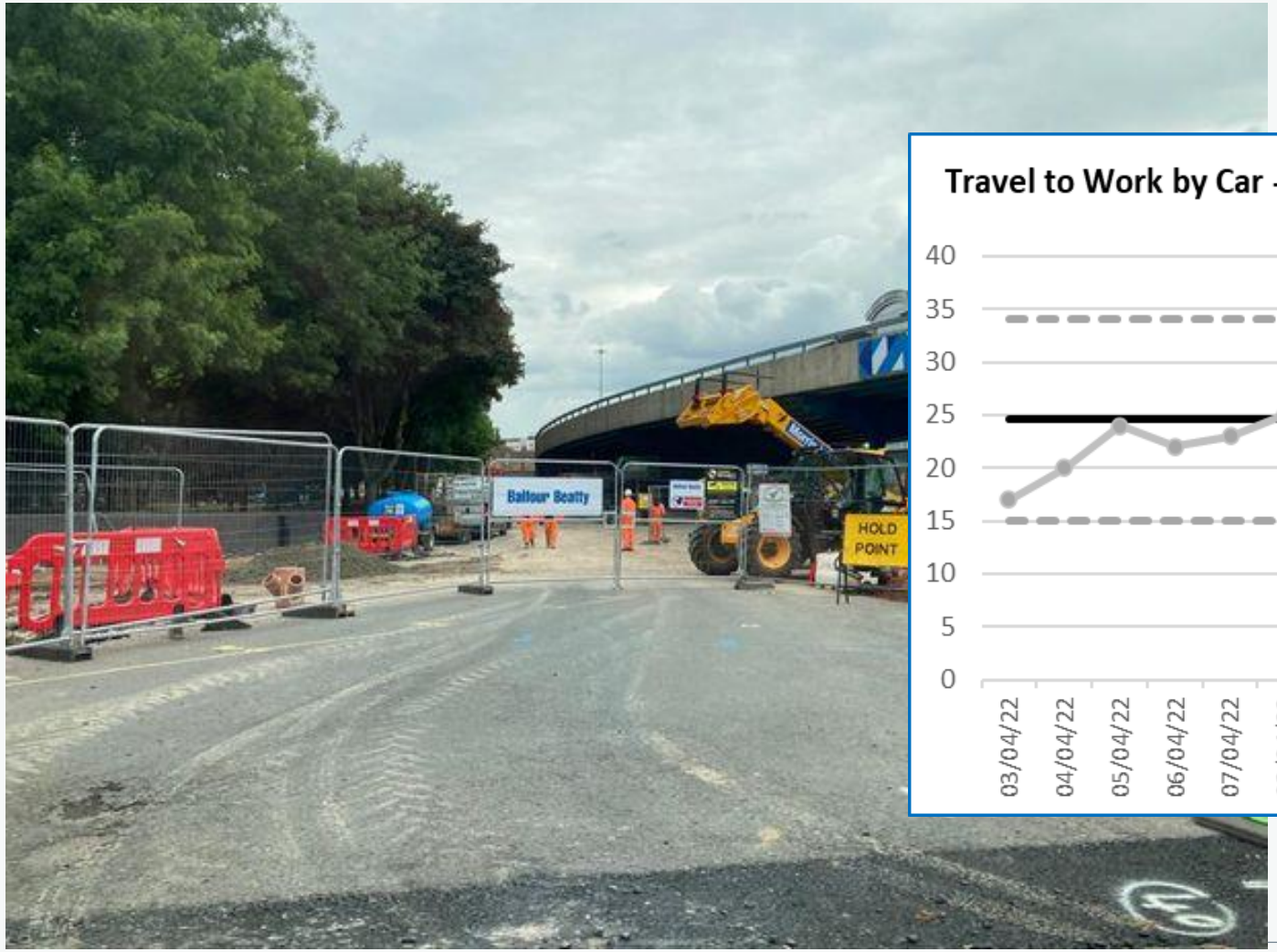


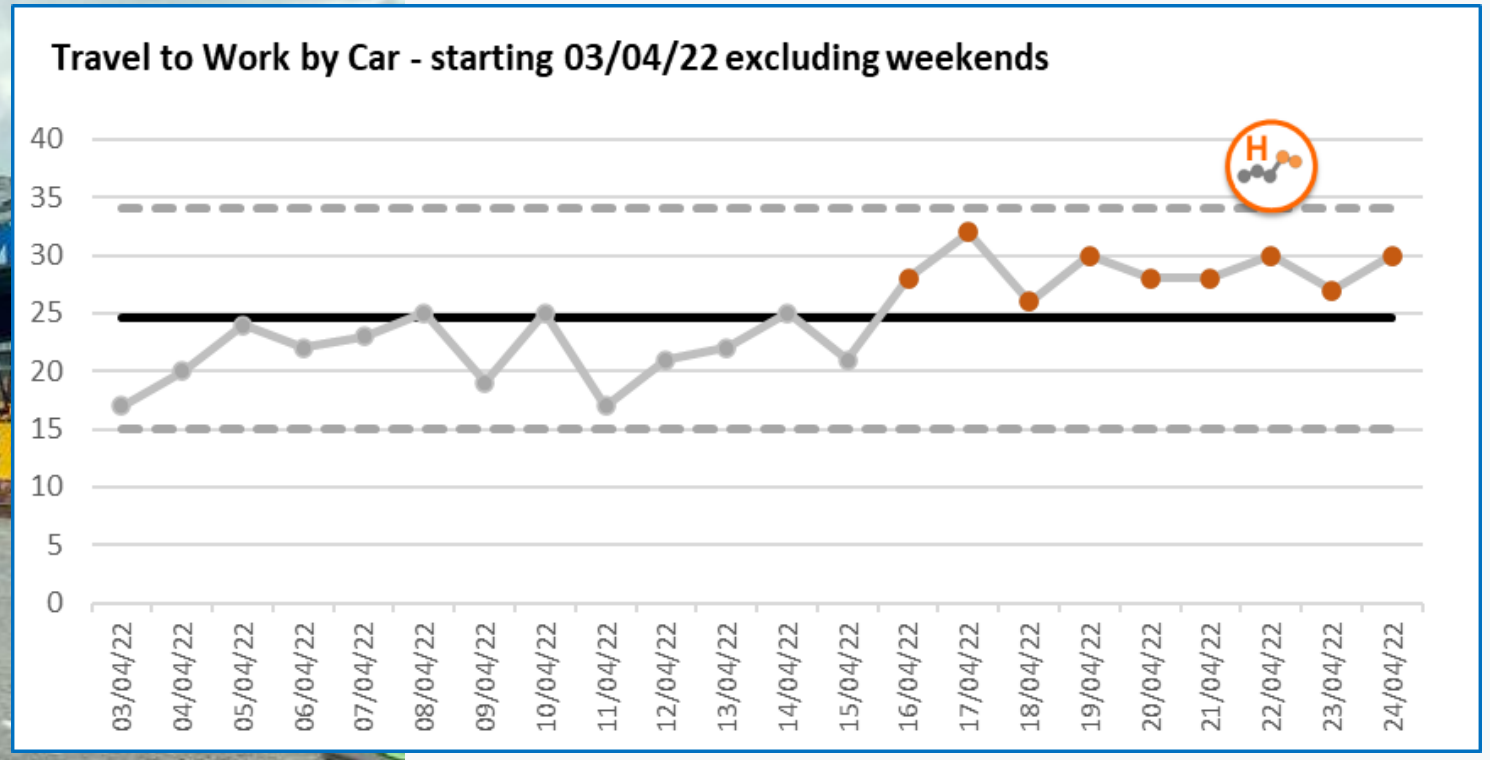
Variation matters : unusual one off (special cause)





Variation matters : unusual sustained (special cause)





Frequently seen in the NHS

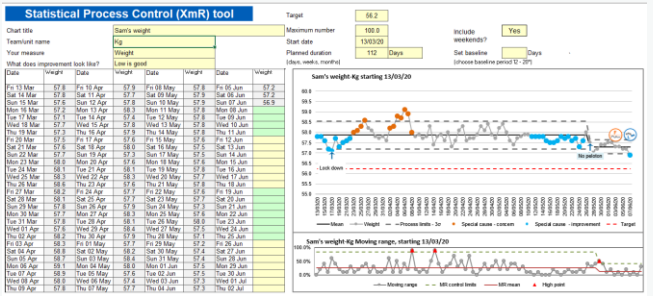
To make a
as if they v

Are you spuddling?

What is Making Data Count?

Teaching materials

Data for better decision making

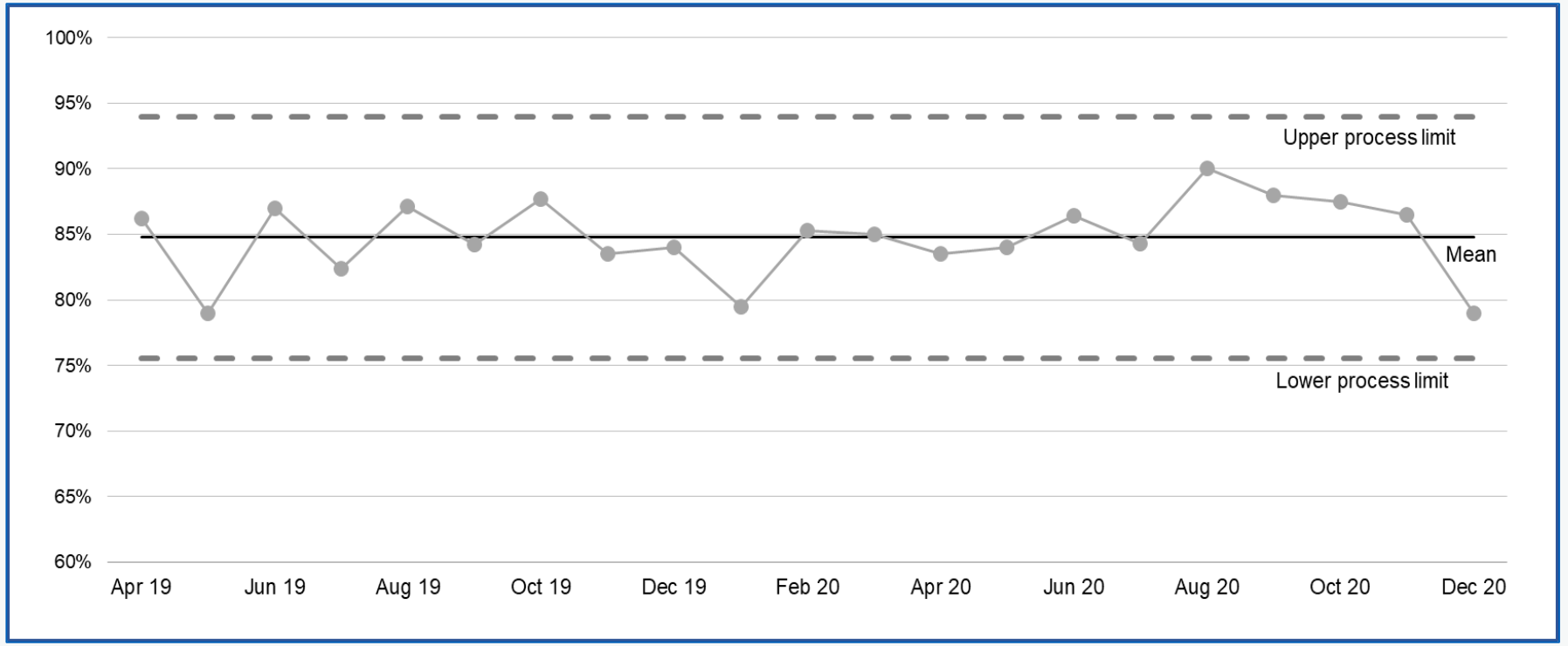


Training

Tools

The anatomy of a SPC chart

Time series line chart with 3 reference lines

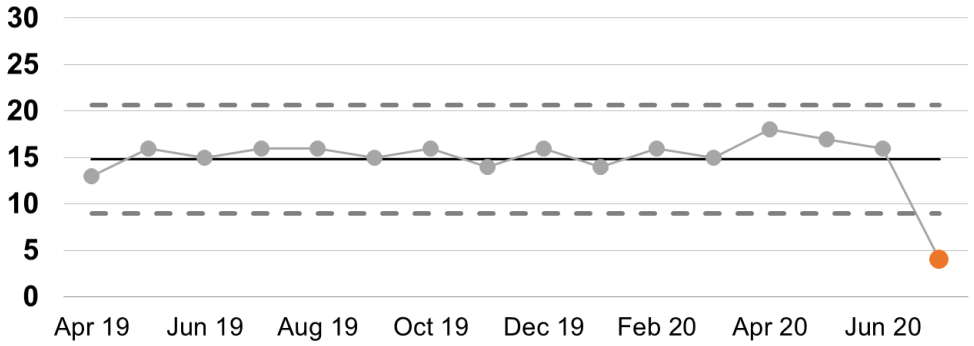


≈ 99% of data

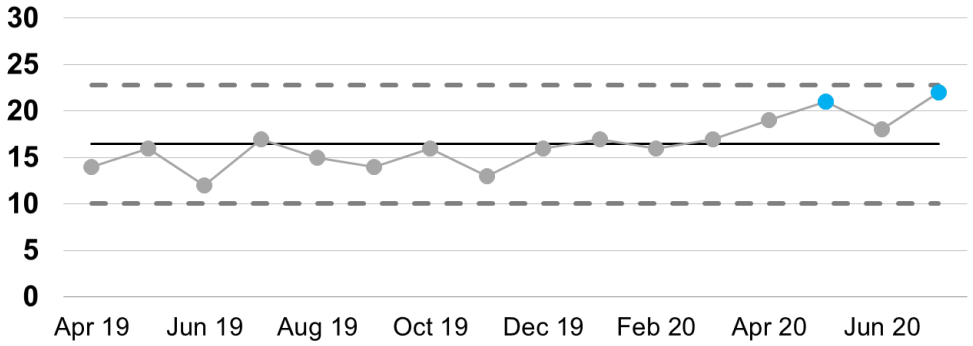
15+ data points for a robust analysis

SPC rules : special cause variation

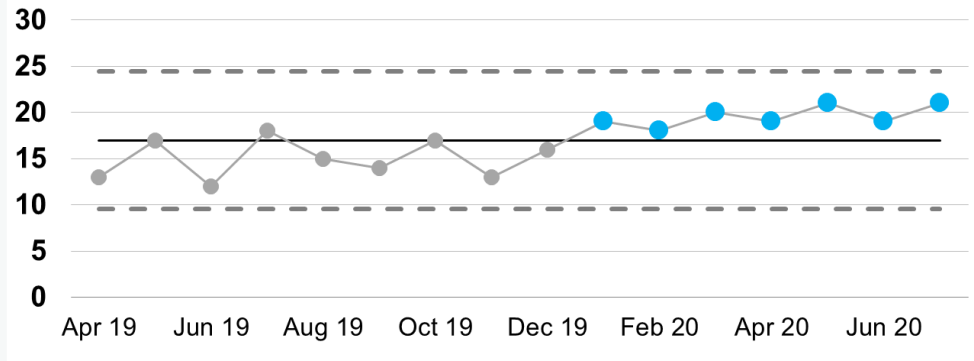
A single point outside the process limits



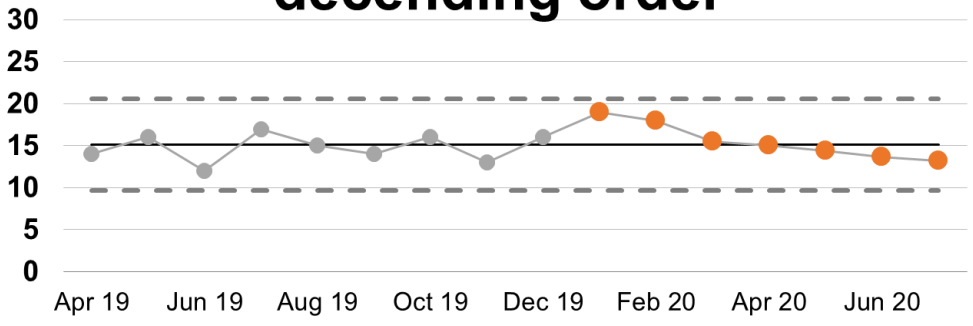
Two out of three points close to a process limit



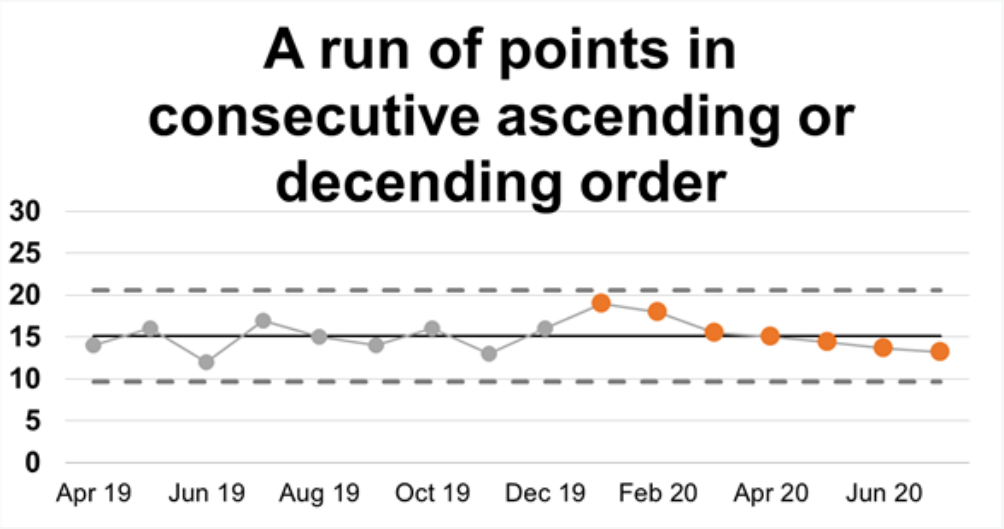
A shift of points above / below the mean



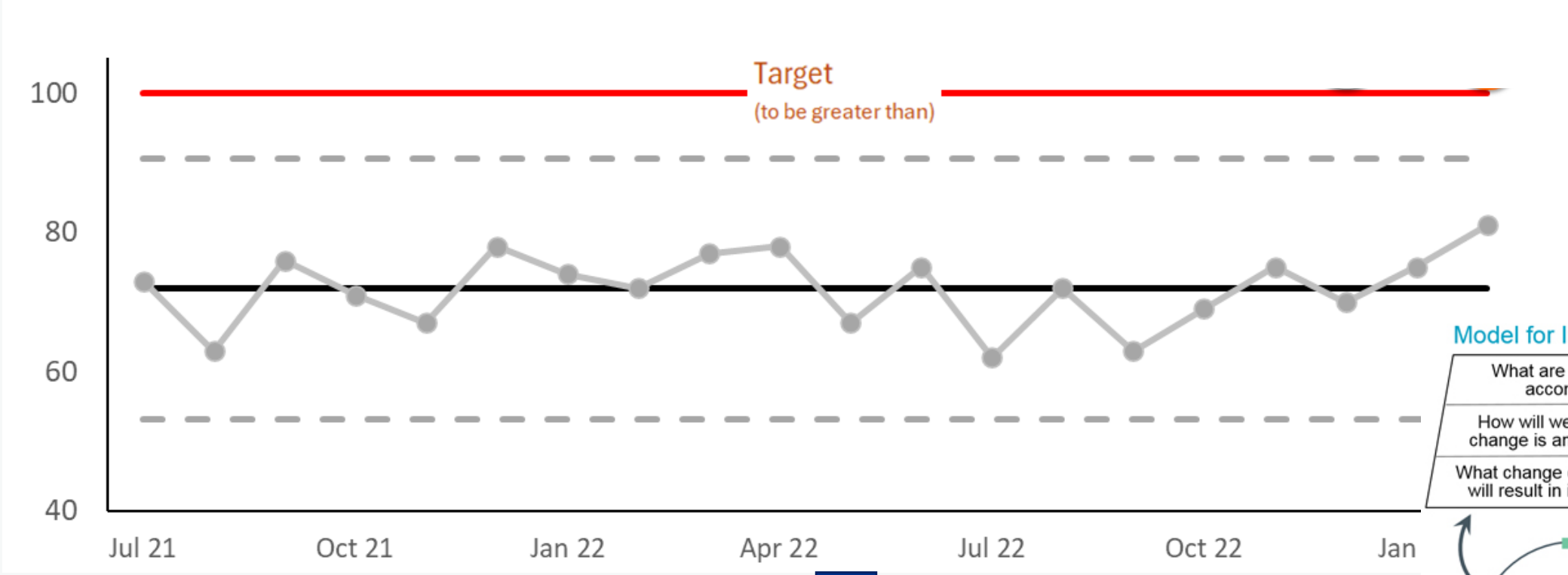
A run of points in consecutive ascending or decending order

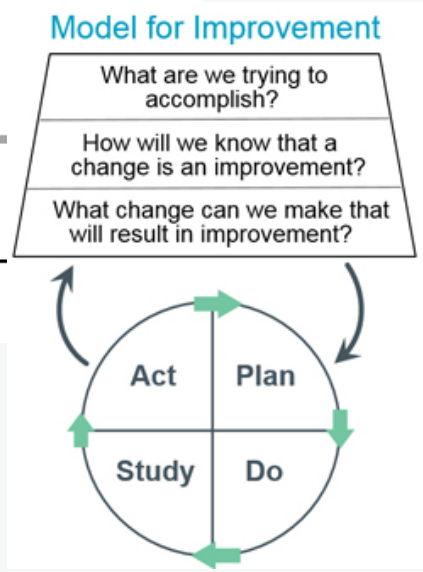


If you see ‘special cause’…….



Expected variation = common cause variation





Redesign the system

Did our changes work?

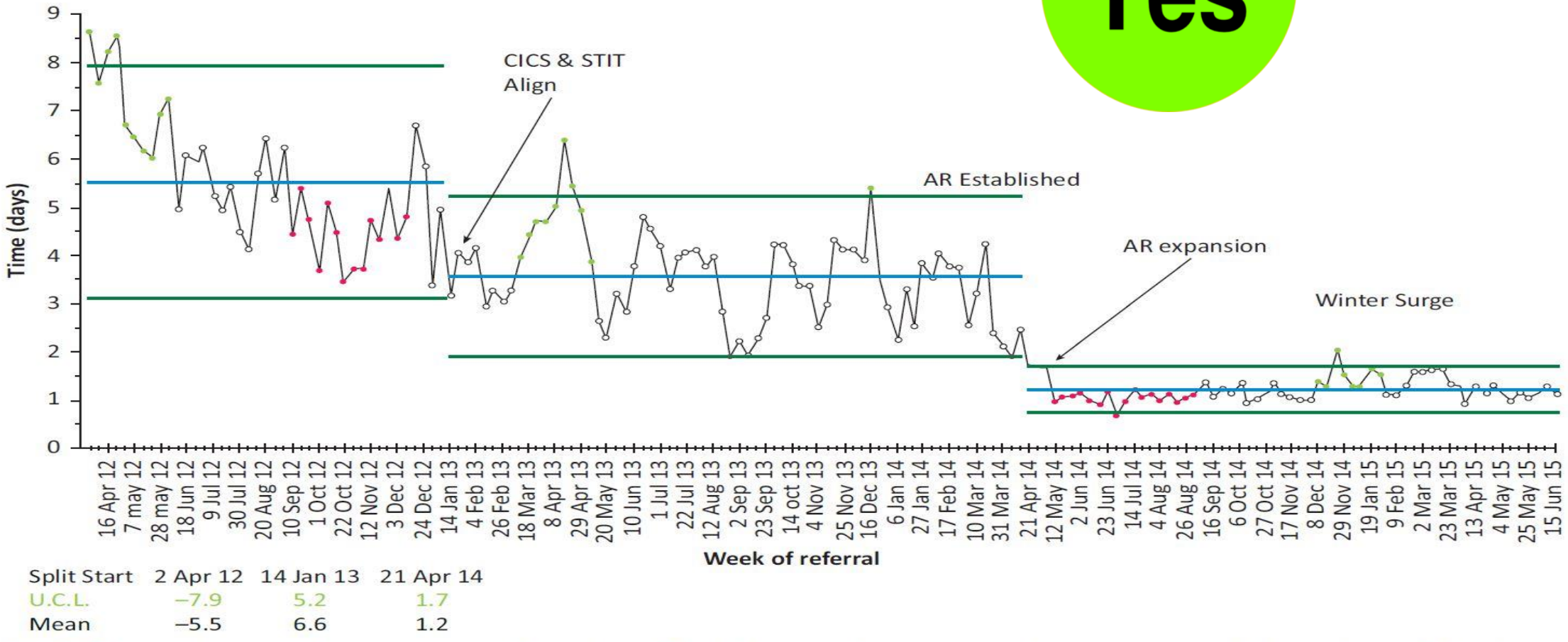
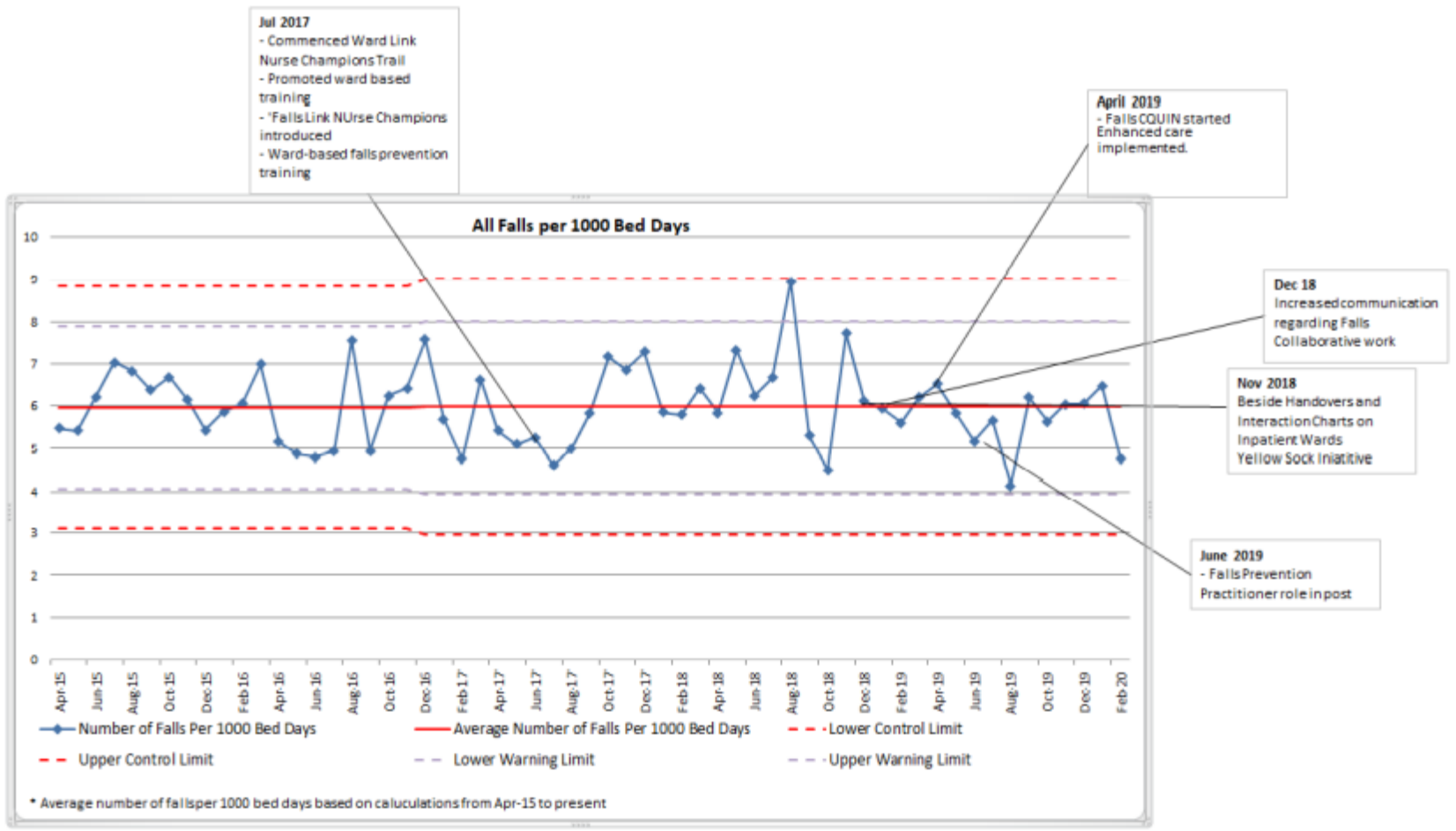


Fig 2. Reducing patient wait for active recovery from a hospital bed. AR = Active Recovery; CICS = Community Intermediate Care Service; STIT = Short Term Intervention Team

Did our changes work?



No

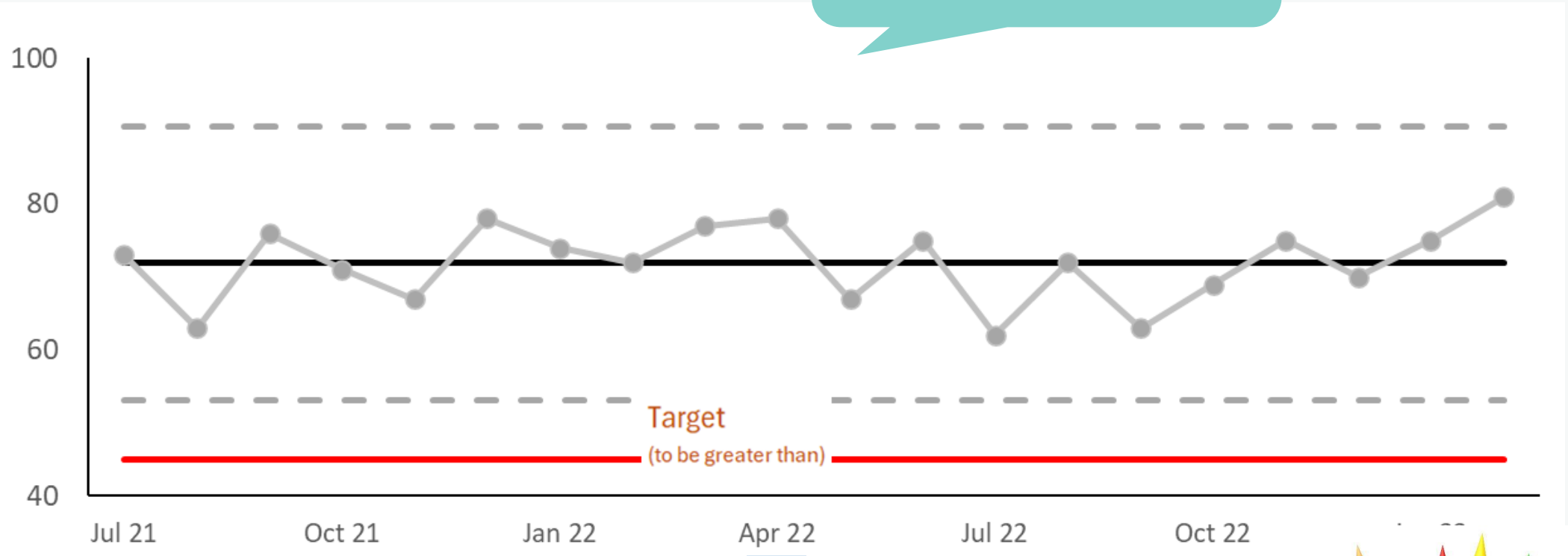
Were these the correct interventions?

Did we implement them properly?

Are there other factors we should consider?

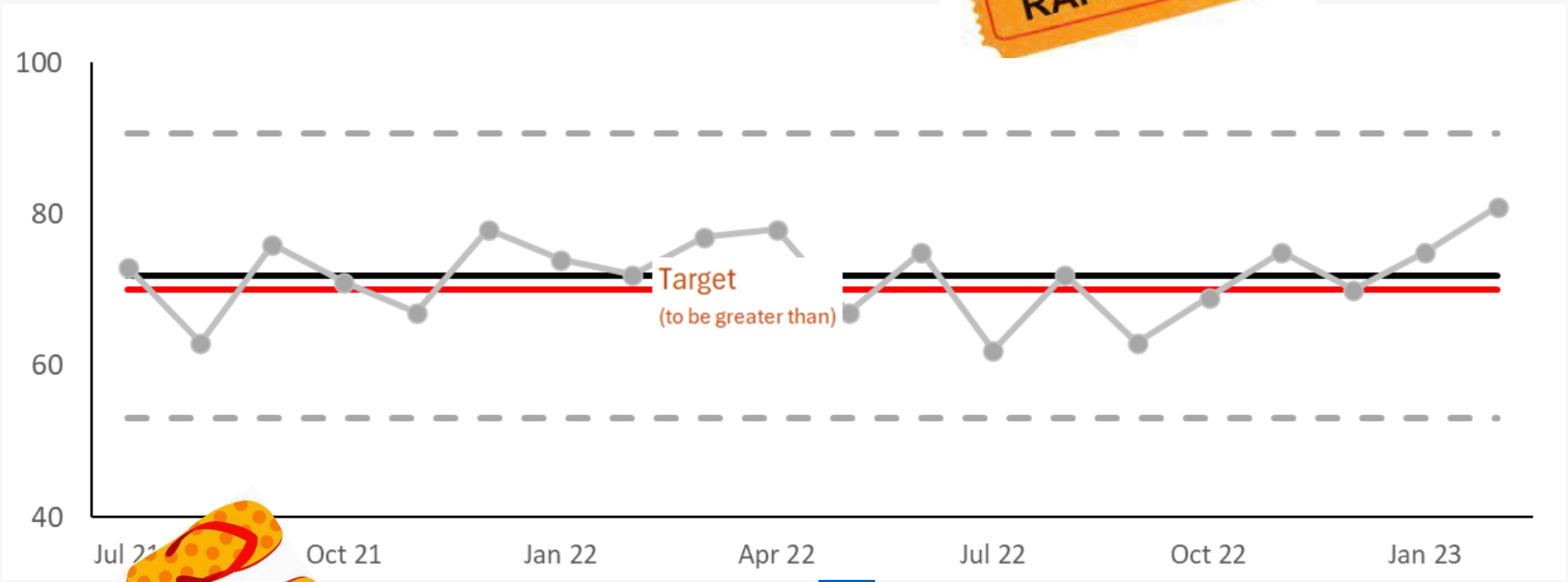
Using SPC for assurance

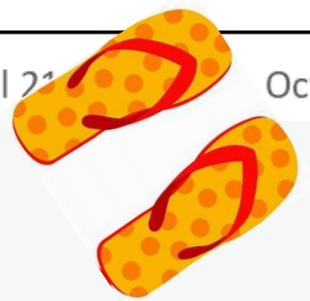
Should we change the target?



Capable system

Using SPC for assurance

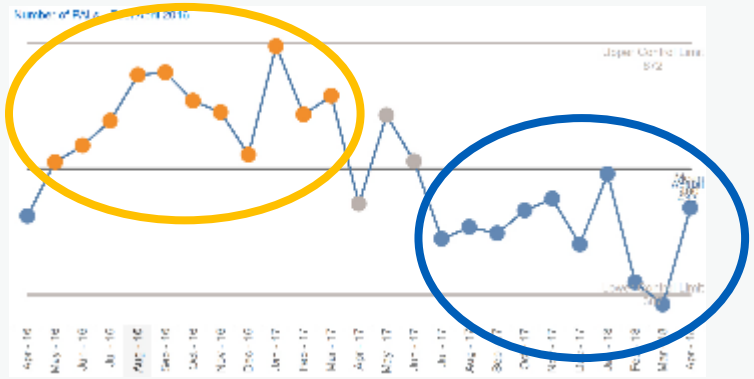




Will not reliably hit the target

Making data count conventions

Highlight special cause

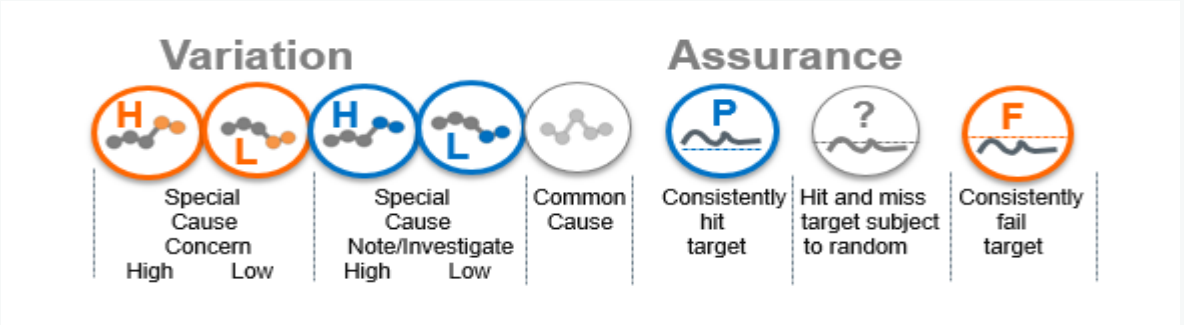


Concern

Improvement

No change

Summary icons



Specialty RTT Performance

Specialty Performance	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend	Trend
Cardiology	94.7%	92.0%	92.3%	92.3%	93.0%	92.7%	94.3%	93.7%	94.4%	↑	0.7%
Dermatology	98.4%	98.1%	98.2%	95.8%	89.3%	85.7%	90.3%	90.8%	92.1%	↑	1.3%
Ear, Nose & Throat	92.0%	92.9%	92.3%	91.8%	90.0%	89.1%	88.4%	88.4%	87.0%	↓	-1.4%
Gastroenterology	86.5%	87.7%	86.3%	87.7%	87.7%	86.7%	85.8%	85.5%	86.1%	↑	0.6%
General Medicine	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%		0.0%
General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	↓	-0.9%
Geriatric Medicine	98.9%	98.9%	98.0%	96.3%	94.4%	96.9%	98.0%	99.1%	98.6%	↓	-0.5%
Gynaecology	87.0%	87.8%	89.3%	89.3%	88.9%	87.9%	87.9%	87.1%	85.3%	↓	-1.8%
Neurology	92.1%	92.1%	92.8%	89.2%	83.2%	84.7%	86.3%	87.6%	86.7%	↓	-0.9%
Ophthalmology	81.2%	84.5%	84.9%	86.3%	89.2%	89.3%	90.4%	90.0%	87.6%	↓	-2.4%
Oral Surgery	78.8%	81.8%	83.6%	82.6%	81.8%	83.9%	84.6%	85.7%	83.5%	↓	-2.2%
Orthopaedics	88.6%	92.0%	91.4%	89.3%	87.4%	87.1%	85.5%	83.6%	83.2%	↓	-0.4%
Other	87.9%	88.4%	90.0%	89.7%	89.8%	89.6%	91.0%	91.5%	90.4%	↓	-1.1%
Plastic Surgery	82.2%	84.7%	87.6%	89.2%	88.7%	88.2%	88.6%	87.9%	84.7%	↓	-3.2%
Respiratory Medicine	79.3%	83.4%	87.5%	89.8%	92.2%	93.2%	92.6%	92.2%	86.1%	↓	-6.1%
Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%
Urology	85.4%	87.5%	88.7%	89.9%	91.5%	91.4%	92.0%	92.2%	90.6%	↓	-1.6%
TRUST	86.1%	87.7%	88.7%	88.7%	88.3%	87.9%	88.7%	88.7%	87.4%	↓	-1.3%

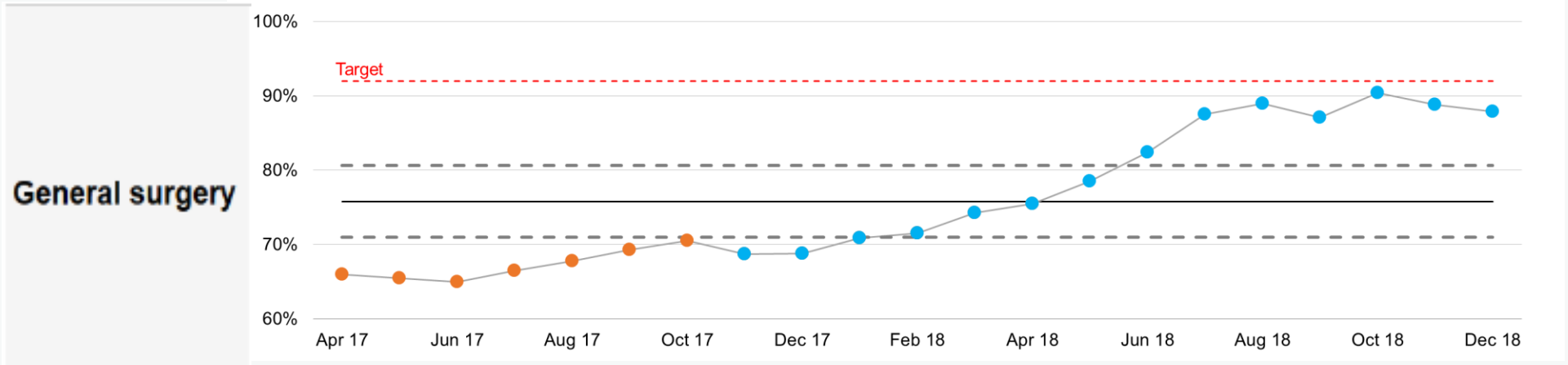
Declining and failing?

Specialty RTT Performance

Specialty Performance	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend	Trend
Cardiology	94.7%	92.0%	92.3%	92.3%	93.0%	92.7%	94.3%	93.7%	94.4%	↑	0.7%
Dermatology	98.4%	98.1%	98.2%	95.8%	89.3%	85.7%	90.3%	90.8%	92.1%	↑	1.3%
Ear, Nose & Throat	92.0%	92.9%	92.3%	91.8%	90.0%	89.1%	88.4%	88.4%	87.0%	↓	-1.4%
Gastroenterology	86.5%	87.7%	86.3%	87.7%	87.7%	86.7%	85.8%	85.5%	86.1%	↑	0.6%
General Medicine	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%		0.0%
General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	↓	-0.9%
Geriatric Medicine	98.9%	98.9%	98.0%	96.3%	94.4%	96.9%	98.0%	99.1%	98.6%	↓	-0.5%
Gynaecology	87.0%	87.8%	89.3%	89.3%	88.9%	87.9%	87.9%	87.1%	85.3%	↓	-1.8%
Neurology	92.1%	92.1%	92.8%	89.2%	83.2%	84.7%	86.3%	87.6%	86.7%	↓	-0.9%
Ophthalmology	81.2%	84.5%	84.9%	86.3%	89.2%	89.3%	90.4%	90.0%	87.6%	↓	-2.4%
Oral Surgery	78.8%	81.8%	83.6%	82.6%	81.8%	83.9%	84.6%	85.7%	83.5%	↓	-2.2%
Orthopaedics	88.6%	92.0%	91.4%	89.3%	87.4%	87.1%	85.5%	83.6%	83.2%	↓	-0.4%
Other	87.9%	88.4%	90.0%	89.7%	89.8%	89.6%	91.0%	91.5%	90.4%	↓	-1.1%
Plastic Surgery	82.2%	84.7%	87.6%	89.2%	88.7%	88.2%	88.6%	87.9%	84.7%	↓	-3.2%
Respiratory Medicine	79.3%	83.4%	87.5%	89.8%	92.2%	93.2%	92.6%	92.2%	86.1%	↓	-6.1%
Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%
Urology	85.4%	87.5%	88.7%	89.9%	91.5%	91.4%	92.0%	92.2%	90.6%	↓	-1.6%
TRUST	86.1%	87.7%	88.7%	88.7%	88.3%	87.9%	88.7%	88.7%	87.4%	↓	-1.3%

General Surgery

General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	↓	-0.9%



The same story?

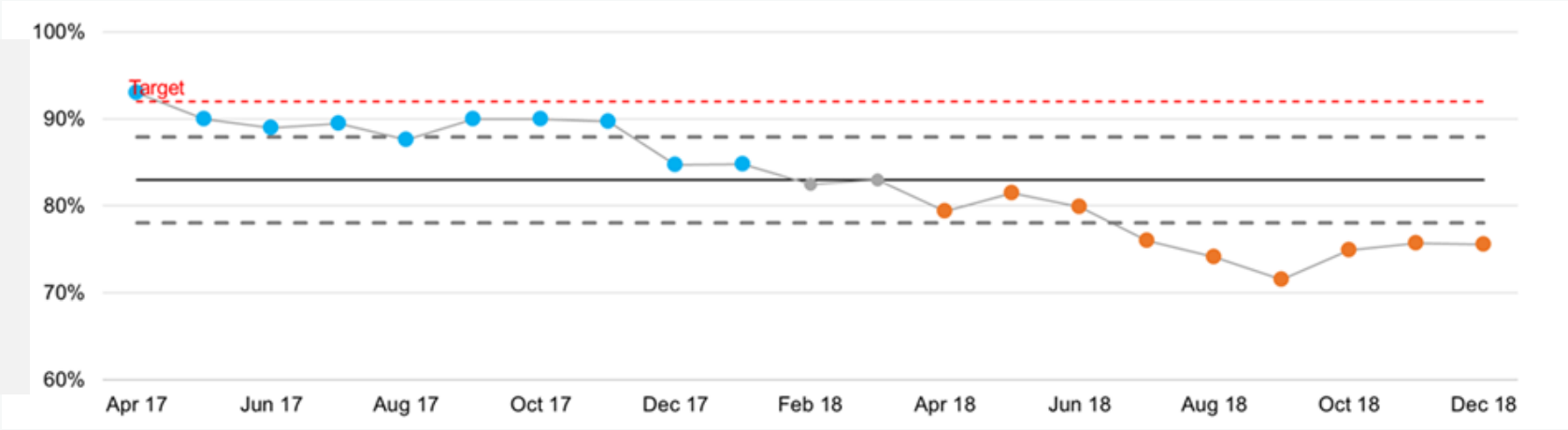
Specialty RTT Performance

Specialty Performance	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend	Trend
Cardiology	94.7%	92.0%	92.3%	92.3%	93.0%	92.7%	94.3%	93.7%	94.4%	↑	0.7%
Dermatology	98.4%	98.1%	98.2%	95.8%	89.3%	85.7%	90.3%	90.8%	92.1%	↑	1.3%
Ear, Nose & Throat	92.0%	92.9%	92.3%	91.8%	90.0%	89.1%	88.4%	88.4%	87.0%	↓	-1.4%
Gastroenterology	86.5%	87.7%	86.3%	87.7%	87.7%	86.7%	85.8%	85.5%	86.1%	↑	0.6%
General Medicine	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%		0.0%
General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	↓	-0.9%
Geriatric Medicine	98.9%	98.9%	98.0%	96.3%	94.4%	96.9%	98.0%	99.1%	98.6%	↓	-0.5%
Gynaecology	87.0%	87.8%	89.3%	89.3%	88.9%	87.9%	87.9%	87.1%	85.3%	↓	-1.8%
Neurology	92.1%	92.1%	92.8%	89.2%	83.2%	84.7%	86.3%	87.6%	86.7%	↓	-0.9%
Ophthalmology	81.2%	84.5%	84.9%	86.3%	89.2%	89.3%	90.4%	90.0%	87.6%	↓	-2.4%
Oral Surgery	78.8%	81.8%	83.6%	82.6%	81.8%	83.9%	84.6%	85.7%	83.5%	↓	-2.2%
Orthopaedics	88.6%	92.0%	91.4%	89.3%	87.4%	87.1%	85.5%	83.6%	83.2%	↓	-0.4%
Other	87.9%	88.4%	90.0%	89.7%	89.8%	89.6%	91.0%	91.5%	90.4%	↓	-1.1%
Plastic Surgery	82.2%	84.7%	87.6%	89.2%	88.7%	88.2%	88.6%	87.9%	84.7%	↓	-3.2%
Respiratory Medicine	79.3%	83.4%	87.5%	89.8%	92.2%	93.2%	92.6%	92.2%	86.1%	↓	-6.1%
Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%
Urology	85.4%	87.5%	88.7%	89.9%	91.5%	91.4%	92.0%	92.2%	90.6%	↓	-1.6%
TRUST	86.1%	87.7%	88.7%	88.7%	88.3%	87.9%	88.7%	88.7%	87.4%	↓	-1.3%

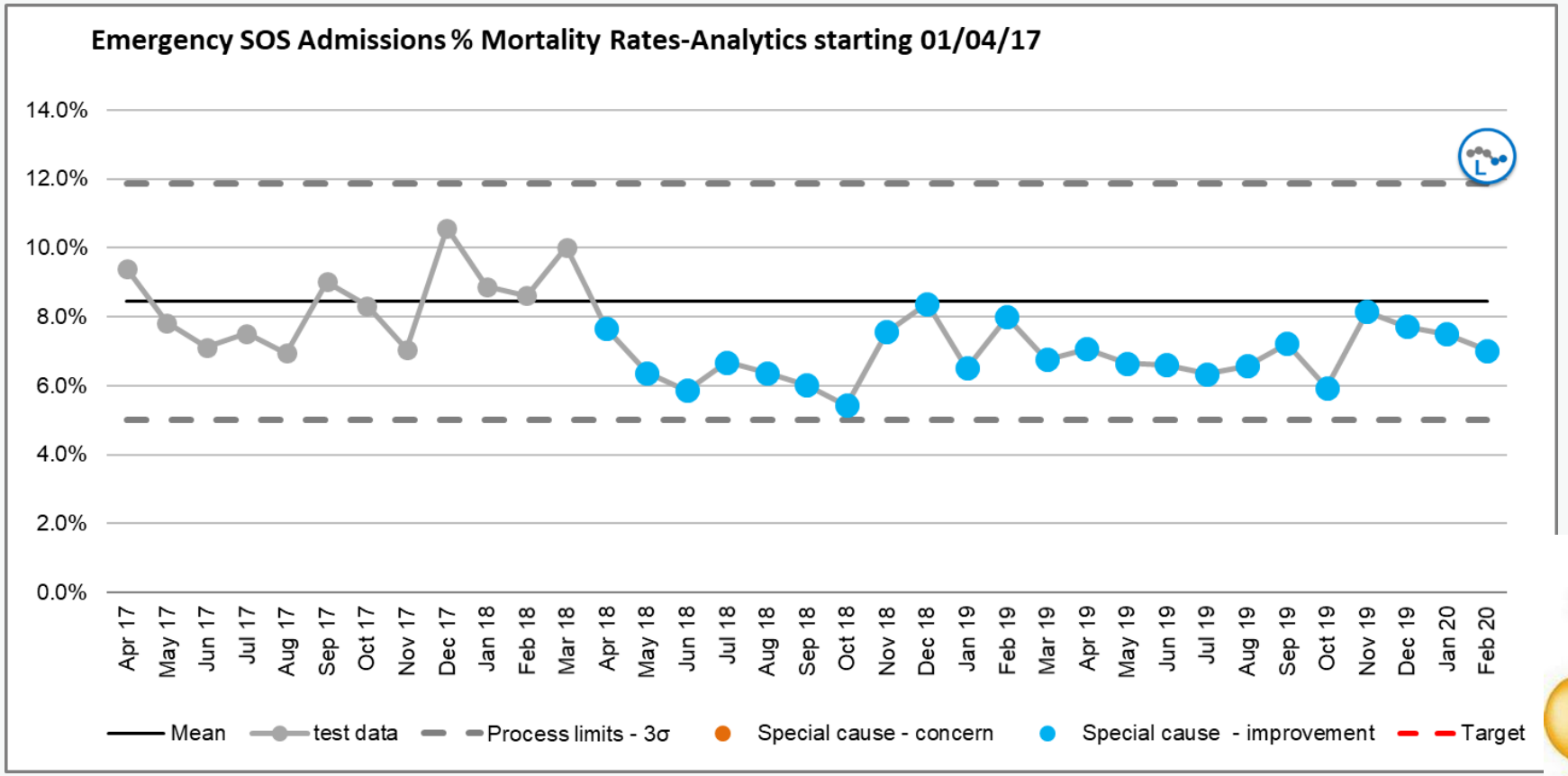
Rheumatology

Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%

Rheumatology

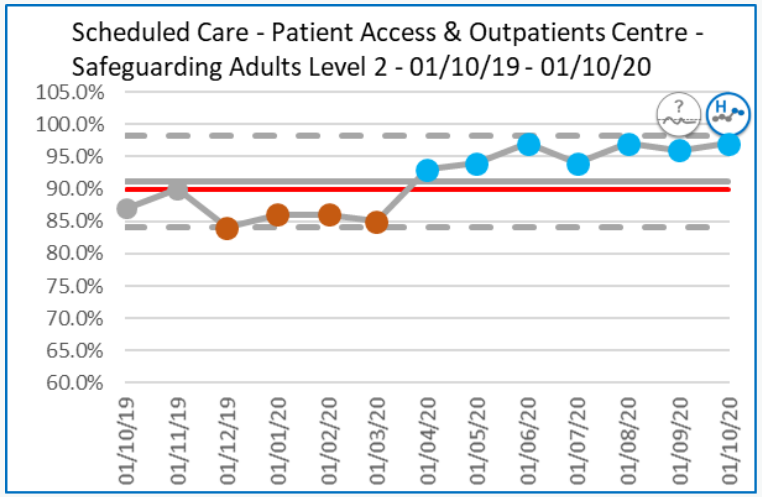


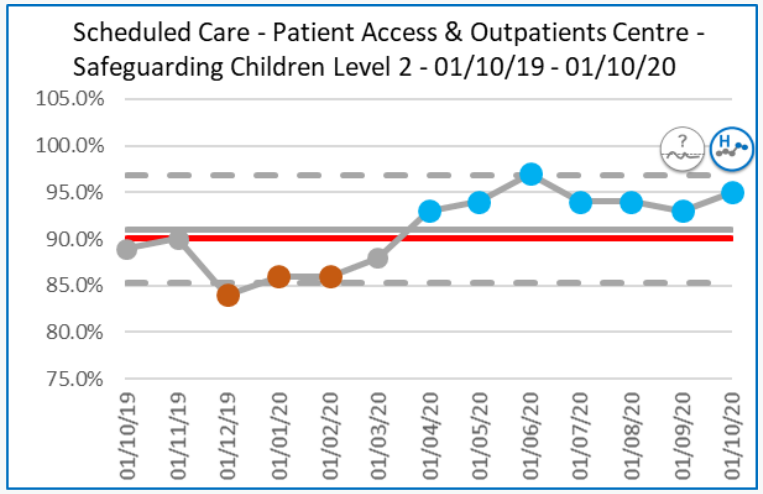
Reduction in mortality

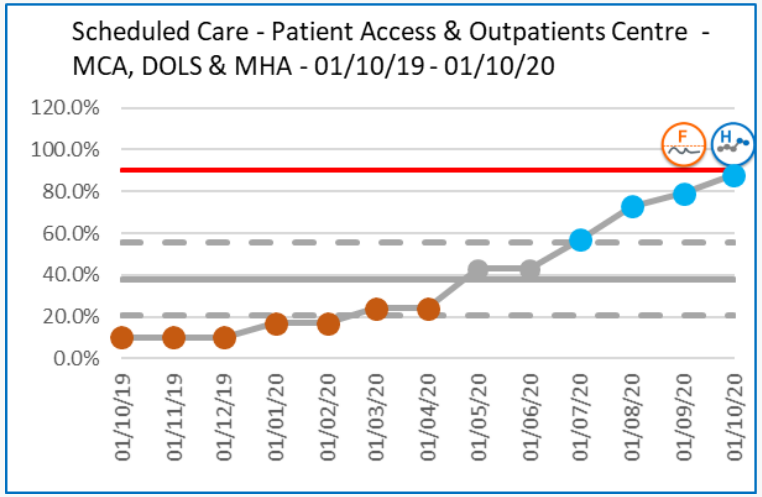


Significant improvement since April ‘18

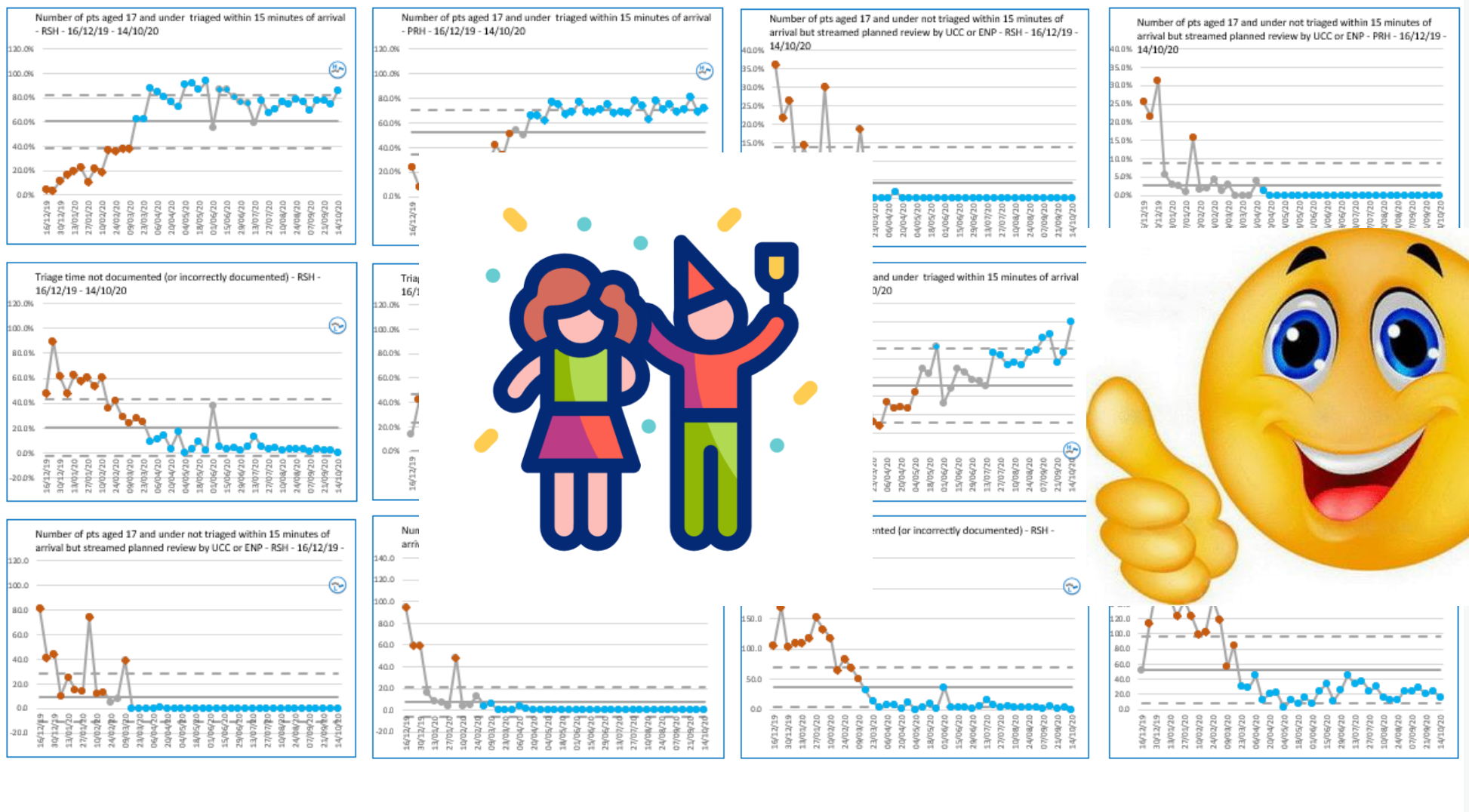
Improvement in safeguarding training







A&E improvements across 2 sites



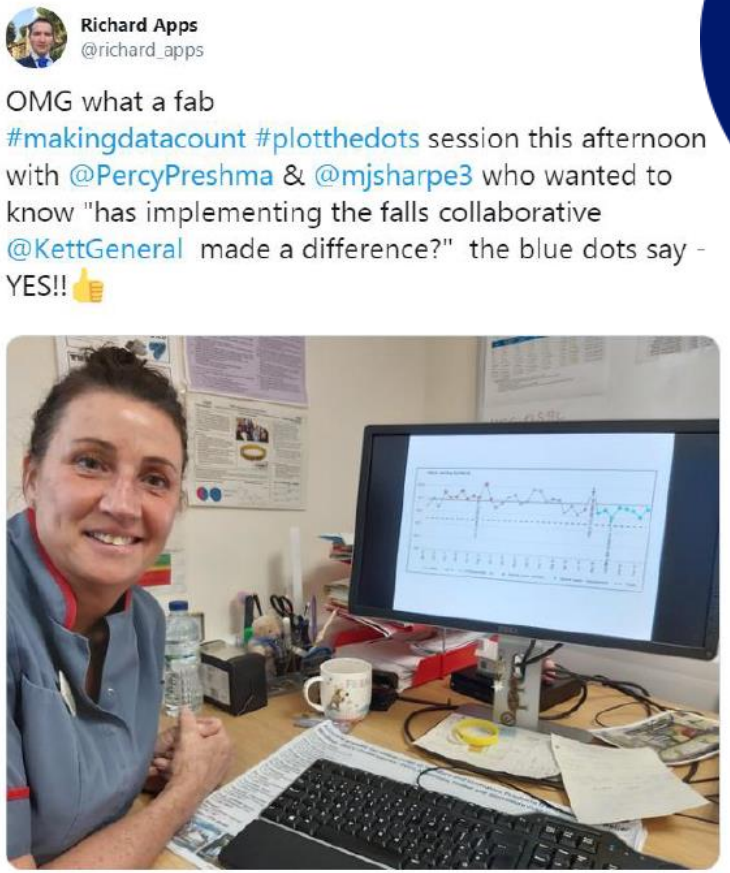
Rie's question…..

Has the falls collaborative made a difference?

Rie Sharp from the Practice Development team has been leading the Trust's work on reducing harm from patient falls; although a lot has been done, there is no explicit evidence that a change has occurred, or if that change is an improvement.
Rie had one question –

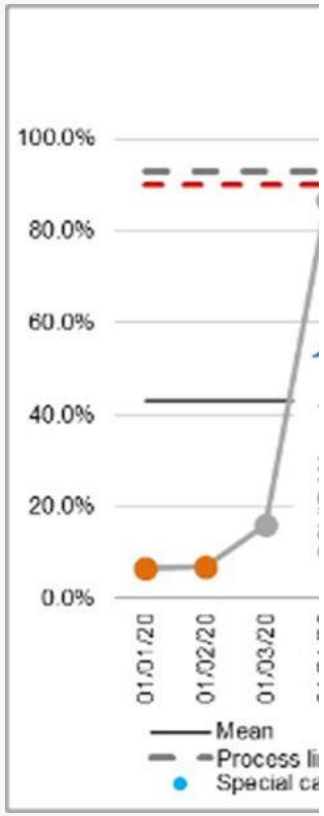
"Has implementing the falls collaborative made a difference?"

Using the SPC tool gave the almost instantaneous answer - YES – a statistically significant reduction in reported patient fall incidents can be seen directly after the introduction of the falls collaborative – and it has sustained…!



The blue dots say yes!!!!

Using data to evidence improvement



Open access Quality improvement report

BMJ Open Quality

Novel solutions to old problems: improving the reliability of emergency equipment provision in critical care using accessible digital solutions

Christopher Mark Hunter ,[1] Daniel Paul ,[1] Benjamin Plumb[2]

To cite: Hunter CM, Paul D, Plumb B. Novel solutions to old problems: improving the reliability of emergency equipment provision in critical care using accessible digital solutions. *BMJ Open Quality* 2022;**11**:e001953. doi:10.1136/bmjoq-2022-001953

CMH and DP contributed equally.

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ABSTRACT

Reliable provision of emergency equipment in Critical Care is key to ensure patient safety during medical emergencies and transfers. A problem was identified in incident reports and external inspections of processes that ensured the provision of such equipment for use by critical care teams in non-critical care areas in the form of grab bags. A comprehensive project was undertaken to tackle this including the provision of a bespoke digital system. Existing systems were reliant on staff remembering to check equipment and document checks on paper and there was no formal ability to hand over ongoing problems. A local project management approach, '7 Steps to Quality Improvement', which integrated many of the philosophies and tools from Healthcare Improvement was used. A bespoke digital system was designed and implemented with integrated improvements in equipment stocking ergonomics.

The reliability of documented equipment checks improved significantly, there was a significant reduction in the number of incident reports regarding emergency equipment and the time spent by staff doing equipment checks was reduced substantially with significant cost and resource improvements. This was so successful the format has been rapidly translated and spread to other areas such as operating theatres' difficult airway trolleys.

Undertaking a structured quality improvement approach, using appropriate stakeholder engagement, digitalisation of systems and improvements in basic system ergonomics can have a substantial impact on the reliability and safety of emergency equipment provided for use by members of the critical care team.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ National standards exist for the provision of emergency equipment within critical care. There is no established practice or academic research as to how this should be achieved.

WHAT THIS STUDY ADDS

⇒ This report demonstrates that digital solutions can be used effectively to increase patient safety and reduce costs. It describes the digital system used and its advantages over a paper record over a 2-year period.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The authors believe this digital system could be used as a model for further implementation both locally for equipment outside of critical care and regionally to address similar issues with documentation.

PROBLEM

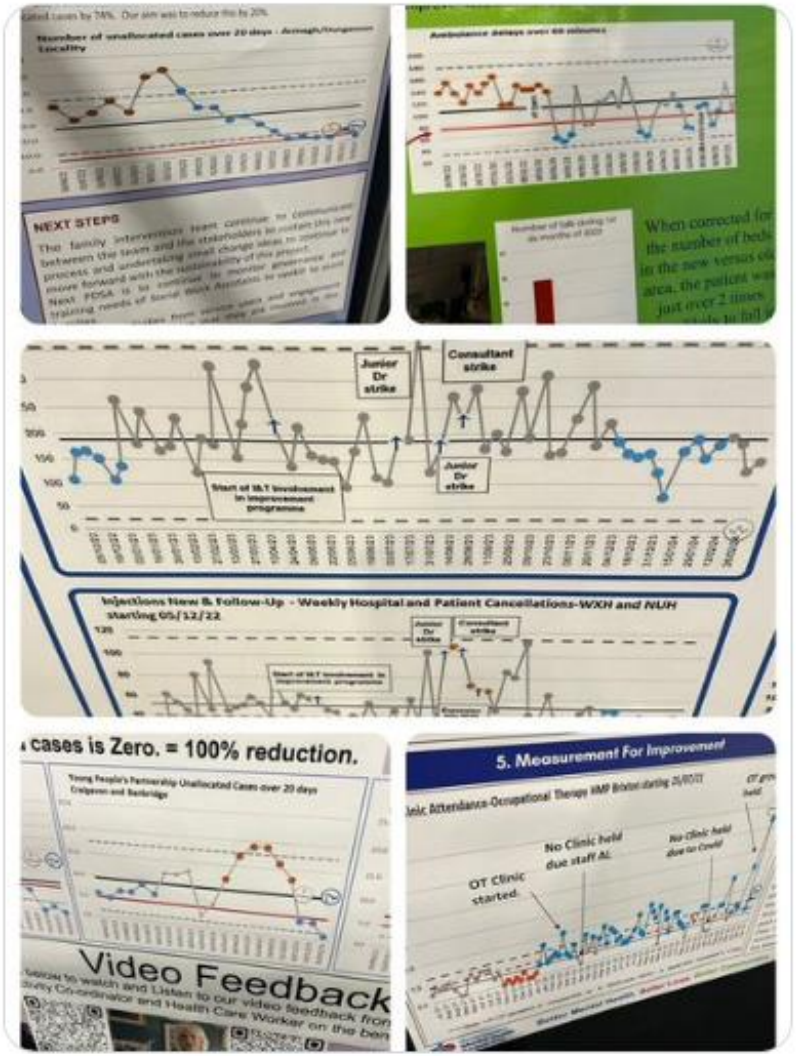
was insufficient evidence of equipment safety checks for transfer bags, emergency drug pouches and airway trolleys. A daily hand-written, paper record of equipment checks was introduced in response.

A subsequent CQC inspection in 2020 highlighted the issue again. The report stated that, "*the checking of the resuscitation equipment was not carried out consistently, as was the case on our previous inspection*" despite these changes.[1] The paper documentation was

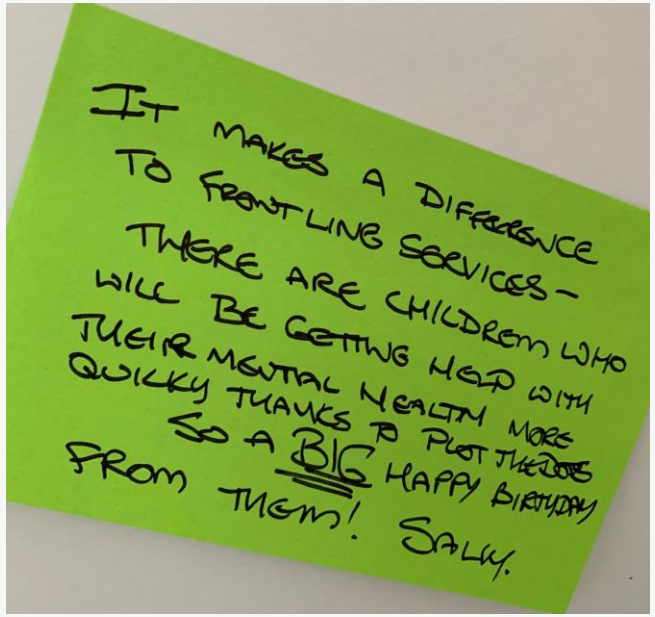
[Novel solutions to old problems: improving the reliability of emergency equipment provision in critical care using accessible digital solutions | BMJ Open Quality]

Adam Sewell-Jones @AdamSewellJones · Apr 12

Great to see so many of the posters at #Quality2024 using #plotthedots resources developed by @NHSImprovement for use by improvers across the globe @samriley

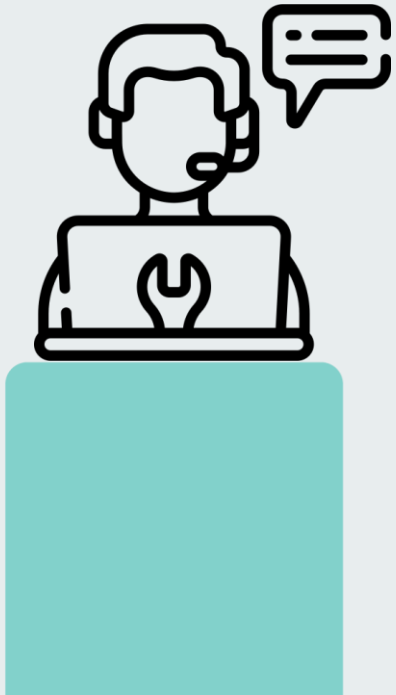


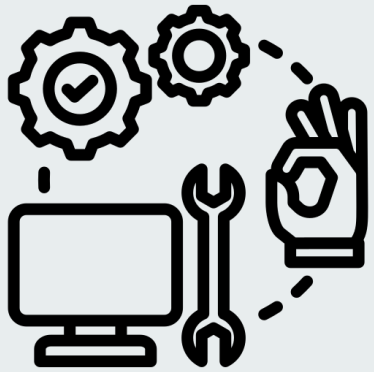
Sally’s #plotthedots story



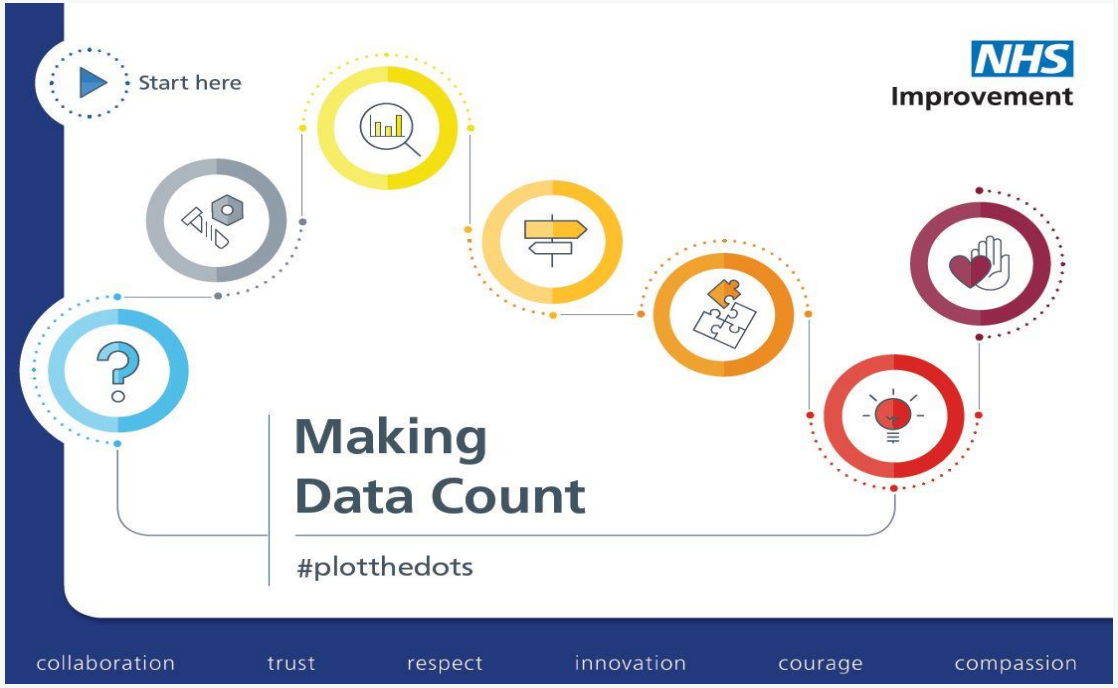
[The role of SPC in improving patient care — a perspective from a clinician - YouTube]

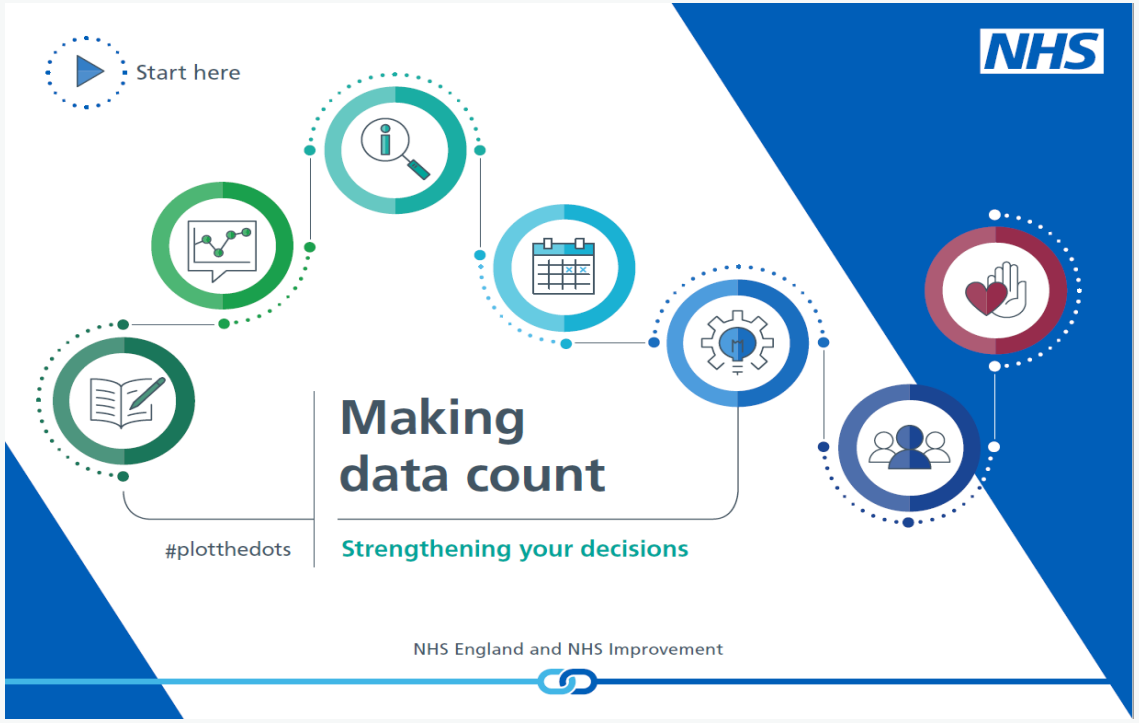
Support and resources





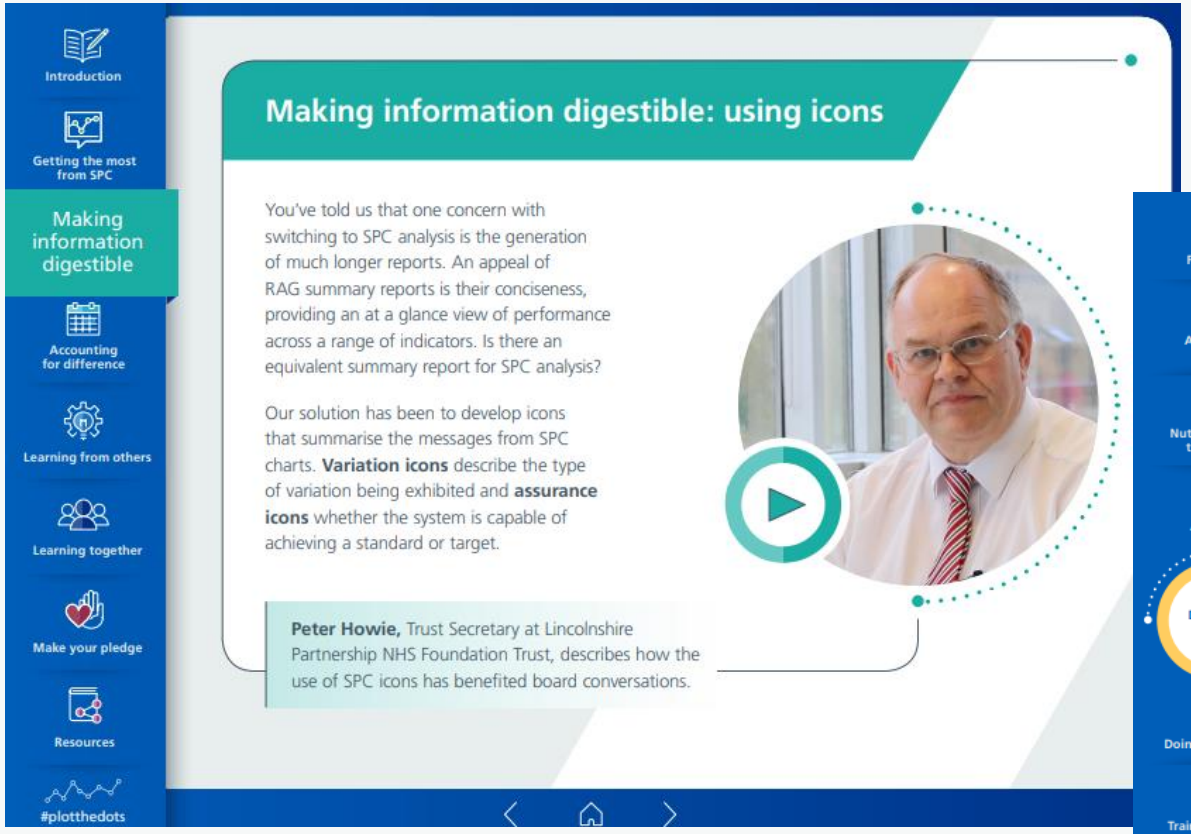
Interactive PDFs

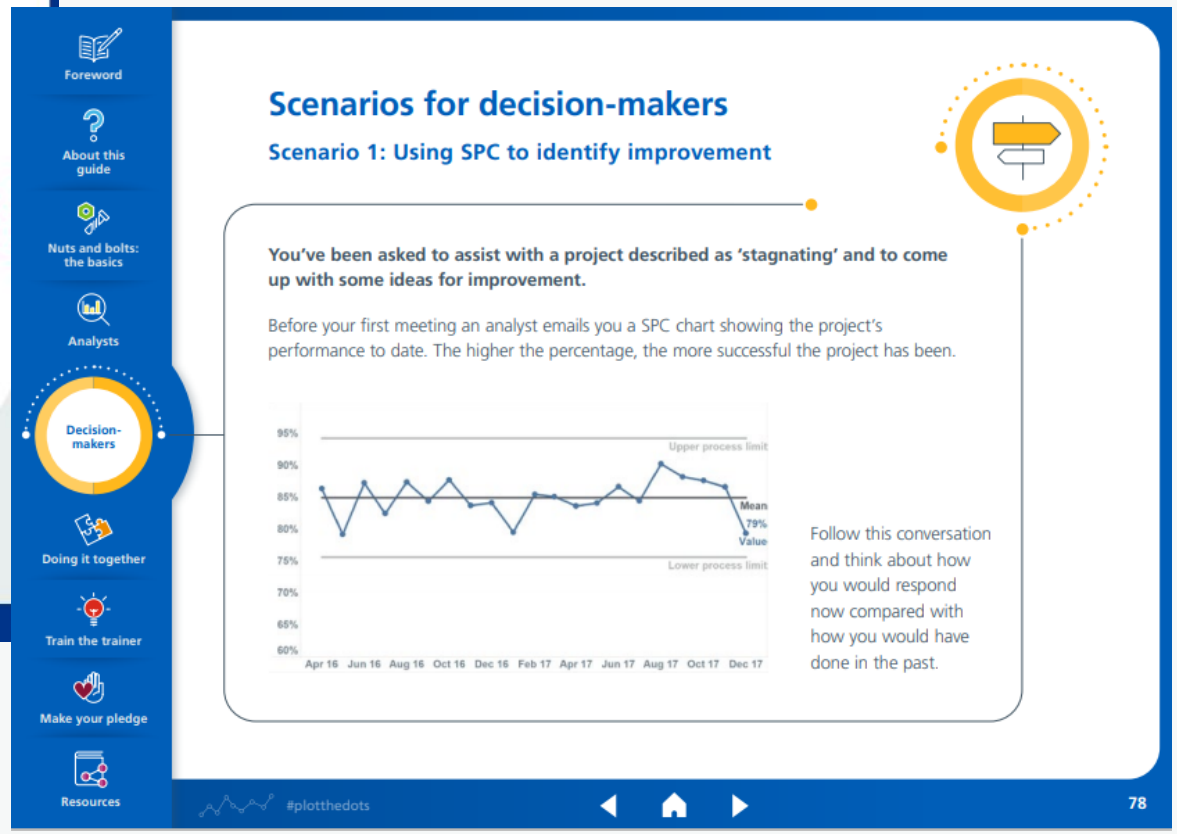




[NHS England » Making data count]

User friendly & easy to navigate





Fancy some of these?

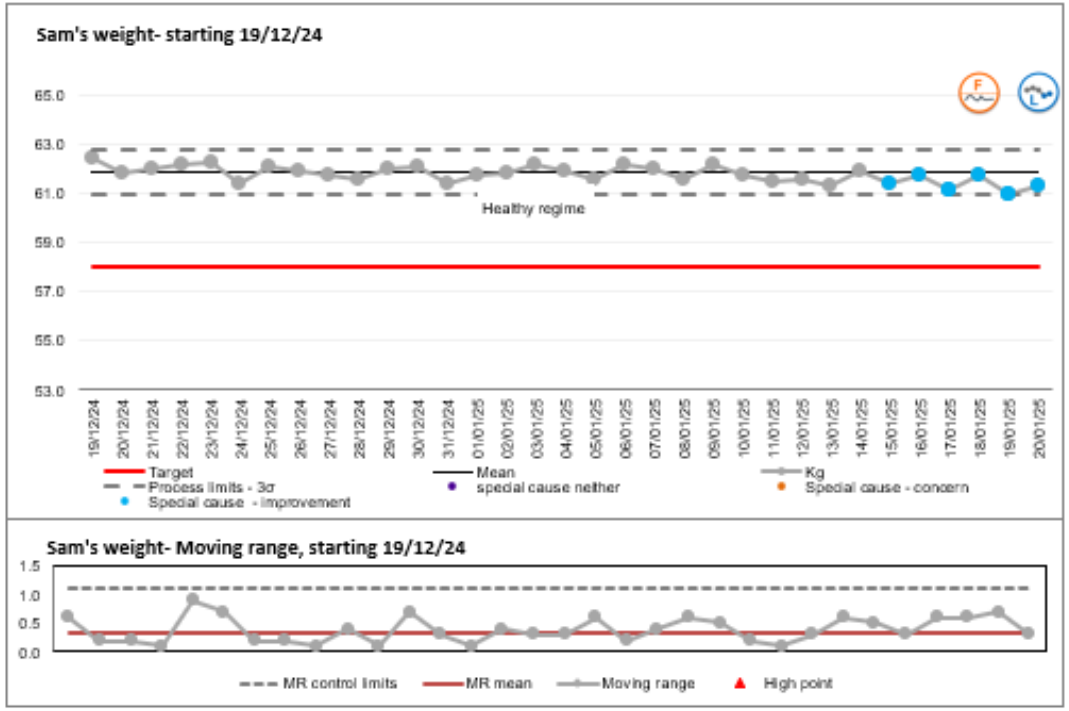
We have SPC tools

Statistical Process Control (XmR) tool

Chart title	Sam's weight
Team/unit name	
Your measure	Kg
does improvement look like?	Low is good

Target	58.00			Points for significance	6	(shift and trend)	
Maximum number	100.0			Include weekends?	Yes		
Start date	19/12/24						
Planned duration	112	Days		Set baseline	15	Days	Icon height 65.00
(days, weeks, months)				(choose baseline period 12 - 20*)			

Date	Kg	Date	Kg	Date	Kg	Date	Kg
19/12/24	62.40	16/01/25	61.70	13/02/25		13/03/25	
20/12/24	61.80	17/01/25	61.10	14/02/25		14/03/25	
21/12/24	62.00	18/01/25	61.70	15/02/25		15/03/25	
22/12/24	62.20	19/01/25	61.00	16/02/25		16/03/25	
23/12/24	62.30	20/01/25	61.30	17/02/25		17/03/25	
24/12/24	61.40	21/01/25		18/02/25		18/03/25	
25/12/24	62.10	22/01/25		19/02/25		19/03/25	
26/12/24	61.90	23/01/25		20/02/25		20/03/25	
27/12/24	61.70	24/01/25		21/02/25		21/03/25	
28/12/24	61.60	25/01/25		22/02/25		22/03/25	
29/12/24	62.00	26/01/25		23/02/25		23/03/25	
30/12/24	62.10	27/01/25		24/02/25		24/03/25	
31/12/24	61.40	28/01/25		25/02/25		25/03/25	
01/01/25	61.70	29/01/25		26/02/25		26/03/25	
02/01/25	61.80	30/01/25		27/02/25		27/03/25	
03/01/25	62.20	31/01/25		28/02/25		28/03/25	
04/01/25	61.90	01/02/25		01/03/25		29/03/25	
05/01/25	61.60	02/02/25		02/03/25		30/03/25	
06/01/25	62.20	03/02/25		03/03/25		31/03/25	
07/01/25	62.00	04/02/25		04/03/25		01/04/25	
08/01/25	61.60	05/02/25		05/03/25		02/04/25	
09/01/25	62.20	06/02/25		06/03/25		03/04/25	
10/01/25	61.70	07/02/25		07/03/25		04/04/25	
11/01/25	61.50	08/02/25		08/03/25		05/04/25	
12/01/25	61.60	09/02/25		09/03/25		06/04/25	
13/01/25	61.30	10/02/25		10/03/25		07/04/25	
14/01/25	61.90	11/02/25		11/03/25		08/04/25	
15/01/25	61.40	12/02/25		12/03/25		09/04/25	



Instructions | Clear all | Export chart to powerpoint | Clear interventions | Print | Sav

Set vertical	* see instruction sheet point 9
min value	53.00
max value	65.00
number format	Decimal
date format	dd/mm/yy

Change axis

Interventions annotation date

select a date and enter a comment

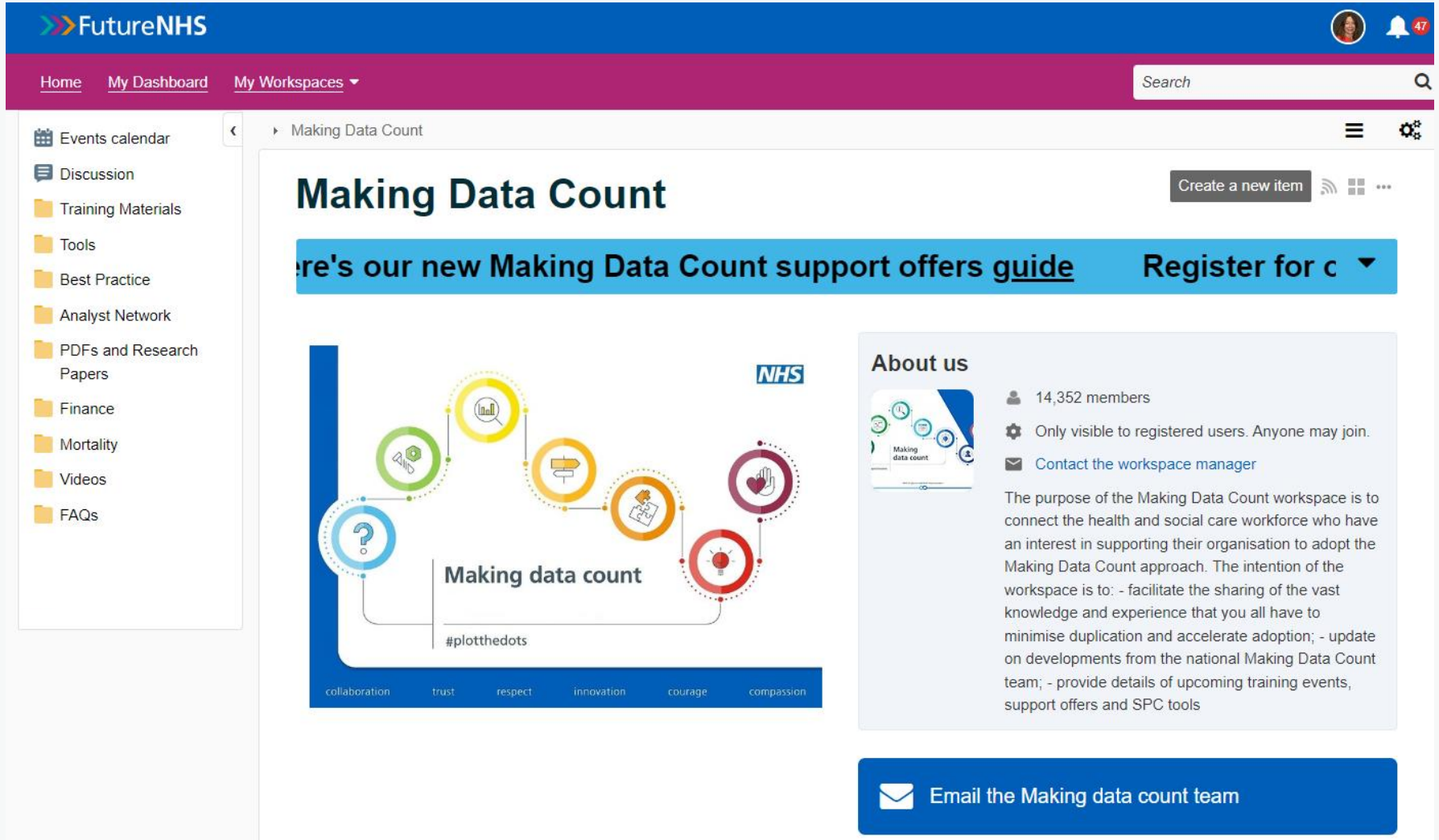
19/12/2024	Healthy regime
28/12/2024	
25/12/2024	
30/12/2024	
02/01/2025	

Recalculating the process limits

select a date and enter a comment

Join our futures site!

https://future.nhs.uk/MDC/grouphome



Our series of training modules


CPD CERTIFIED
The CPD Certification Service
The content of the following has been certified by the CPD Certification Service as conforming to continuing professional development principles
Making Data Count Step 1: An Introduction Training Course
MIXED METHODS TEAM, IMPROVEMENT DIRECTORATE – NHS ENGLAND (010953)
Date: April 2022
Certificate No: A034588

- Introduction to Making Data Count
- Our Tools – Available tools and How to Use Them
- Narrative Writing – How to Drive Action
- Digging Deeper – Add to your SPC Knowledge
- Benchmarking & Comparisons
- Improvement Techniques
- Triangulating Data
- Data Driven Conversations
- Making Qualitative Data Count
- Targets & Trajectories

Become a SPC champion!

Thanks to https://www.flaticon.com/ for the amazing animated icons


THANK YOU!

Don Berwick: Improvement Wisdom

- Not all change is improvement, but all improvement is change
- To make improvements we must be clear about what we are trying to accomplish, how we will know that a change has led to improvement, and what change we can make that will result in an improvement
- The more specific the aim, the more likely the improvement; armies do not take all hills at once
- Concentrate on meeting the needs of patients rather than the needs of organisations

- Measurement is best used for learning rather than for selection, reward, or punishment
- Measurement helps to know whether innovations should be kept, changed, or rejected; to understand causes; and to clarify aims
- Effective leaders challenge the status quo both by insisting that the current system cannot remain and by offering clear ideas about superior alternatives

- Educating people and providing incentives are familiar but not very effective ways of achieving improvement
- Most work systems leave too little time for reflection on work
- You win the Tour de France not by planning for years for the perfect first bicycle ride but by constantly making small improvements

10 minute Break

Donald M. Berwick (1996) "**A Primer On Leading The Improvement Of Systems"** BMJ: British Medical Journal Vol. 312, No. 7031 (Mar. 9, 1996), pp. 619-622 (4 pages)

NHS Confederation

Interface team data packs

Nick Gitsham,
NHS England Mental Health Improvement Support Team

Data pack introduction

Data is an integral tool to support understanding and decision making within a system, organisation and service. Bringing together the quantitative and qualitative information available to you can support you in your improvement programme to monitor and measure the impact of changes you make. This information provides a snapshot and baseline of your performance in a range of metrics in the urgent and emergency mental health pathway. This information can be used to:

- Build a shared understanding across your project team, organisation and system of your starting point in this improvement programme

- Support your project team to dig deeper into what the data is showing you and to enable you to ask and understand why

- Where data looks unfamiliar or confusing, to ask questions internally about how data is collected, shared and used.

This data pack has been developed in July 2025, using data up to May 2025. We will look to reissue these packs towards the end of the programme, to help identify progress and change.

Data pack contents

1. Mental health needs index
2. Mental health investment
3. A&E attendances, admissions and performance
4. Access to crisis care via NHS 111: mental health
5. Coding accuracy
6. A&E 12-hour waits

25 mins

Measurement data and/or generating ideas

Page 6&7

In your breakout team, discuss possible data you need to collect for your project and split them into – process, balancing and outcome measures

List all the different systems you are aware of that could help provide you with the data you need

Be selective in your data, make sure it links directly to the project and that they are essential

In your breakout team, start to think about what ideas/things you want to test out to achieve your aim statement

Write as many ideas as possible and add them to the – go for quantity not quality

Don’t judge them or be critical at this stage, it’s about thinking of all the possible ways to achieve improvement – big and small

Project Driver Diagram

Relationship arrows →

Aim statement	Primary Drivers	Secondary Drivers	Change ideas
To reduce the number of inappropriate referrals to the dermatology department at Hospital X by primary care (GPs) by 15% by 30th September 2024	Communication	Communicate better with GPs	Create a monthly learning forum
		Provide feedback and advice to GPs	A standard feedback template letter
		WhatsApp group	Informal group for general advice/guidance
	Education and training	Offer training / education to GPs	Bi-monthly joined up education session
		Improve criteria for recognition	Written guidance on different lesions
		New Consultants induction	New starter induction process
	Criteria	Improve referral proforma	Robust inclusion criteria on referral form
		Include alternative pathways	Plastics and Maxillo-facial pathways
		Imaging	Process for taking images of lesions for referrals
	Technology	Referral process	All referrals must come through X system
		Images transfer	Transfer images with software X for high quality

Driver Diagram- Top Tips

It's a plan of change ideas on a page: Don't obsess over the connections between drivers
Keep it simple and high level – this is a scoping exercise
Helps provide focus on the cause-and-effect relationships that exist in complex situations
Put change ideas on post-it notes – it can help you group them and understand primary drivers
Change ideas always need to be linked back to the aim you are trying to achieve
Keep referring to your driver diagram through improvement journey to stay on track
You can change things on them – they do not stay static, but always share with the team

What next: action learning period

Between this session and the next one on 24th September you need to use your workbook to complete the following:

Make sure your aim statement, project charter and key stakeholder mapping is completed from last time
NEW TASK: Complete measurement plan, make sure you can extract the data & start to get a baseline chart ready to use – see page 6
NEW TASK: Commit to the online training offered from the Making Data Count session so you can present/read your improvement data and try out the SPC software
NEW TASK: Scope out and gather all the possible change ideas and create your driver diagram – see pages 6-12
NEW TASK: Complete your reflective log questions as they will be used in the next session – see page 12

Next steps

- The next learning session is **24th September 9:30am-12:30pm** – the focus will be on 'human factors and behavioural change' to consider the human elements of delivering change successfully – please complete a quick poll for us before leaving today

- Your facilitator will contact you during the action period (this is the time between this session and the next session) to check in on how you are progressing. It is essential that you meet with your Facilitator **at least once** in between learning sessions – they are there to help and guide you, and also share updates on your progress with the central team so we can have a collective overview of the 12 interface teams.

- You will get an evaluation form straight after this session – please do complete it. It's important to help us ensure we tailor sessions to your needs

- As part of our on-going learning, we are wanting to record video diaries of people's reflections on the journey in the collaborative as well as their own learning on improvement and interface working. If you can spare 5 minutes for this, please contact us after today at acutenetwork@nhsconfed.org

Human Factors and Behavioural Change – Teams Poll

Please rate how strongly you agree with the following statements:

1. ‘In my workplace, Human Factors (e.g., communication, role clarity, cognitive load, situational awareness) within ED and mental health teams, significantly impact the quality of the mental health patient pathway’.

2. ‘There is a clear understanding of the roles and responsibilities between ED teams and mental health teams when collaboratively managing patients’.

3.’How familiar are you with techniques for improving communication and decision-making (i.e. conflict resolution, hierarchy gradient, psychological safety) to reduce the impact of negative human factors (i.e. human error, stress, workload) in collaborative settings (between ED and mental health teams)?’

4. ‘How confident are you in your ability to influence and drive behavioural change (i.e. communicating a shared vision, modelling behaviours, active listening, building inclusive strategies) within your team to improve collaboration between services?’

Thank you

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