Mental Health Access Improvement Collaborative

Learning Session 4
Friday 8 November 2019

#mhimprove
Mental Health Access Improvement Collaborative

Pre work
- Understand local systems
- Identify teams
- Develop Driver Diagram and change ideas

Welcome to the collaborative WebEx

Learning Session 1
Learning Session 2
Learning Session 3
Learning Session 4

Supports
- National and local context
- Aims and measures
- Key changes
- Model for Improvement
- MHAIST Team - Improvement Advisors, Project support, Clinical Advisors, Data analysts
- WebEx’s
- Local and national events
- Team visits

Action periods
- Teams testing
- WebEx’s
- Newsletters
- Team visits

Launch events
- Aug - Dec 2017
- Welcome to the collaborative WebEx May 2018

Learning session 1 June 2018
Action Period 1
Learning session 2 Nov 2018
Action Period 2
Learning session 3 May 2019
Action Period 3
Learning session 4 Nov 2019


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Time to celebrate
Housekeeping

- Fire alarm
- Wi-Fi
- #mhimprove
- Copies of all slides will be made available
Mental Health Access Collaborative

Ruth Glassborow
Director of Improvement
Healthcare Improvement Scotland

Improvement Hub
Enabling health and social care improvement
Control your own destiny or someone else will

Jack Welch
If you remember three things....
1. Remember the greater purpose
2. Keep working on those alliances
Number of monthly referrals to CAMHS (Scotland)

46% increase
Number of monthly referrals to Psychological Therapies (Scotland)

- 31% increase
- 24% decrease
- 49% increase

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Prevention and Early Intervention

Wider System including primary care, social care, housing, third and independent sector, education etc

Specialist Mental Health Services

Develop effective alternatives for individuals who need longer term support including third sector, self mgt and direct access back

Ensure key enablers are in place for the Improvement and Redesign Work
Data (quantitative and qualitative); Effective leadership; Effective infrastructures
Edinburgh’s Health and Social Care System for Older People

Created by Healthcare Improvement Scotland in conjunction with City of Edinburgh council, NHS Lothian and the Edinburgh Health and Social Care Partnership.

February 2016, v0.7 Whole system high-level view

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3. Stick with the method - it works
(and use the data as part of your story)

Number of monthly referrals to CAMHS
(Scotland)

46% increase

Langley, Nolan, Nolan, Norman, Provost;
The Improvement Guide, 1996
The Iceberg Illusion

Success is an iceberg

SUCCESS!

WHAT PEOPLE SEE

WHAT PEOPLE DON'T SEE

Persistence

Dedication

Failure

Hard work

Sacrifice

Good habits

Disappointment

Things I have to give up

@Sylviaduckworth

Picture credits to Sylvia Duckworth
Finally, don’t forget, your work really matters..... it can, and does, change lives
Keep in touch

✉️ info@ihub.scot
＠ihubscot

To find out more visit ihub.scot
Your QI Collaborative Journey

Jennifer Halliday
Marie Claire Shankland
Clinical Leads, Mental Health Access
Improvement Support Team

Improvement Hub
Enabling health and social care improvement
What’s the problem?
Pathway Analysis
Where is the most non-attendance?
Deliver a high quality, consultative role within the SRU at HMP StHils/Redrice to improve the incidence of patients in SRV.

Aim: To increase referrals of Older People into Primary Care Mental Health Services to more than 5% by November 2016.
90% of primary care referrals to Airdrie and Coatbridge PTTs will be offered telephone screening contact within 10 working days of opting into the service by March 2018.

Aim

Primary Drivers

- Opt-in system is working efficiently
- Admin and Clinical staff are working together to streamline processes
- The right equipment is in place to support the process

Secondary Drivers

- Opt in letter is clear
- Clinical staff have a skills mix to deliver a range of interventions
- Time is allocated to take on telephone screening
- Uniform approach to calls
- Clinical staff understand all options and are able to guide patients
- Screening forms are fit for purpose
- Telephones are fit for purpose

Change Ideas

- Develop a new standardised letter for opt-in explaining telephone system
- Staff training on “selling” interventions
- 5 staff doing one day of telephone screening each week
- Marketing materials about interventions for clinicians
- Write to patient with recommendation after the phone call
- Standardise outcome letters
- Forms pre-populated with patient info
- Use a telephone headset to allow screener to type during the call

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Better information before people come here, so they know what to expect

“Better phone access to reception & clearer information about when we will call you back” Male, 40s

“Making sure people have access to what they need after the group finishes” Male, 40s

“Easier access to location” Male, 40s

“Improvements to rooms & signs in the building” Female, 60s

“Better access to care support. Probably the worst thing for me was not having the extra support I needed” Female, 20s

“Could have had longer break…time for coffee & toilet & of course people want to have a wee chat” Female, 60s

“Trying to read the slides, weren’t very clear – slides were fine probably in the dark but it had coloured writing – very difficult to read. The whole screen could have been bigger” Female, 60s

““Toilets were very hard – walking sticks – toilets too low – needed handles” Unaware there was a disabled toilet Female, 60s

“they said you would see a psychologist & I was like, right ok, but again there was no explanation as to why it would be a psychologist. What the relevance of that was…?” Male, 40s

“What we can improve

Pain Management Service

““It was more along the lines of, oh well, there’s this pain management course that I could send you on – do you want to go on it? That was basically all I got asked. I didn’t get any information regarding it from my GP.” Female, 40s

“I left a message but I didn’t know if anyone had got the message – 2/3 days before anyone got in contact – difficult” Female, 50s

“If I dinnae (have a lift) it would be two maybe three buses & that would just be by the time I got here I wouldn’t be in any frame of mind – I would just be agitated & sore & pretty irate – not at you guys but just at potholes & people in Edinburgh in general” Male, 40s

“The only thing is the travelling because I’m through in West Lothian it’s putting another 2hours onto the already 3hours long course so that makes it a very long day. If you’re not having a good day that sometimes can, I mean I’ve thought about ‘oh I really couldn’t face this today’” Female, 40s

“I need to look at after-care support. Probably the worst thing for me was not having the extra support I needed while going through the PMP. Medication wise I have no support. Going to be changing GPs” Female, 20s

“I’ve asked to be referred to Midlothian Active Choices to look at suitable exercise classes in Midlothian – however not available in other areas of Lothian – don’t know why?” Female, 60s

“For us anyway we could have done with a wee bit more time to chat.” Female, 60s

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Whole Team

#mhimprove
All improvement is change (but not all change is improvement)

“What if we don’t change at all ... and something magical just happens?”
Data

The State Hospital

Waiting time between 'suitable to refer' and actual referral to group/low intensity intervention

Implemented automatic referral process 6/8/2018

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Kilwinning Wellness Model
Dumfries and Galloway Data

Communication Disorders Assessment Team

25.4 events

Family contact events

Pilot Assessment Clinic

4.5 events

The number of times each case prompted a direct contact with the family
Lanarkshire Clinical Health Data - DNA

Percentage of people who DNA first appointment

- Median = 13%
- Appointment Letters
- Referral Form Increased Choice
- Map
- Signposting
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act  Plan
Study  Do

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Visualising Data for Insight...
“Play the ball where the monkey dropped it!”
QI tools aren’t an adjunct: they’re a foundation

One person can’t do everything: be a team

If the game matters, keep playing the ball
• Go to the poster that corresponds with your badge.
• Groups will rotate every 5 minutes.
• Remember to collect ideas for your cake.
Refreshment Break- Come back for 12:00
Sharing the learning - MHAIST Toolkit

Claire Mavin
Dan Harley
Purpose: To share learning from collaborative teams and beyond a toolkit is under development.

How will it work: The toolkit will be an online resource with open access hosted on the ihub website.
Purpose of the toolkit

Share practical advice

Share/ Signpost to tools and resources

Provide links to QI tools and resources

Provide links to policy documents/ literature and other work undertaken out with the collaborative.

Share case studies
The Toolkit – a sneak preview!

Mental Health Access Improvement Support Toolkit

The Mental Health Improvement Portfolio hosted a Mental Health Access Collaborative from June 2018 to November 2019 and has also been providing interak responsive improvement support to four NHS Boards in Scotland. As part of the Collaborative, twenty-seven teams learned how to use quality improvement (QI) approaches, and had the chance to learn and share good practice within their specific communities.

The Collaborative consisted of two workstreams:

* Improving access to CAMHS and Psychological Therapies
* Neurodevelopmental Pathways for CAMHS

This toolkit provides a platform to share learning, tools and resources from the responsive support and Collaborative, which can be locally adapted and tested by teams looking to progress this work. The toolkit will also introduce some basic QI tools and methods that are quick to learn and easy to apply.

The toolkit will:

* Provide links to evidence based guidelines and policy documents that underpin this work.
* Provide examples of tools and work carried out to improve access to mental health services.
* Provide and signpost resources to facilitate QI in teams.
We need your help!

• What work have you led/been involved in that could be shared in the toolkit?

• What other work are you aware of that could be included in the toolkit?

• What QI resources would be helpful to include in the toolkit?
Rapid Idea Generation Exercise

Top 10 ideas that get closest to 25 points

1. Write your ONE bold, original idea on an index card. You can talk to each other and find out what ideas others are thinking – so your idea doesn’t overlap.

2. Form pairs. Exchange cards. Exchange thoughts. Score the card in your hand, 1 low, 5 high.

3. Form another pair. Exchange cards and share thoughts again. Score the card, 1 to 5.

4. After repeating the exercise for 5 rounds, tally up the last card in hand. Out of max 25 points, how many points does the last idea in hand have?

5. Whole group shares top 10 ideas with highest scores.
25/10 Crowd Sourcing

Rapid Idea Generation Exercise
Top 10 ideas that get closest to 25 points

1. Think
2. Talk
3. Write your ONE idea on an index card

Music starts
Mill about and exchange cards
Music stops
Exchange thoughts
Score the card in your hand, 1 low, 5 high

3. Music starts
4. Mill about and exchange cards
5. Music stops
6. Exchange thoughts
7. Score the card, 1 to 5
8. We are going to do this 5 times in total
9. After repeating the exercise for 5 rounds, tally up the last card in hand.
10. Out of max 25 points, how many points does the last idea in hand have?

Liberating Structures

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Step 1

Think for 2 minutes about **ONE** good idea to include in the toolkit.

Talk to a partner for 1 minute each about that idea.

Write your **ONE** idea on an index card.
Step 2

When the music sounds people mill around and cards are passed from person to person. Mill and Pass only. No reading.

When the music stops, stop passing cards and pair up with someone to exchange thoughts on the idea on the card in your hands.

Then participants individually rate the idea/step on their card with a score of 1 to 5 (1 for low and 5 for high) and write it on 1 of the boxes underneath.

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Step 3

When the music starts again, cards are passed around a second time "Mill and Pass" until the music stops and then "Read and Score" out of five

We are going to do this 5 times in total
At the end of cycle five, participants add the five scores on the back of the last card they are holding.

Finally, the ideas with the top ten scores are identified and shared with the whole group. And pinned up on flip chart.
What tools have you used to support your improvement work?

Discuss tools used with your team – add these to your cake.
Lunch - Come back for 13:50
Mental Health Access Improvement Collaborative

Learning Session 4
Friday 8 November 2019

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NHS Lothian Attention Deficit Hyperactivity (ADHD) Pathway

Ms. Ciara O’ Driscoll
ADHD Nurse Specialist

Mrs. Martina Mungall
Team leader
What and why?

• Context
• ADHD team established
• In 2015 changes to old pathway
• Why?
• High DNA rate for first appointment/Poor uptake for follow up
Current Team

- 450 open patients currently to CAMHS North
- 53 on waiting list

Team

- Administrative support 30 hours
- 1 consultant Psychiatrist: 4 Sessions
- 2 Speciality doctors: 8 sessions
- Junior Doctor
- 3 ADHD Nurse Specialists’ (2 fulltime / 1:30 hours)
- Clinical psychologist 4 sessions
- Occupational Therapist 1 session
Referral received and accepted
ADHD Questionnaire, Consent form and Developmental Questionnaire sent to home
2 weeks to return questionnaires

Questionnaires returned
Admin to send out School Questionnaire and Information Sheet and underscoring letter
Classroom observation (CAMHS 16)
Team to provide clinic dates for assessment appointments
Admin to send appointment Letter
1st Assessment appointment (CAMHS 17)
2nd Assessment parent appointment (if required)
Feedback appointment date given at assessment appointment, list to go to admin ASAP
Formulation by team
Admin send feedback appointment letter to family
Feedback appointment (If ADHD Diagnosis CAMHS 19, No Diagnosis CAMHS 19)
Standard diagnosis letter to school, copied to home
Feedback letter by team sent to referrer, copied to family, GP, CCH and School Nursing
Date for review appointment with team if required
Date in diary

Questionnaires NOT returned
Highlight to team
Nurse to follow up to confirm discharge
If discharged, discharge letter to referee (copied to GP and family)
Closed on TRAK, notes to Health Records
<table>
<thead>
<tr>
<th>Referral received and accepted</th>
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<tbody>
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<td>ADHD Questionnaire, Consent form and Developmental Questionnaire sent to home</td>
</tr>
<tr>
<td>2 weeks to return questionnaires</td>
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</tbody>
</table>

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<td>Admin to send out School Questionnaire and Information Sheet and under assessment letter</td>
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What has been the impact?

**Successes**
- Improve patient journey /experience
- Reduce DNA Rate
- Clear Pathway for stakeholders
- Better referrals
- New process
- Administrative Support
- Continuous Flow

**Challenges**
- New process
- Admin support
- Continuous flow
- Better data
Next steps

• Develop Neuro Developmental Team

Contact:
Ciara.O’Driscoll@nhslothian.scot.nhs.uk
Martina.Mungall@nhslothian.scot.nhs.uk
Clinical Health Psychology NHS Lanarkshire

Improvement Hub
Enabling health and social care improvement
Project Team

- Dr Claire Gray (Lead for Project)
- Dr Laura Telky
- Laura Dobbie: Data Analyst
- Linda Rankin & Laura Kerr: Administrative support

**Team contact details:**

*University Hospital Monklands, Airdrie ML6 0JS*

Claire.gray@Lanarkshire.scot.nhs.uk
Tel: 01236 712 564
• To reduce the DNA rate for new appointments in the Clinical Health Psychology Service (NHSL) to less than 15% by the 31st of July 2019
Why is this important?

• The DNA rate for new appointments is on average 20% with a higher rate for new appointments.
• High DNA rates increase waiting times as well as increasing admin time (i.e. letters/making phone calls).
• DNAs reduce clinician productivity & can impact on managing a caseload effectively.
• Potentially negative impact on the therapeutic relationship.
• Our waiting times are closely monitored and we are required to meet the HEAT target of 18 weeks from referral to treatment. To maximise capacity and increase access to psychological therapy the service needs to work as efficiently as possible and reduce wasted appointments.
• Service users report that the current waiting times are often too long and frequently telephone the department to enquire about where they are on the waiting list.
• The DNA rate impacts on clinicians, administrative staff service users and referrers.
Driver Diagram

**Driver diagram**

**Imagexmprove**

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**Aim**

To reduce the DNA rate for new appointments in the Clinical Health Psychology Service (NHSL) to less than 15% by the 31st of July 2019

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**Primary Drivers**

- To ensure effective communication/education with referrers on criteria for CHP
- To improve clinician implementation of protocol
- Maximize effectiveness of service

**Secondary Drivers**

- Develop good working relationships with referrers
- Increase knowledge of resources to signpost
- Improve appropriate referrals
- Increase adherence and consistency by clinician of DNA/DNA policy
- Improve clarity of policy
- IT support
- Increase research

**Change Ideas**

- Develop referral form (including referrer has received consent from patient i.e. referral)
- Webpage
- Ongoing LTC resource directory
- Offer signposting app soon after referral
- Clarify DNA/DNA policy with patient at opt-in
- Develop current policy & pilot
- Clinicians discuss DNA/DNA policy with patients at first app
- Send out DNA/DNA policy with 1st app letter
- Ongoing review of text reminders (i.e. update number, receiving message)
- Flexibility of app slot, ask when patient available at opt-in (i.e. AM/PM & days)
- Explore reason for previous DNAs at 3rd app/service user involvement
- Investigate what other services are doing to reduce DNAs at 1st app
Tests of change / PDSAs / Testing

Introduction of signpost clinics from April

Introduction of referral form

Include map and directions

Offer flexibility of appointment slot (location & time)

Change appointment letter

Text reminders for appointments

Accumulating information, data and knowledge

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• **Outcome measures**
  • Monthly DNA rate for new appointments (%)
  • Waiting times (weeks)

• **Process measures**
  • % inappropriate referrals per month
  • % patients choosing time/location of appointment
  • % signposting outcomes (from mid-April)

• **Balancing measures**
  • % appointments cancelled per month
Data

#Returned referrals (%)

- **Appt letters**
- **Referral form Increased choice**
- **Map**
- **Signposting**

##% returned referrals

- **CL**
- **UCL**

##Month

##% returned referrals
- 0% to 80%

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The median waiting time for the service has reduced from 13 to 11 weeks.
Signposting Outcomes

- **CHP**: 19 patients (50.0%)
- **ACCEPT**: 9 patients (73.7%)
- **Stress Control**: 4 patients (84.2%)
- **CMHT**: 2 patients (89.5%)
- **Ccbt**: 1 patient (92.1%)
- **Physio**: 1 patient (94.7%)
- **D/C no signpost**: 1 patient (97.4%)
- **TESS**: 1 patient (100.0%)

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### Learning and Next Steps

<table>
<thead>
<tr>
<th>Learning</th>
<th>Future plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Engage the wider team</td>
<td>• Qualitative data – DNA reasons</td>
</tr>
<tr>
<td>• Impact on admin</td>
<td>• Signposting outcomes &amp; patient perspective</td>
</tr>
<tr>
<td>• Patient perspective</td>
<td>• Share QI work with other teams</td>
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<tr>
<td>• Challenge of IT systems</td>
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<tr>
<td>• MHAIST project updates helpful</td>
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</table>
Questions?
Scale Up & Spread
• Prepare for spread
• Establish an aim for spread
• Develop, execute and refine a spread plan
Definitions...

**Diffusion:** "the process in which an innovation is communicated through certain channels over time among the members of a social system"
Rogers 1962

**Spread:** “deliberate efforts to increase the impact of innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and program development on a lasting basis”
Norton and colleagues 2012

**Going to scale (or scale up):** “at least 60% of the target population that could potentially benefit from the programme receives it”
Rabin and colleagues (2012)
What we really mean

You

Your Pals

Your Organisation

#mhimprove
Hmm... looks interesting, but is it for me...?

What are those weirdos up to?

Yay! Shiny new thing!

Cool kids have a new tool - I want!

I want my fax machine back.
THE REALISTIC INNOVATION DISTRIBUTION CURVE IN ORGANISATIONS.
old power

Currency

Held by a few

Pushed down

Commanded

Closed

Transaction

new power

Mac

NEW POWER

How Power Works In Our Hyperconnected World—and How to Make It Work for You

JEREMY HEIMANS

HENRY TIMMS
**ACTIONABLE:** The idea is designed to make you do something. It might start with sharing but it’s a call to action

**CONNECTED:** The idea promotes a closer connection with people you care about or share values with. It makes you feel part of a community and the network effect creates further spread

**EXTENSIBLE:** The idea can be easily customised, remixed, reshaped by people taking part. It’s structured with a common stem that encourages communities to alter and extend it
**SIN:** Expect huge improvements quickly then start spreading right away.

**DO THIS INSTEAD:** Create a reliable process before you start to spread.

**SIN:** Check huge mountains of data just once every quarter.

**DO THIS INSTEAD:** Check small samples daily or frequently so you can decide how to adapt spread practices.

**SIN:** Require the person and team who drove the initial improvements to be responsible for spread throughout a hospital or facility.

**DO THIS INSTEAD:** Choose a spread team strategically and include the scope of the spread as part of your decision.

**SIN:** Give one person the responsibility to do it all. Depend on "local heroes."

**DO THIS INSTEAD:** Make spread a team effort.

**SIN:** Don't bother testing—just do a large pilot.

**DO THIS INSTEAD:** Start with small, local tests and several PDSA cycles.

**SIN:** Spread the success unchanged. Don't waste time "adapting" because, after all, it worked so well the first time.

**DO THIS INSTEAD:** Allow some customization, as long as it is controlled and elements that are core to the improvements are clear.

**SIN:** Rely solely on vigilance and hard work.

**DO THIS INSTEAD:** Sustain gains with an infrastructure to support them.

**SOURCE:** Institute for Healthcare Improvement. Used with permission.
Scale up and spread is a deliberate, planned act

Beware the chasm and the 7 spreadly sins

Who are your key people?

What method and tools will you use?
Further reading...

IHI Framework for Spread:  
http://www.ihi.org/resources/Pages/IHIWhitePapers/AFrameworkforSpreadWhitePaper.aspx

HIS Guide to Spread and Sustainability:  
http://www.healthcareimprovementscotland.org/about_us/what_we_do/knowledge_management/knowledge_management_resources/spread_and_sustainability.aspx
Exercise
Your Rate of Improvement

| More testing needed | Implement your change(s) | Scale up | Spread |

Where are you on this spectrum with your improvements?

What do you need to do to consolidate or move on?

Add that to your cake...
Showstopper

VOTE!

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Reflections and Star Baker Award