Scottish Patient Safety Programme Mental Health

Creating the Conditions

Improvement Hub

Enabling health and
social care improvement

Introduction

Welcome to the SPSP mental health creating the conditions change package

The aim of the SPSPMH creating the conditions change package is to provide you with evidence-based guidance to support the delivery of improvements in adult inpatient settings. A change package consists of a number of high-level outcomes supported by activities that when implemented, bring about improvement. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

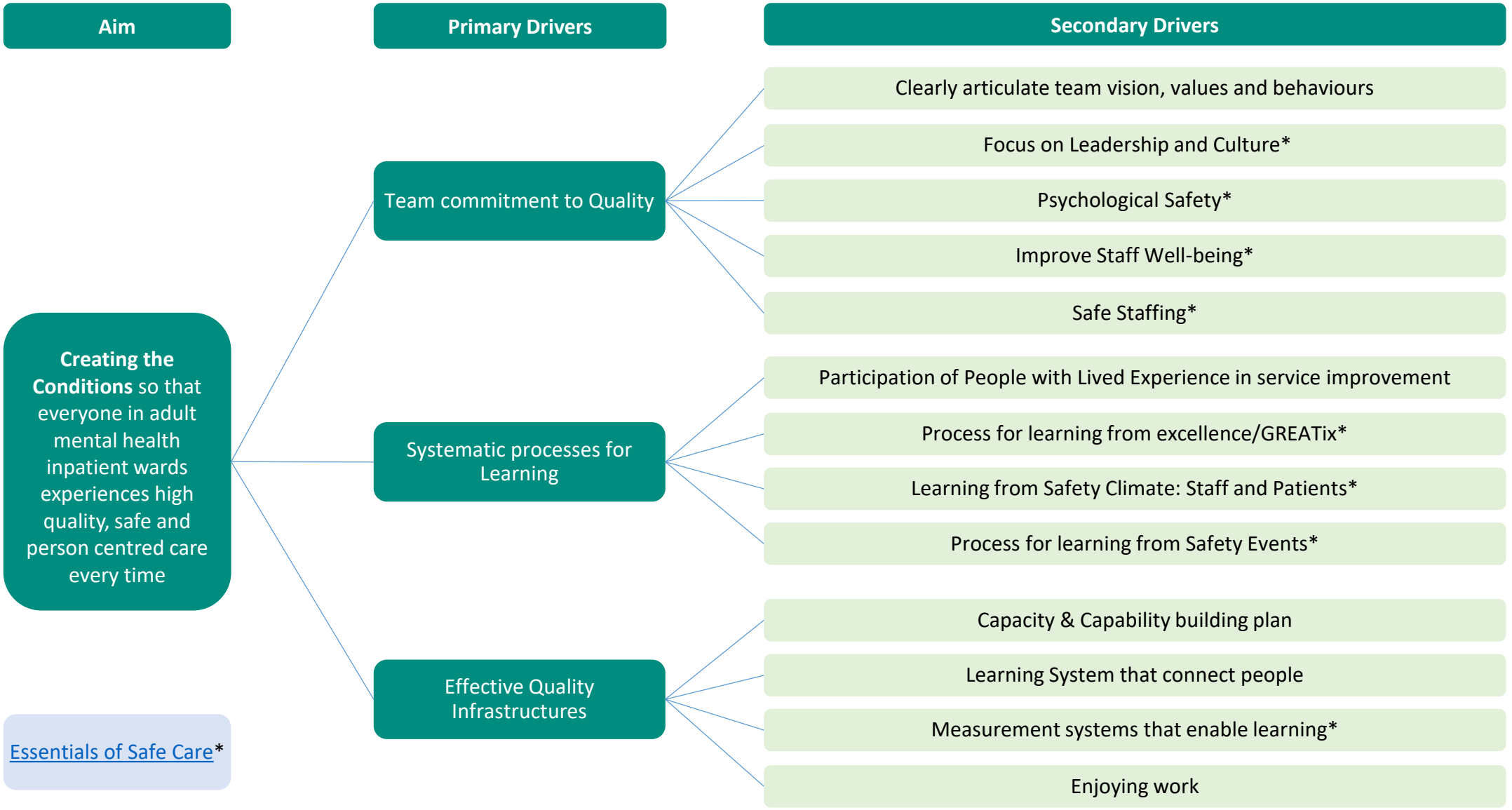
Why have we developed this change package?

This change package is for services providing inpatient care to adults. It will support teams to use quality improvement methods to create the conditions to improve human rights, trauma informed care and reductions in restraint and seclusion practices. This change package should be used in alongside the SPSP mental health change package.

What is included in this change package?

- Driver diagram
- Change ideas
- Guides, tools and signposts to examples of good practice

Driver Diagram



Change Ideas –
Team Commitment to Quality

Primary Drivers	Secondary Drivers	Change Idea
Team commitment to Quality	Clearly articulate team vision, values and behaviours	Co-design a team charter
		Use a collective leadership approach
	Focus on Leadership and Culture	Leadership walkrounds
	Psychological Safety	Structured 1:1 time for all staff
	Improve Staff Well-being	Use iMatter to baseline staff experience
	Safe Staffing	Real time staff risk assessment

Evidence and examples –
Team Commitment to Quality

Why is it important?

The benefit of a team commitment to quality is improved quality of care provided and a reduction in risk, error and harm for staff and the patients. This improvement in care relies on a increase in psychological safety, improved staff well-being and the provision of safe staffing.

Evidence, examples of practice and education

Psychological Safety and Learning Behaviour in Work Teams

The Health Foundation: How can leaders influence a safety culture?

The association between nurse staffing and omissions in nursing care: A systematic review.

Nurse-patient ratios as a patient safety strategy: a systematic review.

Tools

Healthcare Improvement Scotland: Leadership Walkrounds and Safety Conversations

NHS Education for Scotland: Safety Culture Discussion Cards

NHS Scotland: Resilience Resources

There are various resources available to help with workload and workforce planning as well as risk mitigation and escalation. To learn more about staffing tools and methodologies, please click here.

Change Ideas –
Systematic Processes for Learning

Primary Drivers	Secondary Drivers	Change Idea
Systematic Processes for Learning	Participation of People with Lived Experience in service improvement	Patient Safety Climate resource
	Process for learning from excellence	Implement a GREATix process
	Learning from Safety Climate: Staff and Patients	Use NES Safety Discussion Cards
	Process for learning from Safety Events	Review adverse events review process

Evidence and examples –
Systematic Processes for Learning

Why is it important?

Systems for organisational learning aim to accelerate the sharing of learning and improvement work through a range of learning opportunities from all safety events. A learning system that captures information and tracks improvement builds trust and the capacity to drive improvement. Leaders play a key role in creating and maintaining the learning system. By ensuring that the learning system is visible and functional, leaders send an important cultural message – that staff are valued and their feedback needs to be acted on (Michael Leonard & Allan Frankel, 2012).

Evidence, examples of practice and education

An organisation without a memory: A qualitative study of hospital staff perceptions on reporting and organisational learning for patient safety

Learning Systems for Improvement East London Foundation Trust describe their approach to **Learning systems for improvement**

Healthcare Improvement Scotland: Learning from adverse events through reporting and review

Tools

Learning from Excellence. Learning for Excellence is a model to capture excellence in health and care services and learn from what goes well in our work.

NHS Education for Scotland: Achieving Sustainable Change

NHS Education for Scotland: Safety Culture Discussion Cards

Change Ideas –
Effective Quality Infrastructures

Primary Drivers	Secondary Drivers	Change Idea
Effective Quality Infrastructures	Capacity & Capability building plan	3030 initiative
		Test 15s30m methodology
	Learning System that connect people	QI huddles to discuss improvement work
	Measurement systems that enable learning	Data wall or data dashboard
	Enjoying work	Use of a ward improvement board
		Using NES graduates to deliver QI training

Evidence and examples –
Effective Quality Infrastructures

Why is it important?

A Quality infrastructure (QI) refers to the framework needed support senior leaders, operational managers and point of care to implement improvement methods in their day-to-day work.

Evidence, examples of practice and education

Institute for Healthcare Improvement: Framework for Improving Joy in Work Please note this link will require a free registration to IHI

The Health Foundation: Measuring safety culture

The Health Foundation: The measuring and monitoring of safety

Tools

15s 30m is an approach to reduce frustration and increase joy

Making Data Count: Getting Started

NHS Education for Scotland: Quality Improvement Journey - Measurement

Measurement

Measures are essential to help teams to learn if the changes they are making are leading to an improvement. An improvement project should have a small family of measures that track the progress of the project over time. These should include:

- **Outcome measures:** to tell the team whether the changes it is making are helping to achieve the stated aim. For example, number of restraints in your service.
- **Process measures:** to tell the team whether things that have to be done to achieve the desired outcomes are happening reliably. For example, a measure for patients with a person centred care plan in place
- **Balancing measures:** to check for possible consequences elsewhere in the system. For example, staff experience.

More detailed guidance and the full list of suggested measures can be found in the measurement framework.