Quality Improvement in Tobacco Treatment

Learning Set 1

21st February 2023, 10:30 – 15:00

Quality Improvement in Tobacco Treatment

NHS England

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Welcome and introductions

Tom Ayers

Director, National Collaborating Centre for Mental Health (NCCMH)

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Housekeeping

- Toilets are located to the right of the lifts on level 1 (men's and women's toilets) and the ground floor (gender neutral toilets and disabled toilets).
- Lunch will be from 12:40 – 13:30 and will be served on this floor.
- Room 1.1 is available if anyone needs to take a break at any point or needs some quiet space (just outside the main auditorium).

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The programme team

Quality Improvement in Tobacco Treatment Collaborative

Amar Shah

National Improvement Lead

Tom Ayers

Director

Emily Cannon

Head of Quality Improvement

Joanna Popis

Programme manager

Matt Milarski

Senior QI Advisor

Rosanna Bevan

QI Coach

Clementine Fitch-Bunce

QI Coach

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Twitter

- We will be live tweeting this event so you may see the QI coaches on their phones during some sessions. Please also find and follow us **@NCCMentalHealth** or search for **#QuITTCollaborative**
- We encourage use of Twitter and social media to share the work that you are doing throughout the collaborative.
- However, we kindly ask you not to tweet people's names, photographs of people's faces or their talks without their permission.
- Thank you!

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Time	Item	Speaker
10:30-11:00	**Registration**	
11:00-11:05	Welcome and introduction	Tom Ayers, Director, NCCMH
11:05-11:15	Icebreaker	All
11:15-11:25	Overview of the collaborative	Rosanna Bevan, Quality Improvement Coach, NCCMH
11:25-11:45	How we overcame challenges in implementing a Tobacco Treatment Service for inpatients	Helen Phillips & Anna Bukowska, Berkshire Healthcare NHS Foundation Trust
11:45-12:40	Co-production in Quality Improvement	Isaac Samuels, Patient representative, NCCMH Satwinder Kaur, Patient representative, NCCMH Mark Farmer, Patient representative, NCCMH Rosanna Bevan, Quality Improvement Coach, NCCMH
12:40-13.30	**Lunch**	
13:30-14:10	Question wall	Clementine Fitch-Bunce, Quality Improvement Coach, NCCMH
14:10-14:55	Measurement planning session	Matt Milarski, Senior Quality Improvement Adviser
14:55-15:00	Close	Rosanna Bevan, Quality Improvement Coach, NCCMH
15:00-15:30	Reflecting on the day (optional session)	Emily Cannon, Renata Souza, NCCMH

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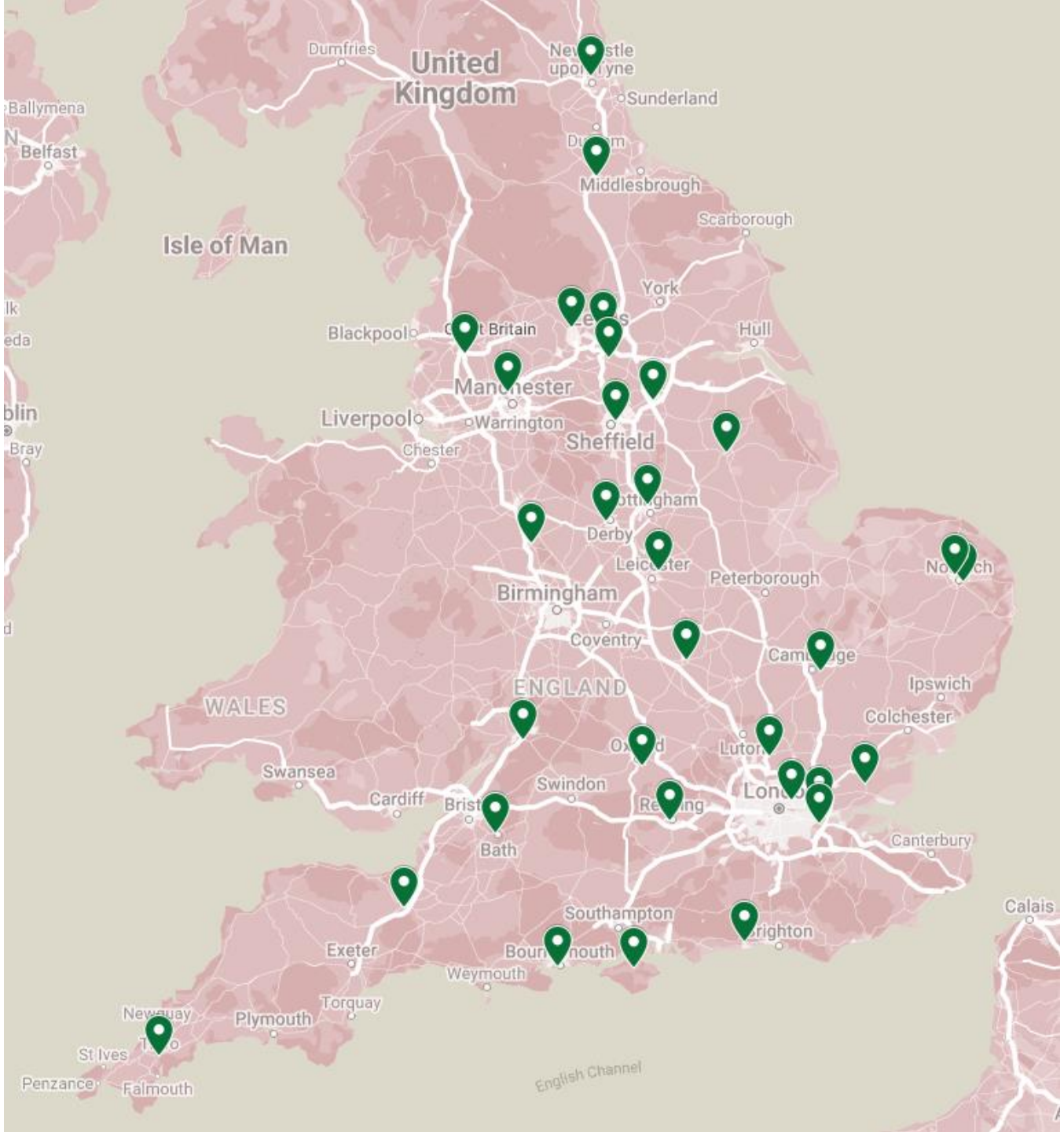
Participating organisations



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Icebreaker

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5 minutes

Find another person you don't know, on the other side of the room wearing the same colour as you, and pick a question to each answer...

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5 minutes

Would you rather automatically sing along or dance to every single song you hear?

Would you rather have feet for hands, or hands for feet?

Would you rather find yourself in the middle of a food fight or a water balloon fight?

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5 minutes

Find someone you don't know, on the other side of the room wearing the same colour as you, and ask them:

‘What are you hoping to get out of today?’

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Overview of the collaborative

Rosanna Bevan
Quality Improvement Coach

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Why?

- People with severe mental illness die 15-20 years younger than people without
- 50% of deaths in people with severe mental illness are due to smoking
- People with severe mental illness have high rates of smoking
  - BUT want to quit as much as the general population

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Collaborative Aim

To increase the proportion of patients on inpatient mental health wards, who smoke, who undertake meaningful tobacco treatment.

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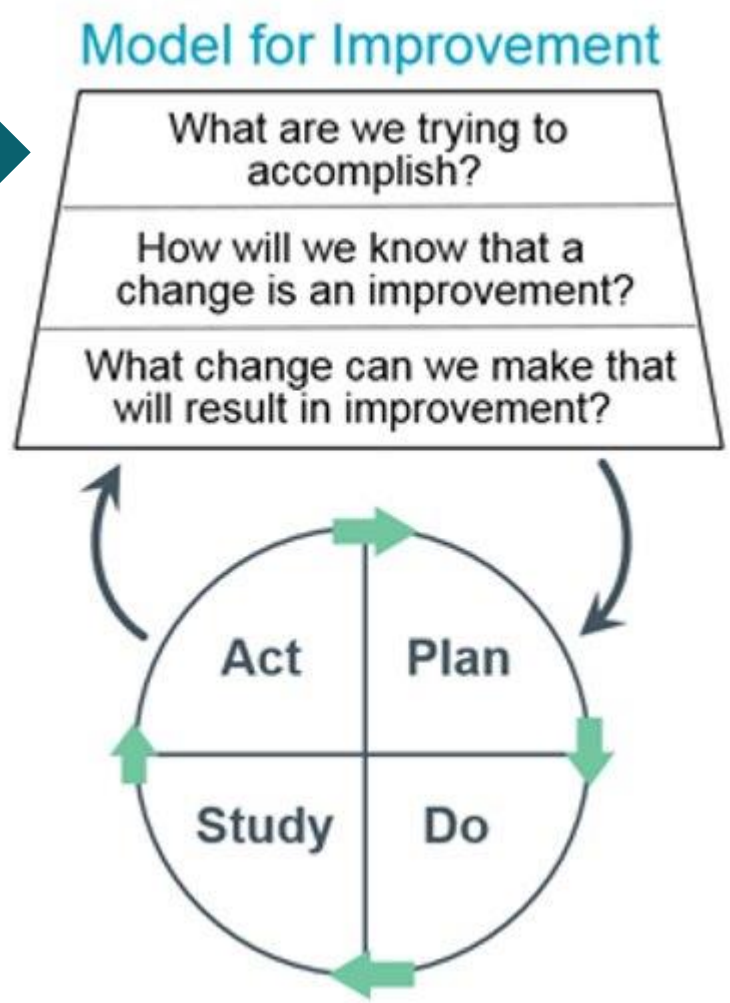
Aim

To increase the proportion of patients on inpatient mental health wards, who smoke, who undertake meaningful tobacco treatment.



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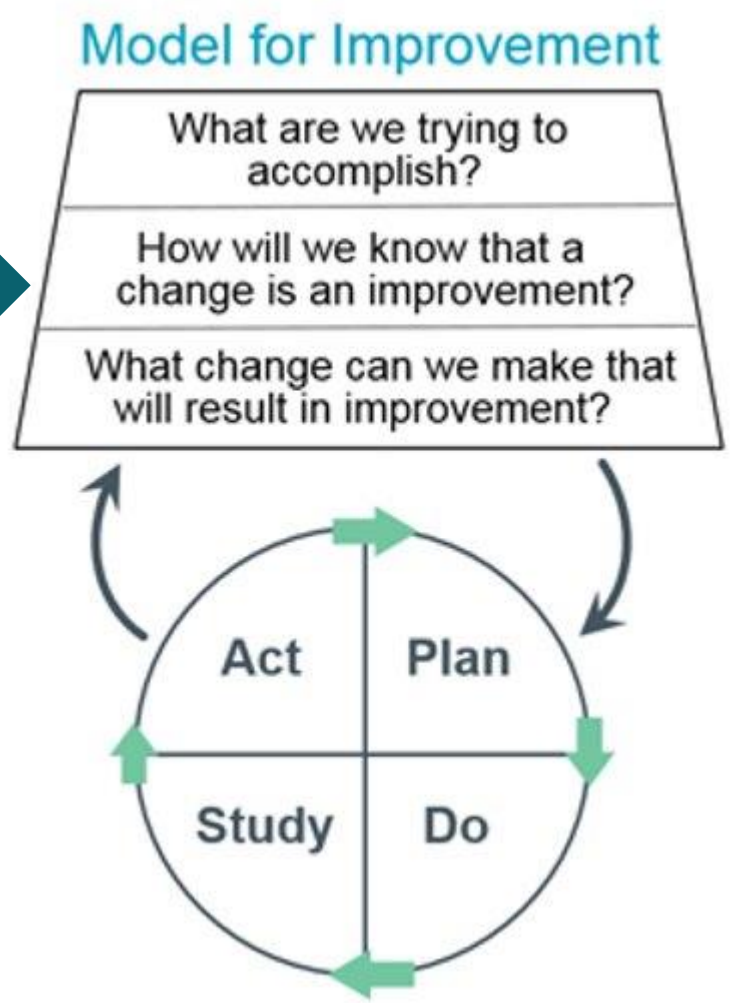
Measures

1. Smoking status screened (monthly)

2. Patients engaged with a tobacco dependency treatment service (monthly)

3. Patients have quit tobacco use (monthly)

4. Support provided by tobacco dependency treatment service is meaningful (monthly)



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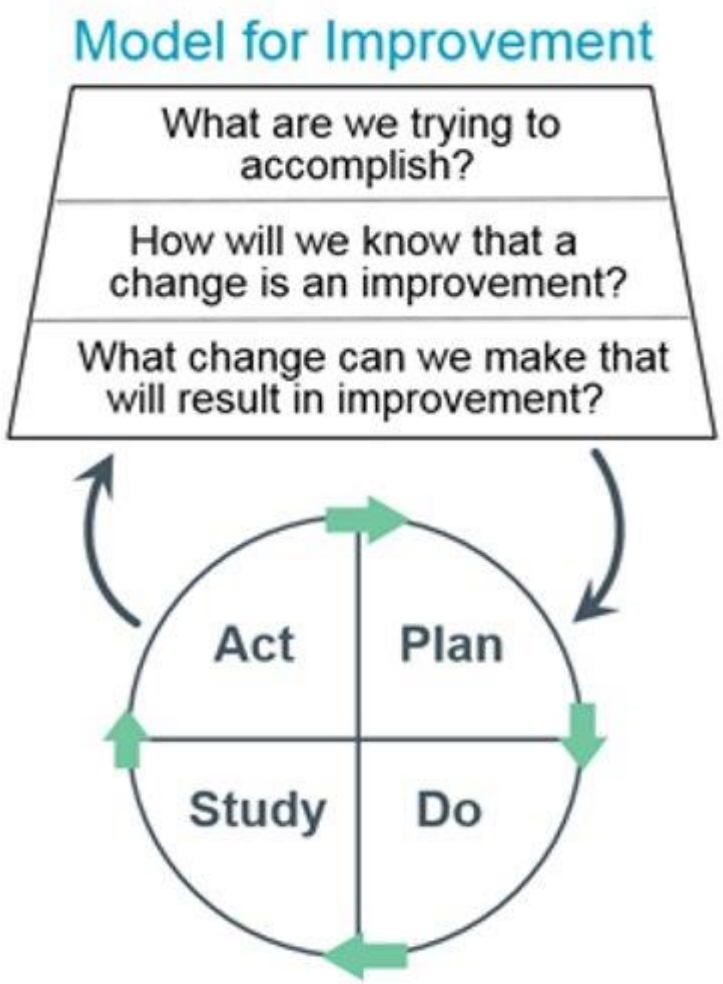
Theory of change



What are the key areas that teams will need to focus on to achieve the aim?

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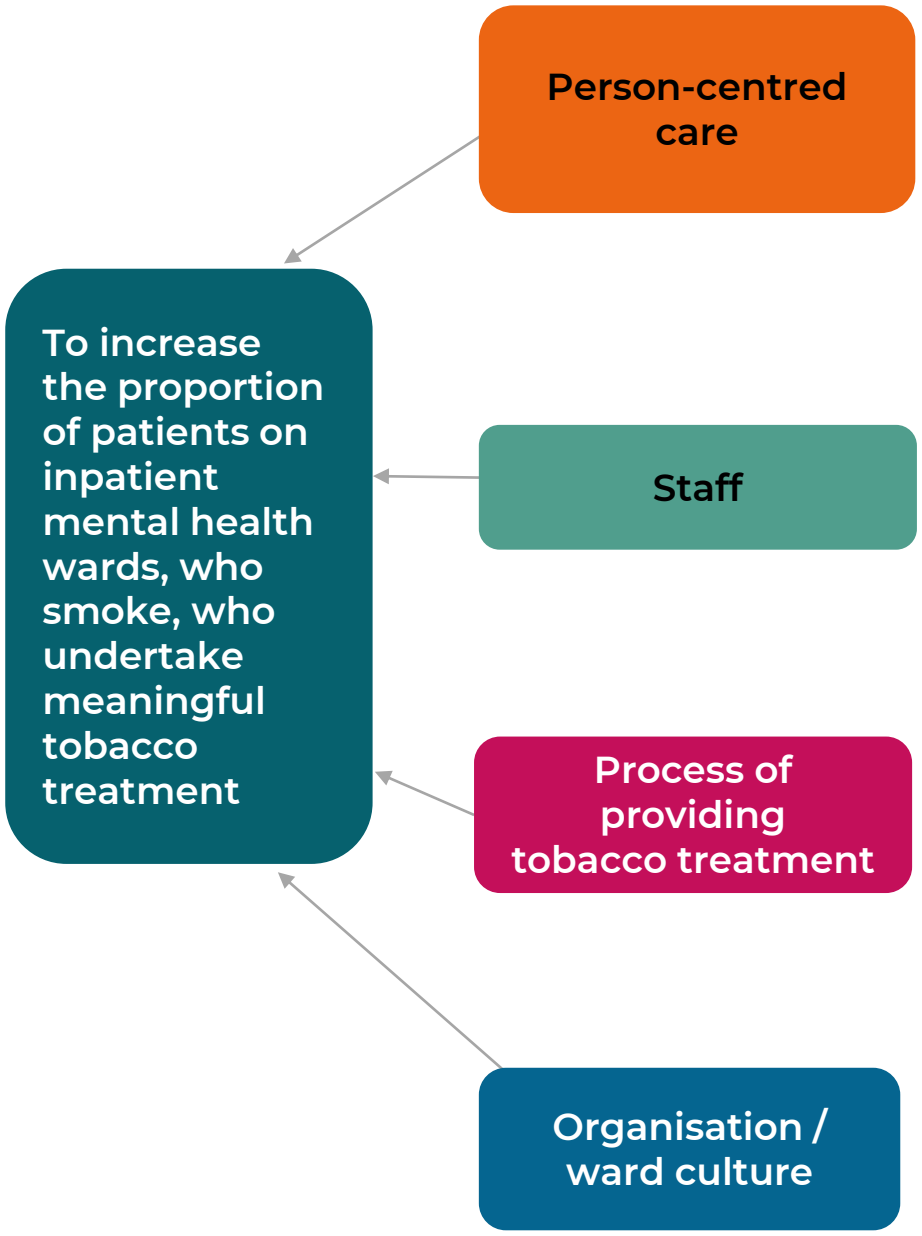
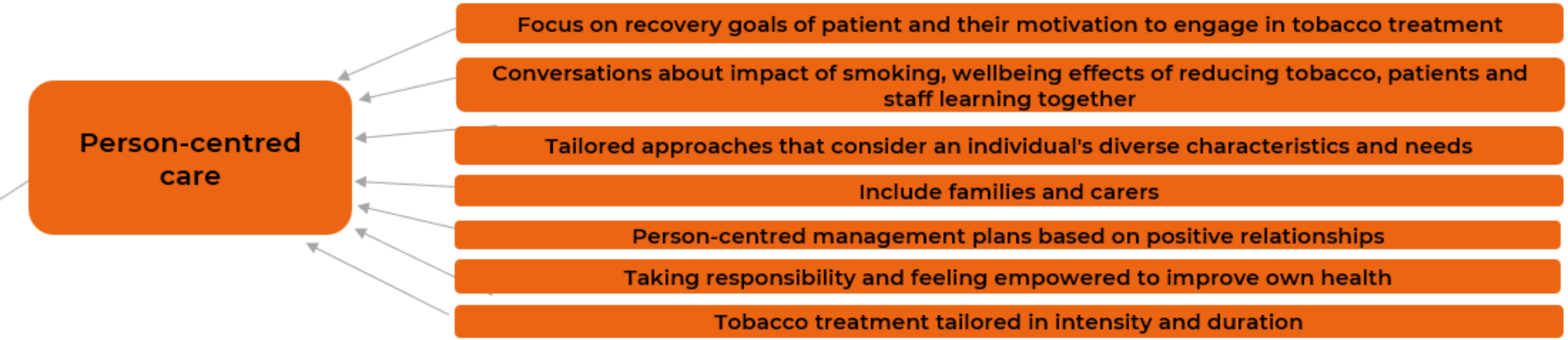
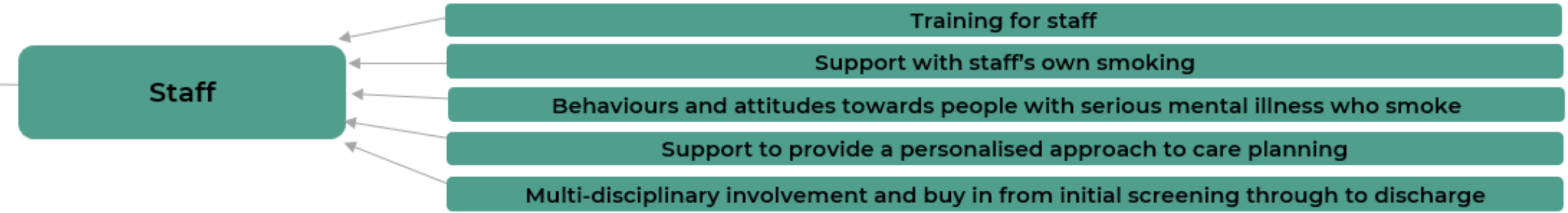
Aim

Primary drivers

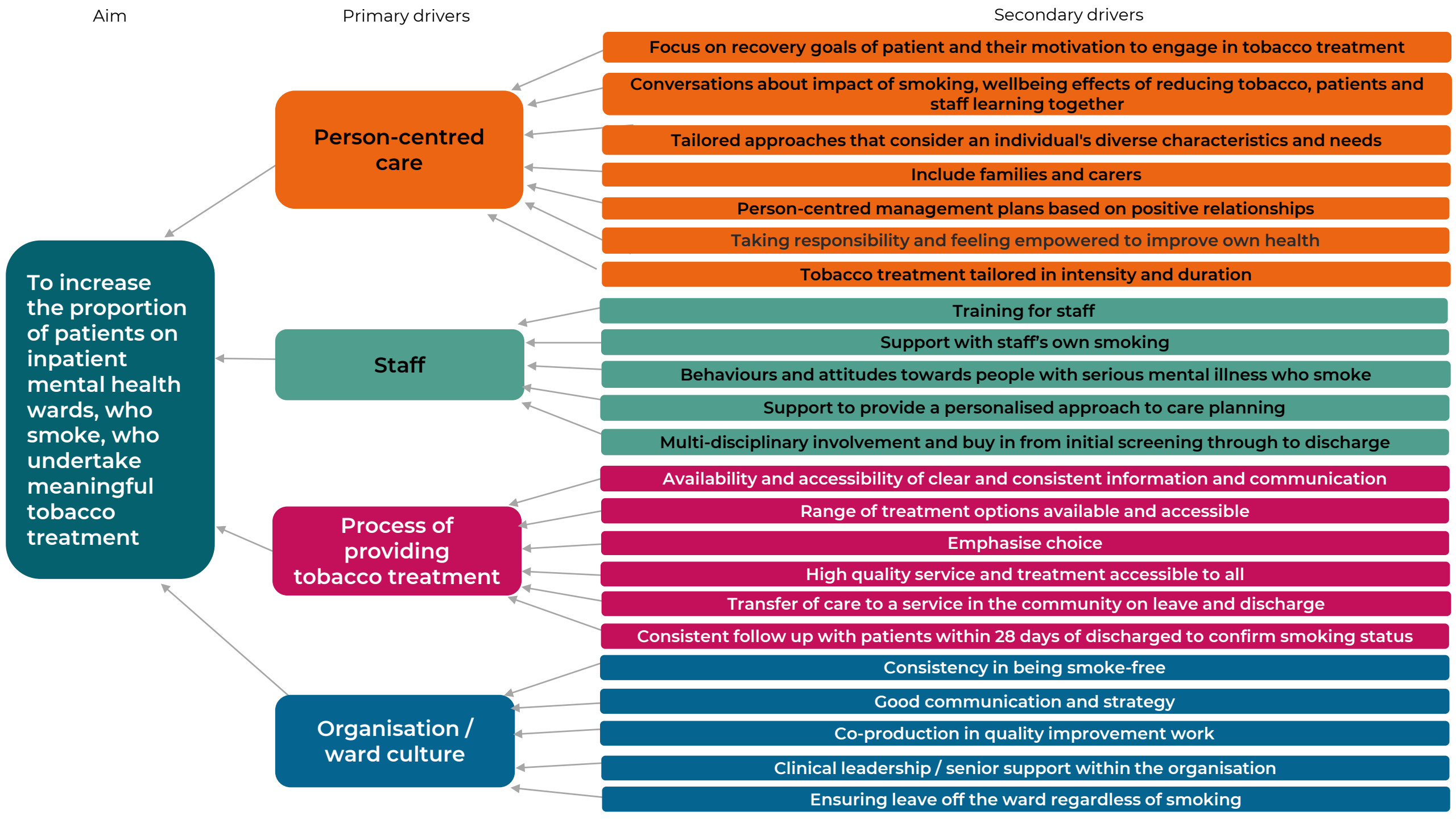



Person-centred care
Focus on recovery goals of patient and their motivation to engage in tobacco treatment
Conversations about impact of smoking, wellbeing effects of reducing tobacco, patients and staff learning together
Tailored approaches that consider an individual's diverse characteristics and needs
Include families and carers
Person-centred management plans based on positive relationships
Taking responsibility and feeling empowered to improve own health
Tobacco treatment tailored in intensity and duration


Staff
Training for staff
Support with staff's own smoking
Behaviours and attitudes towards people with serious mental illness who smoke
Support to provide a personalised approach to care planning
Multi-disciplinary involvement and buy in from initial screening through to discharge


Process of providing tobacco treatment
Availability and accessibility of clear and consistent information and communication
Range of treatment options available and accessible
Emphasise choice
High quality service and treatment accessible to all
Transfer of care to a service in the community on leave and discharge
Consistent follow up with patients within 28 days of discharged to confirm smoking status


Organisation / ward culture
Consistency in being smoke-free
Good communication and strategy
Co-production in quality improvement work
Clinical leadership / senior support within the organisation
Ensuring leave off the ward regardless of smoking


Aim
Primary drivers
Secondary drivers
To increase the proportion of patients on inpatient mental health wards, who smoke, who undertake meaningful tobacco treatment
Person-centred care
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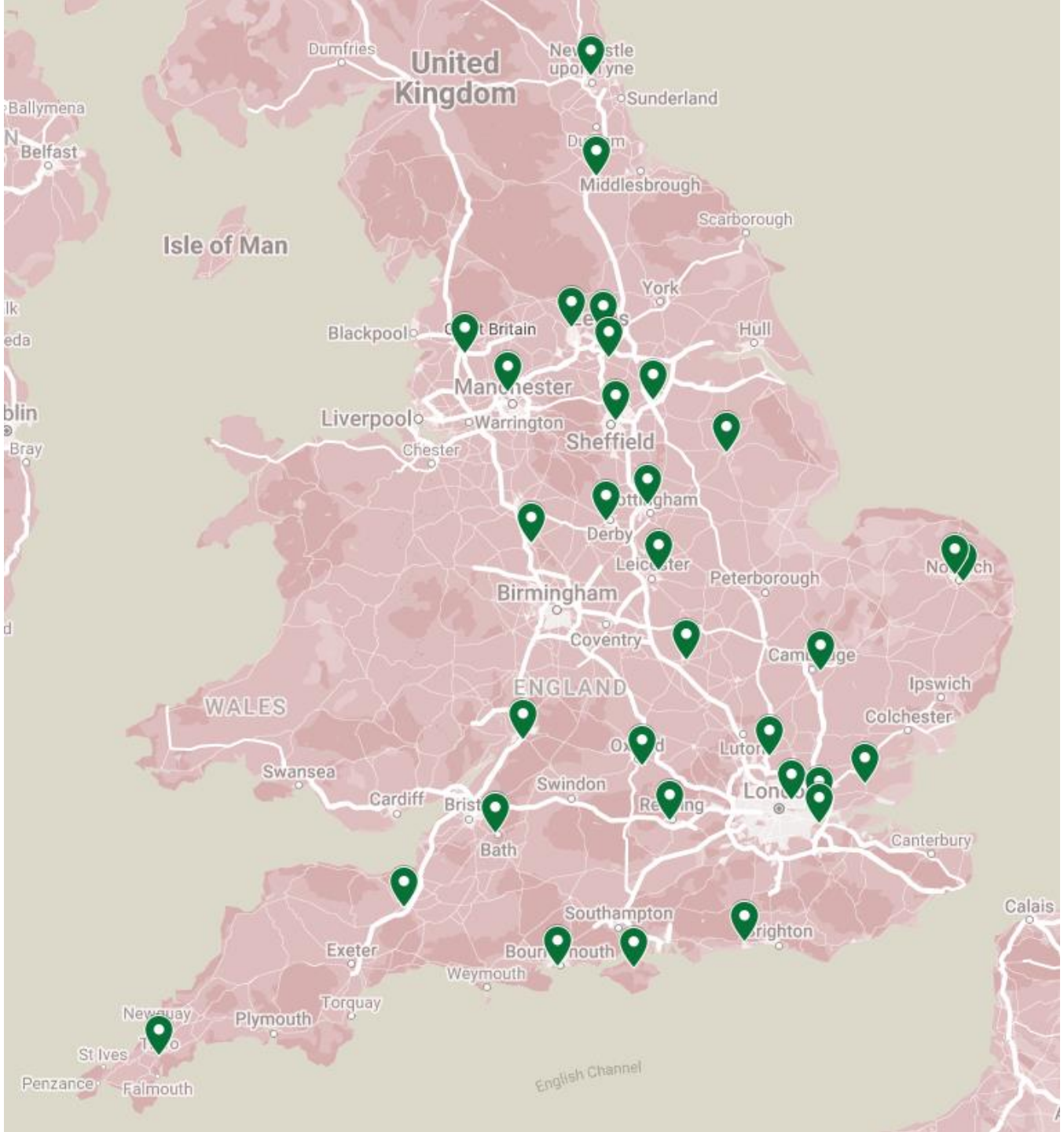
Participating organisations



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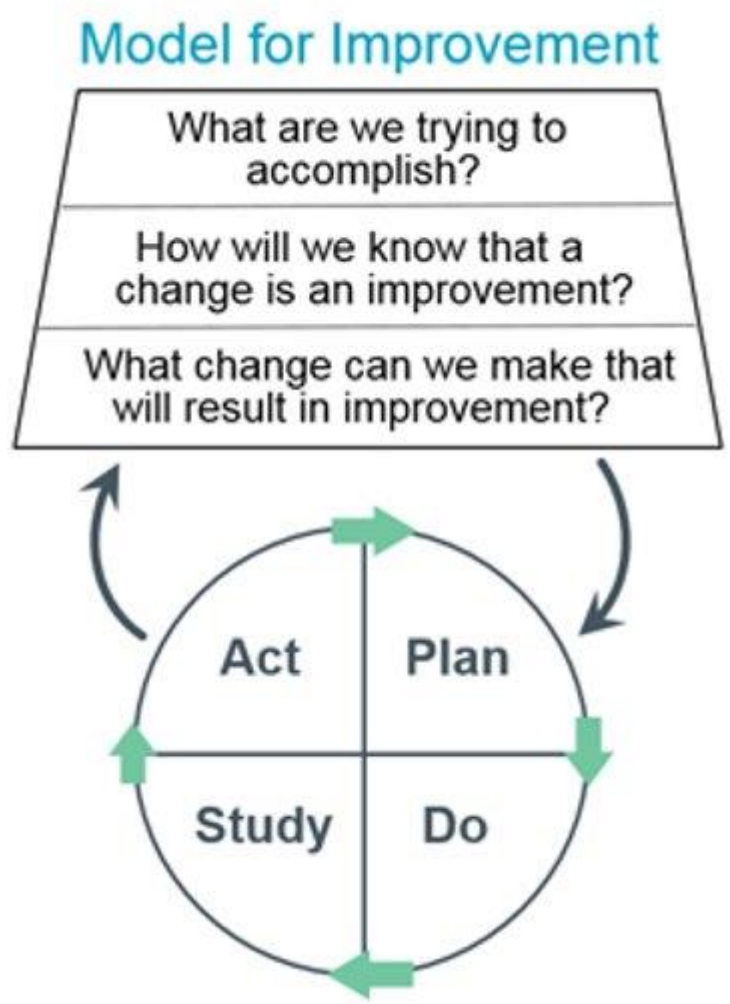
QI coaches support teams to run tests of change on ideas generated by the team that could help achieve the aim

Testing ideas



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Subject matter experts

Theory of change & measurement plan

Quality improvement support

Learning from each other

Story-telling and sharing experiences

Access to LifeQI

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NHS
Berkshire Healthcare
NHS Foundation Trust

Berkshire Healthcare Smokefree Journey

Helen Philips
Drug Alcohol and Smokefree Lead
Prospect Park Hospital

CareQuality Commission Inspected and rated Outstanding

Diversity and Inclusion Bringing us together

GDE Digital solutions for outstanding healthcare

Co-production in Quality Improvement

Isaac Samuels, Patient and carer representative, NCCMH

Satwinder Kaur, Patient and carer representative, NCCMH

Mark Farmer, Patient and carer representative, NCCMH

Rosanna Bevan, Quality Improvement Coach, NCCMH

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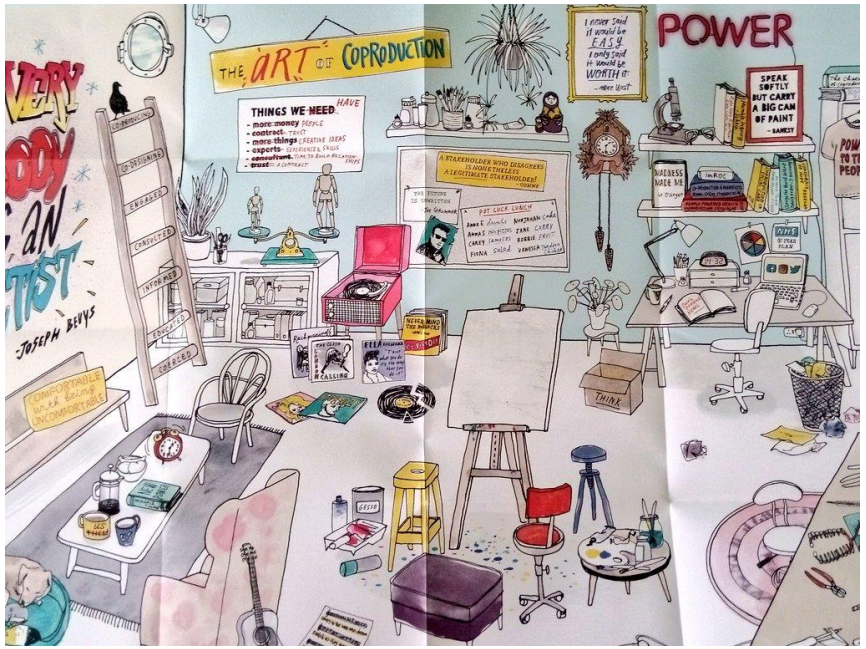
What is co-production?

It is:

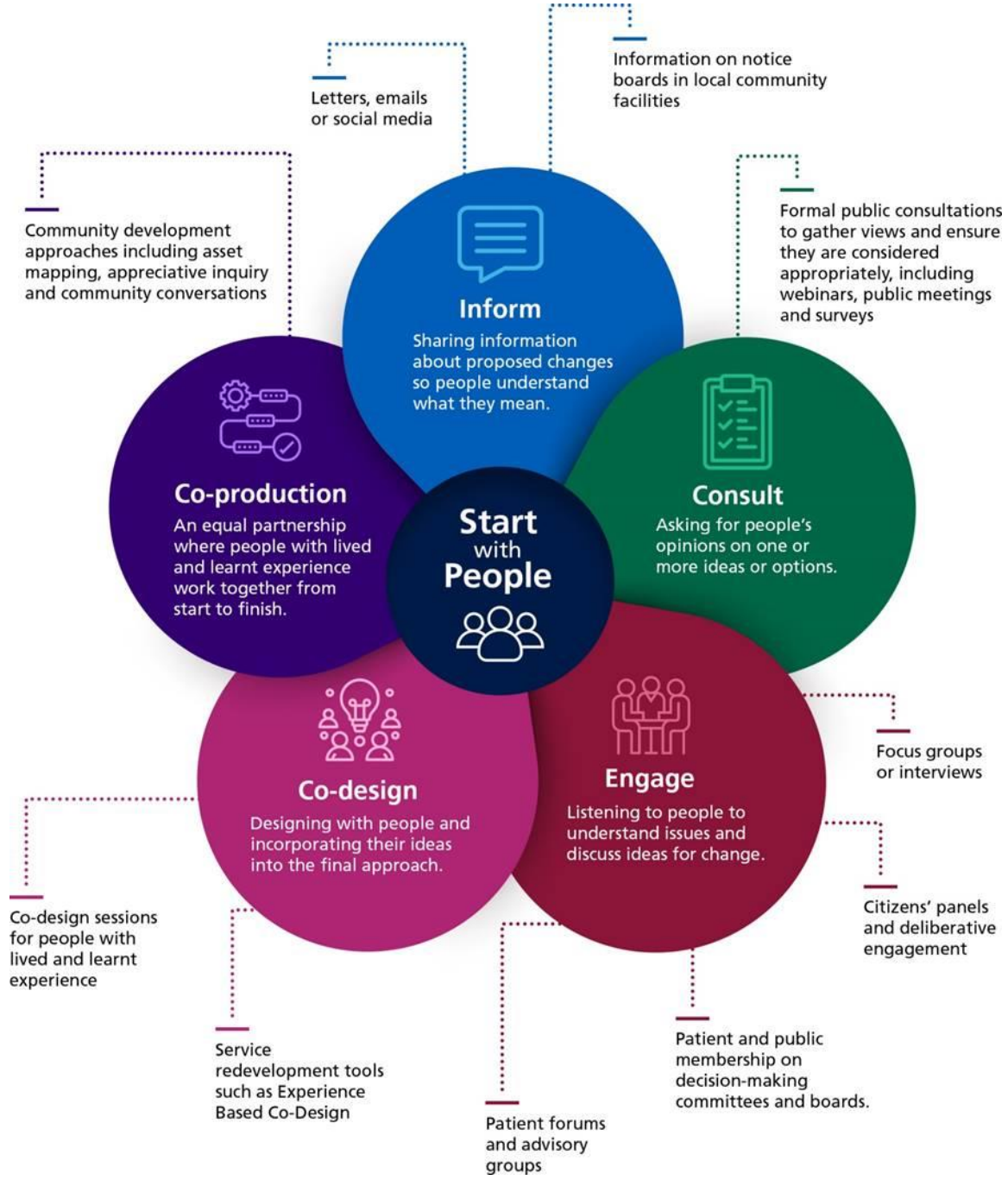
"…a shift in relationships between communities and public services, transforming people from passive recipients of healthcare to equal partners in its design, delivery and evaluation."

The Art of Co-Production a Guerrilla Guide- We Co-Produce, 2019



We can apply this definition to **any type of organisation**, not just healthcare.

Start with People- From Working in Partnership with People and Communities NHS England 2022



What are the benefits of co-production?

This quote, 13 years on, still best encapsulates the benefits of co-production:

"*Co-production makes the system more efficient, more effective, and more responsive to community needs. More importantly, it makes care altogether more humane, more trustworthy, more valued – and altogether more transforming for those who use it.*"

Phil Hope MP, then Minister of State for Care Services, March 2009

Source: Working in partnership with People and Communities NHS England July 2022

Core Values

HUMAN

We value people as people, do everything wholeheartedly, and work to make a genuine difference.

INCLUSIVE

We support everyone to be included and participate fully in our co-production community.

TRANSPARENT

We share power, make decisions openly and collectively, and are accountable to our co-production community.

CHALLENGING

We say it like it is, continually questioning both the status quo and ourselves, even when that's the hard thing to do.

Co-production

The tangible results of creating the right conditions

"Living the Life I want and doing the things that are important to me as independently as possible"

Funguarding

Let's try it
Positive risk taking

What matters to people & communities

Cause good trouble

Relationships

Working alongside people and other 'providers'

Test quickly and fail fast

Re-Humanise

Its about people

Build support around my personal outcomes

Empathy

Co-Creation

Creating the right conditions
New organisational form

Very different conversations

Trust

Flexibility

Let me take risks

Values

Re-write the Rules

Always learning and adapting

The Iceberg Effect…

Curators of Change

The formula to effective co-production is …

Invite people to regular meetings to discuss issues

Ensure minutes + action plan cover everything

$$\frac{\text{4LD + 5 LGBTQI + 3 MH + 6BME}}{\text{Minimum 12 pages}}$$

X 4 meetings per year

There is no magic formula

Co-production

- Working together in equal partnership for mutual benefit
- Sharing knowledge and experiences
- Changing lives as a result of co-production
- Ensuring we have fit-for-purpose service provision
- Seeing the world from the people's perspectives
- Enabling people to reconstruct their narrative and their future

Co-production perspectives

- How do we do this???
- We only want to do it if we can get it “right”
- We might hear things we don’t want to hear or can’t fix
- Makes our work harder, takes more time, costs more, more complicated…

…but ultimately better

CO-PRODUCTION

Culture

Values

Individual/Person

QUALITY IMPROVEMENT

STRUCTURE

Systems and processes

Teamwork

Satwinder Kaur

Tips on how to do co-production

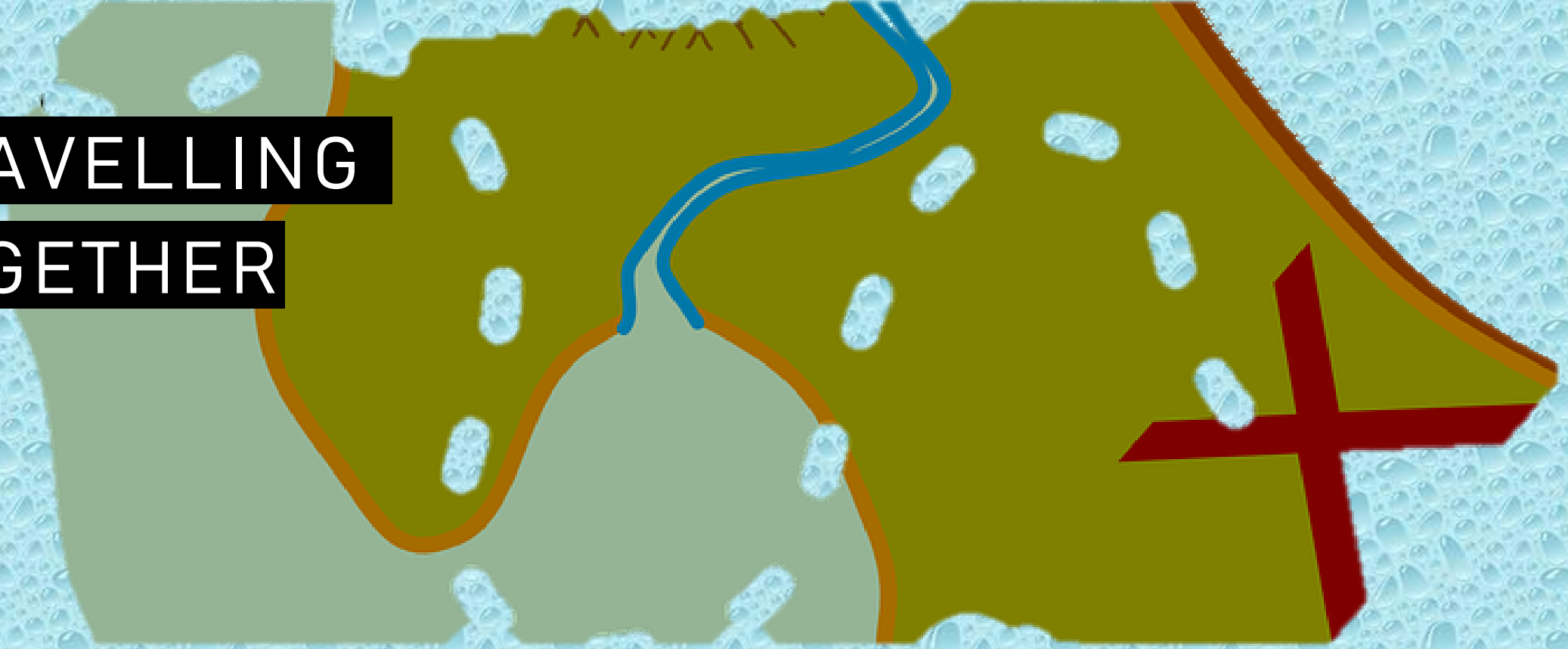
- Create the right conditions
- Just get started
- Be brave
- Get senior leadership support
- Peer support workers
- Put leaflets/posters everywhere
- Talk to patients and carers you already know
- Pay people for their time
- “We said… we did” together
- Give yourself time to build relationships
- Reflective practice

How do you measure the success of co-production?

Co-produce what the impact could look like
And co-produce measurement of it

Keep evaluating what you're doing

TRAVELLING TOGETHER



Your Journey to Co-Production

4/11/2023

How can you involve people with lived experience in your QuITT project?

20 minutes

Please spend this time completing the co-production road map provided on your tables:

- **Write your team name**
- **Work your way through the questions**
- **Focus on sections 1-4**

This will help you to plan how you will involve people with lived experience well in your QuITT project. QI Coaches and patient and carer reps are available to help.

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10 minutes

Feedback from the exercise

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Useful resources

- The Art of Co-Production- A guerrilla guide The Art of Coproduction - A Guerrilla Guide - Ideas Alliance (ideas-alliance.org.uk)
- Working Well Together, Working Well Together | Royal College of Psychiatrists (rcpsych.ac.uk)
- Working in partnership with People and Communities NHS England » Working in partnership with people and communities: Statutory guidance

Lunch

12.40 – 13.30

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Question wall

Clementine Fitch-Bunce
Quality Improvement Coach

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Question wall

Around the room are ‘walls’ representing common challenges so far:

1. Setting up a project team
2. Setting up a tobacco dependency treatment service
3. Engaging people in this work

+ Plus 1 sheet for sharing successes so far and other blank sheets for any other questions

- There will be 10 minutes to generate questions at your table
- Then 30 minutes to stick questions to the question walls and write and add responses to other people’s questions
- The QuITT team will share the Q+A’s and successes following the event

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10 minutes

Spend this time at your tables generating questions for the question walls

Please add 1 question per post-it note

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30 minutes

Stick your questions to the question walls, and write and add responses to other people's questions

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Measurement planning

Matthew Milarski (he/him)
Senior Quality Improvement Adviser

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Collaborative aim

- To increase the proportion of patients on inpatient mental health wards, who smoke, who undertake meaningful tobacco treatment.

- After a period of baseline data collection, we will set a more specific programme level aim and project teams will also be asked to set their own aim. For example, to increase the proportion of patients on inpatient mental health wards, who smoke, who undertake meaningful tobacco treatment **xx% by October 2024.**

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Why collect data?

- So that you can know if changes you are testing are leading to an improvement

- Data for improvement is collected and displayed in real-time

  - For QuITT this is monthly

  - Only collect what you need to see if you are achieving your goal

  - Visualise your data as your project progresses and see, in real-time, what effect your change ideas are having

- Your QI Coach will support you to learn from your data and use it to share your work with others

Collaborative measures

- You will collect data for 6 outcome measures
- Outcome measures 1-3 will be the same data you enter into the NHS Digital Tobacco Dependency dataset
- Outcome measure 4-6 will be collected via the patient feedback questionnaire upon discharge/transfer from the ward(s)
- Each measure will be converted into a percentage value and so will have a ‘Count’ and a ‘Total’ value that will need to be collected and submitted
- If you can backdate any data that will be useful to your project (your QI Coach can help you with this)
- Need to start collecting patient surveys in March (if you haven’t already)

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Outcome measure 1: Smoking status screened

Measure
The % of patients screened for a recorded smoking status on admission

Link to Digital Dataset
What is the patient's smoking status on admission?

Data you will need to collect

COUNT (numerator)	TOTAL (denominator)
All admissions during the month for whom smoking status was screened and recorded which can include the following responses: *- Smoker / Current smoker* *- Ex-smoker* *- Never smoked* *- Smoker undertaking a current supported quit attempt* *- E-cigarette user only* *- Not stated (patient asked but declined to provide a response)* Please note, the following options are **not** included in the count: *- Unknown (Not recorded)*	Total number of admissions to the ward(s) in the month i.e. if entering data for March, the total would be the number of new admissions to the ward(s) you are working with on your QuITT project between March 1st and March 31st

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Outcome measure 2: Patients engaged with a tobacco dependency treatment service

Measure

The % of patients who smoke who are engaged with a tobacco dependency treatment service

Link to Digital Dataset

What intervention was provided by the Tobacco Advisor to the smoker?

Data you will need to collect

COUNT (numerator)	TOTAL (denominator)
All patients on the ward(s) for whom one of the below responses was recorded: *- Smoking reduction (a supported attempt to reduce the number of cigarettes smoked, with or without the use of nicotine)* *- Supported temporary abstinence (supported to remain smoke free whilst in hospital, no follow-up care)* *- Quit attempt with behavioural intervention and licensed medication – recommended NHS intervention* *- Quit attempt with behavioural intervention and unlicenced nicotine containing products* *- Quit attempt with behavioural intervention and without pharmacotherapy*	Total number of people who smoke on the ward(s)

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Outcome measure 3: Patients have quit tobacco use

Measure
The % of patients engaged with a tobacco dependency treatment service who have quit tobacco use after 28 days

Link to Digital Dataset
Was the patient followed up at 28 days, and what was their tobacco care plan outcome?

Data you will need to collect

COUNT (numerator)	TOTAL (denominator)
All patients eligible for 28 day follow up in the month that have quit tobacco use. Includes recorded responses: *CO (carbon monoxide) confirmed quit* *Self-reported (only) quit* Please note, the following options are **not** included in the count: *Confirmed current smoker (not quit)* *Smoking status unknown (lost to follow up)*	Total number of patients who were eligible for 28 day follow up in the past month i.e. if entering data for March, the total would be all patients whose 28-day follow up fell between March 1st to March 31st

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Outcome measure 4: Patient experience survey Q1

Measure
The % of patients who felt able to quit or continue to be smoke free

Patient survey question
Do you feel able to quit or continue to be smoke free?

Data you will need to collect

COUNT (numerator)	TOTAL (denominator)
Number of patients who responded 'Yes' to question 1 *Please see QuITT Patient Survey handout on your table or the QuITT website for full survey details.*	Total number of patients who smoke who completed the survey on discharge/transfer from the ward(s) that month i.e. if entering data for March, the total would be the number of completed surveys between March 1st to March 31st

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Outcome measure 5: Patient experience survey Q2

Measure
The % of patients who rated their experience of the tobacco dependency treatment service as ‘quite good’ or ‘very good’

Patient survey question
How was your experience of the tobacco treatment service during your admission?

Data you will need to collect

COUNT (numerator)	TOTAL (denominator)
Number of patients who responded ‘Very good’ or ‘Quite good’ to question 2 *Please see QuITT Patient Survey handout on your table or the QuITT website for full survey details.*	Total number of patients who smoke who completed the survey on discharge/transfer from the ward(s) that month i.e. if entering data for March, the total would be the number of completed surveys between March 1st to March 31st

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Outcome measure 6: Patient experience survey Q3

Measure
The % of patients who felt that the support to quit smoking was tailored to their needs and preferences

Patient survey question
Do you feel the support to quit smoking was tailored to your needs and preferences (including your ethnicity, disability, sexuality, cultural background, or other personal characteristics)?

Data you will need to collect

COUNT (numerator)	TOTAL (denominator)
Number of patients who responded 'Yes' to question 3 *Please see QuITT Patient Survey handout on your table or the QuITT website for full survey details.*	Total number of patients who smoke who completed the survey on discharge/transfer from the ward(s) that month i.e. if entering data for March, the total would be the number of completed surveys between March 1st to March 31st

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Question 4. Please share any other thoughts or feedback on your experience of support around smoking during your admission. This could include how were your needs understood, what was helpful or unhelpful to you or how the service could be improved.

If you did not wish to receive support from the tobacco dependency treatment service, your feedback on why would be helpful, if you would like to tell us:

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What about the rest of your data?

- Although only certain responses to each question are used to calculate your outcome measure data it is important that teams also keep all their raw data - i.e. all responses to each question each week.

- The reason for this is your raw data can be useful to provide additional learning and insights into your team throughout the collaborative.

Collecting and submitting data

- You will need to submit data on a monthly basis and should aim to submit the preceding months data in the first week of the following month
    - i.e. submit data for March 2023 no later than 7th April 2023
- This will be the same for all teams across the collaborative, so that we are able to aggregate the data
- All data collected will be entered onto LifeQI (online platform for managing your projects)
- Coaches will introduce you to LifeQI and your data charts as the programme progresses
- You can choose to submit your data directly onto LifeQI, or into a spreadsheet which you send to your QI Coach each month. Your coach can provide teaching on how to use LifeQI and/or a QuITT data template.

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30 minutes

Please spend this time completing the measurement plan worksheet provided on your tables

This will help you to plan how you will collect and submit the required data

Copies of the measurement plan and patient experience survey are available on your tables

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What if we're not on Round 1?

ROUND 2 TEAMS

- How can you get your data collection in place ready for the start of Round 2 in November?
- What do you need to achieve this?
- What are barriers and enablers to you collecting the data?

EARLY IMPLEMENTER SITES

- Your QI Coach will support you to design your own QI project including creating a measurement plan
- What is your aim for your QI project? How could you measure this?

OTHER ORGANISATIONS e.g. private providers

- Can learning from the QuITT Collaborative be used in your organisations improvement work?
- Can the QuITT measurement plan be adapted for your setting?

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Close

Matthew Milarski (he/him)
Senior Quality Improvement Adviser

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Next steps

Which of your wards will be involved with this work?

Who will be in your project team?

How can you ensure patients are part of your project?

How regularly can you meet as a project team?

How will you keep in touch with your QI Coach?

Do you need to do/ change anything to be collecting data?

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Next sessions

- Your next meeting with your coach
- Online workshop: Monday 20th March, 14.00-15.00
- Next learning set: Monday 22nd May, 10.30-15.00

See you then!

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How did you find today's event?

We value your feedback as this helps us to continue to improve these events and ensure topics covered are meaningful and relevant to you.

Please use the QR code to access the online form. Paper copies are also available on your tables.

Feedback Form: Quality Improvement in Tobacco Treatment QI Collaborative

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Optional drop-in session

Reflecting on the day

15:00 – 15:30

Room 1.1

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