NHS England

Always Events®

Toolkit

Improving Care Together

Institute *for* Healthcare Improvement

Always Events® Toolkit

First Published December 2016. Prepared by NHS England and NHS Improvement in collaboration with people with lived and learnt experience.

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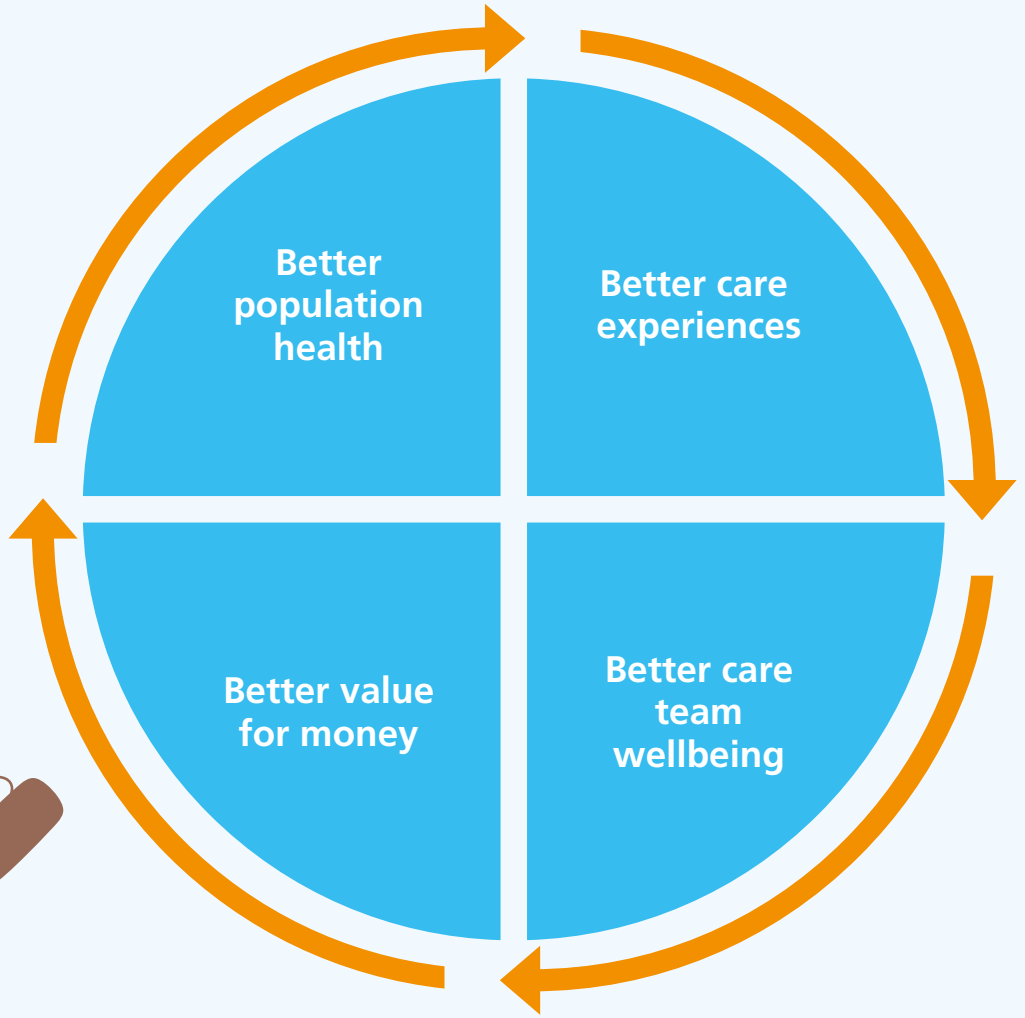
The NHS in England and Always Events

Providing high quality care is often described in terms of the quadruple aim:



The NHS in England and Always Events

If we want to improve healthcare we need to do this together with people who have lived experience and people who have learnt experience, co-producing the improvements in partnership.

"Co-production is defined as a way of working that **involves people who use health and care services, unpaid carers and communities in equal partnership**; and which engages groups of people **at the earliest stages of service design**, development and evaluation".

"Co-production acknowledges that **people with lived experience** of a particular condition are often **best placed to advise on what support and services will make a positive difference** to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective".

"A model for co-production: NHS England and NHS Improvement and Coalition for Personalised Care (formerly Coalition for Collaborative Care) (2020)"

The NHS in England and Always Events

Back in 2015 NHS England began looking for a methodology that would support the co-production of quality improvements. They came across the Always Events methodology and began working in collaboration with Picker Institute Europe and the Institute for Healthcare Improvement (IHI), to develop, implement and spread an approach to reliably integrate Always Events into delivering care in a range of settings. Working together, with three organisations, a programme was developed to test the Always Events framework in the English health care system and a toolkit was created and first published in December 2016.

The Always Events programme has continued to grow and evolve and there are now in excess of 150 provider organisations involved. Case studies of where the methodology has been used to co-produce improvements in a range of settings can be found here. The methodology has also been applied in Integrated Care Systems (ICSs). The programme has been evaluated a number of times, the last time being in 2021 and the reports can be found here.

Always Events are a co-produced quality improvement methodology which starts by understanding what really matters to people using services, their families and carers. The NHS Long Term Plan published in 2019 sets out the vision for the NHS for the next 10 years.

The plan identifies that personalised care will become business as usual across the health and care system and Universal Personalised Care confirms how we will do it.

Chapter 3 of the Long Term Plan sets out how people using services will have more control over their own health and states that the NHS needs a more fundamental shift in how we work alongside individuals to deliver more person-centred care, recognising the importance of 'what matters to someone' is not just 'what's the matter with someone'. What Matters To You? - (wmty.world)

The NHS in England and Always Events

Research published in 2021 into the accelerated changes within health and social care, which happened as a direct result of the COVID-19 (pandemic), identified 4 critical ingredients for change in implementing COVID-19 related beneficial changes and recovery. Co-production as default was the number one recommendation, that is working "with system partners to place co-production - including people with lived experience - at the centre of how the health and care system learns and embeds change from the response to COVID-19."

Critical ingredients for change	
1.	Co-Production as Default
2.	Prioritise reducing inequalities
3.	Leadership for innovation
4.	Innovation-Friendly Environment

This would mean that in local services, in Integrated Care Systems and nationally:

- We always start from what matters most to people who use and work in services
- We work with people who have relevant lived experience (patients, service users, unpaid carers and people in paid lived experience roles) and with staff, in everything we do to directly connect with multiple and diverse voices
- We build equal and reciprocal partnerships with people who have relevant lived experience and staff, including with those from disadvantaged and minority communities, from the very start of, and throughout, all our work

What are Always Events

Always Events were initially conceived in the US by the Picker Institute and are now led by the Institute for Healthcare Improvement (IHI). Always Events are a co-produced quality improvement methodology which can practically support systems to co-produce small changes which improve the experience of care for people using services.

Always Events are defined as those aspects of the care experience that should always occur when patients, people using services, their families and where applicable carers, interact with health care professionals and the health care delivery system.

IHI's Always Events Framework (see Figure 1 on page 10) provides a strategy to help health care providers, in partnership with people using services, families and carers to identify, develop, and achieve reliability and consistency in person- and family-centred care.

Always Events are a promise by health care providers to partner with people using services. They are the foundation for co-producing and implementing reliable care processes which will transform their experience of care. The goal of these processes is an "Always Experience". The Always Events methodology provides a practical framework to help achieve this goal

A key distinction of an Always Events is that people using services, families and carers have identified the event as fundamental to improving the experience of care.

A fundamental principle in co-producing Always Events is to move from "doing for patients" to "doing with patients"

For a short (5 minutes) video on Always Events click here.

Criteria for an Always Event

1. **Important:** people using services, their family members or unpaid carers, have identified the event as fundamental to improving their experience of care, and they predict that the event will have a meaningful impact when successfully implemented.

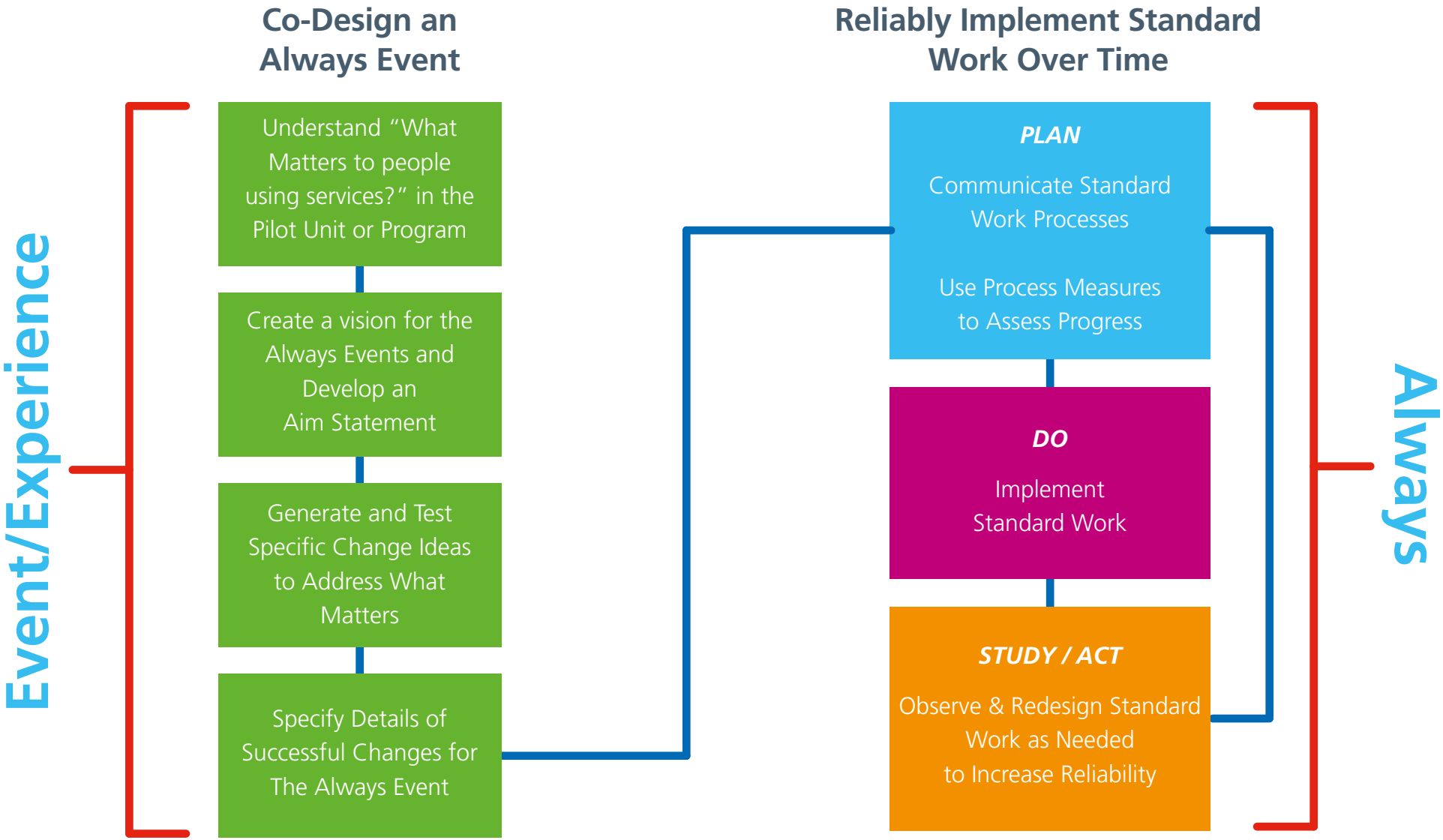
2. **Evidence-based:** The event is known to contribute to the optimal care of and respect for people using services, their family members and unpaid carers (either through research or quality improvement measurement over time).

3. **Measurable:** The event is specific enough that it is possible to determine whether or not the process or behaviours occur reliably. This requirement is necessary to ensure that Always Events are not merely aspirational, but also quantifiable.

4. **Affordable and Sustainable:** The event should be achievable and sustainable without substantial renovations, capital expenditures, or the purchase of new equipment or technology. This specification encourages organisations to focus on leveraging opportunities to improve the care experience through improvements in relationship-based care and in care processes.

Figure 1

IHI's Always Events Framework



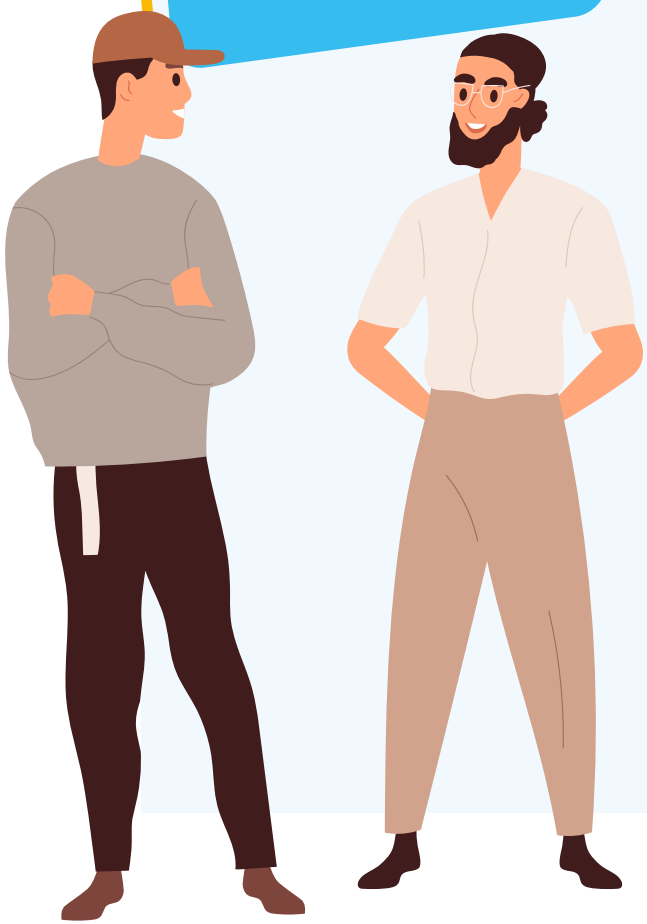
What are the benefits of co-producing improvements?

For people using services	For people providing services
Using my experience to improve services for everyone	As a team/organisation it shows that we care about what matters to people using our services and want to improve their experiences in partnership with them
I feel that my voice is being listened to, I add value, am respected and make a difference	Having people with lived and learnt experience working together to improve care means that the improvements are designed to work and are more likely to be sustained. It may take more time initially but will save time in the long run
Feedback given by people using services is informing improvements and brings about actionable change	When people co-produce improvements it connects them back to why they wanted to work in healthcare services. This results in improved experiences for people using services and also for those providing services
People using services are part of the co-production team and are able to improve experiences of care for people using services going forward	It provides an opportunity to join the national co-production community, share your learning and learn from others
People using services are able to suggest change ideas they feel will make a difference. The co-production team then together decide which to test and inform a better way of working	Always Events demonstrate that the organisation is committed to co-producing improvements, can be used as part of your evidence for CQC and contribute to a positive reputation. See Quality Improvement in Hospital Trusts; Sharing learning from trusts on a journey of QI
You are contributing to a better experience of care for other people using services	Using the Always Events methodology to co-produce improvements and reflect on the impact this has had for you and others can be a great example to use in your clinical revalidation submission or your development portfolio
In addition to your experiences of care you can draw on your other skills and strengths to support the improvement, this might be skills from a previous role you have had.	By engaging in the national programme your team and organisation will be able to apply for the Always Events recognition award to celebrate your co-production and the resulting improved experiences for people using services

Top Tips on How to Co-produce

- **Embrace** partnership and collaboration
- **Encourage** open and honest conversations with all involved
- **Be curious** and eager to **listen to experiences of care, whether "lived" or "learnt"**, about what matters to people and what their change ideas are
- **Don't assume** you know what people will say
- **Be "comfortable with the uncomfortable"** by not knowing the outcome at the start of the journey
- **Keep communicating & going** - co-producing and working differently isn't always easy but it's worth it! It's always better when **we improve together**
- **Know the 'group'** of people you want to engage with and **adjust 'how'** based on this information
- **Decide what good looks like** together. For example, face to face – brief questions work well with groups who are transient ie GP out of hours, emergency departments, Outpatients
- **Look at existing evidence** e.g. triangulate complaints/PALS/Friends and Family Test etc.
- **Use existing groups** – Schools/youth groups, parent toddler groups, faith groups, community groups (and go to them – piggyback) User groups, voluntary sector contacts, governors, Healthwatch, volunteers
- **Social media opportunities** - link to organisational communications teams
- **Be creative** in what works, it will be different for different groups
- **Be clear** about what's in it for everyone

Planning your Always Events



Four distinct phases of an Always Event

Set-up and Oversight of Always Events

Co-designing and Testing an Always Event

Reliably Implementing an Always Event

Sustaining and Spreading Always Events

Stage 1: Set up and Oversight

This stage includes engaging leaders; The most successful Always Events are where leaders at all levels are fully engaged with the programme and committed to co-producing improvements to improve the experience of care using quality improvement methodologies.

Top Tips for setting up and overseeing your Always Event

- Set a positive tone
- Maintain clarity of purpose
- Communicate and engage people across the organisation
- Create and maintain focus
- Reinforce a culture of continuous improvement and learning
- Actively role model and act as an advocate for co-production
- Attend some point of care meetings to listen about what matters and support the team
- Create the airspace for teams to co-produce
- Be a member of the team's support crew who can help remove any barriers
- Invite the team, including the lived experience partners to meetings and committees to showcase the work they are doing

Planning your Always Events

Leaders are essential in sustaining the focus and commitment to the initiative, providing the necessary resources and aligning the initiative with other organisational priorities.

Leaders need to ensure that appropriate resources are made available for a credible evaluation of the Always Events initiative.

To sustain the momentum and spread of Always Events, leaders should communicate the impact of the initiative and describe it in the context of achieving the broader goals of improving the experience of care with people using services, their families and carers.

Convening an oversight team;

This could be an existing team depending on individual organisational governance structures for example an experience or quality committee. The oversight team oversees all aspects of the Always Events initiative, including organisation-wide spread of Always Events, and helps coordinate and integrate all initiatives aimed at improving the experience of care with people using services. Communications and messaging about the Always Events is also a key priority for the oversight team.

Oversight Team - Roles and Responsibilities

Use this table to identify your team members, or write down who in your team will take on each responsibilty.

Role	Responsibilities	Team Member Name(s)
Executive leader	The role of the executive leader is to link the goals of the Always Events initiative to organisational strategic priorities, and to provide oversight and guidance to their teams' work. Depending on the size and organisational structures, executive leaders may include Chief Nursing Officers (CNOs), Directors of Nursing, Medical Directors, Quality Improvement or Programme Leaders.	
Day-to-day leader ie project lead	The day-to-day leader is responsible for coordinating the initiative activities and providing guidance, coaching, and support to the team in the pilot site. The day-to-day leader has dedicated time to support the Always Events initiative.	
Oversight team members	The oversight team includes organisational leaders, clinicians from a variety of professional disciplines, including Information Governance, and staff that represent a cross-section of key representatives and stakeholders committed to ensuring the success of efforts to improve the experience of care with people using services, their families and carers	
People with relevant lived experience	It's important that people have the relevant lived experience in that care environment as someone using the services or as a carer. You can use existing groups (see page 12). Ensure you have diverse voices in the team and that the people with lived experience represent the community, for example, age, race and ethnicity, or socioeconomic considerations. For further information see: • Our Approach I Co-Production Collective • Co-production in social care: What it is and how to do it - How to do co-production - Introduction (scie.org.uk) • Working in partnership with patients (arma.uk.net)	

Planning your Always Events

Opportunities for Improving the Experience of Care within your organisation

Efforts to create Always Events should address using opportunities for improving the experience of care for people using services, families and carers, that are aligned with organisational strategic goals. To better understand improvement opportunities, the organisation's oversight team should collect and review quantitative and qualitative data. Use the table on the next page for data collection and to summarise.

Activity	Responsibilities	Your observations
Review your organisation's strategic plan	• Why is improving experience of care a strategic priority? • What initiatives or other projects are already underway or planned? • How will Always Events help achieve your organisation's priorities and goals for improving the experience of care with people using services, families and carers? • Consider what resources and expertise in quality improvement and data analysis will support improvement efforts?	Key strategic priorities: 1. 2. 3. How do Always Events link to priorities?
Review existing experience data	• Experience of care data might include data from surveys (e.g. Friends and Family Test, inpatient survey data), written comments, feedback from standing Committee meetings, and complaints or PALs (Patient Advice and Liaison Service). • What do your sources of experience data tell you about the greatest opportunities to improve the experience of care? • Note any particular clinical sites, groups of people, or areas where there is significant opportunity for improvement.	Opportunities for improvement: 1. 2. 3. Specific programs, units, or patient populations where significant opportunities for improvement exist: 1. 2. 3.
Talk to people using services, families and carers	• Ask people what matters to them and how their experience of care could be improved. • Use interviews, or focus groups or ask for written feedback via posters in waiting rooms and clinics.	Major opportunities for improvement: 1. 2. 3.
Other	Select other methods to identify the greatest opportunities for improving the care experience.	List those identified here: 1. 2. 3.

Stage 1 Selecting a Pilot Site

Select one pilot site – for example a ward or department, clinical programme, or population to co-design your Always Event. This pilot site should address the area of focus for the Always Events noted on the previous page.

For example, if a main theme is "information during discharge", the pilot site should have enough discharges to do rapid-cycle testing of changes the team hopes will lead to improvement. It is vitally important to start small with this work and not try to take on more than one unit to begin.

This pilot site will co-design and test an Always Events, learning from iterative cycles of testing and redesign in order to successfully implement the Always Events.

Success in this initial site will help build motivation and organisational momentum for spread. Some organisations will want to select a pilot site or area based on the data review and others may select a pilot area with a leader that is particularly interested in or excited about the Always Events work.

Top Tips for selecting a Pilot Site

- A genuine desire to work in true partnership and co-produce improvements with people using services, families and carers – successful Always Events have been delivered in pilot sites who have volunteered to be a pilot site
- Have a champion staff member
- Capability to manage a quality improvement (QI) initiative
- Capacity to take on the improvement initiative

The Point of Care Team – (pilot site team)

Role	Responsibilities	Team Member Name(s)
Point-of-care team leader ie ward manager, operational lead	The day-to-day leader is responsible for coordinating the Always Events initiative activities and providing guidance, coaching, and support to the point-of-care team in the pilot site. The day-to-day leader has dedicated time to support the Always Events initiative. The day-to-day leader develops a process and structure for the initiative, such as a meeting schedule and division of responsibilities at various stages of the initiative.	
Point-of-care team members	The point-of-care team will co-produce and implement the Always Event. This point-of-care team includes clinicians and staff in different roles with a variety of perspectives and skills. The acquisition of new skills (such as testing new change ideas on a small scale) and behaviours (such as co-producing Always Events in partnership with lived experience is a critically important component for the successful implementation of an Always Events).	
People with lived experience	People with relevant lived experience are key members of the point-of-care improvement team to create the Always Events. Without them, improvement efforts — no matter how successfully implemented — may not accurately reflect what matters to people using services, their families and carers, when it comes to their desired care experience. In addition, people with lived experience provide a difference lens and their insights often lead to the most simple and powerful change ideas that are invaluable and critical to the ultimate success of the Always Events initiative.	

Stage 2 Co-designing an Always Event

Understand What Matters to people using services, families and carers in the Pilot Site

After the point-of-care team have been recruited, the first step in co-designing an Always Events is to deeply understand what matters to people using services, families and carers.

There are numerous options for learning about what really matters and it is about finding out what works for you and the people using services.

See the care experience with "new eyes." Bring people using and providing the service together to hear each other's perspectives, making sure everyone is comfortable and supported to share, listen, and learn together. It's really important to recognise that everyone wants to improve care experiences, whether using or providing services, and we listen, are curious and support each other so that we can improve together.

- Conduct observations of the processes to be improved (e.g. discharge preparations, communication, care planning) and/or use interviews, shadowing, focus groups and/or storytelling to gain a deeper understanding of actual care experiences. These can be captured in writing, through photographs or short films.
- Feedback can be sought using a variety of methods; face to face interviews; telephone calls; via social media; focus groups.
- Observe experiences first-hand by seeing the experience through the lens of the people using the service, families and carers.
- Use shadowing to conduct an in-depth observation.

See how Central London Community Healthcare overcame challenges to co-producing improvements in a community setting with people using their community nursing service.

Stage 2 Co-designing an Always Event

Listen carefully and actively; be careful to listen for new information, not just to confirm pre-existing beliefs. Be open minded and do not assume what people will say matters to them. Collect feedback on all experiences which will include elements that are good and those which are not so good.

For an example of how the Always Events methodology was used to co-produce improvements in an early intervention psychosis unit at Humber NHS Foundation Trust watch their short video here

Seeking out diverse voices:
It is important that when seeking feedback, consideration is given to ensuring those groups whose voices are seldom listened to are given the opportunity to participate and feedback.

Consideration should be given to different methodologies for engaging with diverse communities, groups of people with protected characteristics and others whose voices are seldom listened to such as sex workers, people experiencing homelessness and refugees and asylum seekers.

How can you listen to different experiences?

- Go to existing groups and places within the community
- Don't expect people to come to you, go to them, be curious and ask what matters to them

Co-designing your Vision and Aim Statement
Once you have a good understanding of what really matters to people in the pilot site and you have decided on what to focus on, work on co-producing the vision statement first.

The vision statement is an overarching vision of what you are hoping to achieve by working with people using services, families and carers to co-produce improvements - 'Something people will always experience'.

The vision statement should always be in the voice of the people using the service and be in language that they use. The lived experience partners will be invaluable in co-creating this. For example:

"I will always be supported when moving on in care"

Stage 2 Co-designing an Always Event

Example vision statements:

"I will always know what medication to take when I get home and if not who to contact for advice"

"I will always know how long I will be waiting in the main X-ray department"

Top Tips:

Consider whether people using services, families, carers and staff have worked together to agree the Always Event vision statement.

Is it in the voice of people using services e.g. I will always…?

Is it clear "what" will "Always" happen?

Once the vision statement has been co-produced the next step is to develop an aim statement together. The aim statement will set out:

- How
- What will be done
- By when (specific date)
- Where
- How will you know you've achieved what you set out to do (measurable goals)

Example aim statements:

"By October 2019 95% of people in main x-ray department will know how long they will be waiting"

"By December 2018, 95% of patients and/or relatives will have access to a patient handbook prior to admission to Marie Therese House"

Stage 2 Co-designing an Always Event

Does your aim statement include:

- A date by when the Event will happen?
- measurement to track your progress?
- A statement clarifying what will happen?
- Where the Event will take place?

Once the vision and aim statement have been co-produced, the team, including the lived experience partners, need to identify change ideas that they think will help achieve the aim statement and bring about sustained improvements in the experience of care. A variety of methods can be used to generate new approaches or changes to the way care is delivered.

- Adapt and adopt evidence-based practices and competencies (for example using teach-back to assess what patients understand after discharge teaching/advice/ conversations)
- Brainstorm new ideas and select favourite ones to test
- Use Experienced-Based Co-Design (EBCD) to co-design services. EBCD is defined by The King's Fund as "an approach that enables staff and patients (or other service users) to co-design services and/or care pathways, together in partnership." There is a free toolkit available for download from The King's Fund website.
- Consider using the 15 Steps challenge or Whose Shoes to better understand people's experiences

Testing change ideas

Always Events can consist of just one change idea, or there may be several to test. Agree together which ones to test. Once the change ideas have been agreed with the point-of-care team (which will include people with lived experience, families and carers) then small-scale tests of change need to be conducted in real work settings using PDSA (Plan Do Study Act) cycles.

Plan a test (Plan)

Try it (Do)

Observe the results (Study)

Make adjustments based on the results (Act)

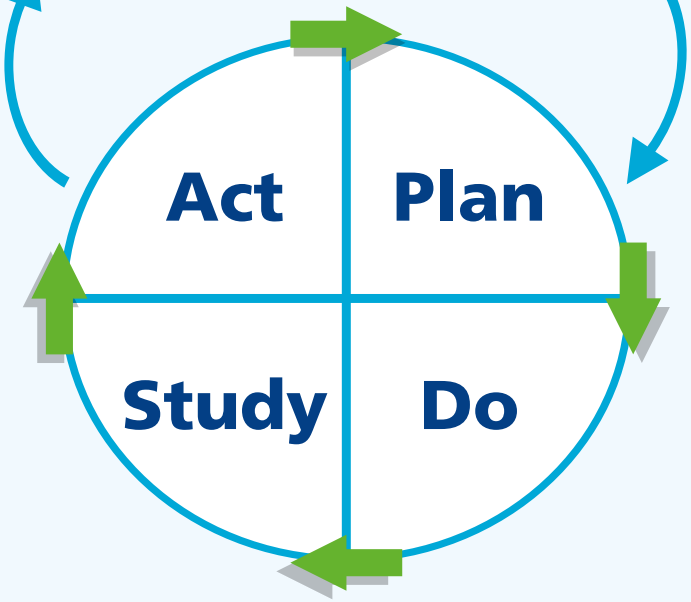
The cycle is then repeated until an improvement can be observed using simple measurements (see Stage 3).

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Stage 2 Co-designing an Always Event

Why test new ideas?

- To increase your belief that the change will result in improvement
- To decide which of several proposed changes will lead to the desired improvement – it might be a few!
- To evaluate how much improvement can be expected from the change
- To decide whether the proposed change will work in the actual work environment in the pilot unit or programme
- To decide which combinations of changes will have the desired effects on the important measures of quality
- To evaluate costs, impact, and possible unintended consequences from a proposed change
- To minimise resistance to implementing the successful changes

Stage 2 Co-designing an Always Event

Top tips for conducting PDSA Cycles

- Keep tests small; be specific.
  Note: Running multiple small tests of change simultaneously will accelerate learning and improvement.
- Make a prediction about what will happen if the tests succeed.
- Each test informs the next. Expand test conditions to determine whether a change will work in a variety of conditions or in different situations:
  - Times, such as day and night shifts, weekends, holidays
  - Staffing, such as when the unit is adequately staffed and when there are staffing issues
  - Challenges with different people, for example, those people whose first language is not English
  - Collect sufficient data to evaluate whether a test has promise, was successful, or needs adjustment. Compare data to findings to learn more and design future tests.
  - Continue PDSA cycles of learning and testing to improve process reliability.

Stage 2 Co-designing an Always Event

From your tests and the resulting measures you will determine whether the change idea is:

- Adopted as it's working
- Adapted as it appears to be working but would benefit from some tweaks
- Abandoned as it was a great idea but isn't creating the desired improvement

To watch a short video on conducting PDSA cycles click here.

A guide to using PDSA cycles can be found here.

Specify Details of Successful Changes for the Always Events
After the team have tested the change ideas and feel confident that the identified behaviours and/or improved processes results in improvements, the Always Events should be translated into standard work.

Don't aim for perfection in this first iteration of standard work because the team may learn adaptations that work better after it is tested.

The organisation should specify the details for implementing each of the successful change ideas that were tested (specific process improvements or behaviour changes) for the Always Events:

- Who will do it?
- What will they do?
- When will they do it?
- Where will they do it?
- How do they do it (include tools that are used)?
- How often will they do it?
- Why should they do it?

Stage 3 Reliably Implement an Always Event

Reliably implementing an Always Events means delivering on the "always" for everyone — in other words, the care experience we want all people to have every time. The process of making an Always Events reliable consists of a series of PDSA cycles.

Before conducting PDSA cycles to learn how to reliably implement an Always Events, design the Always Events with two principles in mind: simplification and standardisation.

Whenever possible, make it easy to do the right thing.

A reliable system makes use of human factors principles (e.g. build on existing habits, use checklists to avoid relying on memory, fool proof the process so that it is impossible to do the wrong thing, use standard protocols and training).

For example, your Always Events might entail integrating new questions or processes into a checklist or into the electronic medical record workflow. As you start to implement the Always Events, there will be a tendency to make the process more complex. The introduction of complexity is natural, but the goal of the team is to ensure simplicity and standardisation through the various iterations of testing. The staff in the point of care team will be really helpful in making sure this happens

Stage 3 Reliably Implement an Always Event

Communicate New Standard Work Processes to Clinicians and Staff

Identify all individuals that will be involved in the new processes. Once identified, all pilot unit or programme staff need to understand the new processes. Make sure that everyone is trained in new skills or competencies and in new process improvements. Use various communication mechanisms for this training (e.g. presentations, electronic information, check lists, and support tools). Consider using peers and champions to help communicate the purpose and details regarding the new work processes. With advice from your Information Governance team assess the need for, and if necessary, conduct a privacy impact assessment.

Measuring for Improvement

> "All improvement will require change, but not all change will result in improvement" G. Langley et al., The Improvement Guide, 1996

Start thinking about measurement early – measures need to link to the original vision and aim statement.

There are three types of measures...

Stage 3 Reliably Implement an Always Event

1. Outcome measures
Does the change have the predicted impact on people's experience?

Are we meeting our aim statement? Types of outcome measures can include:-

- Qualitative feedback such as from interviews or focus groups
- Existing experience measures and these can be national or local measures, e.g. Friends and Family Test, patient-reported experience measure
- Feedback tools specially designed for use with your Always Event
- Before and after photographs
- Films of people's experiences pre and post the Always Events

2. Process measures
Can we implement the change reliably, and consistently for every person, every time?

This is about understanding if the steps in the Always Event are being carried out as planned.

Potential Process measures include:-

- The logging of process reliability
- Ask 5 – ask 5 people using the service/families or carers if the new work process has happened – this will give an indication of process reliability

3. Balancing measures
Does the change have any unintended impacts?

This involves looking at the impact of the Always Event from a different perspective.

It is about understanding what is happening to the system as we improve the outcome.

Balancing measures could include the impact on staff workload or finances. Example balancing measures include:-

- Staff experience survey
- Staff workload measures e.g. time logging
- Recording readmission rates
- Checking budgets

Stage 3 Reliably Implement an Always Event

Questions to consider

Where will you collect the information from?

What will the improvement look like?

- Be realistic
- Be simplistic
- Qualitative v Quantative

Think - how are you going to collect data

What can help

Using flow charts to describe the new process and to check that the Always Event is embedded in practice

Use Statistical Process Control (SPC) charts to demonstrate change from the baseline

Sources of Help

- QI Team
- Analytics
- Experience Team

External resources

For a guide on making data count and plotting the dots see NHS England » Making data count

For an introduction to quality improvement see https://www.youtube.com/embed/CvHNOoYK_bU

To watch a short video on creating a measurement plan visit https://www.youtube.com/embed/spy_z83D1nc

See here for a guide on measuring for improvement.

Stage 4 Spreading Always Event

Sustaining Always Events

The work does not end once the process has been reliably implemented in the pilot unit. The change needs to be transferred from an improvement project to "the way we do things". Sustaining Always Events requires thoughtful planning in three key areas:

1. **Ownership**: During implementation, the work should be transferred from an ad hoc improvement team to a permanent process owner. The process should be written into job descriptions and formalised as a role. Consider what would happen if the improvement team leader left tomorrow. Would the process continue to be sustained? If not, what would make the work more permanent?

> "Hasn't it always been like this? Was there really a time they couldn't have access to their preferred method of communicating with family and people important to them when they wanted it?"
> Amber – New Healthcare Assistant

Quote from a new Healthcare Assistant at Humber NHS Foundation Trust after they had completed their Always Event around improving communication Picker-NHS-Humber-CS-Web.pdf

Stage 4 Spreading Always Event

2. **Data and measurement**: Outcome measures need to be reported and tracked at the hospital or system level as well as at the unit level in order to provide leaders, unit managers, and frontline staff with regular feedback on their progress. Thinking through the data you want to collect and how you will monitor this data is an important piece of sustainability. Identify when and how you will intervene if process reliability begins to if process reliability begins to decrease.

3. **Develop structures to "hardwire" the change**: What infrastructure is needed to make the change permanent? Once you have high confidence in the change, you will need different infrastructure and support. This usually requires revisions to written policies, training, electronic work aids in the electronic medical record, equipment, and other aspects of the organisation's infrastructure that were not engaged in the testing phase. See Herefordshire Community NHS Trust for an example of how they built the Always Event into their electronic health record

The oversight team should be thinking about spread at the start of the Always Events initiative, designing a plan that answers the following questions:

1. What is full scale? If successful, what's the total population or total number of units (wards/departments/teams) that the Always Events will be spread to?

   Example: All people discharged from the hospital, which is an average total of 45 patients per day.

2. Where will you start? This is outlined in the initial steps in much more detail, but it is important to know where you plan to start the Always Events and how quickly it will take to move from testing to implementation.

   Example: Ward 5B (the pilot unit) will take six months to co-design, test, and implement the Always Events.

3. What unit(s) or population(s) will implement the Always Events after the pilot unit? How long will it take to go to full scale?

   Example: Units 5A and 5C will adopt the Always Events next. Based on pilot testing in Unit 5B, this should only take three months in 5A and four months in 5C. We will then spread to all of Units 1 through 4 (where relevant).

Stage 4 Spreading Always Event

When considering spreading an Always Events, it is important to be thoughtful about the process of spread and gaining buy-in from other units, including considering how to customise the changes to the unique needs of different units and how to use pilot sites as messengers and champions for change across the organisation. The evidence from the original pilot site will be shared with new units, and they may want to adapt the changes in their care environment based on what matters to people there. For example, contact cards were developed with people with learning disabilities so that they knew how to contact the team when they moved on in care. When this was spread to another area the people using services asked that this was given out when someone enters the service so they know who to contact throughout their time and on discharge as well.

IHI's "Seven Spreadly Sins" provides some practical tips for avoiding some common pitfalls during spread

Stage 4 Spreading Always Event

Things to Consider:

Have you developed a communications plan, including social media, Trust publications and existing communications e.g. Feedback Friday.

Have you plans to showcase your Always Event at your next Quality Improvement sharing the learning event in partnership with the lived experience partners who have been co-producing the Always Event?

How can you share with other teams at local Leadership Meetings?

Develop a short film to showcase the Always Event and enable peer to peer sharing. Films can powerfully showcase the experience of co-producing an Always Event for people with lived experience and the staff and the improved experiences for everyone.

They can become a powerful "advert" within your organisation and can motivate and inspire other teams to co-produce their own Always Event.

Write a case study to share your Always Event.

Are Always Events included in your organisational quality improvement methodological approach? Does every quality improvement ask the question 'how do we know this matters to people using services'?

Always Events Recognition Award Criteria

Background

Always Events, initially conceived in the US by the Picker institute and now a registered trademark with the Institute for Healthcare Improvement, are defined as those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health care delivery system.

1. **Important:** people using services, their family members or unpaid carers, have identified the event as fundamental to improving their experience of care, and they predict that the event will have a meaningful impact when successfully implemented.

2. **Evidence-based:** The event is known to contribute to the optimal care of and respect for people using services, their family members and unpaid carers (either through research or quality improvement measurement over time).

3. **Measurable:** The event is specific enough that it is possible to determine whether or not the process or behaviours occur reliably. This requirement is necessary to ensure that Always Events are not merely aspirational, but also quantifiable.

4. **Affordable and Sustainable:** The event should be achievable and sustainable without substantial renovations, capital expenditures, or the purchase of new equipment or technology. This specification encourages organisations to focus on leveraging opportunities to improve the care experience through improvements in relationship-based care and in care processes.

Always Events Recognition Award Criteria

There are 3 levels of the recognition award which organisations can apply for;

Level 1	Level 2	Level 3
You must be able to demonstrate that one Always Event:	You must be able to demonstrate that:	You must be able to demonstrate that:
• Has been co-produced with people using services, and where appropriate their families and carers • Is focused on what matters to people using the service • Has resulted in sustained improvements (using measures) • Will continue to be sustained and spread • You will also be asked to submit evidence of sustained improvement every 12 months	• You have sustained your first Always Event for 12 months • Have achieved on a minimum of 2 further Always Events	• You have sustained 5 level 1 Always Events • Always Events and Co-production are embedded into your organisation's strategy and culture • Always Events are recognised as a coproduction method and this is visible for instance on the website; posters; other forms of communication.

Further Information and Resources

Case Studies of Always Events in children's services;

Wirral Community Healthcare Trust – Working in partnership with families to develop a coordinated plan of care for their child

Manchester University NHS Foundation Trust – Implementing an Always Event in a children's ward to improve the communication needs of patients and their families

Case Studies of Always Events in community settings

Herefordshire Community NHS Trust – Developing an Always Event to Improve Experiences of End of Life Care

Central London Community Healthcare Trust - Supporting patients to be involved in planning their care

Case Studies of Always Events in Learning Disability Settings

Lancashire Care NHS Foundation Trust - Improving the transitions of care for people using learning disability services

Humber Teaching NHS Foundation Trust – Working with service users to improve inpatient learning disability services

Case Studies of Always Events in acute settings

Blackpool Teaching Hospitals NHS Foundation Trust – The importance of engaging patients in Always Events

Mid-Yorkshire NHS Trust – Improving patients experiences using the call button

Case study of an Always Events in an outpatient setting

Warrington and Halton Teaching Hospitals NHS Foundation trust – Improving patients waiting times in radiology

Case Study of an Always Event in a rehabilitation unit

Royal Cornwall Hospitals NHS Trust – co-producing better information about a rehabilitation unit

Other Resources and Information

Arthritis and Musculoskeletal Alliance (ARMA) "Working in partnership with patients" Working in partnership with patients (arma.uk.net)

Coalition for personalised Care (2021) "A Co-production model" A Co-Production Model – Coalition for Personalised Care

Co-production Collective (2010) "What does Co-Production mean to us" Our Approach | Co-Production Collective

CQC (2018) Quality improvement in hospital trusts: Sharing learning from trusts on a journey of QI. Available at: https://www.cqc.org.uk/publications/evaluation/quality-improvement-hospital-trusts-sharing-learning-trusts-journey-qi

Frontier Economics (2021) "Health and social care innovation, research and collaboration in response to Covid-19" Health and social care innovation, research and collaboration in response to Covid-19 | Frontier Economics (frontier-economics.com)

Institute for Healthcare Improvement (IHI) Always Events | IHI - Institute for Healthcare Improvement

Institute for Healthcare Improvement (IHI) Patient Care Observation Exercise Patient Care Experience Observation Exercise | IHI - Institute for Healthcare Improvement
Institute for Healthcare Improvement "How can shadowing make care more patient-centred" How Can Shadowing Make Care More Patient-Centred? | IHI - Institute for Healthcare Improvement

Lee H, McNally D (2019) Blog: "Putting Always Events at the centre of patient centred care." Available at Putting Always Events at the Centre of Patient-Centred Care (ihi.org)

Marshall, Claire; Zambeaux, Angela; Ainley, Esther; McNally, David; King, Jenny Miss; Wolfenden, Lorraine; and Lee, Helen (2019) "NHS England Always Events program: Developing a national model for co-production," Patient Experience Journal: Vol. 6 : Iss.1, Article 19. Available at: https://pxjournal.org/journal/vol6/iss1/

May, Ruth (2019) Blog; "We all have the chance to make someone's day".
NHS (2019) Long Term Plan NHS Long Term Plan » Online version of the NHS Long Term Plan

NHS England and Improvement "Delivering Universal Personalised Care" NHS England » Delivering universal personalised care

NHS England and Improvement; "Improvement Fundamentals in a day: PDSA Cycles" YouTube

NHS England and Improvement; Improvement Fundamentals in a day: Introduction to Quality Improvement YouTube

Other Resources and Information

NHS England and Improvement; Improvement fundamentals in a day: Creating a measurement plan YouTube

NHS England and Improvement: Online library of Quality, Service Improvement and Redesign tools;

Plan, Do, Study, Act (PDSA) cycles and the model for improvement Layout 1 (england.nhs.uk)

NHS England and Improvement Online library of Quality, Service Improvement and Redesign tools - Seven steps to measurement for improvement Layout 1 (england.nhs.uk)

NHS England – 15 Steps Challenge NHS England » 15 Steps Challenge

NHS England (2018) "Always Events" Always Events - YouTube

NHS England (2021) "Making Data Count" NHS England » Making data count

Picker Institute Europe: Esther Ainley, Cara Witwicki and Jenny King (2021) "Evaluation of the Always Events Programme" P-101582_Always-Event-Evaluation_Executive-Summary.pdf (picker.org)

Point of Care Foundation "Whose Shoes?" Whose shoes? - Point of Care Foundation

Social Care Institute for Excellence (2013) Co-production in social care: What it is and how to do it - How to do co-production - Introduction (scie.org.uk)

The Kings Fund – The Experience-Based Co-design Toolkit – now available at EBCD: Experience-based co-design toolkit - Point of Care Foundation

Written by two of the 'learnt' experience people on the MSK Lived Experience Group Blog: Why do we fear coproducing health with patients?

NHS England

Always Events®

Toolkit

Improving Care Together

Institute for Healthcare Improvement