SEAMLESS TRANSITION

Summary

The Programme is designed to blend virtual learning and reading resources with face- to- face (virtual) learning half- day events and coaching calls over nine months.

The course is designed so that whatever the specific circumstances at work, the steps and exercises can be undertaken together as a team or individually and then shared in a face-to-face or virtual team meeting. There is uncertainty looking ahead about working limitations week to week as a result of Covid 19. However, we have designed the programme you are starting to give each of you and your team and patients all you need to improve Transition care. We are sure you will be able to find the flexibility and commitment to go through the material and redesign what parts of the Transition journey need changing even if the structure of your working week is uncertain now or changes during the months we are working together.

'Where there is will there is a way' and we are here to support you in finding that way and making it work.

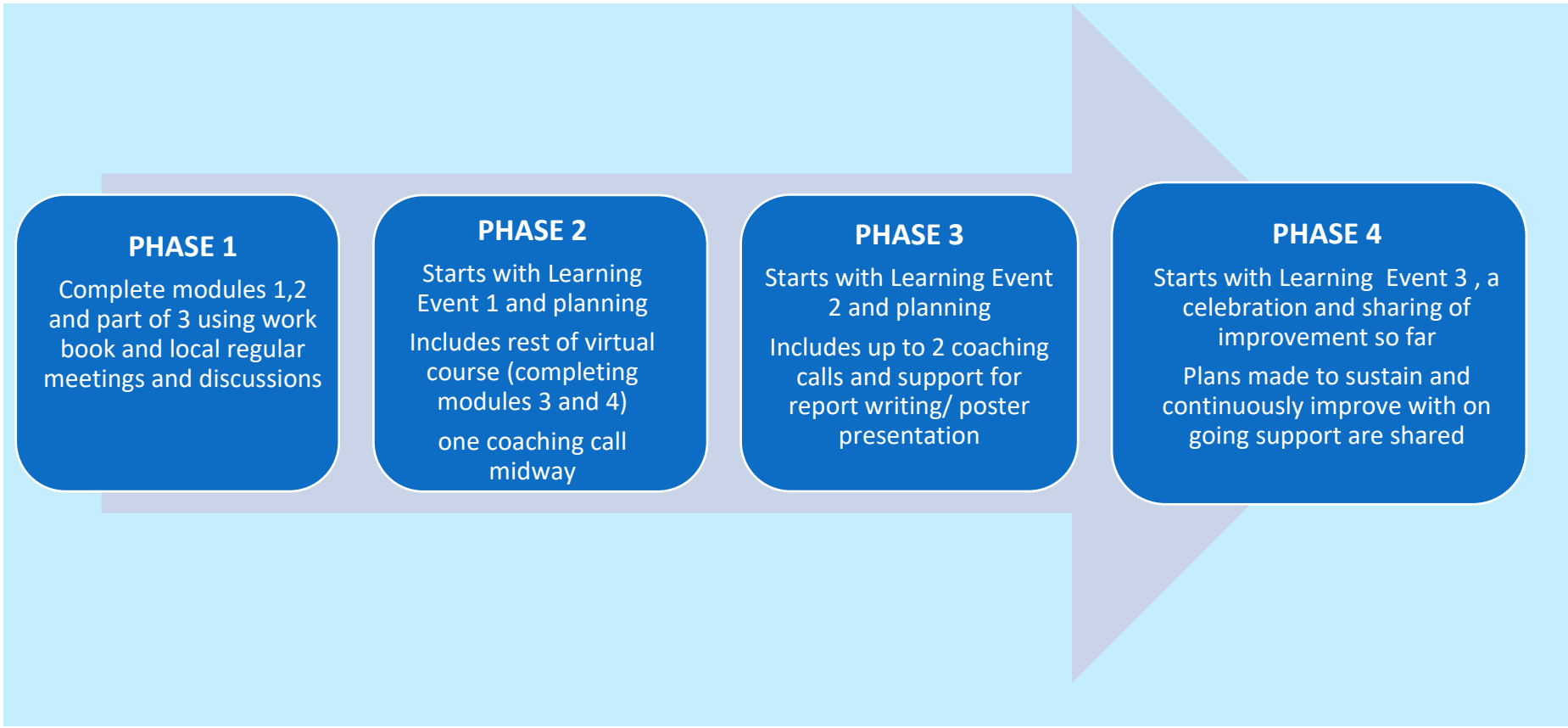
We will start the programme with an introductory webinar (1 hour) and some pre- work guidance based on NPDA and PREM data plus local service reports.

Phase 1 -(12 weeks) covers modules one, two and part of three from the four modules in the virtual programme. There is a workbook that leads you through individual and team exercises to discover more about your service and current best practices to support young people to transition to adult care.

Phase 2 -(8 weeks) starts with a face-to-face (virtual) learning half-day event to share the phase one journey with the whole wave of teams. Plans to build an improvement journey grounded in practical application of Quality Improvement methods are developed during the session. The following weeks include completing module three and module four of the virtual learning programme.

Phase 3- (12 weeks) starts with a second face- to- face learning half- day event and is followed by monthly coaching calls. Improvement during the 12 weeks is based on testing, refining and beginning to embed the improvements you are making into clinical practice.

Phase 4- (on going) starts with a third face-to-face virtual learning half-day event where project posters present the work so far. There is ongoing virtual support from this point as teams further consolidate their improvements and transform Transition in their service.


PHASE 1
Complete modules 1,2 and part of 3 using work book and local regular meetings and discussions
PHASE 2
Starts with Learning Event 1 and planning
Includes rest of virtual course (completing modules 3 and 4)
one coaching call midway
PHASE 3
Starts with Learning Event 2 and planning
Includes up to 2 coaching calls and support for report writing/ poster presentation
PHASE 4
Starts with Learning Event 3 , a celebration and sharing of improvement so far
Plans made to sustain and continuously improve with on going support are shared

Introduction

The virtual materials have been put together to support you and your team in your improvement journey over the coming 9 months. We have put together in one place a combination of up-to-date evidence, guidance and experiences from clinicians and young people to give you and your team all you need to develop a clear aim, agree where improvements are needed and put into action an improvement journey that we will focus on together.

This workbook will support you during your improvement journey. We expect it will take you a total of 3-4 hours to go through each of the four virtual modules. We have organised the material to make it easy to access and given guidance when we think a paper is a must-read or an option. All the videos are relatively short and we indicate their length on the platform to help you plan your time. We encourage you to find a learning system that works for you but most importantly enables you and you team colleagues to share, compare thoughts and develop ideas.

We know that busy clinical teams can find it a challenge to carve out new time together to work on Quality Improvement. This is especially true in 2021/22 when we still have the uncertainty of the pandemic to deal with. We suggest you plan your learning approach. The workbook will guide each of you and if you do an exercise on your own, make notes and reflections and use this to share together so everyone's thoughts help to build the shared purpose and next steps. This sharing could be, for example, via WhatsApp, at an MDT meeting, or even virtually via MS teams.

The workbook is your record and roadmap and we have designed the course and workbook to clearly dovetail together.

With the pandemic still in our minds and on our 'radar', we have not prescribed how to blend personal learning and team learning but we expect you to work out how best to learn, share and act together. We accept this may need some modification if clinical pressures increase, but by agreeing your aim as a team, we know that together we can work to keep your team's improvement on track.

We have blended facts, research and insight alongside quality improvement approaches that we know work in complex systems such as the clinical environment in which you are working.

If new material or evidence comes along while we are working together, we will aim to signpost you to it and incorporate it into our programme.

Clinicians in the NHS have been working hard to bring greater clarity to the competences that enable the highest quality of care for young people as they grow up and move onto adult services for their care. In the appendix we have indicated how the programme aligns with these competences. Here is a summary of the relevance to each member of your improvement team.

Tier 1 colleagues will be involved in the provision of care but not clinically responsible or only working in children's services (assistants, housekeeping, admin for example). The course and the discussions you have as a team about what you are learning and doing will inform and enable them to develop competencies in transition.

Tier 2 colleagues are all the front line, directly working with and for children and young people. The course is specifically designed to cover most of these to a level that will give you a sound basis for ongoing capability building.

Tier 3 are those leading or designing services or indeed hoping to take on these roles and responsibilities in due course. The virtual materials give you significant material that will support the development of your Tier 3 competencies as well as enabling operational knowledge that is so vital for strategic planning.

We have created a check list / recording folder for each of the phases for you to complete so you can show how you have developed better understanding, started to adapt your approach and perhaps already developed new ways of working as a whole team to build the competences into your professional practice every day. This uses the Kirkpatrick approach to learning evaluation; levels 1 & 2 are your response and understanding of the learning material, level 3 is changing what you do and level 4 is the change in results/ outcomes/ services that occur as a consequence. We will ask you to give us examples of level 3 and level 4 as the months progress and your improvements start to embed into the team's ways of working and delivering care.

What are we trying to achieve?

1. Improvement in the quality of the care and service you provide for young people with diabetes transitioning to adult services.
2. Improvement in your 'team working' so that ongoing change and continuous improvements can become part of the way you work for the long term.

How would we all know this programme was a success?

1. Young people transitioning to adult services are more confident in their self-management and feel fully supported by the NHS services around them. Their experience is a positive one and their diabetes remains well controlled and their complications minimal in the short, medium and long term.
2. Young people tell us they feel able to access what they need and know where to ask for help when they need it. There is evidence that they do access what is on offer and that the support is what they need.

3. All young people transitioning to adult care have access to the same support and care and are encouraged to choose what they need when they need it.
4. Clinical teams caring for young people with diabetes are well organised, confident to make change and learn from data so as to continually improve the care they give and the outcomes for patients that they oversee.
5. Outcomes for young people with diabetes improve as measured by median HBa1c, complication incidence, time in range monitoring, self-management skills and the achievement of other life goals in spite of their diabetes.
6. Those who have taken the programme (you) are positive to others about its value and can use the skills learnt in other aspects of their clinical practice.

What will this programme provide?

1. **We know that time to learn is limited and people learn in different ways.**

We have therefore put together a carefully curated virtual course where all you need to know/ gain understanding of is in one place.

2. **We know that virtual learning can be tedious.**

We have made our programme easy to navigate. We have blended reading with short videos and insights from professionals, patients and parents. We have tried to make it digestible and usable for any clinician in a busy working week.

3. **We know that we all learn best when we put into practice new learning.**

We have staged the programme into four phases which we think will support learning/ doing/ reflecting (The Kolb Learning Cycle) and give you time to learn and consider what needs to change.

4. **We know that complex systems are difficult to improve.**

We have added in some material on quality improvement methods to give structure to your approach and to give you new skills that will be of benefit for the long term in your clinical career. You may be familiar with these but the material is there to refresh experienced team members and enable those new to these approaches to gain understanding and confidence in their use.

5. **We know that support from those who have done it before is invaluable, as is sharing ideas and challenges with those who are in the same situation**.

We have put a programme of virtual coaching and peer-to-peer collaboration around the more structured parts of the programme. This aims to provide a strong learning culture and speed up innovation and the spread of ideas between you and those working in the same field across the region

Our teaching style.

1. We are always open to new content that will make the programme even more effective. As more teams participate, we will be looking for teams to share their ideas, their challenges and their achievements so others can adapt or adopt them. As new evidence is published, we will be including it. As you create impact, we will be celebrating with you.
2. We have chosen the material we share to give you the perspective of the person, the professional, the service and its design as well as the context that is our NHS and that has ambitions for Transition care across all long-term conditions.
3. Our coaching is about listening, sharing insights, suggesting strategies and building a collaborative network of clinicians that will live beyond this programme.

Our purpose

1. We believe all clinicians want to deliver excellence to every person they connect with. We know that is hard to do every day for everyone.
2. Through our experience we know that a right balance of shared purpose, understanding of patients, professional teamwork and systems thinking can enable good care to become excellent. We want to support you in achieving excellence as soon as you are able.

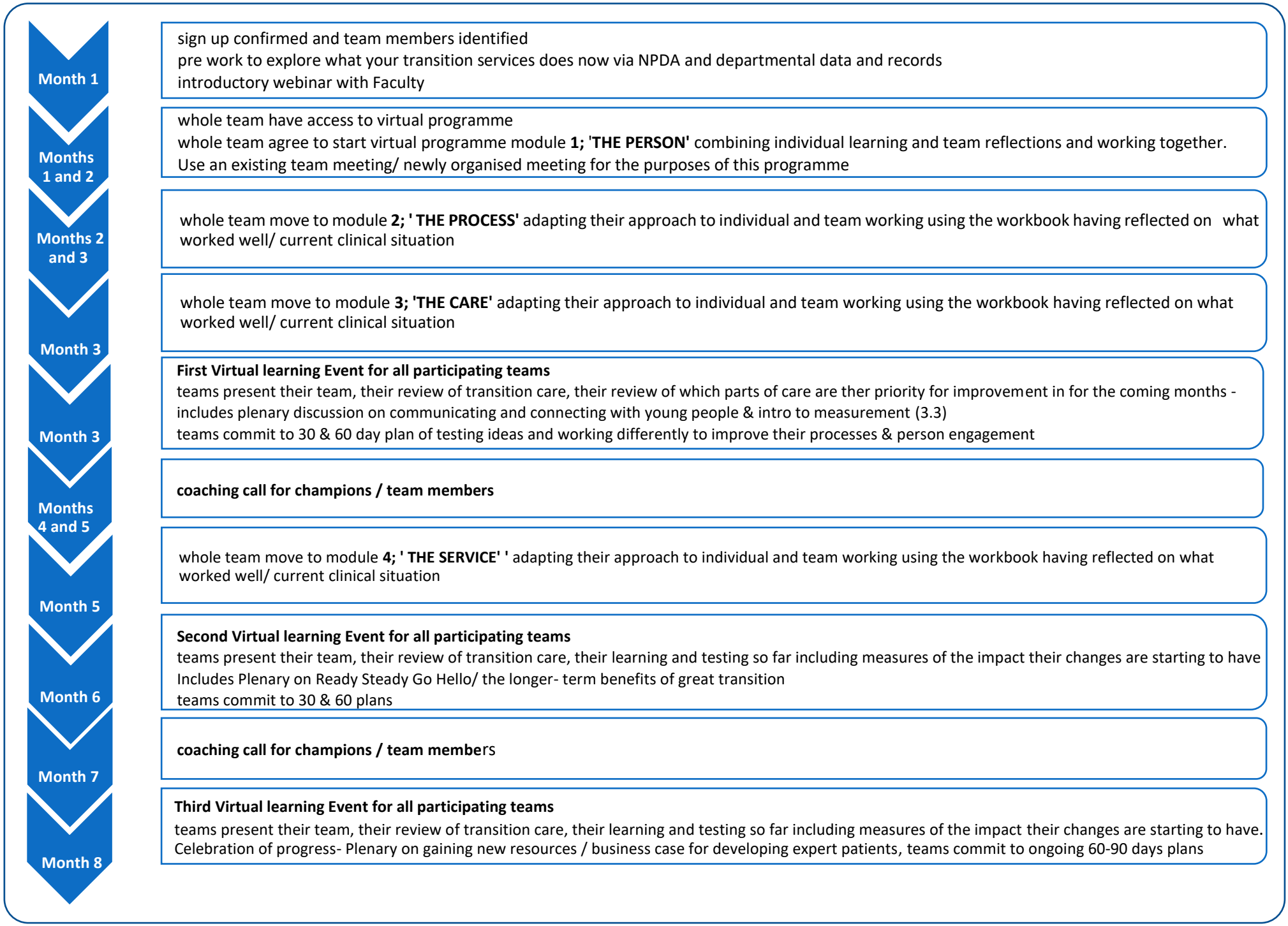
Your approach in the coming weeks.

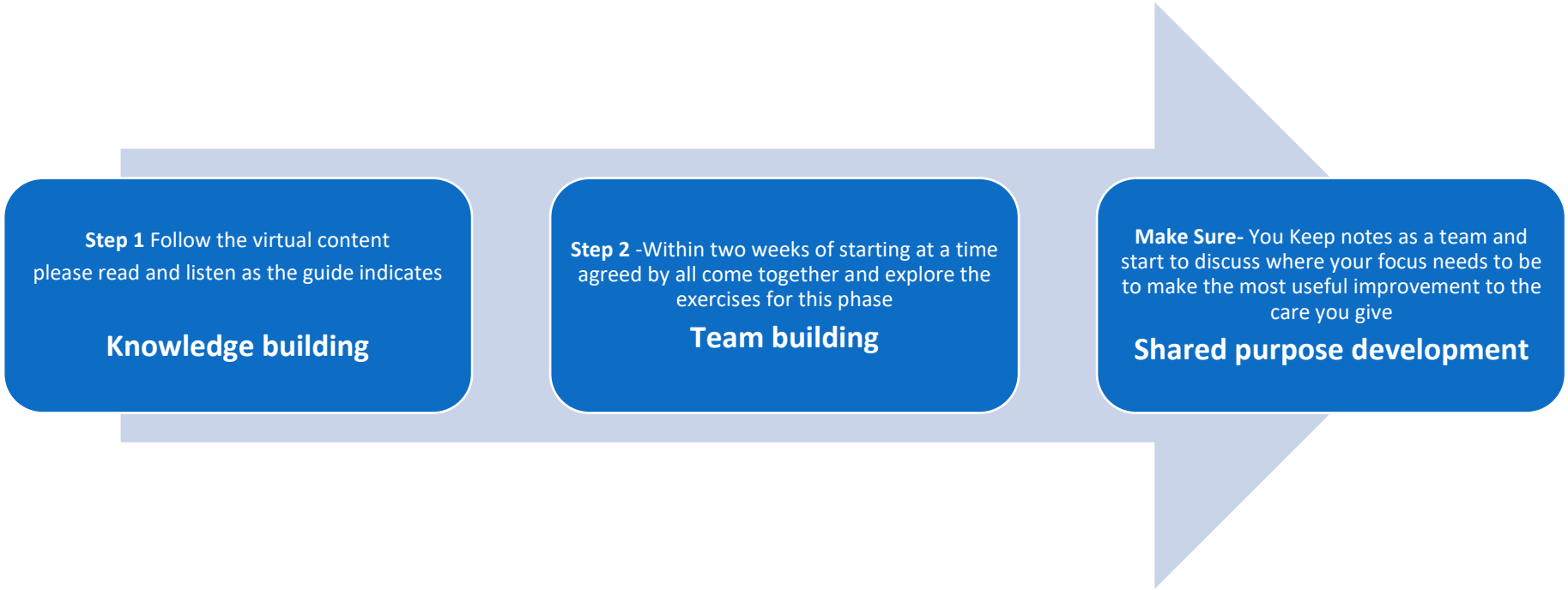
1. Do you have a team meeting each week/ fortnight? If you do then aim to take 15 minutes of that time to focus on this programme.
2. We suggest that, if it is practical, you endeavour to listen to each video as a team and then undertake the questions and considerations together as a team. If this is not possible, then watch the videos alone and share with your team colleagues your thoughts when you next meet using this work book to record your thoughts.
3. We will show you how to become an even more effective team as one of our first learning goals. This will support you at the same time as show you that it is OK to adapt what you do as you make progress.

Whole programme overview

1. We have **a one-hour introductory webinar** before you start the virtual learning to introduce the approach, the content and the journey you are on.

2. Virtual steps- equate to a **structured programme through each of four modules** each with four to five sub-modules. This includes the use of a work book and directed exercises for the whole team. We have included everything you need to have knowledge of as well as a variety of expert views. The module sections need to be opened in order. We have designed the approach to carefully take you on a planned journey and for this reason you will not be able to move on until each section in turn has been accessed.
3. We propose you take 3-4 weeks on each module, that is one sub-module each week to give time to read, reflect and share as a team. However, you can agree to go faster if you like but we suggest you decide this as a team.
4. When you have completed module one, two and part of module three you will have reviewed your service, reflected on some changes you want to make and be ready for our **first virtual collaborative learning event**. Here you will share your teams thinking so far and learn with others and from others to define the best next steps.
5. We have included some **MCQ style questions** at the end of each module to help with building your knowledge and confidence in providing excellent care.
6. Each scheduled **'Coaching hour' is an MS teams meeting for champions and others** keen to join to discuss their current issues with faculty and QI experts. These will further support progress between the collaborative learning half days. There are two coaching calls one in April and a second in July 2022
7. **Two further virtual collaborative learning events** are structured for teams present their progress, explore new QI methods and hear from experts in Transition care. The aim of the learning half days is to consolidate progress, inspire new thinking and to collaborate in a safe space to develop and plan actions for the coming phase. There are three collaborative learning events; April, June and September 2022


Month 1
sign up confirmed and team members identified
pre work to explore what your transition services does now via NPDA and departmental data and records
introductory webinar with Faculty
Months 1 and 2
whole team have access to virtual programme
whole team agree to start virtual programme module 1; 'THE PERSON' combining individual learning and team reflections and working together.
Use an existing team meeting/ newly organised meeting for the purposes of this programme
Months 2 and 3
whole team move to module 2; ' THE PROCESS' adapting their approach to individual and team working using the workbook having reflected on what worked well/ current clinical situation
Month 3
whole team move to module 3; 'THE CARE' adapting their approach to individual and team working using the workbook having reflected on what worked well/ current clinical situation
Month 3
First Virtual learning Event for all participating teams
teams present their team, their review of transition care, their review of which parts of care are ther priority for improvement in for the coming months - includes plenary discussion on communicating and connecting with young people & intro to measurement (3.3)
teams commit to 30 & 60 day plan of testing ideas and working differently to improve their processes & person engagement
Months 4 and 5
coaching call for champions / team members
Month 5
whole team move to module 4; ' THE SERVICE' ' adapting their approach to individual and team working using the workbook having reflected on what worked well/ current clinical situation
Month 6
Second Virtual learning Event for all participating teams
teams present their team, their review of transition care, their learning and testing so far including measures of the impact their changes are starting to have
Includes Plenary on Ready Steady Go Hello/ the longer- term benefits of great transition
teams commit to 30 & 60 plans
Month 7
coaching call for champions / team members
Month 8
Third Virtual learning Event for all participating teams
teams present their team, their review of transition care, their learning and testing so far including measures of the impact their changes are starting to have.
Celebration of progress- Plenary on gaining new resources / business case for developing expert patients, teams commit to ongoing 60-90 days plans



Phase 1- virtual learning modules 1,2 & 3 (up to but need not include 3.3 at this stage)

Virtual content should be accessed as work and other commitments enable each of you over the first two weeks of the programme. Take the following reflective exercises first on your own and then together, within your next team meeting.

Make sure everyone in your team knows how to access the virtual resource and also that week one's content is the objective, though if they want to look at other content, they are welcome to do so.

Module 1 is about The Person – **This module will underpin the development of competences 1,2,5,6,7,8,9,10,**

Focus for week 1

1.1 My teenage life with diabetes (video)

How has this story resonated with the patient stories you know from your own practice? Three questions to reflect on together or individually (then get together to discuss)

1. Is this a patient's experience you are familiar with? If yes, can you add anything?

2. If not, how might you organise your team to interact with patients and families to find out?

3. If these experiences are ones, you are familiar with, how has it influenced your service so far?

Team building questions- Could the approach you each personally took to the course and the conversation work be improved? If so, then try out a new approach in week 2. High performing teams always ask if their ways of working and meeting can be improved as well as the care they provide for patients.

Prompts for you to consider

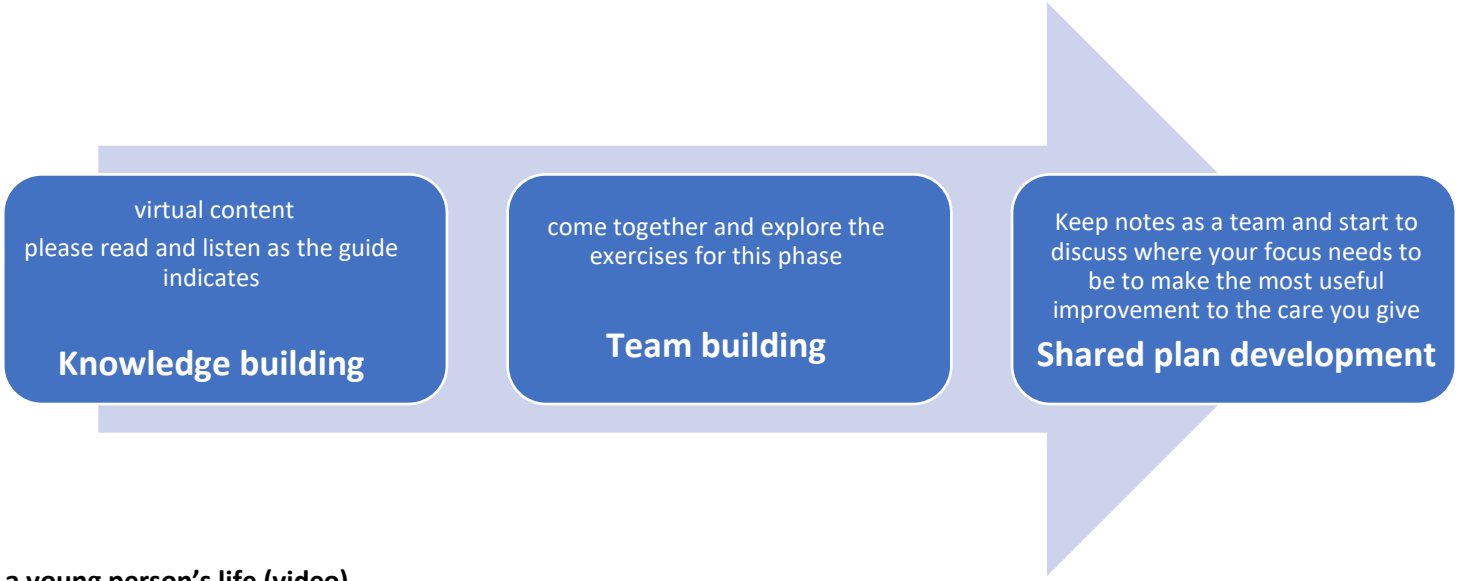
What worked?

What didn’t work?

What ideas do we have to improve things?

What actions shall we take?

Use this three-step reminder to check each week you have built knowledge, built your team and are sharing ideas, reflections and if you have concerns



Focus for week 2

1.2 Impact of diabetes on a young person's life (video)

Divide your group into two.

Half of the team read **Diabetes in Adolescence;** the other half read **Transition in University students.** When you get together, discuss what major problems these papers highlight and what they suggest could be improved.

Major challenges in Adolescence are

1.

2.

3.

4.

5.

Suggestions to improve this are

Major challenges at university (or College) are

1.

2.

3.

4.

5.

Suggestions to improve this are

Focus for Week 3

1.3 Engaging with young people as patients (video)

After you watched the video, please read the document Language Matters

Consider these questions together or individually (then get together to discuss)

1. Who were the adults that most engaged with you as a young person? What did they do or not do that made it easy to engage with them

2. If you were designing your services around building relationships with young adults rather than hospital systems, how would it be different?

3. How could you engage the young adults who use your service more with your service design?

4. What is the one thing your learned today that you didn't know before the presentation?

5. What is the one thing you will do differently are a result of today's learning?

Focus for week 4

We introduce you to some ways to think about system improvement.

1.4 The consequences of a disjointed service (video)

1.4 Mapping the process (video)

Print off in advance the Broken Process log and give each member of the team a copy to complete.

You don't need a lot of detail just answer the four questions for the process you have chosen.

Then look/ talk about the team view, have several of you described the same problem? If so, that would be a good one to look at in detail before next week's meeting.

If you all have different ones then vote on the one that is closest to improving things for you as staff. Improving your own work gives space to do more improvement!

Focus for week 5

We ask you to discover more about why this period of time in the life of a person with diabetes is so important to get right.

1.5 **Making a case for improvement (video**)

What contributes to poor outcomes?

1.

2.

Reading the article that looks at the economic cost of glycaemic control, consider the cost in your health system of the current situation and therefore how improving glycaemic control could make better use of resources as well as improve outcomes for the young people concerned.

Building your shared understanding ready for Module 2

This section is to help you prepare for our virtual learning half- day event and to support your team developing a short presentation to set the scene and explain what you plan to improve in the months ahead.

1.5 Clinical care is a risky business (video)

Action 1
Reflect on your examples when you have listened to the video.
What are the unreliable aspects of your system?
'Process map' the one that you all agree is important to understand better.
Be prepared to share this when we meet as a collaborative in a few weeks' time

Action 2
Down load from the National Audit the data about your young people in the transition group (we will take age 14-19 unless there is a reason for you to change this)
How many people do you care for in this group?
What proportion of all your patients are in the transition age group?
What gender are they?
What age distribution (how many are 14-15, 15-16 etc) are they
What HBA1c patterns?
What DNA rates?
What complications / evidence of screening abnormality already exists?

Action 3
Put this into some slides to help you share with the whole group in a few weeks' time (5 will be enough). Think about how you would make the case for improving your chosen area of care and who you would make the case to. A short summary sentence or two (elevator pitch) is a useful way to finish off your presentation and prepare you and anyone in your team to make the case whenever the opportunity comes along.

1.6 National Picture (articles)

A drive to Improve – please read one or two of these standards/ guidance documents.

Please consider the following questions together or individually (and then discuss when you get together).

Who might you connect with to make a case for improving transition in your service?

How would you justify why it matters?

Module 2 is about The Process - This module will underpin the development of competences 2,4,6,7,8,10,

Focus for week 1

2.1 Building trusting relationships with young people (video)

Before you watch the video please download and read the accompanying hand out 'Problem Free Talk'.

When you have watched the video reflect on these questions and share your thoughts with your team when you are next together.

1. What will you try to do differently next time you have a clinic conversation with a young person?

2. What would others notice about the different way you are working?

3. How might you keep this idea alive, as doing something unfamiliar can be hard to keep up when you get started?

4. What might get in the way of working like this and is there anything that would help, for example what could you do to prevent/ mitigate for / avoid this?

Focus for week 2

2.2 A parent's perspective (video)

Please watch the video and consider together or individually.

1. From what you heard please identify one thing you would consider changing in your practice now you have listened to the parent's perspective.

2. Share your ideas and thoughts as a team at your next meeting / via WhatsApp or in conversation

Focus for week 3

2.3 The wider context of our work on transition for young people with diabetes (video)

Please listen to Sue Humbold from West Yorkshire and Harrogate explain the new Integrated Care Systems that are coming into being and how they intend to join up the various organisations in healthcare, social care and communities to develop and deliver better care for children and young people.

Now consider together or individually:

1. You will have an Integrated Care System within which you are now placed. What is it called and check their web site for their aims and priorities. Also look at the geography of your Integrated Care System. Which other acute hospital are partners? How many young people are there in the population? Are there any specific characteristics of the young people that the Integrated Care System is emphasising that may be helpful in your work. For example, seeking to increase technology use but enable this for those with poor access to computers or phones. This would be useful to know and to connect with others so you can work on a solution together.

2. Sue mentions the phrase 'wicked problem' towards the end of her talk. This is an academic term for a problem that is a social or a cultural problem that is difficult or impossible to solve due to its complex and interactive nature. When you look into such a situation there are multiple reasons some of which are positively or negatively impacted by solving a part of them.

   Such an example would be designing an improved annual review clinic to avoid missing doing the right things but in the process of making a change in the clinic templates you overlook the need for young people to understand; why that clinic matters, feel comfortable with providing the necessary samples, have the right preparation for the conversations on blood glucose control etc. People turn up but its not able to achieve excellence as intended.

   This is where QI methods can help as they ask you to explore the various related aspects to ensure excellence is achieved.

   Take this example and draw a mind map of all the things that you have heard so far that will impact on a successful annual review and WHO you need to work with to make an improvement over the situation now.

Focus for week 4

2.3 **Reliability by design (video)** – this short video on quality improvement is to show how important it is to understand the steps in a work process. It is critical to make sure they work effectively and efficiently every time and that the whole team has worked to design them to have no gaps and to be best for everyone (patient, family, other stakeholders).

1. As a team think on one aspect of your transition clinic/ care and work out how you could do a swift audit of how reliable it is. We suggest a small sample say 5/10 cases in a clinic to give you an idea. If the steps are less than 90% reliable you will detect variation easily in such a small number unless the situation that day is very exceptional.

2. What did you find out? How can you all make it easy to do the right thing for the right patient every time?

Focus for week 5

2.5 Building a High-Performance Team (video)

Listen to the video and then reflect on your team meetings so far.

1. Download the check list/ table and review whether your team should adopt the checklist as is or with adaptions to build higher performing team

2. Agree on how your next meeting will try these changes and how you will decide whether they have had the impact you intend.

Building your shared understanding ready for module 3

Together consider

1. **How as a team and as individuals you need to test out ways to improve the building of a trusting relationship with young people and their families. List three ideas you are going to test out, decide which clinic, who and how you will consider the impact in the first instance**

What are we / am I going to do differently

1.

2.

3.

When?

Who?

How did it go?

Module 3 is about The Care - **This module will underpin the development of competences 3,5,6,11,15**

We will be using the 'Ready Steady Go Hello' approach as a tool to improve all aspects of Transition for young people with diabetes.

Focus for week 1

3.1 Ready Steady Go Hello (video)

Watch the video.

Download the Ready Steady Go Hello documents (Parent Plan, Getting ready questionnaire, Steady questionnaire, Go Questionnaire, Transition Plan)

Read the document Transition: Moving to Adult Care

1. Having reflected on the videos and the Ready Steady Go Hello documents how would this tool to further improve the care you provide for your young people in the transition group?

2. If you need to rethink the journey for your young people consider a process map, a fishbone analysis and talk to the young people themselves

Focus for week 2

3.2 Our joint clinical approach (video)

First read the short paper by Dr. Zaidi.

Then watch to the video.

1. Choose one item in your service that you and the team consider to be the most important part of the Transition service you provide needing to be improved. How would you start this improvement journey?

Focus for week 3

3.3 Managing problems in transition and unravelling complexity (video)

3.4 Fishbone diagram (video)

Listen to the video and use the fishbone tool to explore your chosen area of service that needs to be improved so it better aligns with best practice

1.Spend 30 minutes together with your team putting a fishbone diagram together for your chosen area for improvement.

Save this as it will be a useful diagram to include in discussions when we all meet as a collaborative in a few weeks. It can always be added to or modified as you learn more or consider more things need to be included.

Getting ready for the End of Phase 1 and our first Virtual Learning half-day

1. You have now completed 75% of the virtual material and explored various aspects of transition care together with your team.

2. We are about to have our first Virtual Collaborative Learning Event. Please work together now to prepare a short presentation on your team, your service, your analysis of the current transition service and what you want to focus on and why it is important to you and your patients.

3. We have a power-point template for you to use, insert photos of your service and your team, keep to the guidance with no more than 7 slides so as to fit into a 10-minute presentation to the whole group.

4. Use the material you have already collected for the exercises in module 1 and 2 on Building your Shared Understanding.

Use the High Performing Team Check List to guide your team meeting in the learning session and at your next team meeting

PHASE 2 including virtual learning 3.4 through to the end of module 4

Following the Collaborative virtual learning half- day

Module 3 – return to the virtual programme and module 3

Focus for week 4

3.4 Measurement in improvement (video)

This will add to the summary presented in the half-day event

1. Review your system for transition and what your focus for improvement it going to be.

2. How would you know a change you had made WAS an improvement?

   What would happen, what would not happen, how would it feel for the young person, what would they say, how would it feel for you what would you see/ observe, hear happening that is new and an improvement/

3. How could you measure this change had started to happen, was sustained and was actually delivering the improvement that was intended

4. How would you collect the data/ information to show this (ideally this should be real time and, in the workflow, not collected long afterwards)?

5. How could you display this data regularly to the whole team (every week/ fortnight)

Focus for week 5

3.5 Outcomes from improved transition (article)

Read the short paper on the success for patients with renal failure when clinicians changed and improved their transition service.

1. Can you think of any similar examples in your practice?

2. What useful learning can you derive from this case study that is applicable to your plans for your Diabetes services for young people?

Module 4 is about the Service - This module will underpin the development of competences 10,11,13,14

Focus for week 1

4.1 Quality Planning (video)

Reflect on the relationship between quality control, quality improvement and quality planning. Download and review the project charter form and share it with your other team members at your next meeting how you might complete as many of the sections as you can and what you might do about those you cannot complete right now. Each section can be quite a short description but it will help you communicate what, why and how to each other and those whose support you might seek or need.

1. Do you need to inform and involve some other stakeholders?

2. What might the barriers to change be? Who could help you understand these better and perhaps help you reduce them so they don't slow down progress in the coming months?

Focus for week 2

4.2 Developing a Business Case (article)

Read the 'cost of hospital treatment' report using the speedier reading tip below. This data derived from the NHS and is focused on adult diabetes. Of course, many of these patients will have developed diabetes while a child or young person.

Speedier reading tip. Read the abstract, read the material in highlighted boxes, charts and tables. The read the discussion and the conclusion and go back into the main paper if you have any questions or concerns about where the conclusions have come from.

1. Make notes on what the key benefits are to overall cost of higher quality care and better diabetes self-management for the NHS as a whole.

2. How could you accurately put this into two sentences to share with a senior leaders/ other stakeholder?

   For example, '7% of people in England have diabetes (type 1 and lifestyle related type 2). Yet on any one day some 18% of all hospital beds are occupied by someone with diabetes, this is a bit more than one in six of all beds. Improving the ability to self-manage as well as supporting/ providing the ongoing monitoring and expert advice from outpatient teams should reduce the need for admission in people with diabetes and could enable more available capacity for other NHS care.

4.2. Writing a business case

We have included a generic business case plan but also explore what your Trust requires and then use what you have considered so far on the programme and how it might start to fit the template.

Tip- keep it short, factual and try hard not to repeat items already mentioned!

Put your examples (brief description) for translating quality care into a business case for support and better resource use.

1.

2.

Your thoughts on what data you and your team might need for a fuller business case

1.

2.

Focus for week 3

4.3 SWITCH- when change is hard (video)

After you watched the video, download the ‘using switch guide’ and explore the ideas and the content that would describe your project to others so that they can be clearer about how the improvement journey for them would look and feel like so they can be more comfortable about how can contribute.

Focus for week 4

4.4 Patient feedback (video)

Having watched the video and downloaded the short guide, consider the approaches to patient feedback described.

1. Think of one thing you would like to improve in your service, how would you collect patient feedback to see if it’s working?

2. What method/s would you use (check the table in this section for ideas)?

3. What would be the most effective and or efficient way to routinely collect service feedback from your patients?

4. How would you work with your team to make sure this is not just collected but used all the time to inform ideas/ changes/adapting changes/ checking things are as reliable as you think they are/ need to be and this feeds into your QI work?

Preparing for PHASE 3 and accelerating your improvement ideas and testing

4.5 Benchmarking your service and setting aims and objectives for improvement (video)

Listen to the video and download the guide to using the Benchmarking Tools for Transition.

Reflect on the data needed/ available to you:

1. How would you collect and store this data?

2. How would you discuss and analyse the data?

3. Are there any other measures you would like to add? How would this help you with your improvement work?

Focus for week 5

4.6 The Wider Context of Adult Care (video)

Reflect on how you are working with your adult and primary care colleagues and how this might change to ensure transition is designed together and is delivered so whatever the circumstances for a young person with diabetes they are supported, informed, encouraged and advised in ways that mean their care and their outcome is of the highest possible quality (safe, timely effective, efficient, equitable and person centred).

Preparing for the second online Collaborative Learning Event

Check these items and we will provide a template for you to complete before we meet.

1. Review your analysis, your ideas, your tests, their impact and how you have measured whether a change has been an improvement
2. What data do you have (young person comments, some actual numerical changes, staff or family feedback?
3. Who have you connected with to help you with your work?
4. How have you engaged differently with young people?
5. What changes are you feeling positive about?
6. Are there any looming barriers we need to talk about together?

PHASE 3

Following the Collaborative Virtual learning Event 2

1. At your next team meeting create/ develop your existing 30 (end of July), 60 (end of August) and 90-day (getting ready for learning session 3) plan
2. Use the team planning guide to steer the meeting efficiently
3. Reflect on what you have heard from others and had insight into during learning session 2
4. What barriers seem the most pressing to deal with?
5. Do you need your in-house leadership team/ QI support team to give you some support?
6. Review SWITCH ideas; right people in the team, clear steps in the journey, plenty of feedback to tell you what is working and what need adjusting

How we will help you in Phase 3?

1. We will have two coaching calls - each a month apart to help you make progress in the presence of barriers or challenges
2. We will be available for support if you have questions or need a signpost to a resource that may help

3. We will provide examples of the end of programme posters from other similar collaboratives so you can develop your own material as best explains your journey and your progress

Working successfully as a team in Phase 3

1. Review the various tools you have used to explore your service.

2. Meet frequently, ideally weekly even if just for 15 minutes. Even if some cannot make it do meet and communicate the progress and next steps and plans to all.

3. Test your ideas and refer to the plans and ideas developed and the fishbone/ process maps etc. Make each step small enough to do in a week or less.
4. Use the measurement concepts/ measurement approaches **now** to understand if your tests of change are an improvement in the way you intend. If not, adapt the idea.
5. Use this data and patient experience feedback to review progress as often as you can.

6. Try to stick to the high performing team advice on roles, responsibilities and keeping to the shared purpose agreed by all. Keep meetings short and focused.
7. Bring any barriers or problems to the next meeting for consideration of what to do. Don't delay dealing with them, if you need senior help ask for it.

8. There will be *Muddle in the Middle* as the book Switch describes, but you will be able to manage through if you share early, think together and work with stakeholders if that seems useful.

9. Use the coaching calls to explore options and seek support or advice.

When we meet at the end of Phase 3 projects will be starting to show sustained progress even if some of the longer outcome changes are not yet evident. This will be what we celebrate when we meet at our last face to face session.

Appendix 1

SEAMLESS TRANSITION

Cross reference with NHS England Transition Service Competencies Framework

V is a video talk, R is a reading, Ex is a practical or reflective exercise, presentation is a QI slide set and filmed explanation

Module 1

Competency cross reference	**Week**	**modality**	**Activity**	**Step Number**	**Step Title**	**What? What is being covered conceptually by the step**
Ref tier	***week 1 The Person***		Activity title		My first step	
1, 2- tiers 1,2,3	My teenage life with diabetes	V	Patient story video	1.1	**Who am I**	the real-life concerns and hopes of a young person with diabetes
5 - tiers 1,2,3	Impact of diabetes on the life of a young person	V+ R+ex	Video by Dr Zaidi Clinical readings/ narrative summary	1.2	**Why does it matter**	medical literatures on the impact of poor/good transition on life chances /health/complications
11,8,9- tiers 1,2,	Engaging YP as patients (how it is different from adults)	V+ex	Communicating with young adults interview video	1.3	**How do I listen & learn**	the psychology of communication with young people
10 - tiers 1,2,3	The consequences of a disjointed service (separate systems)	V+ex	How bad can it be patient video	1.4	**When it goes wrong**	examples of problems/ poor experience/ complications etc
6 - general intro	Policy context – transition standards, national drive to improve	R+ex	The national guidance reading	1.6	**The Policy context**	summary narrative with links to full documents

Module 2

competency cross reference	Week 2	modality	Activity	Step Number	Step Title	What? What is being covered conceptually by the step
Ref tier	***week 2 The Process of Transition***					
2 - tier 1,2,3	Building trusting relationships with YP	V	Interview with Psychologist/ Youth Worker	2.1	**Communicating change**	empathy and understanding
7- tier 1,2	The parent's perspective	V	interview/ comments	2.2	**communication in practice**	empathy and understanding
10,11,14 -tier 1,2,3	The wider context for improving transition care	V	Health system leader presentation	2.3	**Wider system of care**	ICS principles, values and workstreams
6 QI to achieve this	Reliability by design	Presentation	The maths behind reliable care	2.4	**Personalising where it matters**	enabling high quality care
10 QI to achieve this	High performing teams	Presentation	High performing teams deliver change	2.5	**High performing teamwork**	coaching on team behaviours

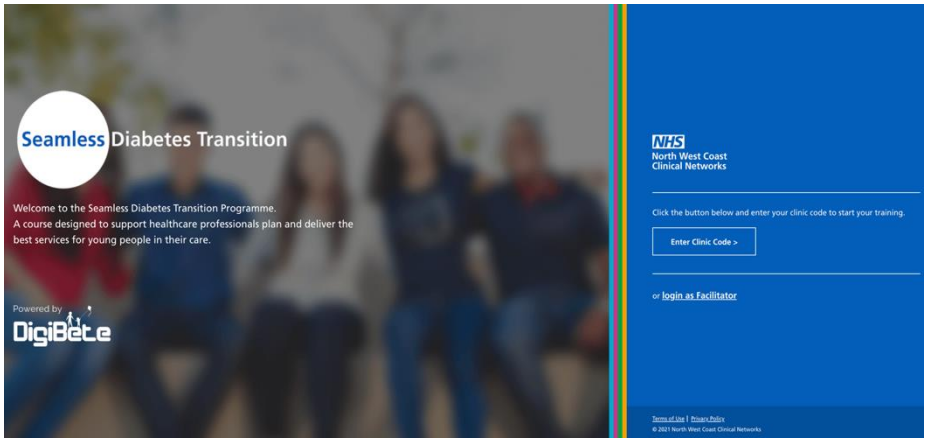
Module 3

competency cross reference	Week 3	modality	Activity	Step Number	Step Title	What? What is being covered conceptually by the step
Ref. tier	***Week 3 Co Producing care***					
6, 11 tier 1,2	Record keeping to support Transition Ready Steady Go Hello	V discussion	Example of how it works and why	3.1	**My journey**	examples of use of new approach
5- tier 1,2	Our Joint clinical approach	presentation	Hearing how it works from peers/ paediatrics and adults	3.2	**How the clinic work**	real life evidence in practice
3- tier 1,2,3	Managing problems	V discussion	Anticipating challenges using Fishbone analysis	3.3	**High Quality Care every time**	Learning from Peers via FAQs
6 QI to achieve this	Measurement in improvement	presentation	Measurement is key to improvement	3.4	**QI Tools for improvement**	Process/ structure/ outcomes
15 - example	Outcomes from improved transition	V presentation	Evidence of improved outcomes involvement of GP/ 1er care	3.5	**So why does this matter**	The importance of follow up

Module 4

competency cross reference	Week 4	modality	Activity	Step Number	Step Title	What? What is being covered conceptually by the step
Ref. tier	***Week 4 Developing a Sustainable Service***					
10, 14 - tier 1,2,3	Quality Planning	Presentation	Understanding Juran's Triangle	4.1	**Building Continuously Improving Systems**	QI tools
14- intro	Business Case development	R+ ex	Making the Business Case	4.2	**Business Case for Change**	assessing resource gaps
10 QI to achieve this	Switch- when change is hard	presentation	Making Change Achievable	4.3	**The Recipe for successful change**	practical way to enable change
11 tier 1,2,3	Patient Feedback	V	Learning from Patients	4.4	**Feedback Loops to sustain the gains**	The need to understand the patient experience
14,13 intro	Benchmarking your service	V/ R	Benchmarking our own Performance	4.5	**Audit, Improvement & Excellence**	The need to monitor and adjust
All	The wider context of young adult care	V	The wider context of this work	4.6	**Young adult services for 2020s**	The NHS

Appendix 2 REFERENCES and USEFUL READING or VIDEOS



Improvement Skills

https://www.health.org.uk/publications/the-habits-of-an-improver

https://www.health.org.uk/publications/quality-improvement-made-simple

https://www.health.org.uk/publications/reports/the-improvement-journey

Improvement Tools

https://www.weahsn.net/toolkits-and-resources/quality-improvement-tools-2/

https://www.england.nhs.uk/wp-content/uploads/2021/03/qsir-seven-steps-measurement-improvement.pdf

https://www.weahsn.net/toolkits-and-resources/quality-improvement-tools-2/measurement-for-improvement/

https://www.youtube.com/watch?v=2nhyyXRoqp0

https://www.youtube.com/watch?v=eYoJxjmv_QI

Diabetes in Children and Young People international reports and papers

https://hqlo.biomedcentral.com/articles/10.1186/s12955-020-01370-8

https://www.nuffieldtrust.org.uk/news-item/challenges-in-diabetes-care-for-young-people#slow-change-in-treatment-regimes

https://stateofchildhealth.rcpch.ac.uk/evidence/long-term-conditions/diabetes/

https://spectrum.diabetesjournals.org/content/33/3/255.full-text.pdf