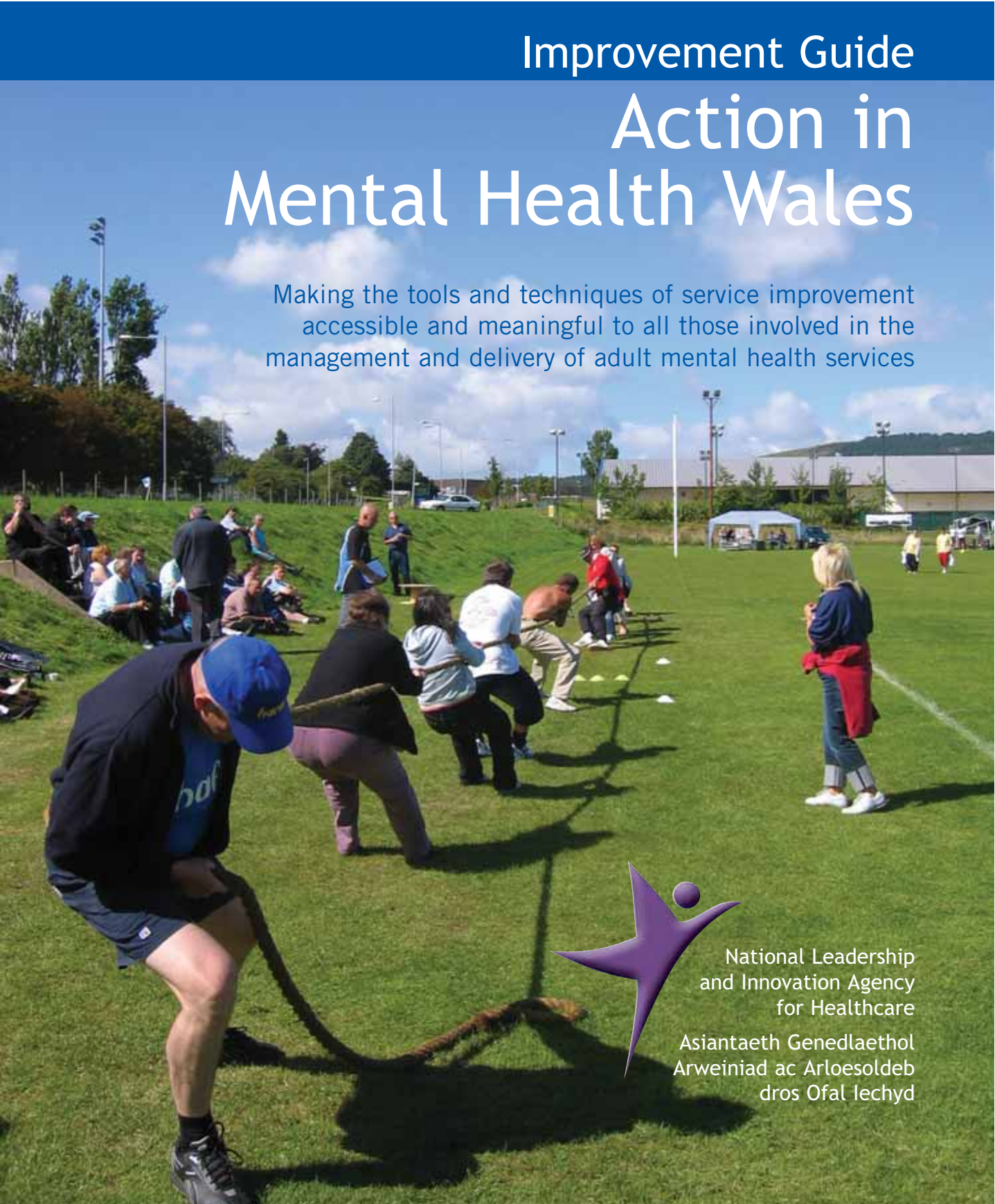
Improvement Guide

Action in Mental Health Wales

Making the tools and techniques of service improvement accessible and meaningful to all those involved in the management and delivery of adult mental health services



National Leadership and Innovation Agency for Healthcare

Asiantaeth Genedlaethol Arweiniad ac Arloesoldeb dros Ofal Iechyd

Published by:

National Leadership and Innovation Agency for Healthcare
Innovation House
Bridgend Road
Llanharan
CF72 9RP
Wales

Phone (+44) 1443 233 333

www.nliah.wales.nhs.uk

Asiantaeth Genedlaethol Arweiniad ac Arloesoldeb dros Ofal Iechyd
Ty Arloesedd
Ffordd Penybont
Llanharan
CF72 9RP
Cymru

Ffôn (+44) 1443 233 333

www.agaaoi.cymru.nhs.uk

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Action in Mental Health Wales

Foreword

by the Minister for Health and Social Services

Mental health is now firmly a part of the health and social care modernisation agenda and I am encouraged by the many new initiatives that are taking place across the whole of Wales.

Throughout the UK and the rest of the world there is now a better recognition that mental health must be taken more seriously and given a higher priority. There is also a general acceptance that if we do not improve mental health there is a burden not only on those who are mentally ill, on their families and their communities, but also an economic burden.

Figures from the Office for National Statistics show that one in six of the general population has a common mental health problem such as depression, anxiety or other neurosis at any one time. The World Health Organisation has estimated that one person in four will be affected by a mental disorder at some stage of life, and has found that depression is the leading cause of disability globally and is currently the fourth leading cause of the global burden of disease.

People with or recovering from mental health problems find it extremely difficult to enter or re-enter the workforce or to enjoy the full participation within society that so many take for granted. Socially excluded within communities and frequently living in poverty, debt and poor housing, this hampers many peoples' ability to recover from a mental health problem and their ability to enjoy full citizenship.

This cycle of social exclusion includes unemployment, debt, homelessness and worsening health. Breaking this cycle requires more than just health and social care interventions. It needs a co-ordinated and multi-agency approach. Such an approach is in keeping with the strategic intent of "Making the Connections". Furthermore the development of Health Challenge Wales, which has mental health and well-being as one of its six key themes, can provide an important means of generating and sustaining this cross-cutting approach to mental health.

Within health and social care services we need to ensure people have the right skills, the right resources and the right training to deliver an effective and efficient service. Often this can best be achieved by organisations and agencies working together across traditional boundaries ensuring that effective partnerships are established. This way skills and knowledge can be shared, and the focus put on the needs of the patient, rather than what suits the organisations providing the service.

Through the National Leadership and Innovation Agency for Healthcare (NLIAH) the Action in Mental Health (AIM) collaborative was established to support implementation of the revised adult mental health National Service Framework launched in October 2005.

The AIM programme has helped ensure that mental health becomes part of the modernisation process and included within the mainstream of health and social care in Wales. It has also helped to develop skills and learning as well as helping promote the spread of good practice across Wales.

I am therefore very pleased to fully endorse this Improvement Guide which shows what service improvement tools are available, how to make best use of them, and the benefits they can bring. I am particularly impressed with the 'personal improvement record' given at the end of each chapter which can be used to measure how the guide itself improves skills and knowledge, and what impact using it has had on service development.

Good progress has been made over the last few years in modernising our mental health services in Wales. New local community services have either replaced or are planned to replace outdated large institutions. The Care Programme Approach has been implemented, and a mental health promotion action plan has been developed.

There is still much to do and a long way to go. It is now very important to ensure that the capacity and the learning that has been harnessed is properly utilised and, with the help of this guide, taken forward to deliver further improvements to our mental health services in Wales.

Brian Gibbons
Minister for Health and Social Services

Rhagair y Gweinidog

Arweiniad yr Asiantaeth Genedlaethol Arwain ac Arloesi mewn Gofal Iechyd ar Wella Iechyd Meddwl

Erbyn hyn, mae iechyd meddwl yn rhan annatod o'r agenda i foderneiddio gofal iechyd a gofal cymdeithasol, ac mae'r amryfal fentrau newydd sydd ar y gweill ledled Cymru yn gryn galondid i mi.

Ledled y DU ac ar draws gweddill y byd, mae mwy yn cydnabod bellach fod yn rhaid i ni gymryd iechyd meddwl o ddifrif a rhoi rhagor o flaenoriaeth iddo. Drwy beidio â mynd ati i wella iechyd meddwl, derbynnir yn gyffredinol hefyd fod baich yn cael ei roi nid yn unig ar y rheini sy'n dioddef o salwch meddwl, ond ar eu teuluoedd a'u cymunedau, ac ar yr economi.

Mae ffigurau'r Swyddfa Ystadegau Gwladol yn dangos bod un ymhob chwech o'r boblogaeth gyffredinol yn dioddef o broblem iechyd meddwl cyffredin, megis iselder, poen meddwl neu niwrosis arall, ar unrhyw adeg. Mae Sefydliad Iechyd y Byd wedi amcangyfrif yn bydd anhwylder meddwl yn effeithio ar un ymhob pedwar ohonom ar ryw adeg yn ystod ein hoes, ac mae wedi canfod hefyd mai iselder sy'n bennaf gyfrifol ar draws y byd am achosi anabledd. Ar hyn o bryd, mae iselder yn bedwerydd o blith yr afiechydon sy'n bodoli ledled y byd.

Mae'n anodd iawn i bobl sydd â phroblemau iechyd meddwl, neu sy'n gwella ar ôl dioddef problemau o'r fath, ddod o hyd i swyddi, neu fynd yn ôl i'r gweithle. Nid yw'n hawdd iddynt ychwaith gael cyfle i chwarae rhan lawn yn eu cymdeithas: cyfle y mae cynifer ohonom yn ei gymryd yn ganiataol. Mae'r bobl hyn yn cael eu hallgáu o'u cymunedau, ac yn aml, maent yn byw mewn tlodi a dyled, ac mewn cartrefi gwael. Mae hyn yn amharu ar allu llawer o bobl i wella ar ôl dioddef problem iechyd meddwl ac ar eu gallu i fod yn ddinasyddion cyflawn.

Mae'r cylch hwn o allgáu cymdeithasol yn cynnwys diweithdra, bod mewn dyled, bod yn ddigartref, ac afiechyd. Er mwyn chwalu'r cylch hwn, mae angen gwneud gweithredu mewn meysydd heblaw am y rhai iechyd a gofal cymdeithasol. Mae angen i sawl asiantaeth weithio gyda'i gilydd mewn ffordd gydgysylltiedig. Byddai gwneud hynny yn gydnaws â nod strategol "Creu'r Cysylltiadau". At hynny, gall datblygu Her Iechyd Cymru, lle mae iechyd a lles meddwl yn un o'r chwe thema allweddol, fod yn ffordd bwysig o greu ac o gynnal y dull trawsbynciol hwn o weithredu ym maes iechyd meddwl.

Mae angen i ni sicrhau bod gan bobl yn y gwasanaeth iechyd ac yn y gwasanaethau gofal cymdeithasol y sgiliau a'r adnoddau priodol i ddarparu gwasanaethau effeithiol ac effeithlon, a'u bod yn cael yr hyfforddiant priodol. Yn aml, y ffordd orau o wneud hyn yw trefnu bod sefydliadau ac asiantaethau yn cydweithio ar draws y ffiniau traddodiadol er mwyn sicrhau bod partneriaethau effeithiol yn cael eu sefydlu. Drwy wneud hyn, bydd modd rhannu sgiliau a gwybodaeth, a chanolbwyntio ar anghenion y claf, yn hytrach nag ar yr hyn sy'n ateb dibenion y sefydliadau sy'n darparu'r gwasanaeth.

Drwy'r Asiantaeth Genedlaethol Arwain ac Arloesi mewn Gofal Iechyd, cafodd y Rhaglen Gydweithredol ar gyfer Gweithredu ar Iechyd Meddwl (AIM) ei sefydlu ym mis Hydref 2005 er mwyn helpu i weithredu'r Fframwaith Gwasanaeth Cenedlaethol diwygiedig ar gyfer iechyd meddwl oedolion.

Mae'r rhaglen hon wedi helpu i sicrhau bod iechyd meddwl yn rhan o'r broses moderneiddio a'i fod yn cael ei gynnwys ym mhrif ffrwd y gwasanaethau iechyd a'r gwasanaethau gofal cymdeithasol yng Nghymru. Mae wedi helpu hefyd i ddatblygu sgiliau a chyfleoedd dysgu, yn ogystal ag i annog yr amryfal sefydliadau ledled Cymru i rannu arferion da.

Yr wyf, felly, yn hynod falch o gael cymeradwyo'r Arweiniad hwn ar Wella, sy'n amlinellu pa gymorth sydd ar gael i wella gwasanaethau, sy'n nodi sut i fanteisio i'r eithaf ar y cymorth hwnnw, ac sy'n disgrifio sut y gall fod o fudd. Mae'r 'cofnod personol o welliant' ar ddiwedd pob pennod wedi creu cryn argraff arnaf. Bydd yn fodd i bwyso a mesur sut y mae'r arweiniad ei hun yn gwella sgiliau a gwybodaeth, a pha effaith y mae wedi'i chael o ran datblygu gwasanaethau.

Rydym wedi cymryd camau mawr ymlaen yn ystod y blynyddoedd diwethaf o ran moderneiddio'n gwasanaethau iechyd meddwl yng Nghymru. Mae oes y sefydliadau mawr wedi mynd, ac mae gwasanaethau cymunedol lleol newydd yn cael eu darparu a'u datblygu yn eu lle. Bellach, rydym yn darparu gwasanaethau iechyd meddwl ar sail Rhaglen Ofal, ac mae cynllun gweithredu wedi'i ddatblygu i hybu iechyd meddwl.

Mae llawer eto i'w wneud, a ffordd bell i fynd. Mae'n bwysig iawn bellach ein bod yn manteisio i'r eithaf ar y gallu sydd wedi'i feithrin ac ar yr hyn sydd wedi'i ddysgu. Gyda chymorth yr arweiniad hwn, gallwn fynd ati i sicrhau bod gwasanaethau iechyd meddwl yn dal i wella yng Nghymru.

Brian Gibbons
Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol

Acknowledgements

This guide could not have been developed without the contributions and support of those involved in AIM.

We would like to thank the project managers and the improvement teams who have shared the practice examples included in this guide. These examples have been selected to illustrate application in practice. A full evaluation of AIM is available from NLIAH with an overview of all work achieved by the participating health communities.

The AIM initiative and the development of this guide is evidence that partnership working in Wales is a reality and that there is a strong foundation on which to build a true integration of adult mental health service delivery.

A special thank you is extended to all those organisations who invested the time and commitment to work with us at NLIAH:-

NHS Trusts and Local Health Boards
Primary Care Teams
Social Service Directorates
Welsh Local Government Association (WLGA)
Wales Alliance for Mental Health especially HAFAL & MIND CYMRU
WaMHinPC (Wales Mental Health in Primary Care) network
Wales Collaboration for Mental Health
We also need to acknowledge the knowledge, skills and support provided by
The Sainsburys Centre for Mental Health

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Allan Cumming	NLIAH
Margaret Rennocks	NLIAH
Maria Gallagher	NLIAH

How to use this guide

This guide has been written to encourage, demonstrate and enable those involved in the delivery of adult mental health services to take control and create opportunities for improvement.

In this guide you will find a set of tools and techniques to support improvement in service delivery. These tools have been tried and tested within the Action in Mental Health Collaborative.

Chapter 1 **Making it Happen**

Sets the scene – Action in Mental Health (AIM) encouraged national collaboration to ask "What's our problem?" Collaboratives provide an overall approach, a set of tools and the creation of space to support potential solutions.

Chapter 2 **Making it Matter**

Asks "do you really know what's happening?" and introduces a step by step approach to help you to carry out process mapping, flow analysis and the measurement of capacity and demand.

Chapter 3 **Making it Count**

Introduces data as a useful tool, to identify how good things are working now and what needs to change. This chapter is a brief introduction to encourage you to actively look for the data and to question it.

Chapter 4 **Making it Work**

Looks at how to move ideas forward and turn change into improvement. This means involving others using change management techniques and PDSA Cycles (Plan, Do, Study, Act).

Chapter 5 **Making it Fit (together)**

Explains how to approach the development of 'Care Pathways' to put the user of services at the centre of service delivery and encourages team working across organizational boundaries.

Chapter 6 **Practice Examples**

Practice examples have been included in the main body of the document where they link with the tools. Additional examples of improvement activity to learn and share from can be found within this section.

Chapter 7 **Useful Resources**

Useful reference books, documents, articles and web based information sources.

Each chapter outlines the basic information required to begin developing the skills and confidence in the use of these techniques, to support you in 'getting started'.

Throughout are descriptions of how others have tackled their problems, not to copy slavishly, but to learn and share from. These practice examples have been selected to illustrate the impact and usefulness of service improvement tools within the adult mental health arena. Many more initiatives were taken forward under AIM - for more information on these and who to contact at each of the health communities please contact: Maria.gallagher@nliah.wales.nhs.uk

At the end of each chapter you will find a reflection and planning section. This has been included to encourage you to consider what you have learnt and then to plan how to apply it to your practice. We would also encourage for this to be adapted locally for use by teams. These sheets can be photocopied or down loaded from the NLIAH web page to include in Professional Development Plans and contribute towards the professional appraisal process.

Please note that for ease of reading patients, service users and carers are referred to under the generic title of 'service user.'

This guide is available in both the Welsh and English language as a PDF file.
Web Address: www.nliah.wales.nhs.uk

Who should use this guide?

The AIM Collaborative has worked to make the tools and techniques of service improvement accessible and meaningful and this guide will further support this ambition.

This is YOUR cook book with tried recipes... follow them and experiment to achieve:

- A proactive search for continuous improvement
- Action to ensure that what is good practice in Wales today will be standard practice tomorrow
- Commitment to continually improve services, always seeking to make today's good practice normal, and to develop new standards for tomorrow

This guide is for everyone and is here to be used and be useful, not to fill yet another space on a bookshelf. Please read it, argue with it, take the bits that will work for you and achieve your goals! We hope you will find it of use.

Remember this guide provides an overview of improvement tools and techniques, for more information we have signposted you to additional resources that will support your continued learning.

Maria Gallagher and **Margaret Rennocks**

Making it Happen

1

Delivering Improvement

In Wales there is a real commitment to improve the services and care we provide to all those who experience mental ill health or emotional distress, their families and their communities. To achieve this, at a time of increasing demand, will require radical change in the way we do things currently. This means making changes that cannot be achieved by individual groups or organisations on their own.

For this reason (AIM) was initiated to bring together local teams, link them nationally to ask the question 'What's our problem?', and to work together using a set of tools and techniques, to learn from each other and to test out solutions.

Change cannot be achieved without creating the time and opportunity for those involved in the change to:

- Reflect and discuss
- Test ideas
- Implement

AIM used a collaborative approach working with secondary and primary health care services, social care, the voluntary sector and service users in Wales, to provide the time, the structure and the skills to encourage and drive:

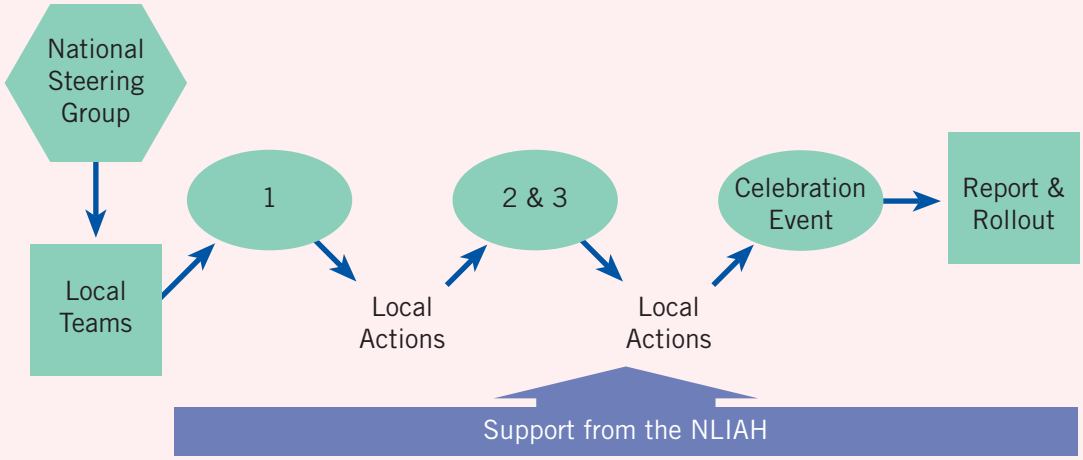
- Service improvement activity locally
- The spread of innovative practice across Wales
- The adoption of agreed good practice

This collaborative approach was pioneered by the Institute for Health Improvement in the USA and has been tried and tested world wide including here in Wales, supporting service improvement in primary care, medicines management and emergency care to name but a few.

Learning Collaboratively

Collaborative programmes are designed to bring together groups of like minded people who are committed to achieving a shared goal. These individuals form improvement teams who work locally on what needs to be done. This local work and the improvement journeys are then shared across all the collaborative teams to allow national learning and prevent wheel reinvention.

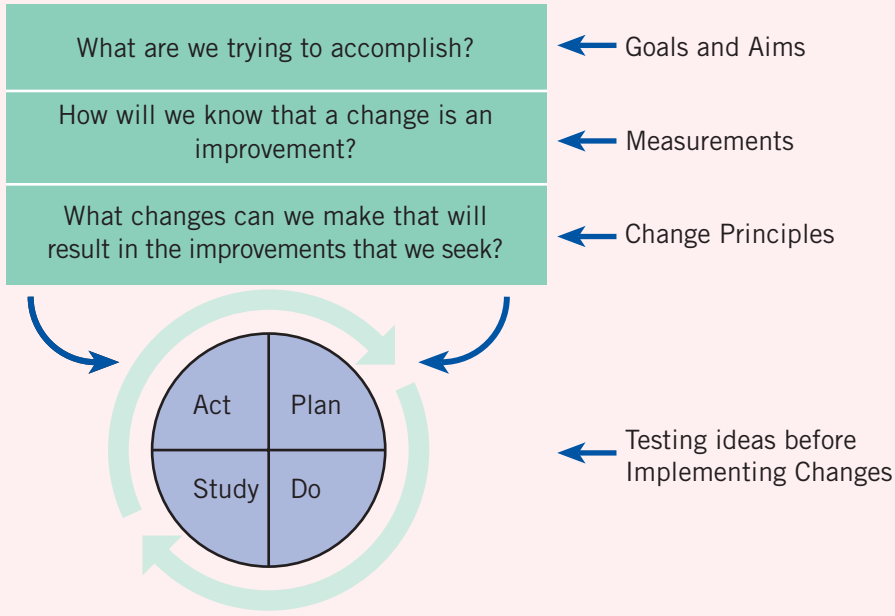
The Collaborative Programme Framework



Model for Improvement

Thinking about improvement is relatively easy but actually making a change can be hard to achieve. Collaborative programmes use a technique known as the 'model for improvement'. This model offers a common approach, making sure that everyone is clear about the reasons for change and have a clear vision of what will be achieved once that change has been implemented. The model breaks down change into manageable chunks and tests ideas for improvement in a way that increases confidence without disrupting existing services.

Model for Improvement



The model for improvement is fundamental and underpins the tools and techniques of service improvement. It asks three questions:

1. What are we trying to accomplish?
The start of the improvement process should be a statement of the aims of the project. It is impossible to reach a goal without knowing what it is. The goal statement should be clear, specific, aspirational and measurable.

2. How will we know that a change is an improvement?
The key to an effective improvement process is measurement. Without effective measures there is no way of knowing whether any change is improving the process. Selection of a range of measures for improvement should be central to any improvement process.

3. What changes can we make that will result in improvement?
Plan, Do, Study, Act (PDSA) Cycles are a way of testing suggested improvements in a controlled environment. The changes that are developed in response to question 3 are the changes that the Cycles will test. Changes can come from those involved directly or from other sites that have looked at the same question.

How this model shaped improvement activity in Wales within AIM

What are we trying to accomplish? Statement of the objectives of the activity.	**AIM GOAL** Development of systems to ensure that people receive timely, effective care and support in a setting appropriate to need, as part of a clear, agreed pathway.
How will we know that change is an improvement? Agreed a common set of measures to understand what is happening.	**AIM Measures** ■ Length of stay on acute adult mental health in patient beds ■ Waiting time from assessment to first appointment with a Community Mental Health Team (CMHT)
What changes can we make that will result in Improvement? The tools and techniques of service improvement are used to identify, plan and demonstrate that changes result in improvement.	**AIM PLAN** ■ Work together with users of the service creating trust and a culture for change ■ Map the current pathway and identify problems ■ Redesign by eliminating blocks and creating improved flow ■ Test ideas using PDSA cycles of change ■ Share learning to prevent wheel reinvention

Contact: Maria Gallagher maria.gallagher@nliah.nhs.wales.uk NLIAH

Working together, across organisations at all levels, to achieve a national goal can only be achieved if all commit to a structured framework and sign up to the following key principles:-

- looking at the service from the service user's point of view
- dedicating time to an improvement programme
- creating opportunities for personal and team development and training
- providing opportunities for multi-disciplinary team working and networking
- empowering all to make changes
- service user participation and involvement
- focusing on 'local solutions to local problems'

Improvement Tools

To support implementation, local teams are provided the opportunity to spend time developing the skills of improvement. These skills focus on the improvement of “processes and systems” – assisting individuals and organisations to:

Use techniques to **identify** what needs to change

Where they are now?

Collect and interpret data to **prioritise** action plans and demonstrate improvement

Where they want to be?

Develop the skills of change management to **implement** and test ideas and solutions

How to get there?

Improvement can only happen by changing processes and affecting the systems within which they operate. This requires an understanding of the processes to be changed and the relationships between those processes - it is not only the parts but the links between the parts that become the opportunities for improvement.

The skills of improvement are centred on creating standard processes to replace chaotic activity.

A process is a set of causes and conditions that repeatedly come together in a series of steps. All processes have inputs, steps, and outputs

A system is an interdependent group of items, people or processes with a common purpose

Inputs, steps and outcomes in both processes and systems provide the tangible elements that can be measured, on which data can be collected and around which changes can be developed and tested (chapter 2)

Whole System Working

Changing processes and introducing different ways of working will require changes in the way people do things and may also require new skills. For this reason improvement activity also requires good change management to engage and involve all. Only then will change be sustainable and totally effective.

A whole system approach to care is essential as the service user's journey crosses organisational boundaries. This requires a collaborative whole system approach to improvement with the service user at the centre of the decision making process.

Involving Service Users

Service users have a unique body of knowledge of mental health services and should be involved at all levels of the improvement process. This includes having a genuine influence over planning, development and delivery.

A number of fundamental principles need to be considered prior to involving service users:

Role

The role of the service user should be agreed prior to any involvement, including:

- Identification of support required to enable service user to have an equal voice.
- Clarify whether they are providing a representative or individual view point
- Agree time commitment
- Plan further involvement - e.g. sub groups (chairing or member), collating service users views
- Provide background information
- Decide remuneration and reward

Empowerment

Empowerment should be embodied within all policies, protocols and processes, assisting individuals towards a more meaningful and fulfilling life, encouraging well-being and allowing the voice of the service user to be heard to influence and facilitate the improvement of mental health services across Wales. This principle has been adopted throughout mental health services as a core component of the RECOVERY model of care.

Development of a value based approach

People with a mental health difficulty have the right to:

1. Be treated with respect and dignity
2. Be treated fairly, equally and as a unique human being
3. Enjoy the best possible standards of health and well being
4. Have access to opportunities which enable achievement of full potential
5. A life free from discrimination and oppression with respect for race, language, gender, age, religious beliefs, sexuality, economic and social status

This will be achieved in partnership with people with mental health difficulties. In doing so this will minimise disruption to lives and relationships and establish control as far as practicable, in the journey to recovery.

This value statement on behalf of Bridgend, Neath Port Talbot and West Vale will address the four principles set out in the NSF in the following ways:

Empowerment

- Listen to and involve people in making decisions about the kind of services they want, how they want them and when
- Help people to develop the skills and confidence to make sure they can have say in decisions about services
- Make sure people are given the information and support to take control and responsibility for their own recovery
- Work together with individuals to address dissatisfaction

Equity

- Provide a range of services to meet a variety of individual needs as well as making information about services available
- Fill the gaps in our services as identified by the people who use them
- Make services easy to access by those who use them
- Services will be delivered in ways that are acceptable to people who use them

Effectiveness

- Provide services that will help people recover from mental health difficulties
- Explore new and different ways of meeting peoples needs
- Incorporate evidence based best practice into service models
- Measure performance against stated objectives, agreed values and beliefs

Efficiency

- Provide sustainable services that can embrace change
- Ask people what they think about services and act on this information to make sure we Get better at meeting peoples needs
- Respond to changing needs and circumstances
- Be open and honest about how well we are doing by monitoring, evaluating and reviewing service provision

Contact: Ian Stephenson; Ian.stephenson@bromor-tr.wales.nhs.uk
Bridgend, Neath Port Talbot and West Vale Health Community

Reflection and Planning Record

This sheet is to record how the learning from this guide has improved your skills and knowledge and to evidence impact on service development

■ action plan ■ record impact ■ capture learning for CPD Portfolio)

What are the main learning points from this chapter?

How can they be applied to your professional practice?

Develop an action plan for improvement

Summarise implementation process

How will you measure the effectiveness of the improvement? A balanced scorecard of benefits

Impact on service delivery	Impact on service users and carers
Impact on outcomes	Impact on staff

How can you share your learning with your team and wider organisation?

Are you able to identify the learning needs in order for you to work more effectively?

How will you access this learning?

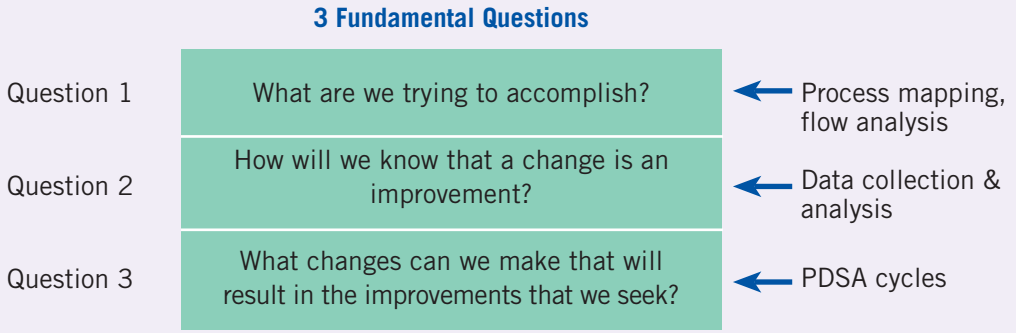
Who could help?

Making it Matter

2

Using the Model for Improvement

The next 3 chapters of this guide use the three fundamental questions in the Model for Improvement to illustrate the application of tools and techniques for understanding and improving mental health services and for ensuring commitment to action.



Many individuals work in a state of continual "'fire-fighting"'. Clinicians and care teams can be caught up in an endless progression of overstretched services and long waiting lists. There is a way of changing this situation.

Three tools are available which will provide the basis for informed process change and performance improvement. The three tools are:

- Process Maps of the key processes in the service;
- Flow Models of the use of key constraints in the service.
- Use of data

These tools have been designed to support clinicians and managers to understand and improve the services they work in.

Question 1: What are we trying to accomplish?

Before embarking on improvement activity we first need to understand what is happening to the service user, where it happens and who is involved. This will help to identify where there are problems within the system.

Process mapping

Process* maps are the single most useful diagnostic tool for determining where problems lie within the system and identifying unnecessary process steps. An example of this is doing something more than once, which is sometimes referred to as rework*.

A PROCESS is a number of sequential steps within a pathway that similar individuals experience when they encounter mental health services

For example each service user that attends outpatient clinic

REWORK is something that is done more than once

For example when referred to psychological therapies assessment can be undertaken in excess of 3 times

There are two stages to process mapping:

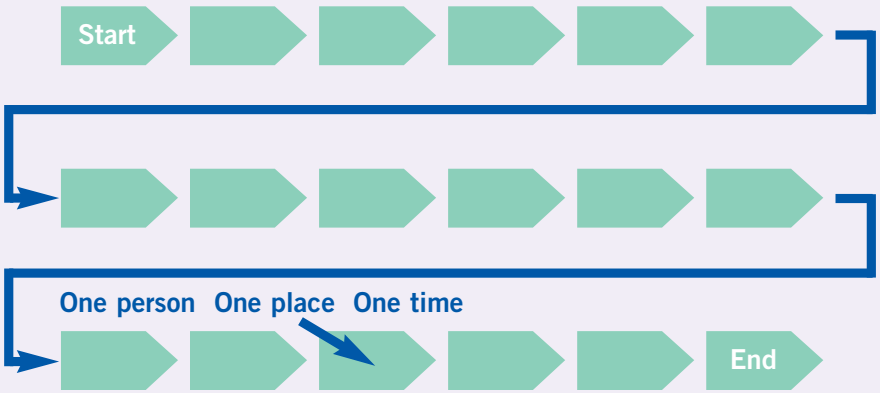
Stage 1 - understand what happens to the service user, where it happens and who is involved.

- Understanding the process from the individual perspective is essential if services are to be improved

Stage 2 - use the process map to determine where there are problems such as multiple hand-offs*, parts of the process that are unnecessary or parts of the process which would flow better if undertaken in a different order.

- These problems can be addressed by designing a new more streamlined process

HAND-OFFS are the points in the patient journey where the patient case is passed from one member of staff to another. They are inefficient and a potential source of error.



The high level process map

The first step in understanding any service is to identify the process and be clear which parts of the process are inside the map and which are outside. At this stage a quick service mapping exercise by a few staff will be useful to determine who will be involved in a more detailed mapping exercise and help to ensure that no staff group is forgotten. Choose clearly defined start and end points.

The second step is to bring stakeholders together to hold a process mapping workshop. Service users experience the journey from a different perspective and should be involved in the mapping process.

At the mapping workshop, use "'post-it"' notes to capture the information about the service user journey down to the level of "O'one person, one place and one time"'.

Arrange the "'post-its"' into order, and look for:

- Rework
- Steps that do not add to the service user outcome - ask "Why is this being done?"
- Hand-offs.
- Identify delays, queues, and waiting built into the process.
- Ask at each step whether the action is being undertaken by the most appropriate staff member.
- Look for "'rework loops"' where activities are taken to correct situations that could be avoided.

Development of Therapeutic Interventions in Mental Health Services

Background

Provision of therapeutic services could not deliver on standards as described in NICE Guidelines; NSF standards; SAFF target 14 (all patients subject to CPA requiring therapy access evidence based psychological therapies within 3 months of assessment).

A mapping exercise identified that it was unclear who was practising what and at what level. Delivery came from a number of sources:

- Central psychotherapy department with a limited number of psychotherapists working across the three counties
- Psychologists attached to the community teams and inpatient units
- Other staff practising from within clinical teams (with different levels of skill and varying levels of training and supervision and some with no supervision at all

Aims

- To agree a service specification available to service users with standards of care appropriate to need
- Development of a clear structure for access (integrated care pathway)
- Development of skills of non specialist clinical staff
- Specialists to provide training and supervision to the non specialists ensuring quality interventions at all levels
- Reduction of waiting lists for formal psychological therapies

Process

A service model redesign toolkit was developed for application to clinical mental health community teams. The 7 step toolkit was piloted in one CMHT.

Step 1 - Assess the skills of the staff within the team

Step 2 - Assess supervision being received by the staff within the team

Step 3 - Assessment of caseloads: numbers and psychological needs

Step 4 - Identify the need for specific interventions

Step 5 - Plan improvements needed to achieve availability of therapeutic interventions
–training (formal, informal)
Supervision (at what level)

Step 6 - Implement the development structure for clinical supervision and training

Step 7 - Review every 6 months to ensure that:

- The evidence base has not changed
- The psychological needs of the service users are still the same
- The psychological needs of service users are measured
- All staff are receiving appropriate clinical supervision
- All staff are on an identified training programme
- Progress is measured and the action plan is amended as appropriate

Discussion

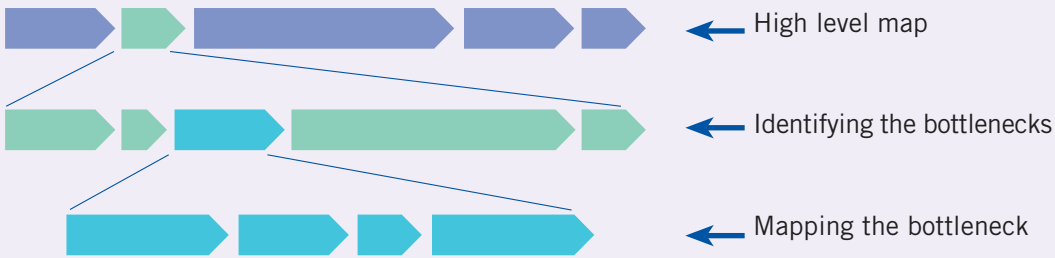
- PDSA's were used to test documentation-format and forms used were appropriate.
- A structure for continuous development of therapeutic interventions has been developed & integrated into the Professional Development Process, informing training needs analysis.
- Increased focus on psychological therapies and raised awareness of team skills.
- Development of supervision and training plan for continuous quality improvement
- The toolkit has become part of the modernisation agenda within the division and will be rolled out to all the community teams.

Contact. Judith Evans Jones judithevansjones@pdt-tr.wales.nhs.uk
Pembrokeshire, Ceredigion and Carmarthen Health Community

Focusing in on the problem

Once the high level map has been drawn and the stakeholders agree with the process, it will be useful to identify where there are bottlenecks* in the process. Which step causes the most delays? This step can then be mapped in more detail, expanding out the process. This can be done several times, each time expanding and getting to a greater level of detail.

BOTTLENECKS limit activity
For example, on admission nurse has to wait for doctor to undertake medical examination. Opportunity to combine these and free up nursing and medical time



Service Redesign Through Understanding Patient Flow

Background

Improving individual flow through a service increases safety, positively impacts on service user and staff satisfaction, and increases revenue (Institute for Healthcare Improvement, 2006).

Aim

1. To identify and collect baseline and outcome measurements to evaluate the effectiveness of later change cycles.
2. To improve patient flow through the Crisis Resolution and Home Treatment service.
3. To understand the perceptions and experiences of service users when in contact with the Crisis Resolution and Home Treatment service.

Process

1. Process mapping – agreeing what currently happens
2. Agree data collection tool
3. Recording throughput – frequency of movement through the pathways and the decisions which underpin movement
4. Analyse patient flow

5a. Conducting a small group of service user interviews to determine potential themes for later larger service user consultation exercise

5b. Hold service user consultation days to determine patient experience

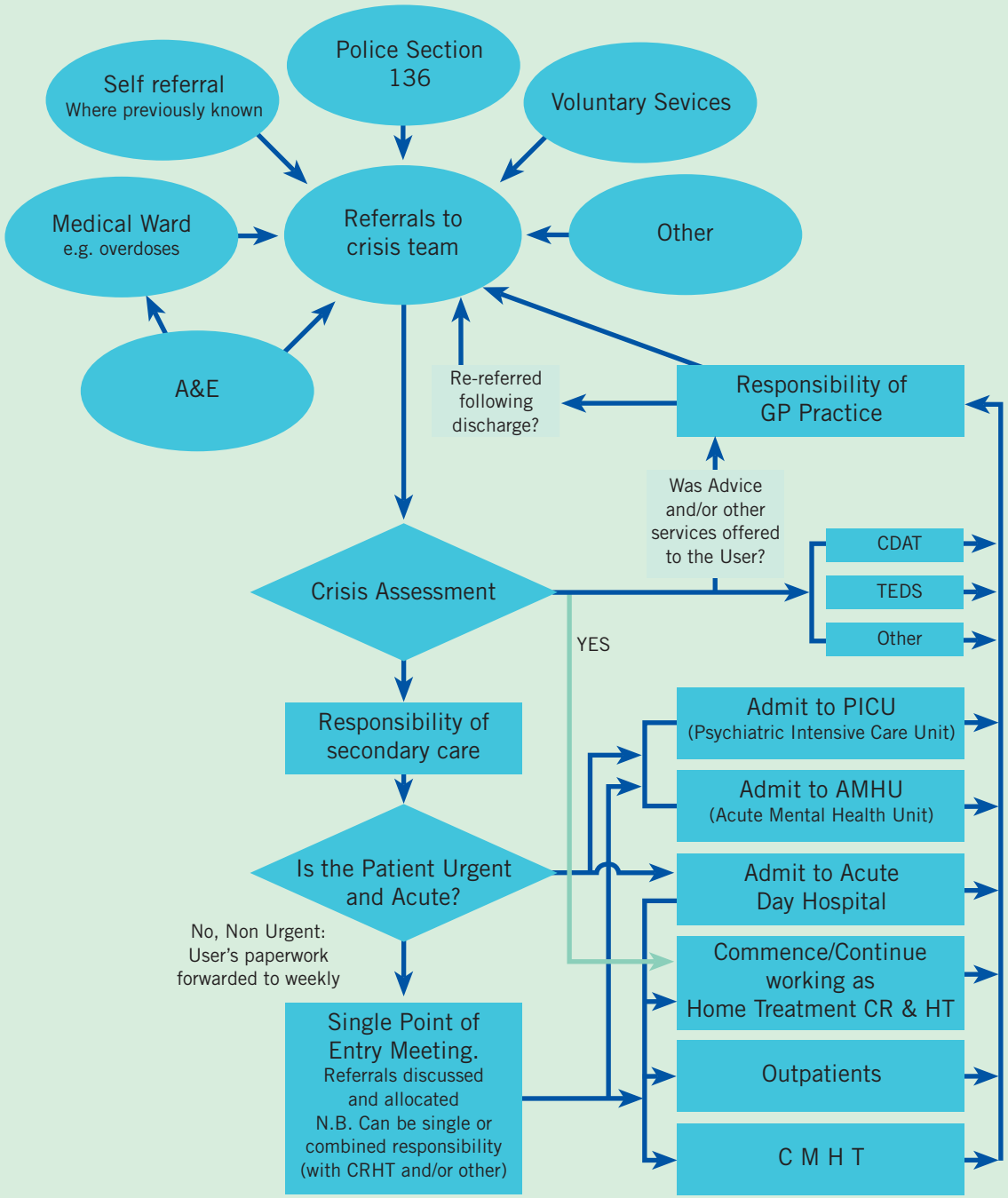
6. Present findings to service and service users
7. Determine and agree how the patient journey and patient flow can be improved
8. Implement change cycles through PDSA methodology

Learning

The patient journey is complex and is influenced by decision making at many stages. Understanding decision making will aid improvement.

Data collected in conjunction with the service user consultation will provide powerful information to ensure service redesign and pathway improvement that is sustainable and understands the potential effect on the total pathway by changing one aspect of it.

Process mapping of patient flow



Contact : Professor Paul Rogers - PERogers@glam.ac.uk
Pontypridd & Rhondda Health Community

Flow Models

Flow models are a way of analysing the constraints* and bottlenecks found during the process mapping, and looking at them from the perspective of the service, rather than the service user.

Flow models are about understanding bottlenecks and determining whether work can be planned around the constraint. It is necessary to understand the details of what is happening at each stage. This builds upon detailed process mapping, but incorporates the new concepts of value and waste analysis.

Value adding activities are those that make the service valued in the eyes of the service user. Some steps will add no value but cannot be eliminated immediately. Note these and aim in the long term to reduce/eliminate them.

Waste is anything that does not add value for the individual. There are several types of waste that exist in service user journeys. These can be found in the Waste Spotters Guide (page 30).

By identifying the waste, and seeking to reduce or eliminate waste from the service user journey, it is possible to provide a service that is more responsive to the individual, and that reduces many of the waits and delays engendered by our current ways of working. List the process points with the most waste, so you can refer to them as you devise the action plan.

Constraint is the factor that restricts the capacity of the system.
For example, Psychiatrist is undertaking tasks that could be delegated.

A Psychiatrist in an out patients clinic in the ????? his/her time can be better used. If tasks not requiring that kind of skill can be delegated.

Preparation

- Define the start and end points of the flow map
- Make sure people are present who have detailed knowledge of the clinical process steps, and of the communication flows surrounding patient flow
- Keep a list of problems and issues that are mentioned by participants

Using the Flow Model and building the Flow Map

Step 1 - is to identify the main high volume flows of service users on the basis of their clinical condition, these are known as runner groups that can be calculated by using the Pareto principle.

Good Practice Point - Pareto's Principle

There is often conflict when undertaking process mapping as to which group of service users represent the normal flow. This analysis needs to be undertaken by the application of Pareto's Law (Koch, 2001), or 80/20 principle that:

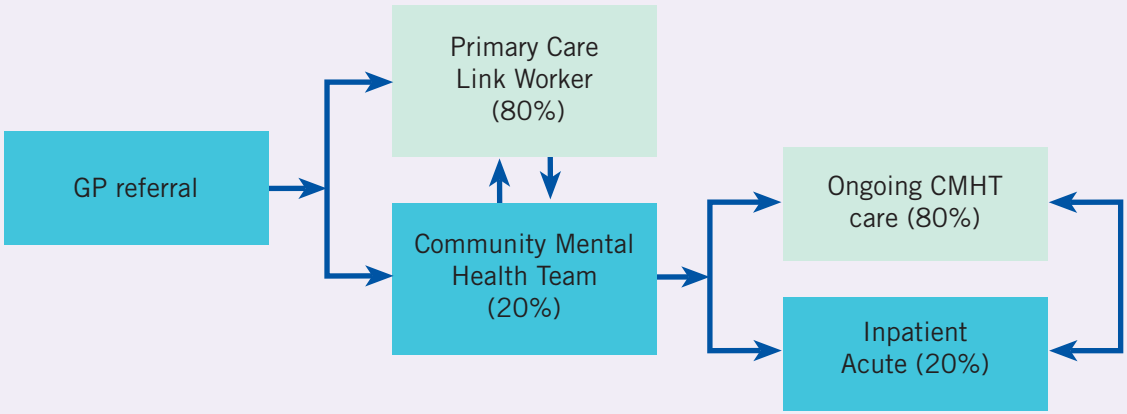
'80% of the benefits will be found in the simplest 20% of the system, and the final 20% of the benefits will come from the most complex 80% of the system'.

It consists of estimating the benefit delivered by each action with subsequent selection of the most effective actions that will deliver the maximum impact.

In the first instance concentrating on the 80/20 principle will be very helpful, and will help sites avoid being side-tracked by discussion about events that happen rarely, or by specialist cases.

Using the Pareto principle, identify the runner group that will deliver maximum impact

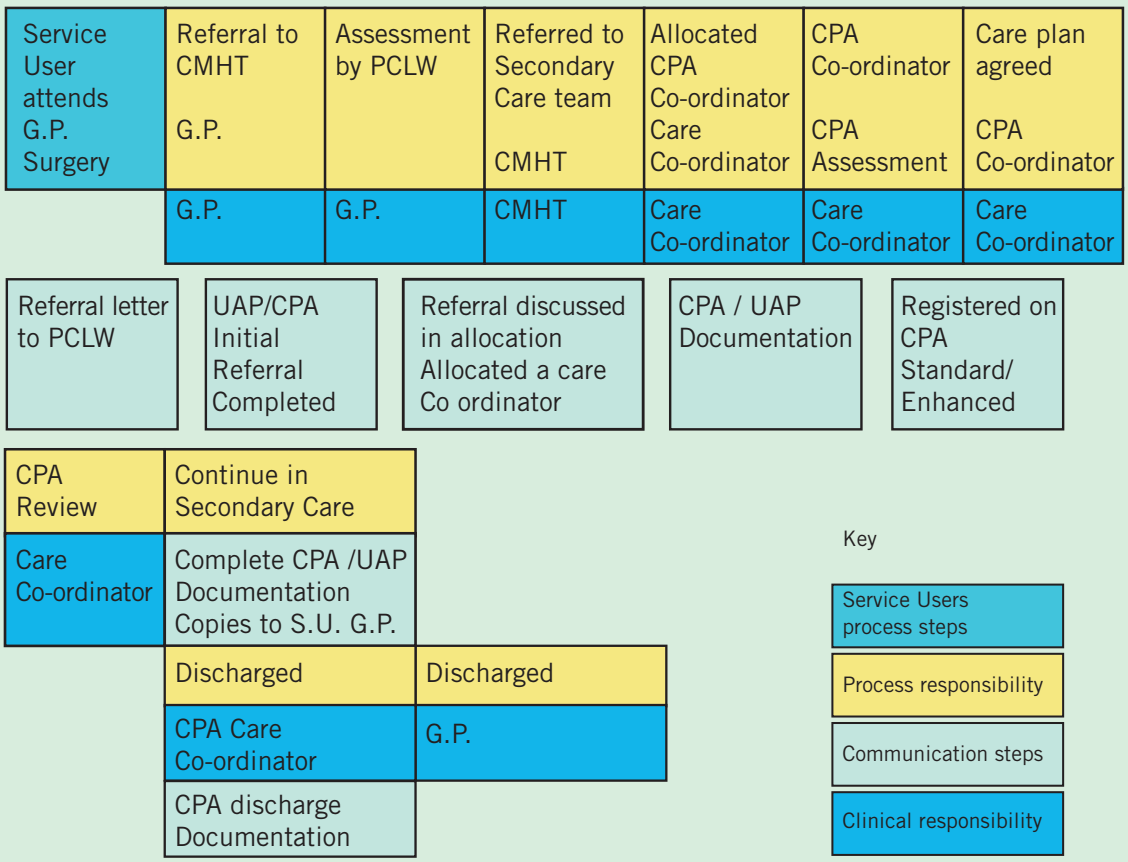
In the example shown below, the service users referred to Primary Care Link Workers are the runner group. The second runner group are the service users who receive ongoing care from the Community Mental Health Team.



Step 2 - is to build the map -this will involve

- Identify high level patient process steps
- Simultaneously identify and map the communication and information steps around the patient process
- Identify who is responsible for:
  The patient – i.e. *who is clinically responsible for the patient.*
  The process – i.e. *who is actually responsible for the overall process at each point.*
  This might be at a departmental, divisional or corporate level.

Essential elements of the flow model



Contact: Alison Avies-Jones Alison.aviesjones@cd-tr.wales.nhs.uk
Conwy & Denbighshire Health Community

Step 3 - is to work out the time the whole process takes by identifying how long each stage of the process takes with a line along the bottom of the map. Use a common unit to record time, e.g. hours, and use this consistently throughout the flow analysis. By doing this you will have created what is know as a 'Flow Analysis Summary'.

Step 4- involves identifying waste as a part of the analysis of the current state map. This is crucial in assessing which steps add value to the process, and where waste occurs. Use the Waste Spotters Guide below to assist you in this process.

Step 5 - is to develop an action plan. This can be achieved by improving your value flow.

Waste Spotters Guide

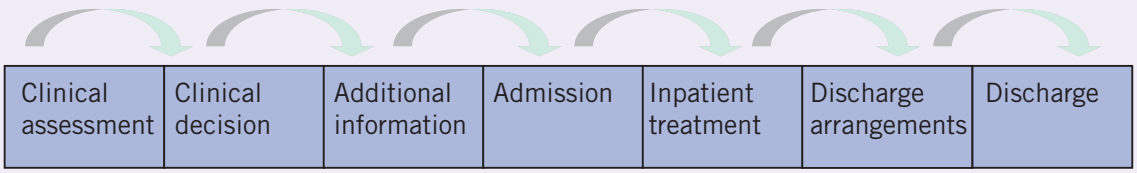
Waste	Symptom	Example
MISTAKES	Clinical Incident Complaints Multiple Checking Systems	Service user with more than one hospital number Service user involved in violent incident Drug error Non-compliance with medication Service user sleeping out on the 'wrong' ward
UNCOORDINATED ACTIVITY	Tests/work undertaken before they are needed' and when they are not necessary	Duplication of work on admission Referral to social worker just in case Repeated assessments
DEFICIENT USE OF FACILITIES eficient use of facilities	Poor ability to respond to problems Improved use of space	Inappropriate referrals Facilities not available at the right time
TRANSPORTATION	Movement of documents, materials and patients	Poor access information resulting in confusion for service users and carers Individuals not attending outpatient for appointment (DNA) Care away from home
UNNECESSARY MOVEMENT	Excessive movement	Travelling time Uncoordinated visits.
INAPPROPRIATE PROCESSING	High variation Duplication Batching	Service user seen by many healthcare professionals when one would do Multiple data entry on information systems which do not communicate Service user details recorded on nursing notes, medical notes, and multidisciplinary team notes. Twice weekly consultant ward rounds
WAITING	Information stored on a computer awaiting action Imbalance between capacity and demand Large Waiting Rooms Long length of hospital stay	Staff and service user awaiting ward round Service user queuing for diagnostic test Medically fit individual waiting to go home

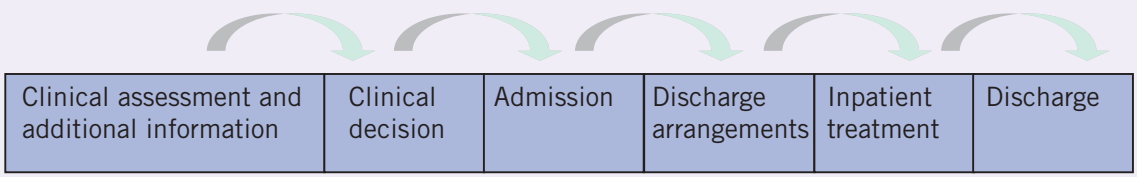
Improving your Value Flow

Establishing the logical flow of service users through a service is key to maximising resources.

The value steps must be in the right order and can be reordered if necessary. For instance, it might be found that clinical assessment occurs too late in the process or that investigations could be moved to earlier in the process. This reordering is very important as it is inappropriate to do more work on a flow that has value steps in the wrong order, or has too many steps.

For instance, the flow for secondary care admission, with value steps may looks like this:





And the flow may be changed to:

There are four key principles when making the flow more effective:

- Small batch sizes
- Setting the pace
- Linked processes
- Overall co-ordination

Small batch sizes

Service users can only move between steps at the rate that each batch is processed.
For instance, if a ward round happens once a day, the decisions to discharge are batched once a day. If a service user is ready to be discharged just after the ward round has been completed, they would have to wait until the ward round the next day for the decision to discharge to be made.

Setting the pace

Each part of the process is able to deal with the same level of demand at the same time, so service users can move from one part of the flow to the next at the same rate. In other words the pace of the flow needs to be the same throughout.

Linked processes

Each stage of the process is linked to the previous one and no one part functions in isolation. This requires good communication and collaboration between departments and other organisations.

Overall Co-ordination

Flows have a single individual or team (or it might be an area) responsible for the whole flow. This works best if they are responsible for the flow from start to finish. Within mental health services, the role of the Care Co-ordinator could fulfill this function within secondary care.

This model is an example of linked processes:-

Good Practice Point - 'Stepped model of Care'
Developing Intermediate Care- Sainsbury Centre for Mental Health

Who is responsible	Health Status	What they Do
Step 5 Inpatient Care: crisis teams	Risk to life, Severe self neglect	Medication, Combined treatments
Step 4 Mental Health specialists Including Crisis teams	Treatment resistant, recurrent, atypical and psychotic depression and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3 Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2 Primary care team, primary care mental health worker	Mild Depression	Year of Care Watchful waiting, guided self help, computerized CBT, exercise, brief psychological interventions
Step 1 GP, Practice Nurse	Recognition	Assessment

Supported Discharge Model

Aim

To deliver an individual graded rehabilitation programme to:-

- support discharge from in patient units.
- speed transfer to rehabilitation unit
- reduce length of stay
- reduce relapse and readmission

Process

An occupational therapy (OT) team provided flexible intensive in reach services based on need.

Step 1 - Screening to identify service user group most likely to benefit from service.

Step 2 - Assessment by dedicated OT's including self care, domestic, leisure, roles and routines.

Step 3 - An individual programme of rehabilitation focusing on activities of daily living (ADL) skills is commenced.

Step 4 - Once a higher level of independence is reached a graded introduction to rehabilitation unit is commenced

Step 5 - Rehabilitation is continued until discharge and support continues in the community setting for a limited time and care is transferred to CMHT

Results

This model has

- Reduced length of stay and facilitates successful discharge.
- Demonstrable improvements in daily social and life skills.

The model requires time for implementation, especially for those individuals with complex needs who often require supported housing is a prerequisite for successful discharge.

Contact. Claire Morgan Swansea Health Community

Reflection and Planning Record

This sheet is to record how the learning from this guide has improved your skills and knowledge and to evidence impact on service development

■ action plan ■ record impact ■ capture learning for CPD Portfolio)

What are the main learning points from this chapter?

How can they be applied to your professional practice?

Develop an action plan for improvement

Summarise implementation process

How will you measure the effectiveness of the improvement? A balanced scorecard of benefits

Impact on service delivery	Impact on service users and carers
Impact on outcomes	Impact on staff

How can you share your learning with your team and wider organisation?

Are you able to identify the learning needs in order for you to work more effectively?

How will you access this learning?

Who could help?

Making it Count

3

Question 2: How will we know that a change is an improvement?

In complex systems such as the health service, it is essential to use information to answer this question. The use of data to facilitate learning and action is an essential element of the model for improvement.

Using data

Data versus Information

In everyday language the terms data and information are used interchangeably. But data and information are radically different terms in the information processing or management literature. Data are defined to be a collection of observations, which may or may not be true. Thus data may not be facts. Data becomes information when processed. To process data one needs to:

1. Clean the data from errors and reduce sources of unreliability

2. Analyse data to make it relevant to the decision at hand

3. Organise data in ways that help understanding

In this definition, information is 'meaningful data'. Likewise data is useless unless organised into information.

Data goes through many distinct steps before it becomes information.

Collection of data

Data are collected to answer a question. Clarity in identifying the information that is required and how the data will be collected and analysed needs to be included in the planning phase of an improvement cycle. To facilitate learning during data collection, problems should be recorded.

It is important to note that sampling* can be used to collect the data rather than trying to capture all available items. This allows for activity based on information rather than waiting or acting on anecdote.

SAMPLING is a representative selection of the available data and analysing it to draw conclusions about the total data

Observations

Judging the success of change by the use of observation, memory and feelings is fundamentally flawed: people filter information from observations. The use of data reduces the impact of subjectivity and facilitates independent analysis.

However, observation plays an important role in the improvement process. Documentation of observations can be quantified by using classifications or counts to enable what is often considered to be qualitative data, to be used in the improvement process.

Personal experience
Capturing the views of those involved with change and in particular service users, can be quantified by using ranking or rating scales.

Stress Control – an educational approach to managing stress and anxiety

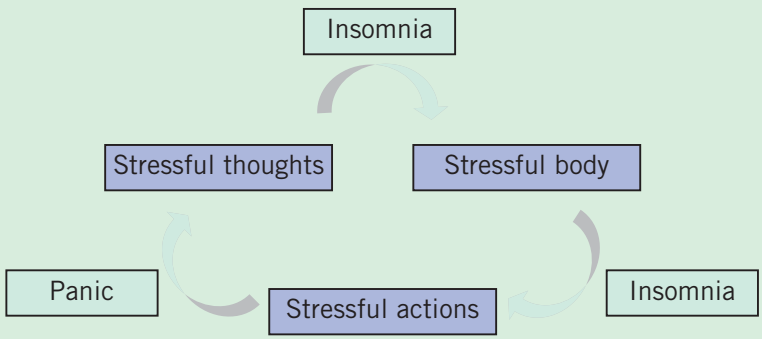
This aims to deliver timely, accessible and effective help for anxiety and related problems of panic, insomnia and depression - and in so doing reduce demand on secondary services.

It is an adult educational intervention based on cognitive behavioural therapy (CBT) principles. It adds the benefits of peer support and professional guidance to an effective self-help package. This follows the NICE recommendation that large group CBT should be considered for generalised anxiety disorder (NICE, 2004).

The intervention is appropriate for people who have:

- Current anxiety difficulties (mild to severe)
- History of anxiety difficulties
- Anxiety related to phobias
- Panic attacks
- Anxiety related to work/unemployment/family/health/relationships/finances
- Mild to moderate depression if secondary to anxiety/stress

Stress Control is a six session course delivered in an adult educational setting. It uses a cognitive behavioural model of interlinked cognitive, emotional, physical and behavioural elements leading to a vicious circle of stress.



Stress Control teaches:

- About the nature, role and causes of anxiety and related problems
- Self-assessment skills so people learn how these affect them as individuals
- A range of techniques so people can tailor their own treatment with minimal therapist contact

In short, people learn to become 'their own therapist'.

Locally, of those starting the course, 92% had clinical levels of anxiety and 65% were also clinically depressed. 76% of starters completed the course. Of those, 78% showed reductions in their levels of both anxiety and depression. The proportion of students who were 'Not anxious' or 'Mildly anxious' rose from 28% to 61%, while those who were severely anxious decreased from 34% to 4%. The proportion that was 'Not depressed' or 'Mildly depressed' rose from 59% to 90%, while those who were severely depressed decreased from 10% to 1%. People also showed overall improvement on measures of wellbeing, functioning and risk.

On measures of client satisfaction, 90% of people said that the service had met 'Most' or 'Almost all' of their needs. All those who completed said that the course had helped them to tackle their problems more effectively 'Somewhat' or 'A great deal'.

Other relevant outcome measures could include -

- Improved knowledge on maintaining mental health
- Reduced demand on primary care for mild to moderate problems
- Reduced referrals to secondary care for moderate to severe problems
- Reduced expenditure on prescriptions

Contact: Steve Woods - woodsd@Cardiff.ac.uk
Cardiff Health Community

Measures

The purpose of developing measures is to identify:

- A starting point
- A means of comparison
- To monitor performance.

Often the data needed to measure the impact of a change will not be available for a long time. If this is the case, use an available measure that is related and will capture change. An example of this would be improved self management; the long term measure could be improved individual health and the interim measure may be readmissions.

When deciding on your measures, ensure that you have:

- Agreed measures at the outset
- Chosen multiple measures to provide a balance among competing interests
- Measures that are easy to collect and are reliable
- Represented the interests of the service user

Measurement needs to take place over time to monitor performance. One or more measures will either increase or decrease over time. This enables patterns to emerge which will demonstrate the impact of improvement activity. Importantly data can also indicate where improvement is required.

Data should be collected both before (baseline) and after a change.

Variation

Variation exists in all processes around us and arises from many sources. There are essentially two types of variation:

- Common cause
- Special cause

Common-cause variation

Common cause variation is an inherent part of every process, is ever present and is due to random causes. The effect of this type of variation is usually minimal and results from the regular rhythm of the process. Common-cause variation is the noise within the system. For example, postal referrals into a CMHT may take a variety of days to be received from the GP depending on the day of posting or type of postage used.

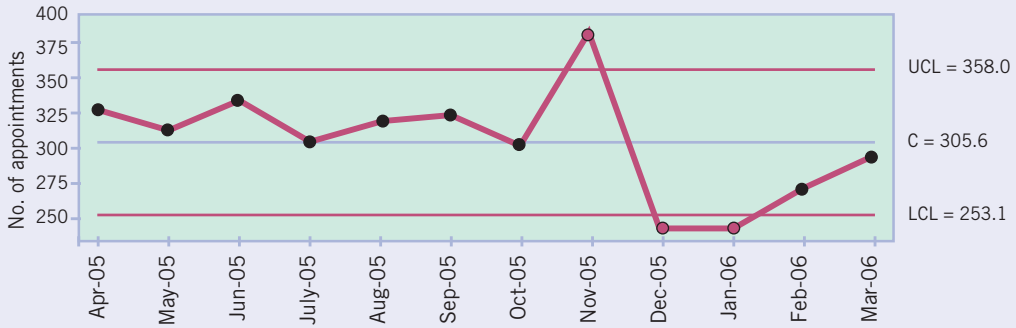
Special-cause variation

Special cause variation is due to assignable causes. It is the signal within a system. This type of variation is due to causes that were not part of the way the process was designed and which somehow "artificially" found their way into the process. Since a reason for its presence can be identified, its effect on the process can usually be eliminated. The effect on the process is usually infrequent, but the effect on the outcome can be huge.

There may be multiple special causes within a process. Elimination of special cause reduces overall variation and is an ongoing process. An example of special cause variation of referrals into a CMHT could be those with a prolonged wait due to staff holidays.

If there is only common cause variation in your process, your process is said to be "in control" and stable. It is predictable and within limits, meaning that the probability of any future outcome falling within the limits can be stated approximately. Conversely, if your process contains special cause variation your process is described as being "out of control", unstable and unpredictable.

In the graph below you can see there are points which fall between the red lines. These indicate common cause variation, which is found in every process. The points that fall outside the red lines indicate special cause. These need to be investigated as they identify an opportunity for improvement.



The main points of variation are:

- Variation exists everywhere
- Processes displaying only common cause variation are predictable and within statistical limits
- Special causes of variation should be identified and eliminated if possible

Monitoring

No system works so well that assumptions can be made that it will work from day one and continue to work. Ongoing monitoring and feedback to staff is essential to the success of the improvement process.

Presentation of data

The question to be answered will help to determine the most appropriate way of displaying data. Information can be presented in various ways using tables and graphs.

Run Charts

A run chart is a line graph that shows data points plotted in the order in which they occur. They are used to show trends and shifts in a process over time, variation or to identify decline or improvement in a process.

Practice example of a run chart
To improve allocation of Care Co-ordinator within a CMHT

Aims

To reduce the wait from assessment to allocation of a care co-ordinator in one CMHT

Process

The team identified the problem following a process mapping event and agreed to and test solutions using PDSA methodology.

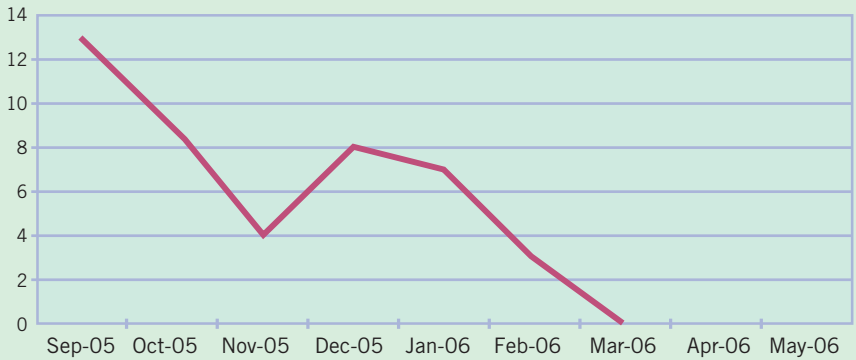
The team agreed that they would take the following one of the actions:

- Allocate for a 6-week assessment period to complete CPA and agree a care plan
- Provide short-term intervention
- Signpost to other agencies
- Discharge as appropriate.

The case would be discussed in the weekly meeting, and allocated to the most appropriate professional to meet the service user's needs.

Results

Patient outcomes have improved with waiting for allocation of care co-ordinator reduced from 14 days to no wait.



Contact: Alison Avies-Jones Alison.aviesjones@cd-tr.wales.nhs.uk
Conwy and Denbighshire Health Community

A Histogram

A histogram plots observations to show their distribution.

Practise Example of a histogram

Restructuring the mechanisms for delivering out patient appointments (OPA) in Deeside and Wrexham South Community Mental Health Teams (CMHT)

Action

Deeside, Pwll Glas and Wrexham South CMHTs changed the culture of routine follow up appointments to no follow up unless clinically indicated. Out Patient appointments are requested by care coordinator or service user.

Rational

Historically clients provided OPA 3-12 months in advance. The system of routinely providing an OPA was not always based on current clinical indicators but on habitual practices.

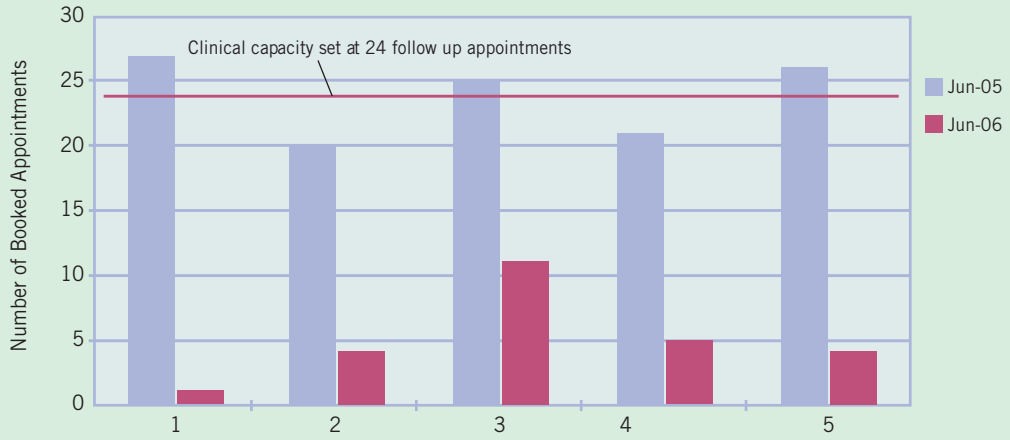
The aim was to reduce duplication of contact, encourage use of recovery model utilising a holistic multi disciplinary perspective, increase capacity of consultant and provide all service users' greater choice and quicker access to an OPA with a consultant when required.

Conclusion

The number of appointments has dramatically reduced, resulting in increased consultant capacity, no waiting list for routine OPA and reduction in non-attendance for appointment rates. Increased consultant capacity has expanded the potential for home visits, the time for case discussions, advice and consultation between the consultant and the mulit-disciplinary team. Extra capacity within administrative staff has occurred due to reduced need to greet clients, arrange appointments and type routine clinic letters.

Capacity

An average of six hours per month has been reinvested back into mental health services from the reconfigured OPA system. Based on one Consultant activity, the average monthly saving for the year, excluding holidays and training, amounts to a saving of 60 hours. If this initiative was rolled out to all consultants across Adult Mental Health services in the locality, adopting this innovative approach to OPA could result in 64 working days being reinvested back into services. Other CMHTs have already adopted this way of working including Ty Celyn in May 2006.



Contact: Andrew Palombella Andrew.palombella@new-tr.wales.nhs.uk
North East Wales Health Community

Understanding the demand for services

Understanding the demand for services and how it balances against the activity the system is producing, is fundamental in understanding where waiting lists come from and how to deal with them.

A brief introduction to this concept is provided here, but for a more in depth understanding please refer to the Guide to Good Practice - Elective Care - NLIAH.

A common unit of measure

Because it is important to compare the four measures described below, the same unit must be used for each. Although other measures can be used, minutes of clinic session is often used as a common unit.

Demand

The demand on the service is all the patients referred into the service from all sources, once again converted to a common measure of time.

Activity

Activity is the throughput of the system - the number of patients seen in clinic, discharged from the ward, or processed through the CMHT. The number of patients must be converted to the common unit of measure. For example, one patient would be 60 minutes of clinic time.

Backlog

The waiting list needs to be converted to the common measure. The backlog may be the number of patients on the waiting list, or it may be the number of patients referred to other services following referral to CMHT. Once again the patient numbers must be converted to the common unit.

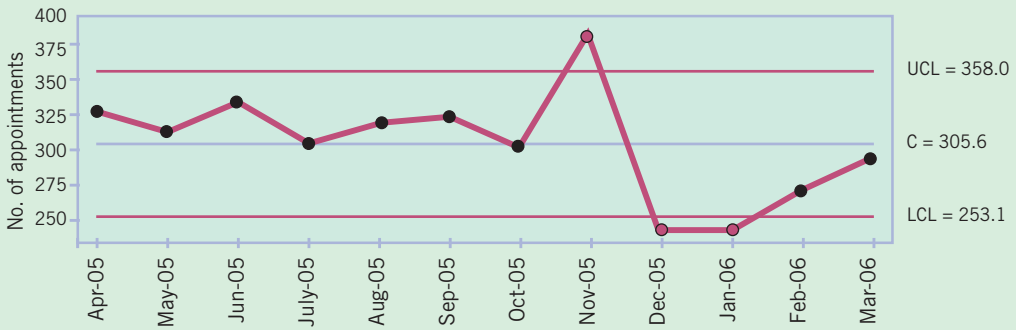
Capacity

The capacity of the system is the time that the resource is available. In the case of clinics, this will be staffed time in clinic sessions.

Practice Example
Analysis of Psychotherapy data

Activity

The graph below illustrates the total appointments i.e. activity undertaken by the Swansea psychotherapy team from April 2005 - March 2006.



The average number of appointments per month = 306, with 4.3 weeks per month. One appointment is provided per therapy session, however group therapy can be provided to a number of individuals at the same time using the same resource. The available data is not able to distinguish between types of therapy provided.

Each full time therapist is allowed by their professional body to provide up to 5 sessions of therapy per day. This equates to 7.5 hour working day i.e. 25 hours per week or 108 sessions per month.

A maximum of 4 hours of therapy are provided by therapists who work 6 hours per day i.e. 20 hours per week or 86 hours per month. This equates to 66.6% of a therapist's working week.

To identify the capacity required to meet this activity the following calculation has been used:-

number of appointments divided by sessions available

Based on the average number of appointments per month 2.83 full time therapists are required to match the average activity. These calculations assume that all sessions are individual appointments, which is incorrect.

Since we don't know how many appointments are provided through group therapy we need to make use of information regarding the approximate number of appointments that are provided by group therapy i.e. in the same session per week. Whilst this varies, a conservative estimate indicates that 3 sessions are taken up by group therapy, offering therapy to a total of approximately 20 patients per week; 86 per month. This indicates that of the 306 appointments per month, 220 sessions are used for individual appointments; 72% of the all appointments.

Recalculating the full time therapists required to provide these appointments gives 2.05 full time therapists needed to maintain current activity.

Capacity

Information supplied regarding the working hours of the therapist team

Number of working days per week	working hrs per week	admin and travel	clinical supervision & management	preparation time	research & study	max capacity per week excl annual leave	actual capacity - all other responsibilities	annual leave	max therapy capacity per week - annual leave	lost capacity (hours per week)
TOTAL	205					137	72.21		115.38	43.17
wte therapy	5.5					3.65	1.93		3.08	1.15

Table 1 above illustrates that 5.5 full time therapists are in post, with 1.93 full time i.e. 62.6% of available capacity providing therapy, indicating possible lost capacity of 1.15 full time therapists time.

Demand

Half of the therapy team provide cognitive therapy and half provide integrative and/or psychodynamic therapy. The amount of sessions provided for each type of therapy varies considerable.

Mean number of new appointments per month	12.3
Mean number of new appointments per week	2.86
Number of sessions per new appointment :	
cognitive therapy	12-30
Integrative / psychodynamic therapy	12-78

Due to the variability in session time, the case mix has a direct effect on the number of appointments needed to attain stability as does the percentage of appointments provided by group sessions.

The data for the last year shows that 2.05 full time therapists were required to provide the appointments based on 28% of sessions being provided to groups. This indicates that the cycle time for the majority of patients is above 12 weeks.

Without the exact balance of the case mix the number of appointments needed to show the demand on the service cannot be accurately calculated. However, table 2 above illustrates that the existing capacity i.e. 3.08 full time are able to provide in excess of 30 sessions for all patients.

Backlog

There is a waiting list of 223, 129 of whom had waited more than 6 months with additions being made to the waiting list on a monthly basis.

Conclusion

The available capacity of 3.08 full time therapists could supply 77 sessions per week; 331 sessions or individual appointments per month. At present 48.3 sessions are provided per week; 207 per month, indicating lost capacity of 28.7 per week, 124 sessions or individual appointments per month.

2.47 full time therapists are needed to provide 30 sessions per patient, offering a surplus of 0.6 full time therapists. This surplus capacity could provide 10 sessions per week.

To address the waiting list the capacity could be used to provide 12 week sessions 2 patients requiring individual sessions or could be removed from the waiting list per week, or 2.24 patients requiring group therapy.

Contact: Amanda Hall Amanda Hall@swansea-tr.wales.nhs.uk
Swansea Health Community

Reflection and Planning Record

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■ action plan ■ record impact ■ capture learning for CPD Portfolio)

What are the main learning points from this chapter?

How can they be applied to your professional practice?

Develop an action plan for improvement

Summarise implementation process

How will you measure the effectiveness of the improvement? A balanced scorecard of benefits

Impact on service delivery	Impact on service users and carers
Impact on outcomes	Impact on staff

How can you share your learning with your team and wider organisation?

Are you able to identify the learning needs in order for you to work more effectively?

How will you access this learning?

Who could help?

Action in Mental Health Wales

Making It Work

4

What changes can we make that will result in Improvement?

Good practice point

All Improvement involves Change but not all Change is Improvement

Managing Change

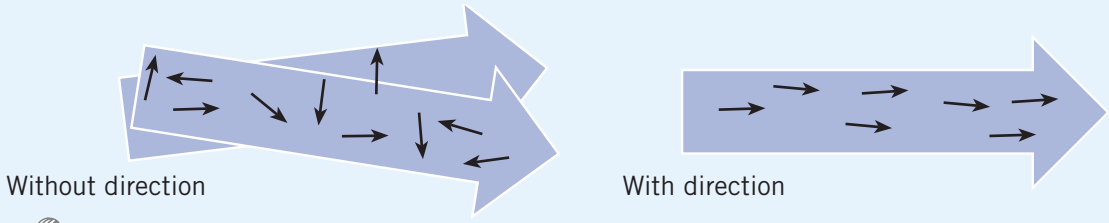
Without change there will be no improvement and most individuals will embrace change if it is well managed. Change can pose major challenges and requires sound project management, an appreciation of the human dimensions of change and sound leadership.

Effective change requires vision, attention to process, a constant learning cycle and an emphasis on relationships.

John P Kotter (1996) provides us with the essential components that must be considered and actioned for an effective change management strategy :

- Establishment of a clear understanding of the reasons for change. Ensuring there is an appreciation by all that the existing situation cannot continue. Creation of an urgency and a growing pressure for change.
- Leadership from a sufficiently powerful guiding coalition to drive the change. Ensuring that those in authority, at Board and Chief Executive level, lead and support it.
- Development of a clear vision of what the change will achieve. All those involved in the change process need to understand and sign up to the vision to ensure a consistent approach. It is imperative that all are moving in the same direction.
- Kotter tells us to communicate the vision by a multiple of 10,100 or even 1000. By this he means that leaders of change go out to meet with and listen to all those at the frontline, to test out the vision, reinforce it and weave a continuous narrative.
- Identifying and unblocking the obstacles to change. In many instances these blocks are individuals who have a vested interest in maintaining the status quo. Techniques for positively challenging existing practices and beliefs are the basis of improvement methodology which are identified throughout this guide.
- The creation of short term wins. It is important that there are opportunities to experience some measure of success.
- Ensuring that change is anchored firmly and integrated into the culture- as Kotter says “in the final analysis, change sticks only when it becomes the way we do things around here”

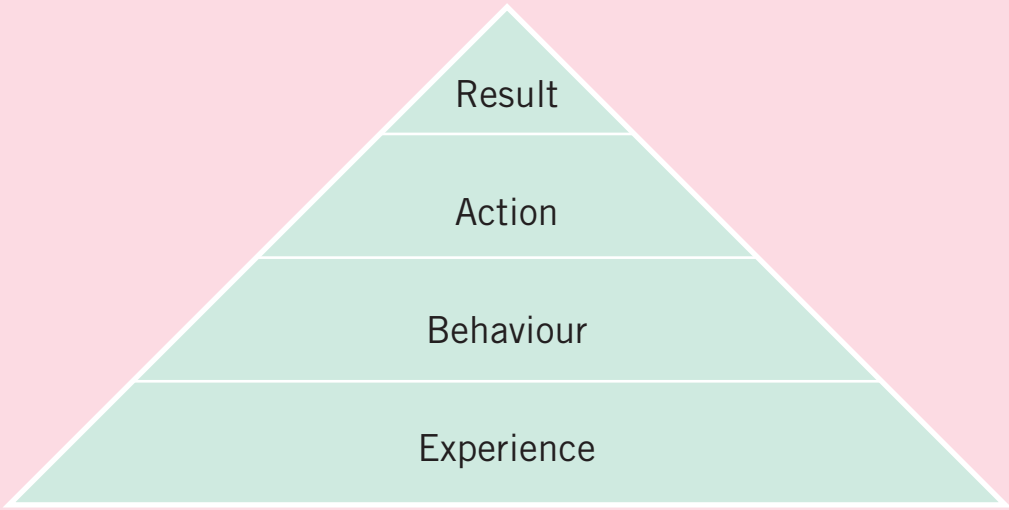
The goal will not be achieved unless all are moving in the same direction



Good practice point

Development of vision

Clarity of vision with detailed goals will allow development of a plan to shape the experiences of those involved which in turn will raise awareness of the future vision to alter behaviours in order that actions can be implemented and integrated to achieve the final result.



This basic change management approach is used not only in effecting service change but is also the basis of the recovery/refocusing/tidal model approach.

Taking recovery to a new level in Powys - a training package to develop a skilled workforce.

Background

Powys has introduced the Recovery Approach to improve the therapeutic environment of inpatient units and other mental health facilities across the county. This has required implementation of a service-wide training programme and the introduction of Support, Time and Recovery (STR) Workers.

Aims:

- To successfully implement a working culture receptive to the integration of the Recovery Approach concept
- Employment of Service Users as Support, Time and Recovery (STR) Worker posts
- To identify a suitable training package to support skills development

Employment of Service Users as STR Workers could potentially have two clear benefits:

- Provide a way of stepping into employment
- Bring benefits to the service through the employment of people who have first hand experience of mental distress

Methods Used:

A training package developed in Queensland, Australia was identified and adapted for use in Wales.
This package was piloted with a group reflecting a wide range of stakeholders.
The training package was delivered jointly by a Service User and a Project Coordinator with considerable knowledge and experience of the Recovery Approach.
Each module of the 3 day training package was evaluated for effectiveness and appropriateness
Comments and an overall score were recorded for each module
The package was adapted for use in Powys.

Job descriptions for STR Workers have been prepared, including person specification, salary level and joint management structure between health and social care. These new posts will provide the extra capacity to effectively deliver Crisis Resolution and Home Treatment services in Powys.

Contact: susano@powys.gov.uk
Powys Health Community

Implementing Change

No change can be achieved without the support of all those involved. There are a number of approaches to managing the human dimensions of change, and this is a brief introduction of some of the approaches to involve staff in the change process.

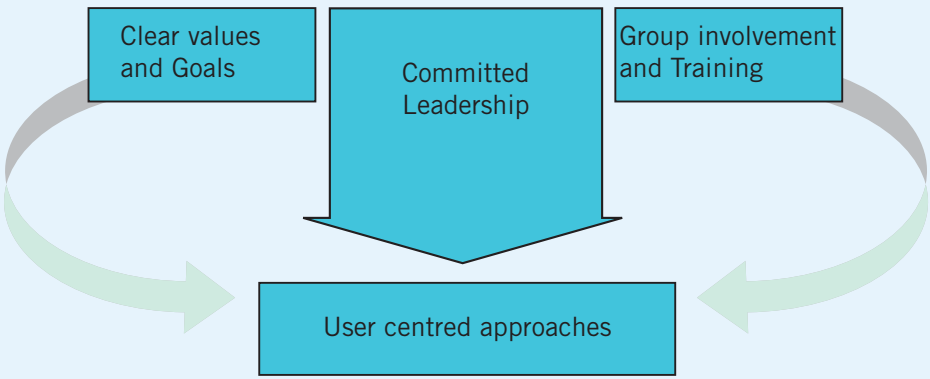
There are two ways of initiating change: change can be imposed by management, or it can develop organically from below.

- Imposed change will usually have a clear plan, will have support and leadership, and will have clear objectives
- Bottom up change is likely to be a continuous, rather than an episodic, process. There is often no plan or clear objective to the change

Successful change requires a combination of the two approaches. Clear leadership and support for the process from management, with clear objectives plus a strategy to engage all as part of the process.

Kotter tells us we need 'intelligent leadership' which means doing things in a planned way with respect for how this plan impacts on others. Clinicians are more likely to become involved in change, if they are confident that managers understand the problems faced by the service, and are competent in the analysis and understanding of data.

Another important component is to identify what is in the change process for everyone involved. In every instance there will be some motivation for either adopting or resisting change.



The Recovery Model

HAFAL has successfully developed and are practicing a model of recovery which is based on change management methodology.

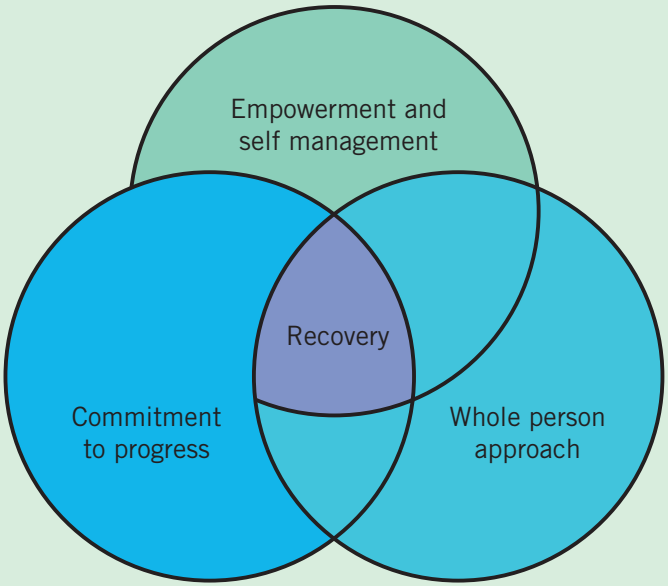
Recovery is the stated vision with agreed individual goals. When planning for recovery the HAFAL model emphasises that it is vital to act upon a step by step, goal focused plan and work according to a timetable.

This plan is based upon the service users:

Commitment to progress which involves actively taking steps to improve their own life. Responsibility lies not only with the care giver but there is a recognition that recovery and its achievement is dependent on positive action by the service user.

Adopting a whole person (or holistic) approach, addressing all the key aspects of life which together contribute to well-being. By setting goals in all areas of life it is possible to approach recovery more comprehensively.

Taking ownership of your own health is also important. The HAFAL model is based on empowerment and self management. HAFAL is clear that this will mean exercising rights and responsibilities in making choices but are clear that some individuals will need support in regaining mental health and achieving a better quality of life.



Contact: HAFAL hafal@hafal.org

Many people do not like change. Implementing change successfully inevitably means working with people who might prefer things to continue as they are. How is it possible to get people to not only co-operate with the change process, but to be enthusiastic about it?

First steps

There must be a clear understanding by all of what will happen first. Overcoming inertia is easier if there is a clear plan, with manageable first steps.

The Comfort Zone

Part of involving people is getting them out of that comfort zone where they feel that the status quo is OK. But it must be done in such a way that does not create panic. In any group there will be those in the 'comfort zone' (I don't want to change), and those in the 'panic zone' (I can't change). The art is in moving both into the 'discomfort zone' (I can change).

What is in it for me?

The best way to move people is to identify what is in the change process for them. Everyone will have some motivation for either adopting or resisting change. Everyone will have something about the current process that they do not like. The key of good change management is to identify and use these drivers. Ensure that solutions to problems meet the needs of the staff, and they will be much easier to implement.

Changing services

Improvement techniques will identify issues in the current processes that are the source of dissatisfaction. The key of good change management is to identify and use these drivers. Ensure that solutions to problems meet the needs of everyone involved and change will be much easier to implement. It is also important to communicate a clear view of what will be achieved during the change process. A balanced scorecard approach will demonstrate the benefits and provide a range of quality standards to be achieved.

Good practice point

A balanced approach to performance management

The balanced scorecard enables services to assess where they sit in the eyes of their service users and demonstrates how ready are they to meet the challenges they may face to allow them to be considered as an excellent provider, or if they have already achieved this what is required to ensure that they are equipped to maintain these standards of delivery. The four quadrants of the balanced scorecard can assist the service in assessing this, and can individually support the improvement and development process or can link with other quadrants to support the process.

Why use a balanced scorecard?

The balanced scorecard is a recognised performance management tool that helps us to assess how well we are doing!

For many years health services have been measured only in terms of results.

The balanced scorecard provides a systematic framework for considering not only the outcomes of services, but what needs to happen to achieve these with regard to resources, processes, customers and results.

The following example demonstrates it's use.

Balanced Scorecard to achieve quality services

Process
Impact on service delivery

- ✔ Improved process flow
- ✔ Single assessment process (CPA and UAP)
- ✔ Unnecessary admissions avoided
- ✔ Readmissions reduced
- ✔ Shorter length of stay
- ✔ Earlier and co-ordinated discharge planning
- ✔ Care packages available in primary care
- ✔ Improved capacity
- ✔ Reduce demand on secondary services
- ✔ Fewer cancellations and DNA
- ✔ More effective use of resources
- ✔ Cost savings

Customers
Impact on users of the service

- ✔ Less duplication
- ✔ Access to services nearer to home
- ✔ Improved choice
- ✔ Better co-ordination of care
- ✔ Reduced delays in discharge
- ✔ Reduced delays and shorter waiting for services
- ✔ Less anxiety and greater satisfaction
- ✔ Clearer decision making
- ✔ Greater control in self care
- ✔ Better information and improved communication
- ✔ Improved quality of life

Results
Impact on outcomes

- ✔ Speedier access
- ✔ Improved quality indicators
- ✔ Better crisis management
- ✔ Improved care outcomes
- ✔ Improved prevention
- ✔ Improved recovery rates
- ✔ Improved clinical care for people with long term conditions
- ✔ Improved physical health
- ✔ Increase in service users obtaining employment
- ✔ Effective use of advance directives
- ✔ Increase in uptake of direct payments

Resources
Impact on workforce

- ✔ Less turnover
- ✔ Improved sickness and absence rates
- ✔ Improved recruitment
- ✔ Better demand management
- ✔ Improved staff satisfaction and morale
- ✔ Reduce firefighting
- ✔ Complimentary skill mix
- ✔ Professional and career development
- ✔ Role development- supplementary & independent prescribing
- ✔ Gaining dual qualification
- ✔ Utilisation of existing skills base
- ✔ Opportunities to work across professional boundaries

Managing the transitions

A skillful approach during the process of change is also required. Every change destroys something that has gone before, and some people will regret that loss even if they are happy with the new process.

William Bridges calls the process that people go through as they face change 'transition'. Transitions start with an ending, goes through a period of uncertainty, and ends with a new beginning.

1. Managing the ending

Before you can start something new, you must end what used to be. To do this effectively you must understand who is losing what? What is over? You must positively acknowledge the losses and be clear what is over and what is not.

2. Managing the neutral zone

Neither the old ways nor the new ways seem to be working. This is the dangerous time, where anxiety rises and motivation falls. There will be more illness, but it is also a more creative time - redefine it and use it constructively. Create temporary systems to manage this stage.

3. A new beginning

This is the easy part, especially if the endings have been managed. You must clarify and communicate the purpose, painting a picture of how it will be. Create a plan, and show everyone their part in the future.

How to get people on board

Do not target everyone straightaway. Focusing efforts initially on those who want to test out new ideas and make improvements is often more successful. These are the Innovators and Early Adopters. Research suggests that engagement of 20% of a population leads to the rest following in due course (Rogers 1985). The term laggard is used for someone who has not seen a need for change or does not believe it will meet the need.

Building trust and relationships

Having good relationships and mutual trust between yourself and colleagues is more likely to lead to people being receptive to new ways of thinking and the improvement methods you want to introduce.

Trust requires a degree of competency and caring, doing what you say you will do, listening carefully and understanding what matters to people (Scholtes 1998).

When taking forward change the following table is a useful tool to check that all issues have been considered:-

Good practice points for managing change: Goldratt

Issue	Change Management Techniques
■ Any improvement is a change	■ Help everyone to see and understand the current process
■ Not every change is an improvement	■ Involve service users and help staff to understand their views and concerns
■ Improvement will not occur without change	■ Set aims and measures to ensure that all implemented changes do make improvements
■ Any change might be perceived as a threat	■ Set up systems to make sure improvements are sustained
■ Any threat gives rise to emotional resistance	■ Understand what is important to individuals and groups
■ It is rarely possible to overcome emotional resistance with logic alone, it usually requires a stronger emotion	■ Use the "what's in it for me" (balanced scorecard example)
	■ Recognise and understand differences in how people react
	■ Develop flexible ways to relate to and build rapport with different people

Communication

Making improvements and sustaining them requires good communication at all levels.

Exploring is the use of questions to understand issues. Active listening enables a better understanding, sharing of opinions and feelings that will facilitate better engagement.

General tips for good communication:

- Seek first to understand then to be understood
- Communicate directly with the people who matter in a transparent two way process
- The result of communication might be different to what you intended
- You will always be communicating, even when you think you are not – behaviour is the highest form of communication
- Uncertainty is often more painful than bad news, so communicate early and often

Development of a Web page to support the implementation of CPA

Aim

To ensure consistency and quality of implementation across the health community.

Objective

Development of a web based tool to provide

- Policy and guidance
- Pathway processes
- Tools to be used at each stage of pathway
- Training information and links to useful resources

Process

A project management approach was utilised:

- Establishment of groups to oversee and assume leadership (for all stakeholder groups)
- Formation of project group with skills required to achieve objectives (for instance IT expert with knowledge of web development)
- Agreed timeframe for completion – 3 months
- Clear responsibilities with project leadership vested in one individual
- Development of specific outcomes to measure progress against the aim
- Communication strategy to share progress and test change

Learning

The introduction of change is challenging:-

- can lead to inconsistent interpretation of expectations
- can cause anxiety if the reasons for and requirements of change are not communicated

Results

The development of the web page has made information regarding the change and continual changes required, more accessible to everyone. It has also supported implementation providing a mechanism for feedback, information giving and consistent use of guidelines.

1. Developed system for CPA and CMHT Pathway audit across community and early indicators show improvements in consistency of approach with new tools being used across all areas
2. Provided vehicle for collection of service user experience information
3. Web page is used extensively especially for purpose of practice update and to access forms
4. Audit of 7 day follow up discharge standard has demonstrated improvement

Visit web page: www.pdt.tr.wales.nhs.uk
Contact: Jayne Anderson jayne.anderson@pdt-tr.wales.nhs.uk
Carmarthenshire, Ceredigion and Pembrokeshire Health community

The PDSA Cycle

The PDSA cycle is a technique for testing new ideas before initiating large scale change. This is not a new concept and are like audit cycles. However there are some fundamental differences

- They can be applied in any situation
- They typically involve small numbers
- They involve individuals not whole organisation
- They are not an end in themselves but will initiate another piece of work

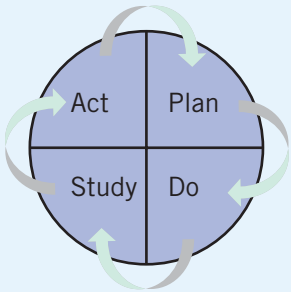
If there is an idea that may provide a solution to a problem or may start a process of change, then that idea can be tested using a PDSA Cycle. One of the greatest benefits of PDSA Cycles is that individuals in all organisations and at all levels of that organisation can perform Cycles related to their own work and circumstances. PDSA Cycles ensure that everybody's contribution and work is recognised and valued.

Advantages of PDSA Cycles

The PDSA model is ideally suited to introducing change in a complex clinical environment, where there is a high element of risk. Small changes are more acceptable to staff and service users, and there is far less disruption than the more traditional 'major redesign programme'. The process also promotes the philosophy that change is a normal continuous process that all can be involved in, rather than a major event that 'happens' to people.

Not every PDSA Cycle will lead to improvement but work from these will not entirely be lost as the information gathered may be useful in other areas and can inform future Cycles. PDSA's cycles work as we learn from our mistakes as well as our successes.

PDSA
A cycle involving 4 key steps to test a change and learn from impact



A similar model is RAID - Review, Agree, Implement, Demonstrate

Plan

Define the question that you want answered in this Cycle, including what you would expect the outcome to be. Design an experiment to test the question, covering the 'who, what, when and how' of the Cycle, and the measures that will be used to determine success.

Do

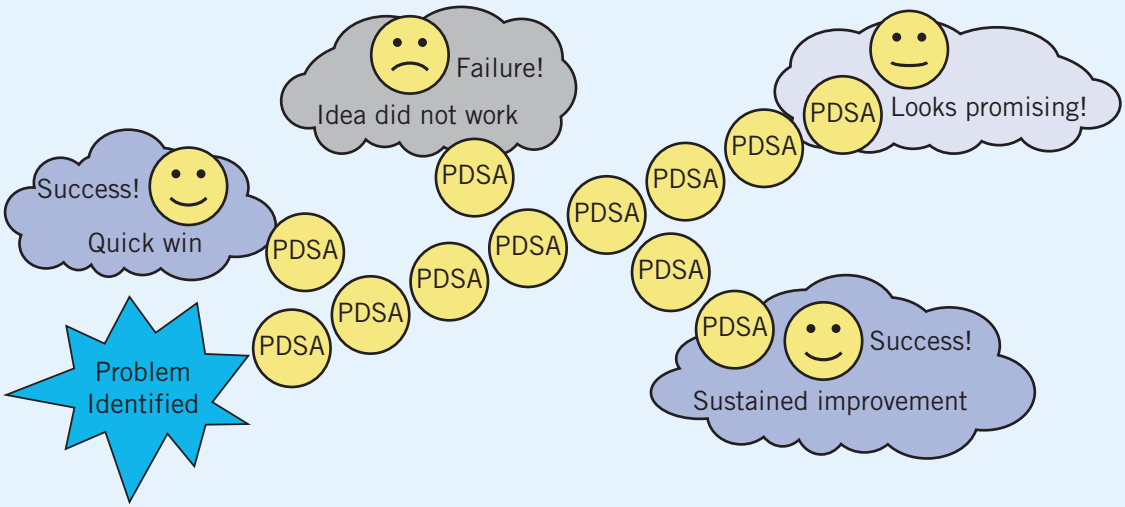
Do the experiment, ensuring the data has been collected. Record what went wrong, and what went well. Were there any unexpected out-comes?

Study

Get everyone together to look at the data. What has been learned? Do the outcomes agree with the predictions? Are there circumstances where the outcome might be different?

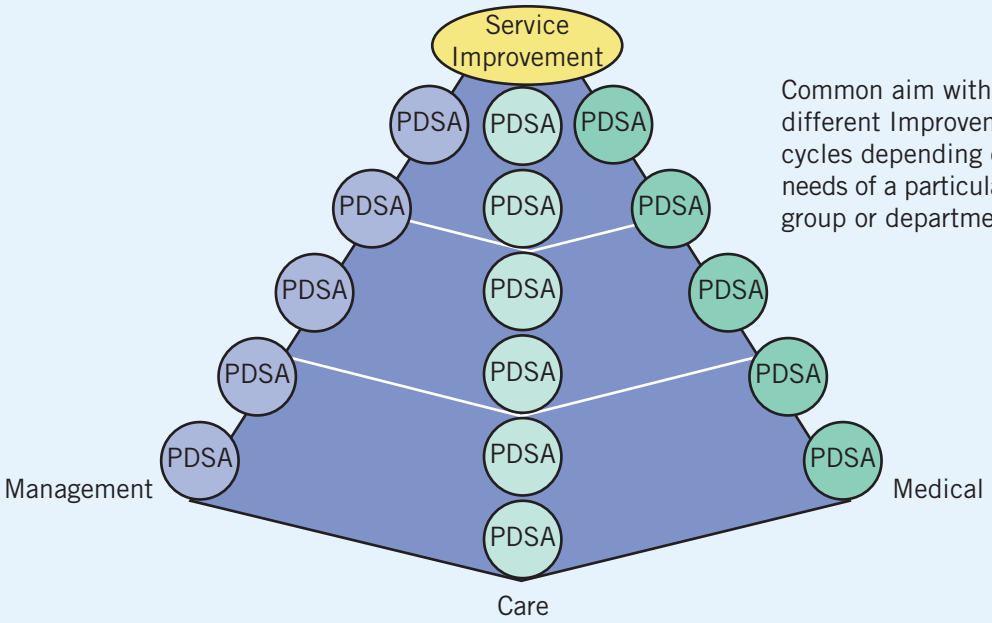
Act

Decide what to do next Cycle. Should the change be imple-mented more widely? Can it be extended, or is something else necessary? What will be the objective of the next Cycle? If the change was unsuccessful, it should be amended for the next Cycle — there should not be pressure to adopt every change..



A series of Cycles

Improvement is the result of a continual series of Cycles building on previous results. Each PDSA Cycle is short, making small improvements to the status quo. The result is a steady improvement in process over time. One 'ramp' of Cycles relating to one process may be undertaken in parallel with another series dealing with a different problem, but the key is to have a series of changes, made in a systematic fashion, with evidence of the results from each Cycle, over a period of time.



Good Practice Point

- PDSA Cycles are not long projects but short tests of change- When planning to test an idea- if you are planning to test for a month–plan for a week- if you are planning for a week –plan for a day;
- Break down Cycles into their smallest components
- Manage and report Cycles using the forms provided (in the appendix)
- Remember if it cannot be measured it hasn't happened so use tables or graphs to demonstrate results
- Many PDSA Cycles should be in progress at the same time- involve all actively in the change plan
- Very few require statistical analysis – so everybody can use them

Assessment of Urgency Referrals using the Threshold Assessment Grid (TAG)

Action in Mental Health PDSA Worksheet

Background
Referrals to CMHT's marked 'urgent'-receive priority and are dealt with promptly. This has resulted in a longer waiting time for those deemed not urgent. Analysis of 'urgent' referrals showed that a high percentage did not require urgent assessment.

Objective
To develop a system for assessing urgency of referrals.

Plan
To pilot an assessment tool (TAG).The TAG tool was developed by the Institute of Psychiatry to assess quickly a person's vulnerability, disability and risk.

Do
The tool was piloted by Duty Workers:

- On receipt of referral, referrer was contacted to obtain standard information
- Information used to score against TAG criteria and TAG score provides indicator on urgency of referral
- CHMT response in accordance with level of urgency

Study
Tag assessment found that 60% of urgent referrals were classified inappropriately

Act
Capacity to deal with the urgent cases has improved
TAG has been a useful tool to reduce anxiety of referrer
Roll out to be discussed at clinical governance meeting

Contact: Alun Davies Alun.davies@cardiff-tr.wales.nhs.uk
Cardiff and Vale Health Community

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■ action plan ■ record impact ■ capture learning for CPD Portfolio)

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Impact on outcomes	Impact on staff

How can you share your learning with your team and wider organisation?

Are you able to identify the learning needs in order for you to work more effectively?

How will you access this learning?

Who could help?

Making it Fit (together)

5

Care Pathways

All improvement activity within adult mental health services is driven by the overall goal of ensuring that service users receive appropriate effective evidence based care to support recovery and movement back to supportive self management. It is important that the delivery of that care is joined up and that all the pieces of the care jigsaw fit together. Care pathways provide the vehicle around which these goals converge. Care pathways describe what should happen, where and when it should take place and by whom.

What is a Care Pathway?

Care pathways are a description of a process or sequence of episodes that a patient may pass through during the course of their condition. Key features of a pathway include the fact that it crosses organisational boundaries, that there is an order to events and that it is essentially descriptive.

What is an Integrated Care Pathway?

An integrated care pathway (ICP) is a multi-professional documented plan of care that provides detailed guidance for each stage in the care of a service user. An ICP takes the description of the process as developed in the care pathway, increases the level of detail for a defined section of the pathway and then puts in place mechanisms to measure how well an individual followed that pathway.

Good Practice Point –Gold standard for development of ICP's (agreed by ICP network 2003)

A care pathway describes what should be delivered

An integrated care pathway documents what has been delivered

An ICP is anticipated care placed in an appropriate timeframe, written and agreed by a multidisciplinary team. It has locally agreed standards based on evidence (e.g. NSF's or NICE Guidelines) to help a patient with a specific condition or diagnosis move progressively through the care experience. It forms part or all of the clinical record, documenting the care given. It facilitates and demonstrates continuous quality improvement. It includes patient milestones and clinical interventions noted on the day or stage they are expected to occur. It will include all of the following standards to show evidence that the right care is being achieved to the right standard:

- MUTIDISCIPLINARY
- REPORTS WHAT GOES WRONG
- SERVICE USER INVOLVEMENT
- STANDARD FORMAT
- BUILT ON AUDIT
- SINGLE DOCUMENTATION
- VARIANCE ANALYSIS
- CROSS BOUNDARY
- OUTCOME FOCUSED
- EVIDENCE BASED

Modular Care

It would be unreasonable and probably unworkable to expect individual users to fit into a standard ICP. Each individual pathway is complex and may contain a wide range of options. The modular pathway means that rather than a single document an individualised care record can be made up of multiple modules or forms used to create a flexible needs lead journey. This modular style facilitates the use of additional pathways but using the main information and data set reducing duplication. CPA documentation will contain the main information requirements to which modular ICP's can be bolted on as required.

The Care Programme Approach (CPA)

CPA supports the delivery of quality patient pathways for those patients requiring secondary care services. CPA is seen as a specialist domain of UAP. A Users guide to CPA can be found on www.hafal.org

Unified Assessment Process (UAP)

Used by all health and social care agencies as the core generic and specialist assessment.

Advantages

At present, there is not always consistent care and treatment is often episodic and access to secondary care is due to crisis, when an earlier primary care intervention would have been more appropriate. ICP's are a way of standardising and improving the delivery of care offered to all service users.

Year of Care Concept

A 'year of care' is a simple way of placing a defined start and finish date around an ongoing process of supported management, ideally delivered by the primary health care team (PHCT). A Year of Care is an ICP. This ICP will start with referral back to the care of the GP and an assessment visit with the GP or gateway worker. The Year of Care will document the specific care needs of individuals with standards and outcome measures to monitor (variance tracking) and ensure these standards have been achieved, finally concluding with another assessment visit in 12 months.

Where an individual departs from an ICP Year of Care, due to crisis for example, other pathways will come into effect and the stopping of the Year of Care would be treated as a variance to be recorded. It is anticipated that the individual would go back onto the Year of Care pathway following resolution of the acute crisis.

What is Variance?

Throughout the pathway, clear standards **or** actions are set out, such as assessment carried out within a certain time frame. These standards and actions will be derived from GOOD practice standards, NICE guidelines and NSF requirements. Where standards or actions have not been achieved or there has been deviation from the specified pathway this is classified as a variance. These can be the result of an omission due to circumstances or choice based on clinical judgement to do something differently.

Measurement of variance is important because:

- Provides explanations of why something has not happened as expected
- Records clinical reasoning to support clinical governance
- Monitors effectiveness of pathway
- Captures information on reasons why pathway has not been achieved, such as resource issues, training issues or ineffective processes supporting the pathway

Development of an CMHT ICP

Aims

- To reduce variation across the 5 CMHT's
- Improve access and equity of provision
- Collect care delivery information to further inform service development

Process

Development of the ICP followed the model outlined in the NLIAH integrated pathway publication (see resource section)

A process mapping event was held with team managers, multi disciplinary leads, inpatients and service users and carers. The current pathway was mapped which demonstrated to all:

- Variation across the teams
- Inefficiency in allocation of care co-ordinators
- Delayed discharges and extended length of stay.

A second event was held with a larger group to ensure wider engagement. This event resulted in agreement on a revised pathway and minimum delivery standards.

This was followed by team away days to map existing processes against the revised pathway resulting in identification of areas requiring change and an action plan to implement this change.

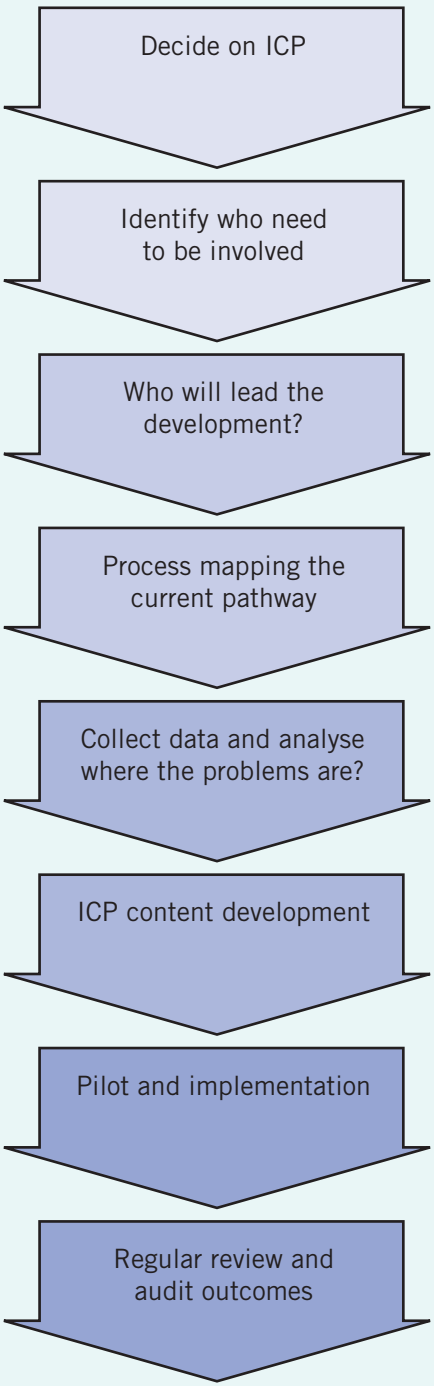
Results

The pathway has been implemented:

- An audit tool is being tested to monitor pathway based on minimum standards
- Pathway is informing the development of the IT infrastructure required to monitor delivery of Care
- Patient outcomes have improved with waiting for allocation of care co-ordinator reduced from 14 days to no wait

Contact: Alison Avies-Jones Alison.aviesjones@cd-tr.wales.nhs.uk
Conwy and Denbighshire Health Community

Implementation Model



Conwy and Denbighshire Partnership

Stage 1 - CMHT identified as cornerstone of mental health services and therefore prioritised

Stage 2 - The multi disciplinary leads were involved with service users and carer representation attending 2 full days

Stage 3 - The project lead was identified.
Each team accepted responsibility for agreeing and developing the pathway. The partnership manager lead on its implementation with team managers applying this in practice.

Stage 4 - 2 process mapping days – first to map existing pathway -2nd to agree CMHT ICP with clear criteria for the service based on best practice (Slade et al) and fair access to care incorporating minimum standards

Stage 5 - In the absence of robust data- minimum standards were agreed based on good practice and CPA processes

Stage 6 - The content was agreed during 2nd mapping event but these were researched, confirmed, written up and circulated widely

Stage 7 - Individual team away days resulted in action plans against the ICP, an audit tool developed and piloted

Stage 8 - Minimum standards, documented on ICP provide the framework for the audit tool and the IT system. CPA has provided the variance tracking utilising the unmet need form

An Integrated performance group will monitor minimum standards

Practice learning - Learning from Implementation of ICP's

This community has successfully implemented a Care Pathway for the service users journey through secondary care services using the model explained above. Implementation has demonstrated the need for flexibility and a modular approach.

A high level pathway development has included detailed sections within it dependent on need (modules)

The secondary care pathway has 2 options

- Acute inpatient
- Crisis resolution and home treatment pathway

However both are linked to the high level care plan to ensure seamless flow from admission or discharge from or into each service.

These pathways then feed into a CMHT pathway which has distinct phases

- Pre referral/referral/screening
- Assessment/care planning/review
- Discharge

Piloting and implementation relies heavily on PDSA cycles and introduction and testing in small stages.

Contact: Jayne Anderson jayne.anderson@pdt-tr.wales.nhs.uk
Carmarthen, Ceredigion and Pembrokeshire Health Community

The four stage meeting model for the development of ICP's

Meeting 1- Preparation

Before the meeting; collect baseline data on patient/condition relating to ICP and allow team to learn about ICP's and see a model documentation:

- Develop a high level patient pathway
- Identify where the ICP will start and finish
- Identify the stages in care
- Agree criteria for leaving the ICP e.g Discharge
- Identify perceived problems with current care

Meeting 2- Preparation

Before the meeting circulate and confirm with wider teams criteria agreed and check problems with current state:

- Confirm perceived problems
- Plan the collection of sample data to provide evidence to support perceptions
- Develop list of patient outcomes that the ICP will deliver

Meeting 3- Preparation

Before the meeting; agree areas of responsibility for development and research evidence based care for each stage of ICP:

- Share areas of responsibility
- Interrogate data to confirm issues to be addressed
- Identify how to solve issues
- Determine criteria, protocols and standards for each stage of the ICP

Meeting 4- Preparation

Before the meeting finalise list of professional inputs and patient outcomes. Draft and circulate clinical and patient versions of ICP:

- Review final ICP and make amendments
- Quality assure teams ability to deliver expected outcomes
- Develop plan for ICP pilot stage
- Set up variance tracking database

Working in partnership

Provision of an effective health and social care system and the implementation of care pathways will not be achieved without multi-disciplinary and joint organisational working. Whole system partnerships involve secondary services, primary care, social care, voluntary organisations and service users and carers working together.

Although whole system working can be a difficult concept to achieve it is worth pursuing if:

- Your team shares similar issues and would benefit from the same solutions as other teams and organisations
- Numerous efforts to solve problems have not resulted in success
- Ideas that could work for you would be unacceptable & cause increased stress to others
- Gaining co-operation and agreement from stakeholders involved in the solution is preventing action.

A stepped approach to developing a systems approach to care delivery

The improvement model can support implementation of whole systems working. As with all improvement remember to ask the three fundamental questions.

Good practice point - always consider using the model for improvement

What are we trying to accomplish?	Identify common ground and shared vision between partners
How will we know that change is an improvement?	Specify detailed outcomes of care
What changes can we make that will result in an improvement?	Map the relevant services with all partners and develop a system where all the parts fit together

Step 1 - Define your system - what are the boundaries?

There are different ways to define a system:-

- Around a specific service user group, for example, older adults with mental health issues
- As a health and social care partnership within a particular locality
- Around a specific diagnosis

Step 2 - Define the rules

All involved must agree to a common set of rules that will underpin partnership working:-

- A willingness to put the shared agenda before individual needs
- Time to learn and understand counterparts roles and ways of working in order to develop sustainable working relationships

- Prepared to work together honestly in identification of current state with sharing of what works well and what does not
- Agreement to use a common language, with no jargon

Step 3 - Define the purpose

Time needs to be protected to work together to develop:

- A shared understanding of the problem
- Agreement on a shared vision with clear objectives
- Detailed descriptors of the outcomes of working together

Step 4 - Define the people

Leadership and engaging the right individuals is paramount:

- Senior figures to initiate and drive change
- Individuals with the authority to change policy, procedures and working patterns
- Influential groups and networks who can support and publicise the benefits
- Involvement of all to identify what needs to change and to test improvement ideas

Step 5 - Define the barriers

There will be tensions and it will be important to identify those areas of change which will cause discomfort:

- Changes in the definitions and understanding of roles and responsibilities
- Changes to existing processes and the IT system
- Different budgets
- Adapting to changed loyalties, such as the team, profession, organization
- Different value bases of the different organisations, for example, excellence in parts of the system at the expense of equity in all parts and cost versus outcome

Step 6 - Define the plan

Whole system working will require well managed transition as two or more organizations or teams become one. This transition will require:

- Shared learning to understand different working relationships
- Communications strategy to share progress, and reduce anxieties
- Involvement in the development of new delivery models
- Agreement from all to test the changes in small pilots PDSA Cycles

Conwy & Denbighshire Adult Mental Health and Social Care Partnership

Summary

This project is the largest and first of its kind in Wales evolving from a number of drivers including recommendations from SSIW and Joint reviews with political support in the form of project management funding.

Locally there was a desire to develop an organisation with the critical mass to develop a whole system approach to service delivery building on existing working relationships. CMHT's had been working conjointly since the mid 90's, common values had been established around service user involvement and mutual respect but there was variation around interventions and no real shared sense of priority.

The formalised arrangements have enabled a shared sense of direction. The right person being appointed to post when traditionally these posts would have been reserved for a particular profession. A community approach to modernisation (e.g. primary care link workers) rather than potentially five different views.

Project management was essential to move the partnership forward due to the highly complex issues around finance and the law.

Partnership Purpose

It is important to define carefully what the project will deliver and agree this with partners.

'Full formal stakeholder engagement in joint commissioning and planning to review and influence patterns of service provision'

in order to:

- Improve access particularly to out of hours services
- Improve cohesion between in-patient/residential resources and community based health and social care facilities
- Provide adequate alternatives to admission to hospital, commissioned across the health, social care and voluntary care sector spectrum with a specific focus on the rural population

User involvement and partnership working.

Service user involvement is integral to the partnership - two service users and a carer sit on the board who are remunerated for their inputs. There is also a service user PA who deals with all requests for involvement to ensure a wide and varied representation. This leads to a variety of inputs informing strategic direction. Therefore when services are developed and implemented the impact on service users has been fully considered.

Aims

- To create a single management structure to enable partner agencies to work to common values, objectives, and standards across the whole service
- Service users and carers to be at the heart of the service. The service should focus on the whole person with staff and partner agencies working towards shared goals whilst recognising diversity
- To minimise duplication of services, improve co-ordination and enable services to be client focused
- To address the NSF/SSIW reports in Conwy & Denbighshire and utilise section 31 of the Health Act (joint flexibilities)

Background

The partnership development was based on:

- Shared vision
- A history of effective joint working as partnerships do not solve the problems of organisations with interagency tensions
- Executive buy-in and drive
- Effective project management
- Utilisation of change management tools

Methods used

The approach to the project is based on partnership and joint working. An independent Project Manager facilitated the developments leading up to the partnership going live. The following four levels of management ensured the project objectives were fulfilled:

- Project Board
- Project Manager
- Project Team
- Task Group Leader

All project stakeholders were represented in all groups to ensure all views and aspirations were recognised.

The task and finish groups considered organisational processes that would need to be harmonised and developed and the work plans to achieve this. Examples are performance management, supervision, training and development and incident reporting.

Ongoing challenges

- To keep service users on board whilst attempting to establish a remuneration framework. (MIND service payment policy)
- To continue the momentum
- To demonstrate that partnership will deliver not just structural benefits but also benefits to service users and their carers

Outcomes

Since the partnership there has been;

- Reduction in duplication and bureaucracy. A good example of this has been the development of the integrated care pathway for mild, moderate and severe depression.
- Equal consideration to both health and social care reports
- Development of one work plan rather than potentially five, addressing competing priorities and delivering effective joint working
- Delivery of a joint system for the commissioning of individual complex cases and a framework for joint strategic commissioning
- Continual appraisal of the merits of pooled budgets
- System of effective and seamless delivery of the mental health modernisation agenda
- The recent work around the AIM collaborative delivered real service improvements due to the reduced duplication and opportunity for misunderstanding. Also the NSF project work funded by Welsh Assembly Government was successful due to the one point of reference for the project worker

Learning

- It is important to ensure continual parity exists between partners and sectors
- A partnership priority is to develop a communication plan addressing the information needs of all stakeholders. A major weakness of the developing partnership was the absence of an effective communication strategy. If the project were to be rerun this would be an area of particular emphasis. There was not always a uniform understanding across staff groups as to the motivation and benefits of the proposals. Some staff were particularly suspicious of the motives of managers. Systems need to be developed to ensure an effective rumour busting mechanism is in place. Adopt good change management processes to ensure staff in affected organisations are briefed consistently with developments and are given opportunities to address issues and concerns
- There must be a commitment by partner organisations to be willing to change and challenge historical ways of working
- There must be a commitment by partners organisations to be willing to compromise and be sensitive to the requirements of other partners
- There is a need to develop additional integrated support mechanisms such as HR, finance, business activity to support the operational management and service delivery structures

Contact: Robin Holden Robin.Holden@cd-tr.wales.nhs.uk
Conwy and Denbighshire Health Community

New Ways of Working

Partnerships and improvements to existing service delivery models will inevitably involve new ways of working and the development of new roles. Evidence demonstrates that role redesign can make a difference and lead to service improvements including:

- Reduction in waiting times - more efficient use of staff skills in the right location leads to efficiencies in service delivery
- Less 'faces' leads to more personalised care and increased consistency
- Managing an ever-increasing workload – more efficient use of staff skills leads to improvements in the management of workloads
- Job satisfaction – joint working and role redesign enables staff to benefit from training, making jobs more rewarding and satisfying, provides diversity and autonomy in providing seamless services
- Creates a change in attitudes and culture, challenging out of date procedures and practice
- Reduces vacancy rates and staff turnover
- Creates attractive posts
- Development of special interests.

Social care and healthcare have been working increasingly closely in recent years but there is still a need for more formalized integration of teams to reduce duplication of care. More use needs to be made of Health Act Flexibilities (1999) to enable Health and Social Care services to create joint teams to focus on the needs of service users in the community. Co-location of services, development of integrated policies and procedure, use of the unified assessment all facilitate cross working between these sectors. It is important to start small and build up. There is often resistance to change and one way of mitigating this is to start with small steps. Small incremental change is usually less threatening.

Many health and social care organisations are now testing and implementing new ways of working to solve specific service problems and offer different ways of working as a means of improving service users experiences. These are also a means of tackling staff shortages and increasing job satisfaction.

There are many successful examples across England and Wales of new or extended roles. These include Health Care Support Workers, Enabling Role of Home Helps, Intermediate Care Workers, Early Discharge Support Worker, Stroke Assistant, Enhance Home Carer, Technical Support Staff, Continuing Health Support Worker, Rehabilitation Support staff, Clinical Care Co-ordinators, Nurse Specialist Older People in Primary Care.

Support Time and Recovery Workers

Powys are introducing the model pioneered in England to provide care for service users living in the community setting. These STR Workers provide high quality, consistent and cost effective health and social care for people with complex needs living within the community. They report jointly to health and social care.

Key responsibilities:

- To assist members of the health and social care team to maintain dependent service users in their own home
- To establish and maintain effective working relationships with service users, their families and members of the multi-agency team
- To implement care as planned and directed by the Team Leader, reporting any changes in the service users condition in a timely manner
- To maintain written records of care in accordance with Trust and local policy
- To promote health, prevent illness and encourage self-care as appropriate/applicable taking account of the service users choice and preference

There is an in-house competency based structure with an allocated trainer, supervisor and assessor and completion off a training log. The Trust aims to train all of these care workers to a Level 3 NVQ.

Powys Health Community

The process of introducing a new role

The way a new role is designed and introduced is crucial to its success.

- The starting point for any role redesign is to involve all stakeholders and to look at the pathway of care as experienced by service users
- Where the care is currently provided and is this the most appropriate place?
- Who provides this care?
- Are there too many people involved?
- Do their roles overlap?
- Are there any gaps in the services provided by agencies involved?

Process mapping is a useful technique to identify all the stages in the service users journey and involvement of all staff.

Looking at the pathway of care may identify the need for a new type of worker. Developing a new or extended role may be beneficial due to a shortage of certain professions, inappropriate use of professional time on routine tasks, to many different workers visiting an individual.

If the type of role needed is clear at this stage, a job description, person specification, and training programme can be drawn up.

If there is an uncertainty about what type of role would best address particular service problems, a workshop could be convened to scope needs with expert external facilitation. If a new role is introduced it is important to measure the impacts and benefits.

Next steps

By following the advice in this chapter, organisations should not only improve whole systems working, access, flow and discharge but also increase patient and carer involvement and achieve greater success against the 6 improvement goals:

- Patient **safety**
- Provision of clinically **effective** services
- Services **centred on patients**
- Services provided in a **timely** way
- **Efficient** provision of services

In depth information on these tools is available from NLIAH:

- Guide to Good Practice - Elective Care
- Guide to Good Practice - Emergency Care
- Skills 4 Change Workshops
- Guide to Good Practice on line : www.nliah. nhs.uk

Reflection and Planning Record

This sheet is to record how the learning from this guide has improved your skills and knowledge and to evidence impact on service development

■ action plan ■ record impact ■ capture learning for CPD Portfolio)

What are the main learning points from this chapter?

How can they be applied to your professional practice?

Develop an action plan for improvement

Summarise implementation process

How will you measure the effectiveness of the improvement? A balanced scorecard of benefits

Impact on service delivery	Impact on service users and carers
Impact on outcomes	Impact on staff

How can you share your learning with your team and wider organisation?

Are you able to identify the learning needs in order for you to work more effectively?

How will you access this learning?

Who could help?

Practice Examples

6

This section contains further practice examples and resources that we hope will further support the improvement journey.

An integrated model of service delivery

Create is 'a joint working partnership involving statutory and voluntary sector services committed to providing access to quality services, tailored to meet the needs of individual mental health service users'.

Objectives:

- Improve access to services
- Reduce bureaucracy for both care co-ordinator and service user
- Improve quality of assessment
- Continuously improve quality of services
- Match provision to demand
- Reduce duplication of provision
- Develop a continuum of services that complement rather than compete

Process

- Mapping of existing provision with identification of duplication and gaps
- Agreement that each provider would focus on a particular area of service and build expertise in this
- Pathway development of structured provision
- Framework for liaison between all providers
- Process development to allow service users access to wide range of services dependent on individual need

Outcomes

The central feature of Create has been the adoption of a common centralised 'one stop' referral and assessment process. This process has allowed a single service request to access a comprehensive assessment of need, information on the full range of services available within the city and county of Swansea and an individual service agreement agreeing a package of support.

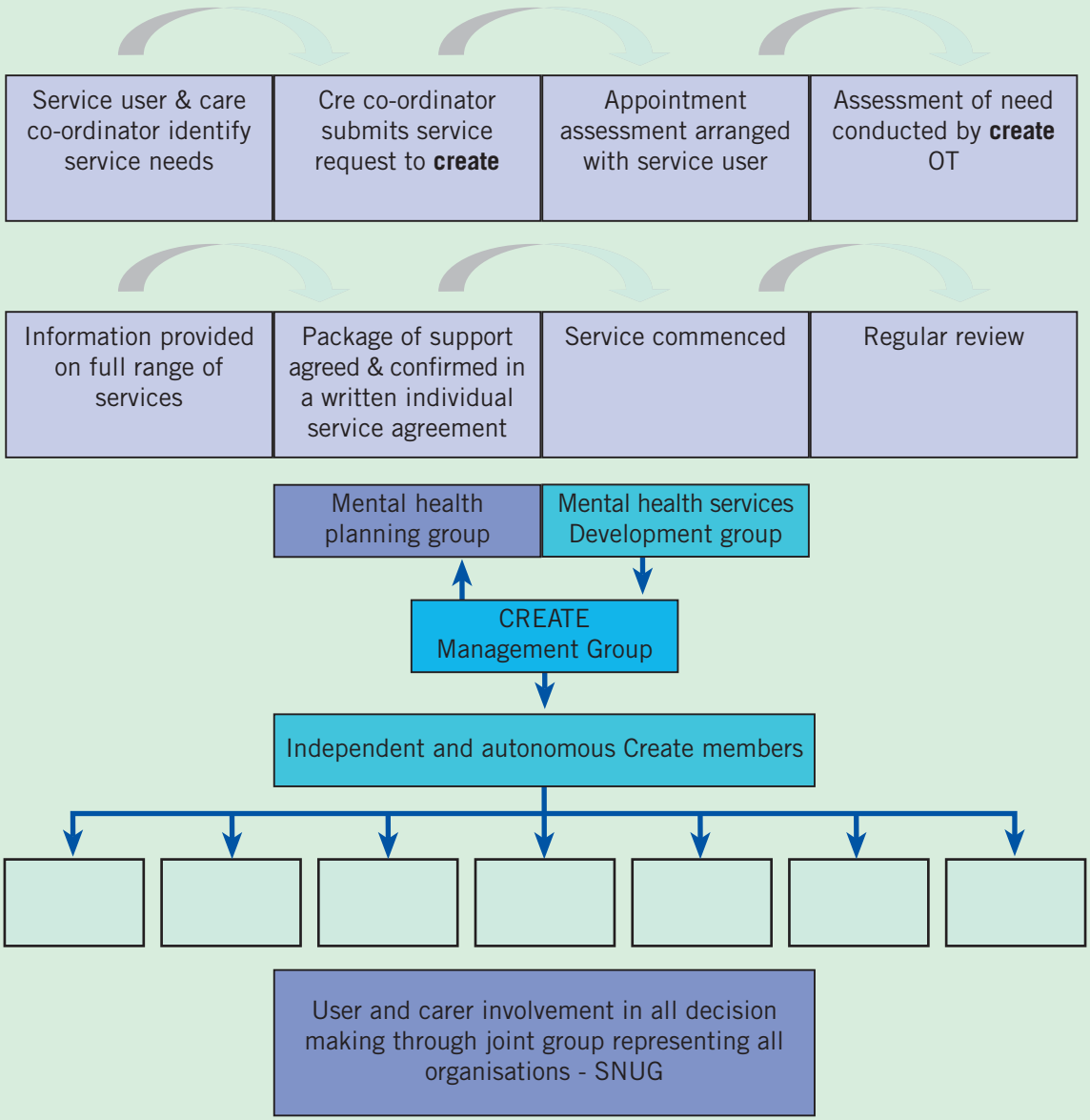
All assessments in respect of Create services are co-ordinated by the Occupational Therapy services of Swansea NHS Trust. This process has:

- Reduced bureaucracy, paperwork
- Reduced waiting time required to process assessments

- Improved quality and consistency of provision
- Improved appropriateness of care

Clear management structures have been developed to ensure delivery of this partnership

Swansea Mental Health day Services



Contact: Clive Prior or John Abbot Clive.Prior@swansea.gov.uk
John Abbot: hafal@hafal.com HAFAL

Identification of community priorities using Community Oriented Primary Care (COPC) (Kings Fund model 2004)

Monmouth health community developed a service strategy in co-operation with a wide range of organisations and individuals to ensure delivery of an effective integrated programme of care for people who use mental health services. Community oriented primary care is a technique widely used in Wales to profile community needs and to encourage equity of participation.

COPC model uses a 7 stage approach:

1. Community Diagnosis
2. Prioritising
3. Detailed Problem Assessment
4. Intervention Planning
5. Implementation
6. Evaluation
7. Reassessment

This example outlines two stages.

Process

The community diagnosis and prioritising stage requires involvement from as many people as possible who live and work in the area with an interest, either professional or personal, in mental health issues. In order to achieve this, two workshops were held to represent the differing geographical areas. An introductory workshop for service users prepared them for the sessions. Training was also delivered to mental health professionals and service users, to develop skills to run the workshops.

Community Diagnosis

All participants were facilitated to develop a comprehensive map of the community, drawing upon the local knowledge and experience of the group. The process involved drawing the area and adding all aspects of the community, for example communication links, shopping and social support facilities. The participants were then asked to map the broad problems and resources of the community before focusing on those more specifically related to mental health issues. A set of issues was agreed by each group to be taken to the next step of the process.

Prioritising

Each of the problems were then assessed using a 'prioritising grid':

- Prevalence/incidence
- Severity of the problem
- Existence of an effective intervention
- Acceptability/feasibility of an intervention
- Community involvement
- Cost and resource issues

Individual scoring was discussed to achieve agreement on a group score of the issues and problems.

- Communication and Information
- The lack of an out of hours/crisis resolution service
- Lack of appropriate day services
- Recruitment and retention of staff
- Transport
- Access to services

This process has resulted in an action plan to develop the Mental Health Strategy for Monmouthshire

94% reported views heard and listened to; 80% agreed with stakeholder mix: 99% agreed with priorities: 92% of service users and carers said they would attend another similar event.

Contact: Beverley Davies. bev.davies@monmouthlhb.wales.nhs.uk
Gwent Health Community

Psychiatric Liaison Follow up Clinics

Background

Patients presenting with self harm in 2004 were in excess of 1500.
NICE guidelines 2004 reinforces the need to provide meaningful engagement with this group.

Aim

To develop a system that allows for appropriate referrals to prompt and timely follow up appointments.

Process

- Engage with staff to identify need for service
- Identify capacity to support weekly clinic in acute hospital site
- Development of criteria for referral
- Training for A&E and Acute Medical unit staff to identify those presentations requiring follow up services
- Primary Care mental health teams engaged
- Operational policy development
- Interview room at DGH and modification of referral form

Measures of effectiveness were identified:-

1. Numbers of sessions per case
2. Outcomes on discharge
3. Future repetitions of self harm or crisis admission to hospital
4. Referral origin and consistency in allocation of cases
5. Qualitative patient feedback

Results

- Brief therapy interventions emerged as problem solving and solution focused therapy
- Choice of referral options increased referrals from A&E
- DNA rates reduced as patients appreciated continuity i.e. being able to return to see the same professional who had undertaken the initial assessment
- Patients more willing to attend follow ups at a general hospital site (reduction of stigma)
- Demand for out of hours assessments at the hospital reduced
- Reduction in referrals to CMHT's

Contact: Russell Jones Russell.jones@cd-tr.nhs.uk
Conwy and Denbighshire Health Community

The primary mental health care team

Aim

To establish a primary mental health service to:

- Provide rapid assessment
- Deliver short term therapeutic interventions in the primary care setting
- Gate keep the specialist secondary care services

Process

The team was based on a liaison model, linking to GP surgeries. Each link worker to 15000 population and assessments were carried out in GP surgery. The criteria within the CMHT pathway was used to clarify roles and responsibilities:

- Short term interventions for common mental health problems (depression and anxiety). Link workers skilled to provide certificate level cognitive behaviour therapy (CBT)
- Sign posting and redirection to other appropriate support resources e.g. Relate and Cruse

Results

- 76% of all referrals could be and were treated in Primary care by link worker
- High DNA rates were addressed
- Waiting times reduced
- Reduction in referrals to secondary care services has reduced waiting lists for those with serious mental health problems

Contact: Alison Avies-Jones alisonaviesjones@cd-tr.nhs.uk
Conwy and Denbighshire Health Community

Improving the therapeutic environment in an acute inpatient mental health unit – 'The meaningful day project'

Background

In response to the reports from Mind 'Environmentally Friendly' and the Sainsbury Centre for Mental Health 'Acute Problems' Powys has sought to introduce a therapeutic environment to address:

- Highlighted boredom that some patients experience
- Lack of something to do, especially activity that is "useful and meaningful to recovery". This boredom can develop into frustration and the perpetuation of a non therapeutic environment. Reflection on these issues led to the development of the Meaningful Day Project.

Aim

To produce a varied programme of activities from which even patients in acute distress may be able to find some benefit and enjoyment.

Process

1. Development of a diverse range of activities which individuals can become involved with if they wish. These include art and craft sessions, a guitar group, yoga, exercise and relaxation groups, a woodwork group, pottery and our most recent addition a gardening group, with which we have exciting plans for the development of an underused area adjacent to the unit. Staff members are involved in organising quizzes and a cookery club. We have purchased larger items of games equipment which is always available for use. We try to organise the activities so that they are available over a seven day period as well as in the evening.

2. Service users facilitate some of the groups as well as individuals who have had no contact with mental health services previously. This, we believe, increases social inclusion.

3. An issue regarding payment of service users has been resolved, with an agreed strategy for payment.

Results

An evaluation, three months after commencement, has demonstrated positive feedback with individuals reporting enhancement of self-esteem and self worth. Patients felt they were given permission to do things that in other circumstances might be viewed as self indulgent. The project has also increased links with the voluntary agencies. .

Contact: Anne Lewis anne.lewis@powyslhb.wales.nhs.uk Powys Health Community

Vocational Services for Adult Mental Health

Aim

Development of a model focusing on service users skills and potential, to reduce dependency and improve self-esteem by developing pathways into vocational and creative opportunities.

Objective

To replace traditional medical model with emphasis on symptom reduction, management, and institutionalisation of individual with a broader community context of care working to support innate creativity, productive occupation, and promotion of strengths and abilities by:-

- Building links across sectors and services to increase resource opportunities
- influencing a culture shift to reduce perceived public stigma and develop 'normalising' vocational and employment opportunities for this user group

Process

- To assess individuals in terms of their potential as well as their problems
- Change in service models to help change the culture
- Establishing partnerships across specialist mental health agencies, and also with generic community agencies and resources; developing appropriate planning structures to ensure that the resources of the partnerships are harnessed in ways appropriate to the needs of service users

Practical steps:

- Development (between the voluntary sector, NHS, service user and Job Centre Plus) of a cross-agency, user owned, vocational planning profile, to be shared by the service user with agencies of choice to support achievement of vocational goals. Profile tool for inclusion in CPA and UAP if relevant. (Electronic copy of tool and booklet available)
- The development of vocationally-directed services(1)The Vale CMHT based day service, linking into community resources and agencies and promoting an internal workforce of service user volunteers; (2) Mind-in-the-Vale day services developed from 'Drop-ins' into mental health resource centres with emphasis on skills development and skills-sharing to promote vocational stepping stones and outcomes.
- Forming and sustaining of partnerships such as the NHS led Occupational Planning Group with health, social care, training and employment agencies; A vocational strategy group with direct links into local NHS planning forums; the Mind in the Vale Vocational Steering Group involving colleges, volunteer bureaux, career organisations and the Spectrum Arts Partnership including a wide range of mental health agencies, arts organisations and individual service users.

Services are developing and interlinking to provide a broad range of vocational possibilities:

- Increased service user participation in their own recovery by encouraging identification of vocational needs and strengths and sharing this with relevant employment, volunteering and training agencies to develop appropriate vocational pathways
- Reduced duplication of information
- Build partnerships between agencies and sectors, including health and employment at time when the government is developing a new approach towards benefits provision

An audit of achievements to date:

Mind-in-the Vale: increase in service users returning to part or full-time paid work:

- 2002/2003 6 returns to paid work
- 2004/2005 14 returns to paid work
- 2005/2006 20 returns to paid work

Volunteering has also increased:

- 2004/2005 volunteering hours = 9825
- 2005/2006 volunteering hours = 12974

Vale Community Mental Health Day Services: increase in service users participating in learning schemes and opportunities i.e. in-house pre-accredited learning modules-accredited in-house-community schemes- college-based Access and degree courses. Figures indicate the growth over the past four years:-

- 2002 - 2003 150 people
- 2003 - 2004 220 people
- 2004 - 2005 260 people
- 2005 - 2006 365 people

Also within this NHS service, from 1 service user volunteer in 2002, there are now 10 in 2006.

Outcomes

Focused partnership working has improved seamless service delivery-

- Identification of resources that for vocational development purposes e.g. development of a joint NHS and community-based sector projects offering vocational opportunities resulting in a
- Better resourced community-based services
- Reduction in stigma of mental ill-health.
- Careers Wales' involvement has led to the identification of a database, 'Learn Direct', which provides information on vocational opportunities

Sustainable change has been achieved

1. Culture change has been possible through a redirection of service provision within existing resources.

2. Improved partnership and co-operation leading to full resource utilisation improved understanding of the needs and potential of service users.

3. Service users treated, not as problem or diagnostic entity, but as an individual with potential skills, abilities and ambitions ready to be harnessed.

Services have been broadened to embrace wider community support. This has increased the opportunities for service users and will result in reduction of demands on crisis services.

Contact: Cherry Stewart, Hafan Dawel East Vale CMHT
Cardiff and Vale Health Community

Introduction of crisis resolution teams, using existing resources.

Before embarking on this change there was a shared aim and all were committed to the need for this service. The drivers for this change were communicated widely and there was engagement from clinicians, managers and users and carers.

Leadership of the project was established to ensure priority and that there was authority vested in this initiative.
The process of setting up a care team involved a number of initial processes:
Agreeing team purpose and role;

- Clear strategic objectives and specific expected outcomes for service and service user
- Outcome measures identified
- Identifying the client group for the service and the size of this group
- Identifying who needs to be in the team
- Setting up and bringing team together

SWW health community developed their teams:

- Identified demand- how many people in area who fit criteria for crisis resolution
- Identified who should be in team
- Identified availability of people locally who could deliver service
- Identified training needs
- Who employs them
- How can stakeholders work together towards managing this team

The precise composition of the team depended on the needs that were identified and the resources available. (Capacity and demand mapping)

The next step was making partnerships work.

It was also important to map what impact this team would have on the other service delivery and these services are now being developed to work with crisis teams.

A communication strategy was developed to inform what the role of this team would be with clear referral criteria.

Contact: Jayne Anderson Jayne.anderson @pdt-tr.wales.nhs.uk
Pembrokeshire, Ceredigion and CarmarthenHealth Community

Improvement of communication between Primary and Secondary Care mental health services

A priority of this health community was to improve communication and engagement with GP's. It was agreed that the first step should be to share information on current services and share plans for future service development to achieve the following objectives:-

1. Evaluate effectiveness of these services from GP perspective
2. Discuss and agree referral criteria to reduce inappropriate referrals
3. Agree referral processes to "home treatment service" for those presenting in crisis
4. Agree access criteria to mental health in patient unit.
5. Develop an improved communication strategy between primary and secondary services
6. Encourage GP's contribution to future planning of mental health services

Background

AIM process mapped existing mental health services with all stakeholder groups and identified:

- MH services were viewed as a priority within primary care
- Increase in the number of referrals despite clear eligibility criteria.
- Poorly established communication links with primary care
- The absence of a clear pathway between primary and secondary care
- Poor information available for GP's to sign post to other services

Process

Continuing Professional Development (CPD) Tutor support gained for a CPD event with focus on mental health services.
Agreement was reached that there should be adequate time for networking throughout the afternoon, to ensure the development of informal communication.
The involvement and commitment of the Consultant Psychiatrists was gained to develop communication links and to present and facilitate the workshops.
Attendance was extended to include practice nurses.

Outcomes

The event was attended by 64 GP's from a total of 84 and 11 practice nurses.
Information on the Home Treatment service improved understanding of expected benefits, access and admission criteria.

Informal communication channels were established with a commitment to formalise these. Meetings have been established between NHS managers and practice staff to discuss patient care, referral criteria and to decide on care options for those who do not meet secondary care criteria.

Consultant psychiatrists meet with GP practices with high inappropriate referral rates to identify solutions.

There is improved engagement across stakeholder groups, primary care, local improvement team, consultant psychiatrists and Clinical Director.

Next steps

The development of the existing care pathway and development.
Continued monitoring of inappropriate referral rates.
Audit of all information received by the LHB from GP's related to mental health.
Information on planning of mental health services is routinely sent to GP's.
Plan for regular mental health event
The event was assessed - 85% rating the day as achieving its objectives

Contact: Melanie Laidler melanie.laidler@newportlhb.wales.nhs.uk
Gwent Health Community

Action planning in Hergest Unit

Acute ward staff had a number of concerns regarding flow of patients through the acute units:

- absence of acceptable CPA documentation on admission,
- lack of a coherent and consistently applied set of admission criteria
- weaknesses in discharge planning and procedural delays in discharge
- pressures and inefficiencies arising from the number of ward rounds on the unit.

NLIAH facilitated a flow analysis mapping day to identify constraints and bottlenecks and to prioritise an action plan for delivery.

Identified Bottlenecks	Action points
No/lack of CPA documentation from CMHT's	1. Audit receipt of CPA at Hergest 2. Compare with Ablett 3. Engage CPA co–ordinator to implement standardised approach
Admission criteria inconsistent across consultants	1. Explore models of Nurse Admission 2. Define statutory status of RMO
Duplication of assessment with Nurse and SHO; SHO- medical history and physical Rx Nurse-Bio/psycho/social assessment	1. Lead role for nurse 2. Better use of PIMS system
No standardised pathway of care Dependent on Consultant practice	1. Analysis of data to demonstrate causal effects of LoS by - consultant - diagnosis - consultant & diagnosis 2. Analysis - primary source of referral - time and day of week 3. Development of standardised procedures 4. Introduction of EDD to support maximum utilisation of flow

Consultant ward rounds ■ Quality of care not equitable waiting time from assessment to consultation 1-7 days ■ No procedure for cross consultant cover ■ 14 consultants rounds each week ■ 2 FTE grade G nurse time taken up per week	1. Cost benefit analysis of reducing ward rounds 2. Develop business case for therapy provision to support recovery 3. Explore new models of consultant practice 4. Develop workforce to support medical roles 5. Research independent prescribing pilot
Definition of delayed transfer of care(DtoC) interpreted inconsistently	1. Nurse audit of clinically defined DtoC 2. Cost benefit analysis for report to Executive Board
Lack of psychological therapies	1. Audit need 2. Skill scan of workforce 3. Business case to develop service from existing resource
TTO's often delay unplanned discharges and leave	1. Develop PDSA and pilot change of practice with Trust pharmacy services
All care and service provision effected by lack of 24 hour service in Community. Acute unit is dumping ground for Out of Hours crisis	2. Work in partnership to support ongoing work to establish CRT
Discharge dependent on consultant availability	3. Nurse led discharge 4. Explore organistional support for nurse led clinical decision and development of vicarious liability
Lack of access to banking Delaying discharge	Audit extent of problem Use PDSAs to test solutions

Hergest Unit, Ysbyty Gwyned. North West Wales NHS Trust

Useful resources

7

This section points you to a number of resources that will allow you to delve deeper into some of the tools and learning resources.

A good starting place for more information is the NLIAH website: www.nliah.wales.nhs.uk

NLIAH Publications

Change Skills Manual ISBN

Integrated Care Pathways 2005

A Guide to Good Practice (Emergency Care) 2004

Government Publications

Raising the Standard, National service framework and action plan for adult mental health services
Welsh Assembly Government, 2005

Co-reccurring substance misuse mental health framework
Welsh Assembly Government, 2005

Designed for Life
Welsh Assembly Government, 2004.

The national service framework for older people
Welsh Assembly Government 2005

Social exclusion and mental health
Office of Deputy Prime Minister

CAMHS Strategy, everybody's business
Welsh Assembly Government 2004

National Service Framework for Children, Young People and Maternity Services
Welsh Assembly Government 2006

Losing Time: analysis of older peoples service
Welsh Assembly Government 2005

Primary Care Strategy
Welsh Assembly Government 2005

Under Pressure Baseline Review of Adult Mental Health Services
Wales Audit Office 2005

Policy implementation guidance: crisis and home treatment services
Welsh Health Circular

Policy implementation guidance: primary care mental health services
Welsh Health Circular

Stronger in Partnership
Welsh Assembly Government 2004

Mental Health Policy Guidance for CPA
Welsh Assembly Government 2003

Summary of Health and Social Care Guidance for Adults. Creating a Unified and Fair System for Assessment and Care Management
Welsh Assembly Government 2001

Securing better mental health for older adults
Department of Health 2005

Who Cares Wins
Royal College of Psychiatrists 2005

Everybody's Business - Integrating mental health services for older adults
Department of Health 2005

Modernisation Agency Publications

Modernisation Agency: Improvement Leaders Guide Volume 1 and Volume 2

1 Process Mapping, analysis and redesign

2 Matching capacity and demand

3 Measurement for improvement

4 Spread and sustainability

5 Involving patients and carers

6 Managing the human dimensions of change

7 Setting up a collaborative programme

Other Publications

NHS Modernisation Agency (2002) Improvement Leaders Guide to Matching capacity and demand.
www.modern.nhs.uk/improvementguides

Managing Change in the NHS - Organisational Change. *www.sdo.lshtm.ac.uk*

10 High Impact Changes for Mental Health Services. *www.nimhe.csip.org.uk*

Community-Oriented Primary Care - Strategy, Approaches and Practices
Abramson JH, Public Health Reviews 1988

Healthcare Improvement

The Neglected Majority. Developing intermediate mental health care in primary care.
John Hague, Alan Cohen the Sainsbury Centre for Mental Health 2005

To Err is Human: Building a safer health system
Institute of Medicine report, National Academy Press, 2000

Crossing the Quality Chasm
Institute of Medicine report, National Academy Press, 2001

Curing Healthcare. New Strategies for Quality Improvement
Donald M Berwick, A Blanton Godfrey, Jane Roessner. Jossey-Bass, 1990

Escape Fire. Designs for the Future of Health Care
Donald M Berwick. Jossey-Bass, 2004

Quality Improvement

The Improvement Guide: A Practical Approach to Enhancing Organisational Performance
Langley, Nolan, Nolan, Norman & Provost.ISBN 0-7879-0257-8

Quality Improvement Through Planned Experimentation
Moen, Nolan, & Provost. ISBN 0-07-913781-4

The Fifth Discipline: The Art and Practice of the Learning Organisation
Peter Senge. ISBN 0-09-182726-4

The Fifth Discipline Fieldbook
Peter Senge. ISBN 1-85788-060-9

The Dance of Change: The Challenges of Sustaining Momentum in a Learning Organisation (a Fifth Discipline Resource)
Peter Senge. ISBN 1-85788-243-1

Understanding Variation: The Key to Managing Chaos (2nd Edition)
Donald J Wheeler. ISBN 0-94532-053-1

The Memory Jogger Plus+ and Featuring the Seven Management and Planning Tools
Michael Brassard. ISBN 1-879364-41-7.

Promoting Advanced Access in Primary Care: A handbook
Thomas S Warrender. ISBN 1-902115-25-2.

Lean Thinking: Banish Waste and Create Wealth in Your Corporation (revised)
James P Womack and Daniel T Jones. ISBN 0-74324-927-5

The Lean Toolbox: John Bicheno *ISBN 0-9513-829-9-3*

Integrated Care pathways in Mental Health
Julie Hall, David Howard ISBN 0-443-10172-8

Presenting Information

Visual Explanations: *Edward R Tufte. ISBN 09613921-2-6.*

The Visual Display of Quantitative Information:
Edward R Tufte. ISBN 0-9613921-0-X.

Envisioning Information
Edward R Tufte. ISBN 0-9613921-1-8.

Leadership Skills

Intelligent Leadership: *Alistair Mant. ISBN 1-86508-052-7*

Leading Change: *John P Kotter. ISBN 0-87584 –747-1*

Making the most of change: *William Bridges. ISBN 0-20100-082-2*

The Theory of Constraints

The Goal: *Eliyahu M Goldratt. ISBN 0-88427-061-0*

It's Not Luck: *Eliyahu M Goldratt. ISBN 0-566-07627-6*

Critical Chain: *Eliyahu M Goldratt. ISBN 0-88427-153-6*

Tools for Team development: *ISBN 0-89106-081-2*
Gregory E. Huszczo

Necessary but Not Sufficient: *Eliyahu M Goldratt. ISBN 0-88427-170-6*

Project Management in the Fast Lane: Applying the Theory of Constraints
Robert C Newbold. ISBN 1-57444-195-7

Goldratt's Theory of Constraints: A Systems Approach to Continuous Improvement
H William Dettmer. ISBN 087389-370-0

What is this Thing Called the Theory of Constraints and How Should it be Implemented
Eliyahu M Goldratt. ISBN 0-88427-085-8

The Haystack Syndrome
Eliyahu M Goldratt. ISBN 0-88427-089-0

Deming and Goldratt: The Theory of Constraints and the System of Profound Knowledge
D. Lepore and O Cohen. ISBN 0-88427-163-5

Management Dilemmas: The Theory of the Constraint Approach to Problem Identification and Solutions
Eli Schragenheim. ISBN 1-57444-222-8

The Measurement Nightmare: How the theory of Constraints can Resolve Conflicting Strategies, Policies, and Measures
Debra Smith. ISBN 1-57444-246-5

Critical Chain Project Management
Lawrence P Leach. ISBN 1-58053-074-5.

Other References

Berwick.D: A Primer on Leading the Improvement of Systems, BMJ, 1996:312: 619-622

Langley.G, Nolan.K, Nolan T, Norman. C, Provost. L.Jossey.The Improvement Guide: A practical Approach to Enhancing Organisational Performance: Bass Publishers, San Francisco 1996.

Donabedian A.Evaluating the Quality of Medical Care, Milbank Memorial Fund Q, 1966; 44 166 – 200

Donabedian A. The End Results of Healthcare: Ernest Cadman, s Contribution to Quality Assessment and Beyond, Milbank Q 1989; 67 233 – 56

Koch,R. 2001 The 80/20 Principle. Nicholas Brearly Publishing. London.

Rogers E 1985 Diffusion of Innovations, Free Press New York

Scholtes P 1998 The Leaders Handbook, making things happen, getting things done.

Rolfe G, Jackson N, Garnder L, Jasper M, Gale A. Developing the role of the generic healthcare support worker: phase 1 of an action research study. International journal of Nursing Studies 1999;36: 323-334

Vaughn B, Lathlean J. Intermediate Care Models in Practice. Kings Fund London. 1999

Websites

howis.wales.nhs.uk/inic

www.modern.nhs.uk
This is the NHS modernisation agencies official website.

www.ihi.org
The Institute of Healthcare Improvement website.

www.audit-commission.gov.uk
The Audit Commission website.

www.nice.org.uk
The National Institute for Clinical Excellence website.

www.cf.ac.uk/carbs/lerc
The Lean Enterprise Resource Centre at Cardiff University

www.qualityhealthcare.com
Quality and safety in healthcare — a journal.

www.lean.org
The official website of the Lean Enterprise Institute

www.goldratt.co.uk
The official Goldratt UK website.

www.brecker.com/quality.htm
The Continuous Quality Improvement movement of Deming and Juran.

Met Office - Forecasting the Nations Health
http://www.metoffice.com/health/

NHS Information Authority
http://www.nhsia.nhs.uk/def/home.asp

National Electronic Library for Health
Bed management page, other pages will also be relevant
http://www.nelh-ec.warwick.ac.uk/ECL_Toolkit/bed_man.ht