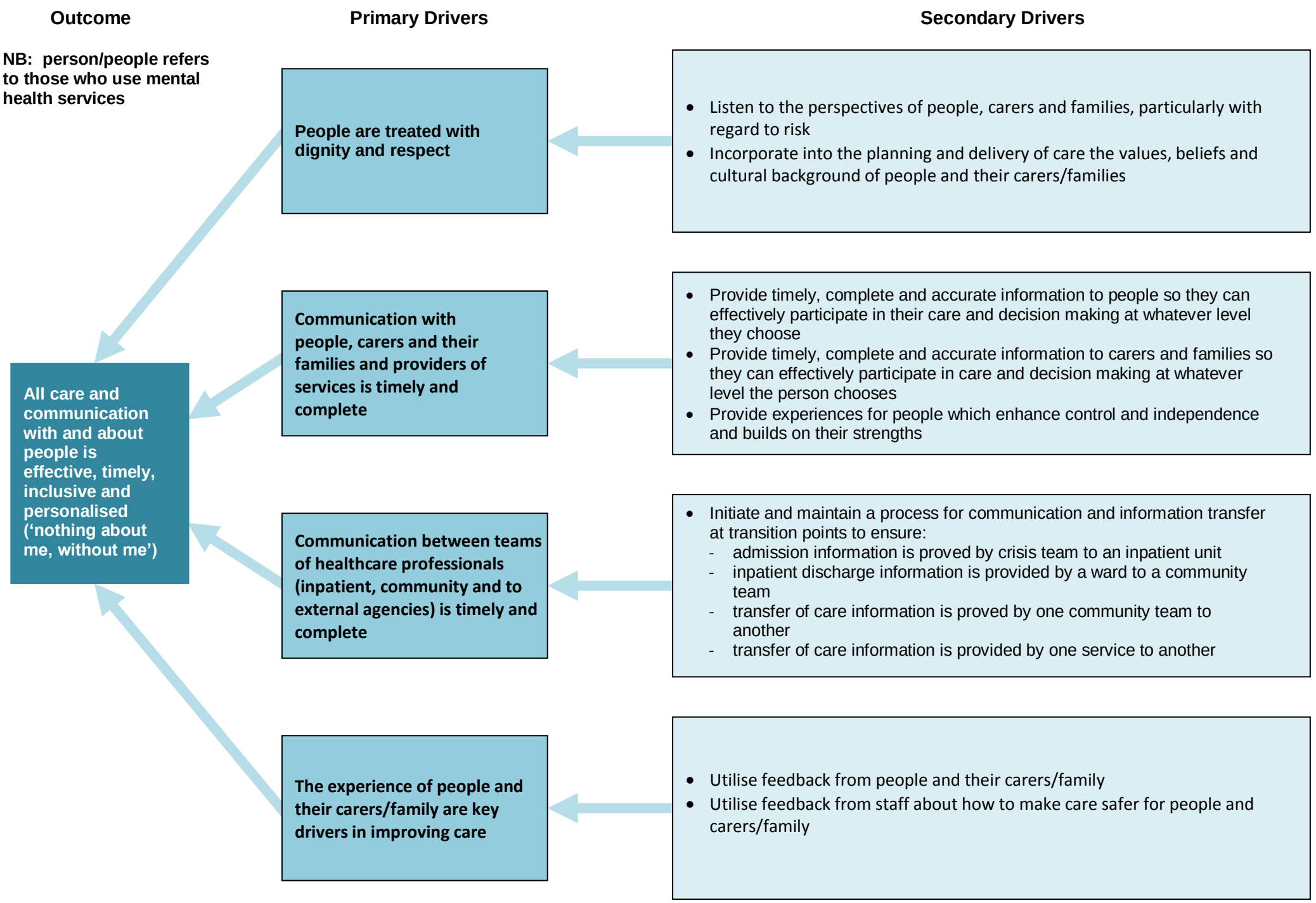
NHS
South of England

South of England Improving Safety in Mental Health Collaborative

Delivering person and family centred care

Driver Diagram and Change Package

A driver diagram is used to conceptualize an issue and to determine its system components which will then create a pathway to achieve the goal. Primary drivers are system components which will contribute to moving the primary outcome. Secondary drivers are elements of the associated primary driver. They contain change concepts that can be used to create projects that will affect the primary driver.
Adapted from the South West Quality and Patient Safety Improvement Programme.


Outcome
Primary Drivers
Secondary Drivers
NB: person/people refers to those who use mental health services
All care and communication with and about people is effective, timely, inclusive and personalised ('nothing about me, without me')
People are treated with dignity and respect
Listen to the perspectives of people, carers and families, particularly with regard to risk
Incorporate into the planning and delivery of care the values, beliefs and cultural background of people and their carers/families
Communication with people, carers and their families and providers of services is timely and complete
Provide timely, complete and accurate information to people so they can effectively participate in their care and decision making at whatever level they choose
Provide timely, complete and accurate information to carers and families so they can effectively participate in care and decision making at whatever level the person chooses
Provide experiences for people which enhance control and independence and builds on their strengths
Communication between teams of healthcare professionals (inpatient, community and to external agencies) is timely and complete
Initiate and maintain a process for communication and information transfer at transition points to ensure:
- admission information is proved by crisis team to an inpatient unit
- inpatient discharge information is provided by a ward to a community team
- transfer of care information is proved by one community team to another
- transfer of care information is provided by one service to another
The experience of people and their carers/family are key drivers in improving care
Utilise feedback from people and their carers/family
Utilise feedback from staff about how to make care safer for people and carers/family

Secondary Drivers	Key change concepts and change ideas for PDSA testing
• Listen to the perspectives of people, carers and families, particularly with regard to risk	• Develop policy/guidance on carers discussing their views and concerns with member of staff • Contact family within three working days of admission if consent is given and provide them with mechanisms for making contact with a member of the clinical team at all times • Recruit staff through behavioural based interviews to understand the skills of the candidate in essential competencies of compassion, communication and team work • Remove barriers between staff and people and their carers/family • Demonstrate respectful behaviour and monitor this through clinical supervision/reflection • Develop and enhance multi-disciplinary teamwork by developing a shared vision • Provide opportunity for people, carers/family to talk to staff
• Incorporate into the planning and delivery of care the values, beliefs and cultural background of people and their carers/families	• Capture during the process of initial assessment • Consider how values, beliefs and cultural background might affect planning and delivery of care • Build actions into care plan
• Provide timely, complete and accurate information to people so they can effectively participate in their care and decision making at whatever level they choose • Provide timely, complete and accurate information to carers and families so they can effectively participate in care and decision making at whatever level the person chooses	• Engage people to actively participate in their care • Engage family/carers in the process of admission • Engage family/carer in care delivery • Make it convenient for family/carers to engage in care processes • Provide mechanisms for carers/family to make contact with the clinical team • Engage family/carer in the process of discharge • Work with people and carers/family as co-partners in their care • Use appropriate language at the level of understanding of each individual • Instigate ‘talk back’ • Use person and carer/family information leaflets on key policy information on admission and where appropriate during their care • Improve the knowledge of the family/carer in relation to the disorder suffered
• Provide experiences for people which enhance control and independence and builds on their strengths	• Check that course of care and expected outcomes are known by people and their carers/family • Use effective observation and engaging policies • Use ward orientation boards • Consider protected time where no ward rounds or visiting takes place • Engage staff to ensure their understanding of ‘meaningful engagement’ • Introduce ‘plan your day’ meetings • Introduce 1:1s with the person and member of staff every day

Secondary Drivers	Key change concepts and change ideas for PDSA testing
• Initiate and maintain a process for communication and information transfer at transition points to ensure: - admission information is proved by crisis team to an inpatient unit - inpatient discharge information is provided by a ward to a community team - transfer of care information is proved by one community team to another - transfer of care information is provided by one service to another - ask the question during executive safety walkrounds	• Understand current system and its effectiveness by process mapping • Use SBAR (Situation, Background, Assessment, Recommendation) as tool for verbal and written communications • Use standardised handover templates • Develop documentation to facilitate transfer of accurate information • Use quick daily multidisciplinary team 'board' round to check care processes • Consider technological solutions to transfer of information • Consider use of checklists – admission, discharge, transfer • Consider needs of staff unfamiliar with the environment • Institute safety briefings to communicate key issues relevant to clinical area • Engage with all the team involved to find solutions and to test improvements • Monitor compliance with agreed timescales aiming for 95% reliability
• Utilise feedback from people and their carers/family	• 'Live the journey' of a person using your service and their carer/family • Have a policy of transparency and apologise when things go wrong • Use stories from people and their carers/family for learning and to motivate and inspire staff • Use formal and informal learning opportunities to educate staff in person and family centred care • Use formal and informal learning opportunities to educate staff on carers rights to involvement in assessment, care planning and discharge • Feedback compliments to multidisciplinary teams • Introduce a simple questionnaire for people, carers/family asking what could be improved • Utilise feedback from patients advice and liaison service, complaints, incidents, findings from root cause analysis and post-incident reviews
• Utilise feedback from staff about how to make care safer for people and carers/family	• Ask the question during executive safety walkrounds