# Experience of Quality Improvement Leadership

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# Wessex Acute Frailty Audit:

- Why did we do  a Wessex wide audit?
- Key themes we focused on
- What did we do and how did we do it?
- How will we use the results?
- What are we doing next as a region?



Wessex Academic Health Science Network

Wessex
Academic Health
Science Network


- **Improve** people's health, **achieve excellence** in healthcare and **boost** innovation and growth in our region's life sciences and healthcare sector.
- Connect academics, NHS, industry and others to **bring fresh energy** to old problems, **inspired thinking** to new ones and to **spread innovation** and best practice.

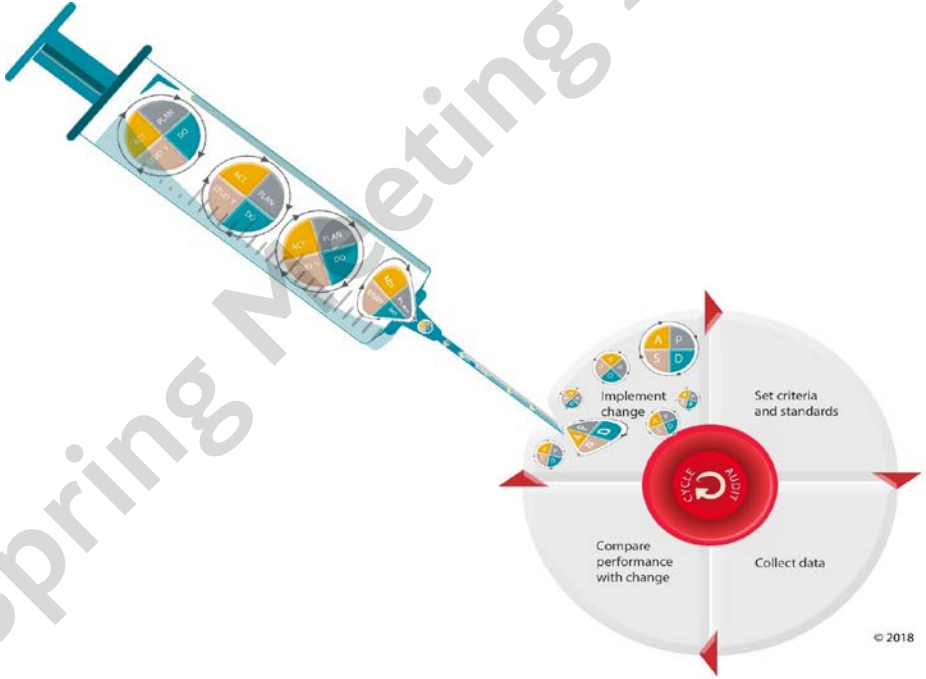
# Why audit?

**People living with frailty are at risk in hospital.**

**We don't always spot them when they arrive so we don't always give them the care they need!**

- To design and pilot a new frailty audit for acute hospital settings
- To use quality Improvement methodology to design & implement
- To share findings from the audit and encourage national take up
- To drive up the standards of care for those at risk of, or living with frailty

# Based on research: *Injecting Q.I into Audit*

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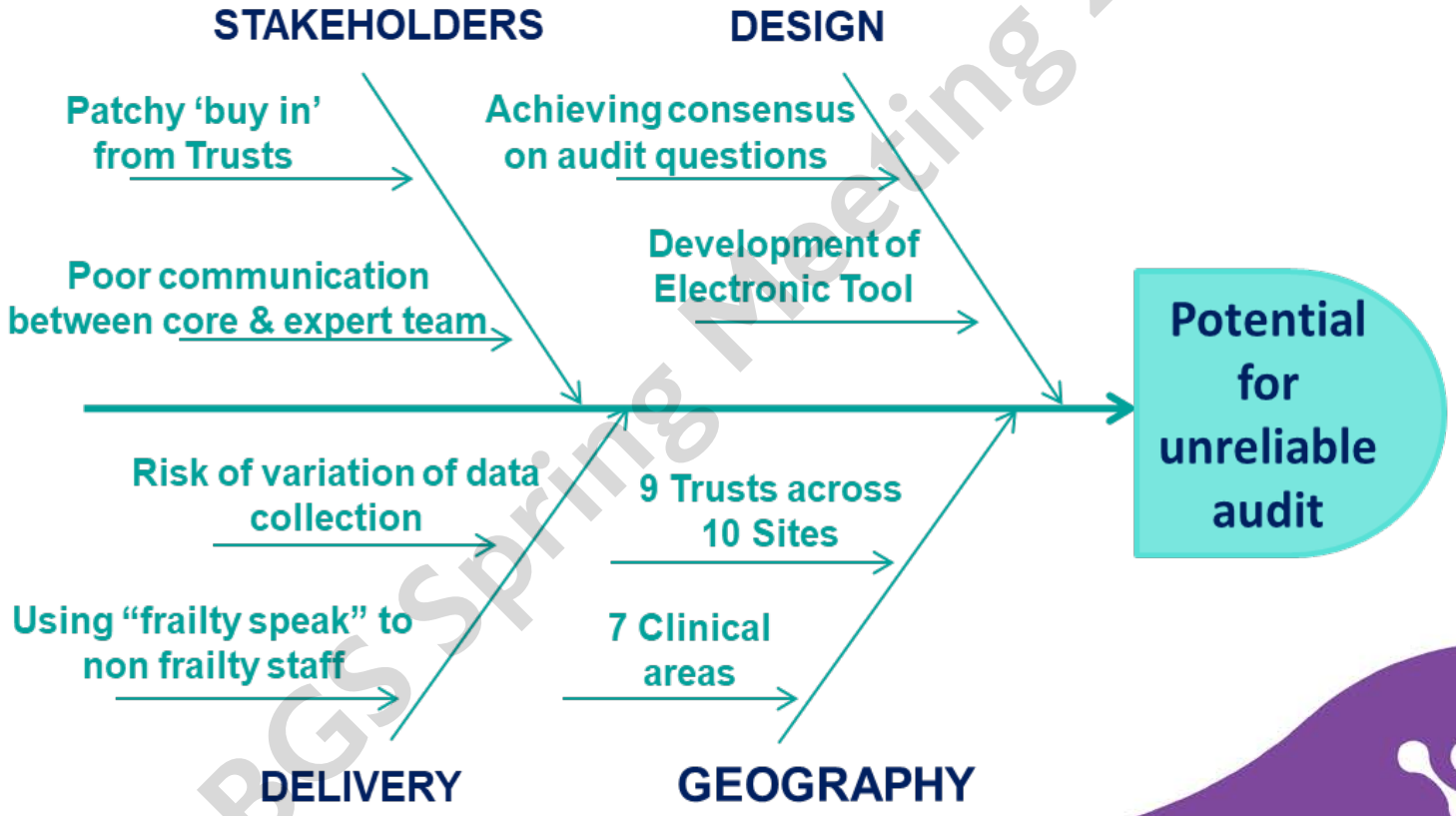
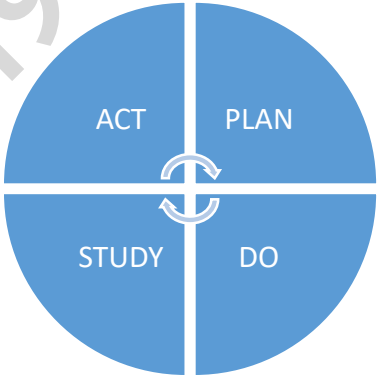
# Using a Fishbone diagram to understand risk



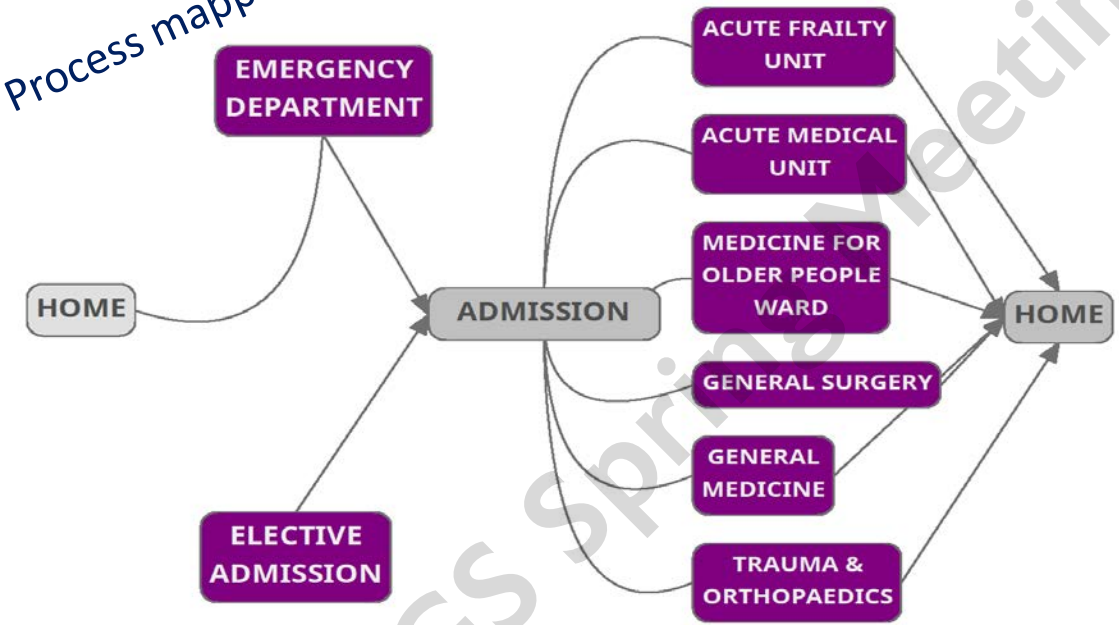
# Plan Do Study Act Cycles




- Designing Audit Questions
- Testing Audit Questions across two sites
- Testing electronic tool in three clinical areas of one hospital
- Trained Data collectors
- Ensuring good communication between the expert group, data collectors, Trust clinical leads and data collectors

# What did we want to know?

Process mapping




# Workshop Outcome – action for change

- ***Identification and screening:***
  - To have consistent screening on admission across all settings
  - All discharge letters to include Clinical Frailty Score (CFS)
  - Clinicians have access to community records to improve quality of care

- ***Management and Discharge:***
  - Involve individuals and those close to them in decision making and management
  - Electronic version of Comprehensive Geriatric Assessment (CGA)

- ***Workforce and training:***
  - Frailty awareness and training for all – Board to Porter
  - Mandatory, tiered training & competencies to meet individual staff needs & their role
  - Work with Universities in delivering frailty in undergraduate training

# What next as a region?

- Regionally focused Quality Improvement e.g. Frailty training
- Bespoke Quality Improvement projects for individual trusts
- Adapt for community setting
- Service user involvement

# Acknowledgements


- Dorset County Hospital NHS FT
- Poole Hospital NHS FT
- The Royal Bournemouth and Christchurch NHS FT
- Salisbury NHS FT
- University Hospital Southampton NHS FT
- Portsmouth Hospital NHS Trust
- Hampshire Hospitals NHS FT (Winchester and Basingstoke)
- Lymington New Forest Hospital (Southern Health NHS FT)
- Isle of Wight NHS Trust

# Background

## Capacity & Capability

## - Making better use of specialist Parkinson's clinics



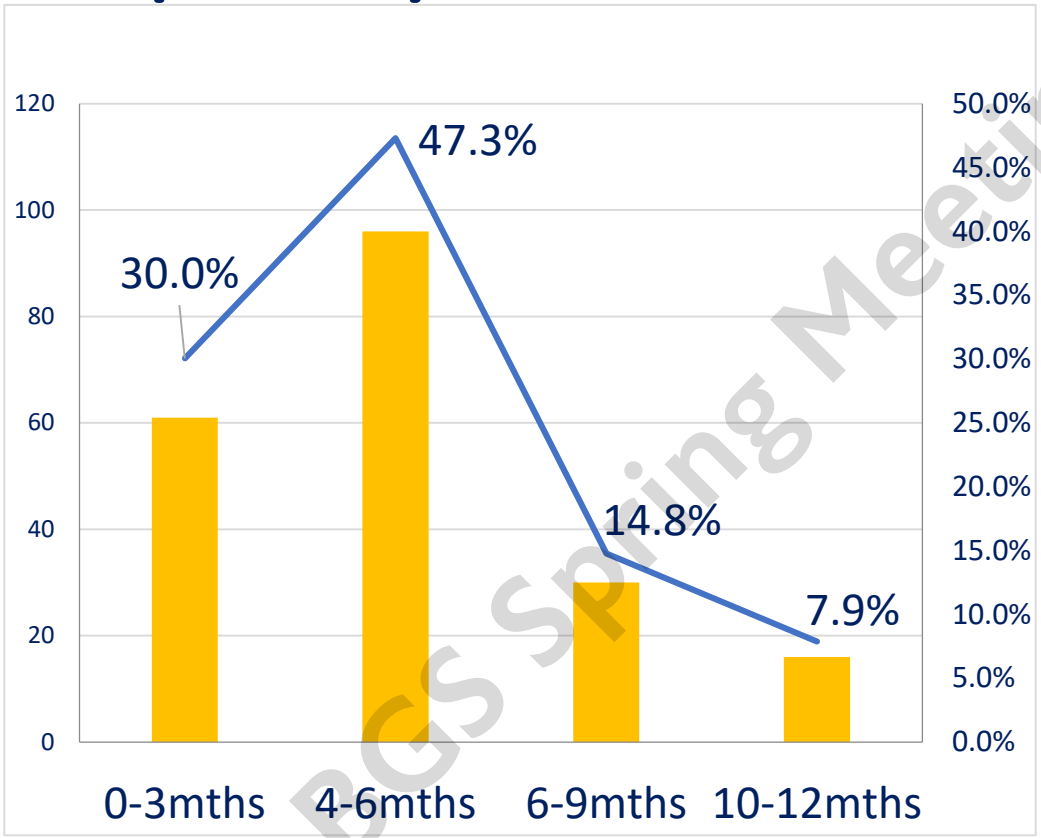
Problem

- Parkinson's clinic appointments are full
- New patients are waiting more than 6 weeks for an appointment
- Consultants and specialist nurses wanted more clinics
- Majority of patients attended clinic more than 6 monthly
- Patients are routinely followed up, based on timeframe, not need.

# What did we want to know?

- How frequent where patients being seen in clinic
    - Every 3, 6, 9 or 12months
- How many appointments were available per year
- Based on the frequency, how many appointments does this require?

# Frequency of attendance




Yearly Number of ***required*** appts
**679**

Yearly ***available*** clinic appts
**441**

# Aim

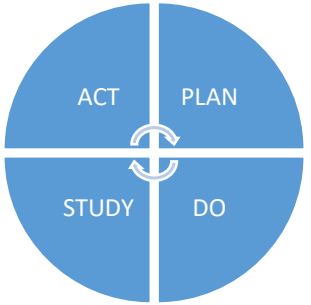
For people with Parkinson's to receive their review appointment based on clinical need.

i.e **40% of people who attend clinic in to receive a follow up appointment every 6-12 months.**

*NICE guidelines* state People with Parkinsons to be reviewed yearly or more often depending on need.

# Plan Do Study Act Cycles

- Manually collect & understand clinic capacity & frequency of attendance
- Update service specification to support actions required to meet clinic needs.
- Involve patient in ideas for change
- Identify and arrange people for follow up appointments at 6-12 months
- Record frequency people attended clinic.



# Involving patients in QI

Find them and
go to them


# Involving patients in QI

**Patient Comments**

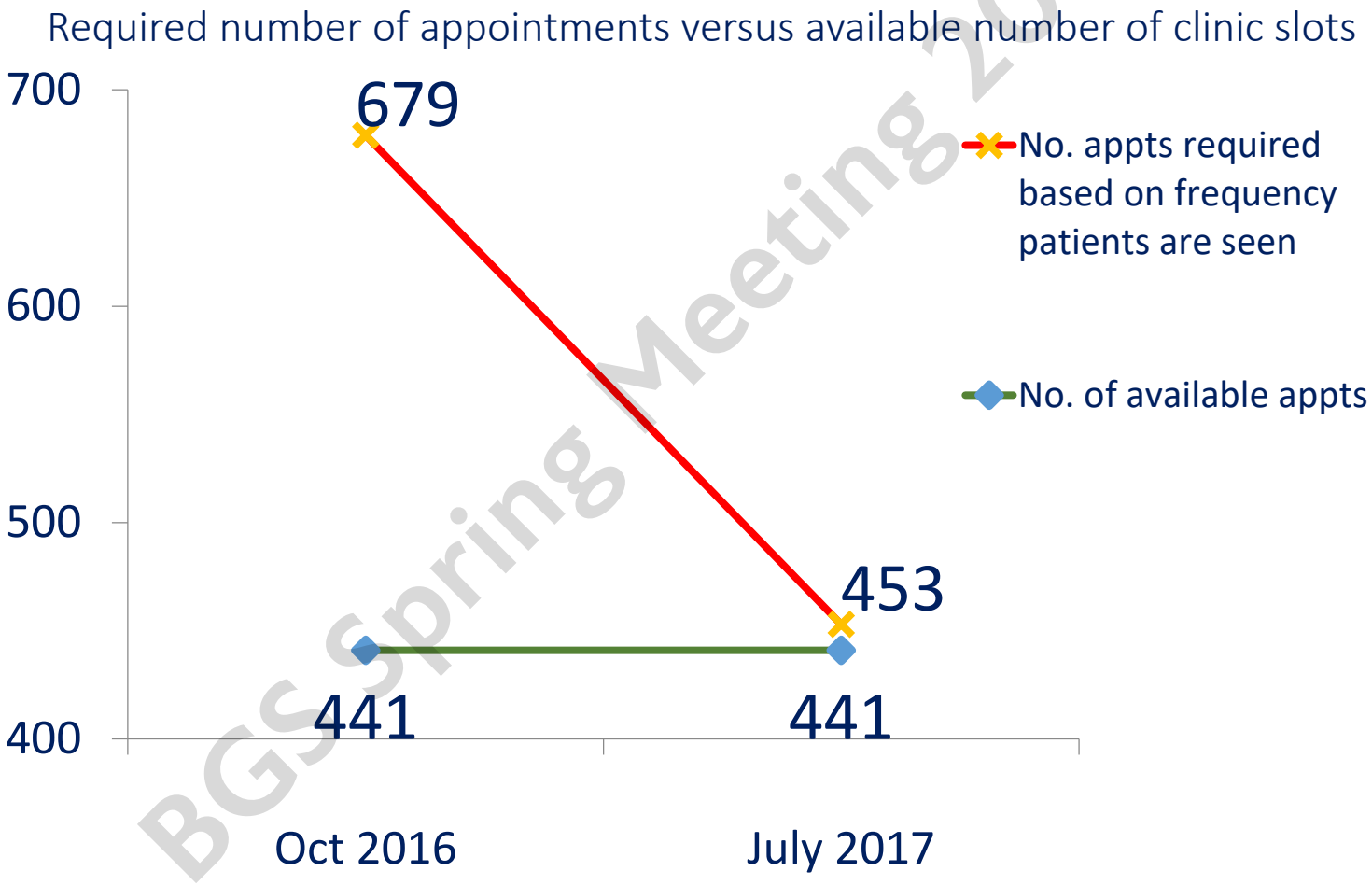
‘I don’t know why I visit the clinic every 6 months’

‘I have always attended clinic every 6 months’

‘When it is explained to me, then it is fine to have my appointment less frequent’

‘I am happy not attending clinic so frequent as I can phone the nurse when I need too’

# Outcome



# Experience of QI

- Understanding the capacity data supported the team to arrange appointments based on clinical need.
- Data can gain a great understanding of clinic demand verses capacity.
- Reviewing why we see people so frequent can support service redesign.

# Effect of involving patients

- Involving patients in QI
  - Willing to share experience and the patient perspective
  - Variable ideas and insight into your QI
  - Find out and access

- Combining ***data and involving the patient*** provides a a greater understanding and influence.

# 10 lessons for NHS leaders

1. Make quality improvement a leadership priority for boards.
2. **Share responsibility for quality improvement with leaders at all levels.**
3. Don’t look for magic bullets or quick fixes.
4. Develop the **skills and capabilities for improvement**.
5. Have a consistent and coherent approach to quality improvement.
6. **Work as a system.**
7. **Use data effectively**
8. Focus on **relationships and culture.**
9. Enable and support frontline staff to engage in quality improvement.
10. **Involve patients, service users and carers.**



The Kings Fund: Making the case for quality improvement: lessons for NHS boards and leaders - 10 lessons for NHS leaders

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