



# World Quality Day

# SET Quality Awards

# Transferrable Learning



# Dr. Alison McKenna, Consultant Clinical Psychologist & Ross Anderson, Service User - First step to Wellness

## Learning

### **Co-Production as a Standard Practice**

- Co-Production adds value and meaning when service users are involved from the beginning.

### **Supporting People While they Wait**

- 'Waiting well' matters - people need support and engagement during delays.

### **Tackling Bottlenecks Systematically**

- Bottlenecks affect flow and experience; resolving them requires visibility and collaboration.

### **Mixed-methods Data for Insight**

- Both qualitative and quantitative data are essential for understanding impact

### **Reconnecting staff to core Values**

- Staff want to care deeply but system pressures disconnect them from their values.

## Application

- Embed co-production in all service redesign projects, not just psychotherapy
- For CAMHS and other waiting lists, involve young people and families in shaping support options during waiting periods
- Create a checklist or framework for co-production steps across programmes

- Extend this principle to other groups (e.g. elective surgery, community mental health)
- Develop toolkits or resources for staff to implement waiting support strategies.
- Pilot peer-support or digital engagement options for those on long waiting lists.

- Use process mapping in other pathways (e.g. CHAMS, outpatient clinics)
- Share learning through a cross-service improvement programme to identify common bottlenecks and solutions

- Build a learning programme for staff on using mixed-methods evaluation
- Apply this approach to measure improvements in waiting list initiatives and co-production projects.

- Develop a '@Stop, Start, Continue' plan by asking staff and patients what matters most.
- Consider reflective spaces or wellbeing initiatives to sustain connection to purpose

# Mark Cadden, Radiology Governance Lead - Pause, Check, Protect

## Learning

### **Using Engaging Learning Formats**

- Bitesize videos were highly effective for sharing knowledge.

### **Incident Management and Lessons Learned**

- Radiology's structured approach to managing incidents and learning is a strong model.

### **Process Review and Redesign for Safety**

- Simplifying processes improves safety and reduces error potential

### **Understanding Error Margins and Risk**

- Systems need to quantify and mitigate error potential.

### **Teamwork and Commitment**

- Success depends on having the right people and long-term commitment.

## Application

- Consider creating similar training videos for new service developments.
- Explore different ways to deliver messages - visual, interactive, and accessible formats
- Build a video library for onboarding and safety training.

- Adapt this process for other vulnerable systems in your organisation.
- Include feedback loops from staff post-improvement to ensure changes are not solely data-driven
- Use process mapping and link to other tools for deeper analysis.

- Apply this approach to new service developments - start with mapping and risk analysis
- Use redesign principles to circumvent future incidents proactively.

- Develop risk assessment tools for other clinical and administrative processes.
- Train teams on identifying vulnerabilities and prioritising mitigation strategies.

- For new projects, ensure team composition includes diverse expertise and sustained engagement.
- Build project governance structures that support longevity.

# Paige Lyttle, Admin, Flaxfield Children's Home - Making Homes Homely

## Learning

## Application

### **Person- Centred and Co-Designed Care**

- Listening to service users and acting on feedback builds trust and improves experience.
- Co-design fosters accountability and pride in their environment

- Embed co-production in all improvement projects from the start
- Roll out co-design approaches across services, including children's homes, older people's care home and inpatient wards

### **Environment and Experience**

- A welcoming, homely environment is critical for wellbeing and smooth transitions.
- Sterile spaces negatively impact comfort and sense of belonging.

- Introduce welcome packs for inpatients (bedclothes, toothcare, snacks reading materials, USB cables).
- Work with estates and care teams to create ward, personalised spaces across residential and hospital settings.

### **Small Changes, Big Impact**

- Simple solutions like bedroom resets and welcome packs make a significant difference.
- Even minor adjustments can transform a young person's experience.

- Identify quick wins in other services (e.g. inpatient wards, community care).
- Share examples of small changes that had large impact to inspire teams.

### **Scale and Spread**

- Successful initiatives should not remain isolated - they need structured spread.
- Staff and service user involvement is essential for sustainability

- Develop a spread strategy for rolling out improvements to other children's homes and care settings.
- Support services with resources, training, and leadership commitment for longevity

### **Supporting Staff and Systems**

- Staff need wraparound support to sustain improvements.
- Interdependent systems (care and estates) must work together for success.

- Provide training and wellbeing support for staff implementing changes.
- Use process mapping and risk analysis to identify vulnerabilities and prevent future incidents.

# Sarah Moran, Falls Co-Ordinator - Think Yellow Falls Prevention

## Learning

### **Multi-professional Collaboration**

- A multi-professional approach led to a 31% sustained reduction in ED falls, supported by regular feedback.
- Collaboration and shared accountability were critical for success.

### **Data-Driven Improvement**

- Falls data is plentiful and, when used effectively, drives improvement
- Financial and health consequences of falls highlight the need for prevention

### **Simple but Effective Interventions**

- The yellow blanket initiative was a simple, low-cost solution that improved patient safety and staff satisfaction.
- Simplicity is key for adoption and sustainability

### **Patient-Centred Risk Identification**

- Highlighting individual patient concerns helps tailor interventions.
- Falls have long-term personal and system-wide impacts - prevention is critical.

### **Communication and Stakeholder Engagement**

- Sharing results and involving stakeholders at every stage sustains engagement.
- Co-production and staff involvement were key to success

## Application

- Provide regular feedback on QI initiatives in your role to maintain engagement.
- Replicate multi-disciplinary teamwork in other safety areas (e.g. pressure ulcers, medication errors)

- Use measurement dashboards to track falls and other safety indicators.
- Share results widely to influence change and sustain improvements.

- Consider physical objects as clinical markers for other risks (e.g. delirium, infection control)
- Explore how this concept could be transferrable to inpatient single rooms or other settings

- Make at-risk patients more visible through clear markers or alerts
- Train staff to identify and act on individual risk factors.

- Apply lessons on influencing change without authority by building strong communication channels and stakeholder buy-in
- Use visual tools (videos, posters) to communicate success stories and encourage adoption.

# Stephen Rose, Digital Safety Officer - Enhancing the Applicability and Use of Patient Safety Metrics in encompass

## Learning

### **Streamline Digital Systems for Staff**

- encompass offers opportunities to improve workflow and safety, but it must be tailored to local needs.
- Making it easy for staff to do the right and safe thing is essential

### **Align Data and Metrics to Project Aims**

- Be mindful of what is recorded and ensure it directly relates to the project's target or aim.
- Safety metrics are key but must be relevant to the clinical area.

### **Data for Safety and Efficiency**

- Patient and workflow safety metrics can improve care and enhance efficiency.
- Rationalised, relevant metrics support better decision-making and patient flow.

### **Simple, Visible Solutions**

- Simple fixes can solve big problems - simplicity is key for adoption.
- Visibility of tasks and risks improves compliance and safety.

### **Use Expertise and Co-Production**

- Involving experts and stakeholders at every stage ensures relevance and sustainability.
- Co-production strengthens engagement and adoption.

## Application

- Work with the digital safety team to streamline encompass for teams and their metrics
- Tailor encompass dashboards to ward-specific needs to mobilise and support ongoing processes.

- Develop a rationalised metrics list tailored to ward needs and concurrent processes.
- Use MDT input to agree on what should be measured for improved patient safety and flow.

- Develop a robust system to address workflow and safety problems using data insights.
- Share results regularly to sustain engagement and demonstrate impact.
- Use data to identify opportunities for spread to other wards and services.

- Make discharge summary completion visible to all staff via dashboards or status boards.
- Apply similar visibility strategies to other clinical processes.

- Use stakeholder feedback loops to refine processes and digital tools.
- Apply lesson on influencing change without authority through strong communication and collaboration.