The Quality Improvement Guide

Allied Health Professions Edition

Improving care, delivering quality

1000 LIVES +

‘Count me in!’

GIG CYMRU
Improving Quality Together
Gwella Ansawdd Gyda’n Gilydd

Wales
What they’re saying about The 1000 Lives Plus Quality Improvement Guide for AHPs

“This is a call to action! Improving patient experience and outcomes starts with you. The quality improvement guide provides a series of techniques for everyone to take part in small step local improvement to achieve better outcomes for our patients. I think this approach is empowering because you can see whether they have benefit relatively quickly.”
Julie Wilkins, Chair of Welsh Therapies Advisory Committee

“Already Allied Health Professionals across Wales have been involved in the good progress to improve patient care. They have been supported by the clear, evidence-based improvement methodology that is outlined in this guide. It’s important to know whether changes we introduce are effective and we must be able to to demonstrate and share improved outcomes. This guide will help every AHP to introduce changes and know they are improving care for patients.”
Director of Therapies and Health Science LHB
“Working in healthcare provides numerous opportunities to make a significant difference in the lives of people. We have to be continually seeking to learn - and this guide from 1000 Lives Plus provides a great template for introducing new ideas and making sure they deliver lasting benefits. It will equip us all to meet the needs of the people we care for.”

Judyth Jenkins, Head of Nutrition and Dietetics, Cardiff and Vale University Health Board

“We are delighted that our members play such an important part in quality improvement in NHS Wales. We are committed to empowering frontline staff to deliver improvements, because we know the impact this can make. This guide is an essential help in delivering changes that will make patients’ experiences even better in Wales.”

Professional body
Foreword

The Role of the Allied Health Professions (AHPs)

AHPs are a distinct group of health professionals who apply expertise to diagnose, treat and rehabilitate people of all ages and all specialities.

Through both leading and working within multi-disciplinary teams AHPs play key roles and add critical value across the full spectrum of primary and secondary prevention, diagnosis, treatment and recovery.

In addition, many AHPs play a crucial role in research, education, management and health policy. Because AHPs are involved in all stages of health care delivery they are uniquely placed to help people navigate the journey out of hospital and back to home, return to work and participate in community life.

Quality improvement has a significant impact not just in improving patient/client care but also in terms of achieving social equity and lowering the cost of care.

There are approximately 4,589 (3825 WTE) AHPs working in the NHS in Wales and a significant and increasing number working in other public services including social care and education, and in the private and charitable sectors. Therefore the AHP contribution to the quality improvement agenda is essential.
AHPs in Wales have expressed strong support for the principle of quality patient/client care. However this may not translate into a clear understanding of how quality might be defined, recognised or improved, which is how this guide can help.

The work of the Welsh Therapies Advisory Committee has shown that AHPs are able to overcome the barriers to quality improvement. This is an opportunity for AHPs to be involved in the transformation of healthcare through improving your own work and developing an integrated, collaborative and consistent AHP community dedicated to clinical excellence and quality assurance.

*Alison Strode, Therapy Advisor for Wales*
The 1000 Lives Plus Quality Improvement Guide

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The 1000 Lives Plus Quality Improvement Guide for Allied Health Professions

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1 Introduction
Introduction

In common with most large organisations in healthcare and elsewhere, in NHS Wales we need to improve in order to provide the best possible care and reduce harm, waste and variation. The experience of the health service, and of the people of Wales is that excellent care can be provided, but it’s not always provided reliably and consistently.

The 1000 Lives Plus programme has shown that those working in NHS Wales are committed to improving care. However, the biggest challenge has been using the right techniques to achieve improvement. This has sometimes given the impression that there is a lack of commitment, but we know that nobody wants to do harm or a poor job for their patients.

The new Improving Quality Together framework provides the opportunity for staff to develop a set of common techniques to achieve improvements in care. Building on the work of 1000 Lives Plus, it sets out an approach to quality improvement that can be used by any member of staff anywhere across NHS Wales. This common and consistent approach to improving the quality of services will help improvements take place more quickly and spread effectively throughout the country.

This guide introduces a common language for improvement and some of the techniques underpinning the Improving Quality Together framework. It shows how these techniques can be applied in different settings to encourage and equip everyone working in NHS Wales to be a catalyst for improving care for the people of Wales.
The first question that needs to be asked is: “How should we set about making this improvement?” Scientific models which promote and support new knowledge, exciting innovations and best practice offer one-off solutions, but they’re not improvements. They can distract from the regular and often painstaking work of providing a reliable service and continuous improvement. The good news is that there are better ways to manage improvement, but we will need to learn them (Berwick, 1992 I and Berwick, 1992 II).

Experience has shown that some simple principles and techniques can increase success. Even so, improvement will only be maintained and spread if those techniques are widely understood and shape the way that whole organisations work (Shortell, 1998).

For improvement to be maintained there must be:

- **Will** - we must want to improve;
- **Ideas** - we must know what to try; and
- **Execution** - we must know how to change.

(Berwick, 2003 and Nolan, 2007)

This guide does not cover every aspect in detail. The themes are explored further in the ‘How to Improve’ and ‘Leading the Way to Safety and Quality Improvement’ guides available on the website at www.1000livesplus.wales.nhs.uk

In the first section of this guide, three examples are used to illustrate the point being made.

The first examples is road safety, is a hypothetical example that refers to how to prevent deaths and injuries due to road traffic. This example has been deliberately chosen because it
Introduction

is from outside healthcare. It shows that the same methods can be used in a wide range of improvement efforts.

The second example is improving stroke care, shows how people in Wales can receive better treatment. It applies the method to improve the way services are organised and provided. This example shows how anyone who has a stroke should receive the same evidence-based care within an appropriate time frame wherever and whenever they have their stroke.

The third example is about falls, which are recognised as a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK. The Welsh Ambulance Service NHS Trust reported that, between September 2008 and September 2009, 16% of all calls were due to falls from standing height. This example illustrates how falls prevention initiatives can reduce the number of falls by between 15 per cent and 30 per cent.
Person centred care
Putting the person at the centre of all care delivered

The people we care for should be at the heart of all that we do. Our starting point should always be what is best for the person as whole Analysing the real life experiences of people in your care helps to determine what individuals want and expect from their care. Patients are not outsiders to the healthcare system. In many ways, they are the only true ‘insiders’. They are the ones who experience healthcare most personally - the reliability of the system and effectiveness of treatment can literally be a matter of life or death to a patient (Davies, 2012).

Person driven care is a priority in healthcare as evidence shows that it can lead to improved quality, reduced waste, a better experience of care, and better use of resources. A popular definition of person driven care comes from the Institute of Medicine: ‘Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions’ (National Research Council, 2001). However there are a number of definitions available from across the globe and they all have common themes:

- Users identifying areas that need to change.
- Involvement in decision making and respect for patients’ preferences.
- Empathy, dignity, compassion and emotional support.
- Clear, comprehensible and timely communication.
- Fast and smooth access to optimal care.
- Education and empowerment to manage their conditions and care for themselves.
Person centred care

A genuine partnership between the public and healthcare professionals must exist to design and deliver true person driven care. To achieve this, staff need to view the services being delivered through ‘the patients’ eyes’, in order to meet their needs in the ways most valuable to them:

Three simple questions that are helpful in achieving person-centred care are:

1. What does the person need/want?
2. What is important to the person as the initial need for a service arises?
3. What is important for the person following their last contact with the service?

How to achieve person driven care

Stories for Improvement

Capturing healthcare experiences are proving an effective and powerful way of making sure the improvement of services is centred on the needs of the people using them. All experiences are equally valuable and can provide great insight into the care provided.

Individuals are interviewed and their stories are analysed and used in numerous ways - as a tool to identify areas of good practice or improvement, to support spread of evidence based interventions, to support effective communication, and to help all staff members to appreciate the impact of the care provided.
Person centred care

Shared decision making

The majority of individuals want to play an active role in their treatment decision. Shared decision making tools are designed to support patients during consultations when presented with different treatment options. Option grids are developed to support such treatment choices and encourage an equal partnership with those we care for. Find out more at www.optiongrid.org

Provide dignified care

Dignity in care is at the heart of caring for people. It allows everyone to effectively engage in their care as partners and is a cornerstone to person driven care. Simple things such as supporting individuals to set their own daily goals and helping them achieve simple tasks can have a big impact in their healthcare experience. This has been achieved in Wales through the use of simple questions, such as ‘What can I do for you today?’

Communicate effectively

Effective sharing of information is key to achieving person driven care and can reduce demand on the system. Avoiding medical jargon and using effective communication skills can ensure individuals are more able to access and navigate the system, and better manage their health. Communication techniques and tools are available to support healthcare professionals and members of the public to work together more effectively.
The Model for Improvement
The Model for Improvement

The Model for Improvement provides a framework to structure improvement efforts. It was originally developed by Associates for Process Improvement (www.apiweb.org) to provide the best chance of achieving goals and adopting ideas (Langley et al, 1996).

The model is based on three key questions, known as the thinking components:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in improvement?

These questions are then used in conjunction with small scale testing, the doing component known as Plan-Do-Study-Act cycles (PDSA) as outlined in figure 1.

For further details about the Plan-Do-Study-Act cycles, see page 30.
1. What are we trying to accomplish?

Improvement requires effort, so it is important to direct our efforts to the right problem. The first thing we have to do is be clear about what we aim to achieve. For example, is the aim to reduce death, avoid dependency or illness, or reduce risk?

This sounds obvious, but is often hard to answer precisely. Without this clarity, it is impossible to decide what action to take or to know whether the outcome is an improvement. So the vital question is: “What outcome do we want?”

The table below sets out the desired outcome of each of the three example cases:

<table>
<thead>
<tr>
<th>Desired outcome</th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce death and injury on UK roads</td>
<td>Improve the outcomes for people following a stroke</td>
<td>To reduce the mortality and harm from falls that occur in the community</td>
<td></td>
</tr>
</tbody>
</table>
2. How will we know that a change is an improvement?

Once we are clear about the desired outcome, the next task is to choose a standard to measure the outcome against. At best, this measurement will be simple and easy to use, but it is often difficult to find a perfect measure. We may need to accept some imperfection and collecting the necessary information may be difficult.

The principles to follow when selecting a measure are:

- Use a measure which is:
  - well defined;
  - allows comparison between sites and over time; and
  - already in use, if possible.

- Use a measure that is specific and sensitive enough to allow you to identify and monitor outcomes. Here are two examples to illustrate the terms ‘specific’ and ‘sensitive’.
  - When trying to reduce deaths on the road, monitoring all deaths in the UK may well miss the outcome achieved because the deaths on the road are not distinguished from deaths from all other causes. The measure is not specific enough. See page 22 for an appropriate measure.
  - When trying to reduce people’s exposure to health risks, monitoring harm from medicines by counting mistakes in prescriptions might produce very misleading results because many cases of harm from medicines are not the result of prescription mistakes. In this case, the measure
is not sensitive enough. (It is also not specific enough because many mistakes do not result in harm).

- Don’t reject a measure simply because other factors could affect the effectiveness of the measure. If those other factors are likely to stay constant, the measure may still be valuable.

- When choosing an outcome measure, favour one that can be applied to the whole community, population or system.

Whether using an existing measure or creating new ones, it is vital to be clear about how they are defined. If using an existing measure, it is likely to have been developed for a different purpose, so take time to understand how it was put together. Make sure that everyone involved in collecting information for new measures knows why they are doing it.

Lastly, improvement work sometimes needs to go ahead without there being a good outcome measure, and often before monitoring is stable. This is because improvement work is not an experiment trying to prove the value of an action, it is about adopting and adapting practice, based on evidence. For this reason, and also because it can take a long time for any change in outcome to be recognised, we should also have at least one measure of process. Guidance on how to choose appropriate process measures is given on page 38).
Here are the outcome measures for our three examples:

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deaths each year from road accidents in Great Britain</td>
<td>Number of deaths each year from stroke</td>
<td>Number of calls for 999 ambulances as a result of falls from standing height</td>
<td></td>
</tr>
<tr>
<td>Casualties per 100 million vehicle kilometres</td>
<td>Hospital mortality rate from stroke</td>
<td></td>
<td>Number of hip fractures registered on the National Hip Fracture Data Base</td>
</tr>
<tr>
<td>Road deaths per 100,000 people</td>
<td>Change in Barthel score while in hospital</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. What changes can be made that will result in improvement?

It is essential to link outcome measures to ‘interventions’ - the systems and processes that will help us achieve the desired outcome. We will not make consistent progress towards improving outcomes by focusing on outcome measures alone.

There are two parts to this question - “What is wrong with the system now?” and “What works?”

What is wrong with the system now?

The experience of our staff, the evidence of our own eyes, and feedback from our patients and other service users will all help us identify what we need to focus and concentrate our efforts on.

We need to consider the following:

- What will deliver the biggest benefit? This is often addressing the things that are done most often or the area where most waste is incurred.
- What do typical cases tell us about the system?
- Are demand and need understood properly? How much demand is repeat work or work caused by another part of the service?
- What is the high-value part of the system (the part that delivers real benefit)? Is it the same as the part which has the highest costs?
The Model for Improvement

- What can simplify the process?
- How can we use the knowledge of service users and people in other parts of the process?

In other words, we need to make a conscious effort to:

- Avoid making change for change’s sake.
- Avoid considering one interesting, seemingly urgent and personally fascinating topic at the expense of important mainstream work.
- Avoid focusing only on ‘special causes’ which are particularly serious or unusual as they will often give false information about how to improve the system in general.

To improve, we need to focus on the things which regularly cause unreliability. For example, in acute stroke services, some of the biggest causes of unreliability result from certain staff not being available outside ‘office hours’. Approaches to improve reliability have tackled the skill mix of the staff available at any one time and re-examined segregation of duties to reduce the differences in care that patients experience at different times.

- Avoid adding extra steps to ‘fix’ a system that isn’t working. Especially avoid adding a solution while allowing a problem to continue. This is what Balestracci refers to as “scraping burnt toast” (Balestracci, 2005). Such steps will add handovers, bottlenecks and bureaucracy but will not improve efficiency.
- Avoid the ‘silo’ mentality where departments or groups do not want to share information with others. Do customers get what they want from parts of the service?
Are we running a ‘great’ department while quietly blaming other departments for poor delivery?

- Avoid confusing information on performance (whether targets have been met) with information on improvement (how the system is working).

What works?

To find out what works we first need to gather evidence of how a good system should work. Don’t make this unnecessarily hard by going into too much detail. Greenhalgh (2004) has shown that successful change is most likely to be achieved using simple steps that can be applied in local situations.

We use the evidence gathered to produce driver diagrams to summarise desired outcomes and how they can be achieved. Pages 27, 28 and 29 give examples of driver diagrams based on the desired outcomes of how they can be achieved.

The first step to producing a driver diagram is to gather evidence of what works. The best evidence is published accounts of controlled experiments or, better still, systematic reviews of several publications. If that evidence is not available, professional guidelines, national service frameworks and evidence of good practice may be useful, but we need to be aware of their limitations.
When producing driver diagrams there are some basic rules which must be followed:

- The first column - ‘Aim’ - shows the desired outcome of the service (the simpler the better).
- The second column - ‘Drivers’ - shows the factors that affect the outcome.
- The third column - ‘Interventions’ - shows the actions that have been shown to make a difference and bring about improvements.

A panel of experts will have to agree the driver diagram. It should be brief and simple, and contain only evidence-based and important interventions.

As far as possible, the interventions should state what happens to the patient and not specify where care takes place or the type of staff involved.

There is a large amount of literature available on achieving change and we have deliberately kept this text short. However, Pronovost provides another very accessible approach for medical settings (Pronovost et al, 2008).
An example of a driver diagram that might be used in road safety

<table>
<thead>
<tr>
<th>Aim</th>
<th>Drivers</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Reduce death and injury on UK roads | Safe roads | • Clear Road markings  
• Clear road signs  
• Safe Road Layout  
• Re-design accident blackspots |
| | Safe vehicles | • MOT Testing  
• Manufacturing Standards |
| | Competent and safe drivers | • Skills and knowledge tests  
• Testing for over 80s  
• Medical grounds for not driving  
• Alcohol testing  
• Drug testing  
• Speed and signal traps |
| | Competent pedestrians | • Television advertising  
• In-school training  
• Well-designed crossings |
| | Effective response to accidents | • Fast ambulance response  
• Paramedic training  
• Air ambulance available |
An example of a driver diagram for improving outcomes after stroke

**Aim**

- Improve the outcomes for people following a stroke

**Drivers**

- Rapid recognition of symptoms and diagnosis (within three hours)
- Emergency treatment for people with stroke (within 24 hours)
- Getting the patient mobilised following stroke (within three days)
- Specialist care after a stroke (within seven days)

**Interventions**

- Rapid diagnosis using a recognised tool (for example ROSIER)
  - Diagnosis confirmed by experienced clinician
- CT scan
  - Admission to stroke unit
  - Check ability to swallow
  - Nutritional screening
  - Prescription of regular aspirin (if non-haemorrhagic stroke)
- 72 hours physiological monitoring
  - Assessment of manual handling
  - Specialist medical review
  - Physiotherapy assessment started
  - Getting patients out of bed
- Occupational Therapy assessment started
  - Full screening and appropriate assessment of remaining problems
  - Multi-disciplinary team goals set
  - Information shared with patients and carers in an appropriate format
  - Estimated discharge dates discussed with patients and carers
**The Model for Improvement**

**An example of a driver diagram for reducing harm from Falls**

<table>
<thead>
<tr>
<th><strong>Aim</strong></th>
<th><strong>Drivers</strong></th>
<th><strong>Interventions</strong></th>
</tr>
</thead>
</table>
| To reduce the mortality and harm from falls that occur in the community | Trigger Bundle  
The falls event will be logged and initial screening completed within 24hrs | • Complete the initial screening using an agreed tool  
• Log the fall on falls register  
• Notification of the fall as per locally agreed pathway, copy to GP |
| | Assessment Bundle  
Basic multifactorial risk assessment is completed within 7 days | • Take falls history  
• Complete a basic falls risk assessment using an agreed risk assessment tool  
• Provide written and verbal information about falls prevention.  
• Make appropriate referrals for specialist assessment and intervention based on the |
| | Intervention Bundle  
An agreed multifactorial plan of specialist assessment and intervention is in place and in progress within a maximum of 6 weeks | • Initiate a bespoke plan for each patient, dependant on need  
• Agree the plan with the person and / or their family or carers  
• Agree time scales and a review date  
• Copy of the plan to go to the GP |
| | Monitoring Bundle  
Progress against the plan is monitored within 6 months | • Review compliance with the plan  
• Evaluate the efficacy of the plan in terms of further falls or injury  
• Update or close the plan as appropriate and update the falls register |
How do we introduce changes to processes?

In the 1000 Lives Plus improvement work, we have learnt that to try something new in a reliable way, it is best to start small - one person, one setting, one service provider.

Even if something has been shown to work in other settings, we should take the time to do a small-scale trial. There are almost no ‘plug and play’ solutions that work in all situations. Testing allows us to adapt actions to particular settings. To test a new procedure or technique, we need to ‘plan, do, study and act’ as explained below.

**Plan**
Plan what you are going to do differently - ‘who, what, where and when’.

**Do**
Carry out the plan and collect information on what worked well and what issues need tackling.

**Study**
Gather relevant team members as soon as possible after the test for a short informal meeting. Analyse the information gathered and review the aim of the new procedure or technique against what actually happened. Questions that need to be asked include the following;

- ‘What is the information telling us?’
- ‘What worked and what didn’t work?’
- ‘What should be adopted, adapted, or abandoned?’
Act
Use this new knowledge to plan the next test. Agree the changes and amend the outcome measures if necessary.

We should continue testing in this way, refining the new procedure or technique, until it is ready to be fully introduced. But, do it quickly (think in days, not weeks). When the change has been reliable for 90 to 95 per cent of patients, spread to more sites.

Don’t assume that a change can simply be ‘rolled out’ once it has been successfully tested. The introduction needs to be managed at every stage. There is no hard and fast rule for how fast to introduce the change. Once it has been introduced in a new area, test the change again.

We must remember to account for the organisation’s ability to make sure it can manage a larger number of new sites while continuing to maintain existing ones.
Measurement and reliability
Measurement and reliability

To summarise the last section, improvement cannot happen without measurement:

- We cannot try a solution until we understand the problem.
- We cannot test a solution unless we are measuring its effect.

Study the system to see which action offers the most potential value. Use a spreadsheet to count all critical parts in the process. Alternatively, use “process mapping” which converts the process into a visual, step-by-step diagram, or existing audits or recent reports.

However, bear in mind that audits and reports are likely to study small fractions of the information available and may be inaccurate. For both these reasons, they can lead to false conclusions. There is no substitute for looking at the system personally, seeing where any measurements come from and how they are made.

How we measure

The diagram on the next page, ‘The seven steps to measurement’, illustrates the complete process. The first three steps have been covered in earlier sections of this guide. ‘Decide aim’ (step 1) is covered in ‘What are we trying to accomplish?’, and steps 2 and 3 are covered in ‘How will we know that a change is an improvement?’

Steps 4 to 6 form the ‘Collect-Analyse-Review’ cycle. First collect some information (step 4), then analyse it and present it in an appropriate way to convert it into useful information (step 5), and finally review the information to see what decisions need to be made (step 6). The Collect-Analyse-Review cycle then starts all over again (step 7).
Measurement and reliability

Figure 2: The Seven Steps to Measurement

The seven steps to take are:

Step 1 - Decide your aim
Step 2 - Choose your measures
Step 3 - Define your measures
Step 4 - Collect your baseline data
Step 5 - Analyse and present your data
Step 6 - Meet to decide what it is telling you
Step 7 - Repeat steps 4 to 6 each month or more frequently

The first Collect-Analyse-Review cycle will provide a ‘baseline’ of current performance (the starting part). If we collect data about 20 - 25 times and plot the results on a chart, this will provide an ideal number of points to create a baseline or identify a trend. One way to get more points is to measure more frequently.

Often the information needed is not currently being collected. If so, start collecting your information straight away. But we do not have to wait to start making small changes. They will not affect the overall situation while creating the baseline.

Using ‘run charts’ is a simple way to help analyse information, and a statistical process control chart will help you look at your information and understand any variation in the process you want to improve. ‘Plotting the dots’ is very effective because it helps us to spot trends and patterns displayed to us.
The frequency of measurement, often carried out weekly, is a major difference between measurement for improvement and more traditional forms of measurement.

Traditionally, figures are smoothed out to get to ‘the real underlying trend’ by taking an average of the period. The problem comes when comparing the previous average with the current one to see if there’s been an improvement. Simply comparing two numbers and knowing that one will be bigger than the other gives a 50 per cent chance of being better (or worse)! In contrast, run charts and statistical process control charts have rules which provide confidence that when a change has been spotted, it really is one. We give an example run chart at the end of this section (please see page 40).

Finally, step 6 reminds us that it is vital to set time aside to look at what the measures are telling us. How often the information is collected, analysed and reviewed sets the pace for change being introduced.

When we are aiming to improve, it is important that measurement is carried out fairly and openly. However, if people think that their measurement will be used to criticise them, then they will be reluctant to collect information. There are three main reasons for collecting information:

- improvement - to help discover ways to improve;
- accountability - to hold people accountable and make sure they are working to an acceptable standard; and
- research - to discover something new.

Figure 3 shows how the way things will be measured will change, depending on what the measurement is going to be used for. (Solberg et al, 1997 adapted).
### Figure 3: Comparison of data requirements for improvement, accountability and research.

<table>
<thead>
<tr>
<th></th>
<th>Improvement</th>
<th>Accountability</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim</strong></td>
<td>Improvement of care</td>
<td>Comparison, choice, reassurance</td>
<td>New knowledge</td>
</tr>
<tr>
<td><strong>Method of testing</strong></td>
<td>Small sequential tests</td>
<td>No testing - simply evaluate performance</td>
<td>One large carefully designed test</td>
</tr>
<tr>
<td><strong>Bias</strong></td>
<td>Accept consistent bias</td>
<td>Adjust what you collect to reduce bias</td>
<td>Design to eliminate bias</td>
</tr>
<tr>
<td><strong>Sample size</strong></td>
<td>Small sequential samples</td>
<td>Potentially large - need to gather all relevant information</td>
<td>Large - need information to cover all eventualities</td>
</tr>
<tr>
<td><strong>Flexibility of hypothesis</strong></td>
<td>Hypothesis changes with learning</td>
<td>No hypothesis</td>
<td>Fixed hypothesis</td>
</tr>
<tr>
<td><strong>Type of analysis and presentation</strong></td>
<td>Run charts or statistical process control charts</td>
<td>League tables, achievement of target</td>
<td>Traditional statistical tests</td>
</tr>
<tr>
<td><strong>Confidentiality of information</strong></td>
<td>Information used only by those involved in improvement project</td>
<td>Information available in the public domain</td>
<td>Results widely available but research subjects’ identity protected</td>
</tr>
</tbody>
</table>
Measurement and reliability

Frequent measures also allow us to monitor reliability - how many times did we do what we intended as a proportion of the total number of tries? For example, if we have a procedure for screening all patients admitted to hospital, what proportion of the total were actually screened? When we try to do two things in a process, reliability gets harder. What proportion of those screened received the resulting intervention? If both steps have 80 per cent reliability, the reliability of the process is 64 per cent (80 per cent of 80 per cent).

Typically, when we measure reliability for the first time, the results are disappointing. 80 per cent is typical for one step, and less than 50 per cent for bundles of steps where four or more steps are linked.

It is often possible to reach 95 per cent reliability for single steps (for example, by providing training, memory aids and built-in reminders). If greater levels of reliability are needed, or if these simple changes do not deliver 95 per cent, the system itself needs to be redesigned. Design is the best tool for achieving reliability.

For more information on measurement and reliability, the ‘How to Improve’ guide published by 1000 Lives Plus covers this in much more detail. The guide is available on the website at www.1000livesplus.wales.nhs.uk
A stroke unit has developed a new process for referring patients for CT scans, along with staff training to communicate the changes in process. The aim of the work was to improve the percentage of patients which receive a CT scan within 24 hours of admission.

The stroke unit has data for the period June 2009 to May 2011. The data for June 2009 - June 2010 is a baseline position prior to any service improvement work undertaken. (Ideally we should use 20 - 25 data points to create a baseline position).

To monitor the impact of changes in process we need to calculate the median average baseline position. The median (15 per cent) has been calculated for the baseline period. This is shown as a dotted line on the charts below. It is projected beyond June 2010, when the service improvement work commenced. The median shows that in half of the months at least 15 per cent of patients received a CT scan within 24 hours. If everything remained the same this would not change.

In July 2010, the staff training commenced and a new referral process was introduced. Figure 5 demonstrates the impact of the changes in process. There has been a “shift” in the data. A shift in the data is represented by six or more consecutive data points above the median line.
Measurement and reliability

Here is a run chart for a process measure from our stroke example:

Once we have established there have been any changes in the data using run chart rules, and we fully understand what changes have impacted on the data we are able to recalculate the median to review for any future changes in the data. See figure 6 which demonstrates a new median of 65 per cent. Now 65 out of 100 patients typically receive a CT scan within 24 hours.
Putting it into practice
Putting it into practice

The Improving Quality Together framework supports individuals and teams put these improvement tools into practice and learn improvement by doing. The most effective way to take this forward is on a micro-system level, where a small inter-professional group of people come together to offer care to a particular population of patients, who are themselves considered an integral part of the microsystem. Elements of support services can either be integrated into these more clinical microsystems or look for quality improvements on specific processes within their workplace. It is essential that teams consider who their ‘customers’ are and involve them in their improvement: whether this be patients, or other departments or services.

Human error

A central tenet of healthcare improvement work is that harm and waste are not caused by bad people but instead by bad systems. Contrary to the media driven image of harm in healthcare caused by malice or intentional negligence on the part of the individual, it is errors of omission that are responsible for most healthcare related adverse events.

One large study has demonstrated that the rate at which basic, standard care was not delivered in US healthcare was 45 per cent (McGlynn et al, 2003) indicating that it is what we don’t do as healthcare teams that causes harm and avoidable mortality. These frequent lapses are not a sign of poor personal standards or of a lack of knowledge or skills. They are the inevitable consequence of attempting to perform in a complex system with human limitations.
As the phrase has it, ‘to err is human’, and whilst human beings are capable of brilliant and innovative solutions to problems, maintaining reliability in care and treatment delivery in the often chaotic healthcare environment under conditions of stress and fatigue make it inevitable that error will occur.

James Reason, one of the pioneers of error reduction in healthcare states that: ‘the paradox at the heart of the patient safety problem... is that medical education, almost uniquely, is predicated on an assumption of trained perfectibility’ (Reason, 2009). It is noticeable that this attitude is not unique to medical education and sets an unrealistic and unachievable standard.

**Human factors - smarter ways of working**

The aviation industry has long been aware that 70-80 per cent of aviation accidents can be attributed to human rather than mechanical error (Endsley, 1988). With other ‘safety critical’ industries, aviation has developed the principles of human factors which work to counter the natural human propensity to error. These non-technical skills are now regarded as so important that competence in human factors is a necessary requisite for continued accreditation as a pilot.

Combined with a very open culture with regard to error and safety, human factors training, known as crew resource management (CRM), focuses on teamwork, communication, flattening hierarchy, managing error, situational awareness and decision making.

In recent years the phrase ‘human factors’ has gradually entered the healthcare lexicon. In the UK, human factors principles form the basis of the NPSA Foresight Training, whilst internationally it is considered an essential part of training in patient safety by the World Health Organization (WHO).
Putting it into practice

The WHO Patient Safety Curriculum Guide for Medical Schools (World Health Organization, 2009) includes the following principles on human factors:

- Avoid reliance on memory.
- Make things visible.
- Review and simplify processes.
- Standardise common processes and procedures.
- Routinely use checklists.
- Decrease the reliance on vigilance.

Creating an improvement culture

1000 Lives Plus has adopted and developed the IHI collaborative programme as the primary methodology for enabling healthcare teams to improve the quality of patient outcomes whilst reducing harm, waste and variation.

The collaborative methodology draws together participants with a shared improvement goal and supports them in using the Model for Improvement and measuring improvement. This encourages the sharing of ideas, experiences and tools, and promotes a culture in which improvement can thrive.

The collaborative programme method has been applied successfully in a wide variety of healthcare settings including the acute hospital ward, primary care, maternity and mental health. All collaborative programmes, whilst having differing goals will progress within the following (non sequential) themes:
Putting it into practice

- Improve team working.
- Set aims and agree priorities.
- Improve your working environment.
- Embed Improvement methodology.

**Improve team working**

One study found that erroneous verbal communication between staff members was a root cause or contributing factor in more than half of severe patient safety incidents (Rabøl et al, 2011) and it is acknowledged that the main reason for poor team working is deficiency in communication.

Clinical teams have used human factors principles to improve communication by adopting safety briefings and using the SBAR (Situation, Background, Assessment, Recommendation) tool in verbal and printed format in settings from the board report to escalating care for the deteriorating patient. The PSAG (Patient Safety at a Glance) board promotes situational awareness for the entire clinical team whilst performing a debrief allows teams to celebrate what went well during a shift or clinical incident whilst planning on how to improve performance next time.

One of the important recommendations of the report of the Kennedy Inquiry into Paediatric Cardiac Surgery at Bristol Royal Infirmary (2001) was that clinical teams that work together should also train together. This principle has long been accepted in other safety critical industries but in healthcare it is common that professional groupings train separately and in areas removed from the clinical setting. Simulation training has huge potential for bringing about better team working whilst promoting collaboration between service and education.
Putting it into practice

Tools

- Briefing and debriefing
- SBAR
- Patient Status at a Glance (PSAG) board
- Simulation

Learning Opportunities

Discuss how team working could be enhanced by using simulation and communication tools in a way that would have minimal resource implications.

Set aims and agree priorities

The most important question in the Model for Improvement is ‘What are we trying to achieve?’ It is important to set a clear vision and direction in quality improvement work. This vision should be shared by the clinical team but should also align with the priorities of the healthcare organisation in which they work.

One of the successes of 1000 Lives Plus has been the alignment of all tiers of the health board from ward to board in identifying and dealing with the adverse events that present the most harm.

When attempting to understand priorities, frontline teams are at the mercy of what is termed the ‘tyranny of small numbers’ where the extent of a problem is viewed on an individual subjective level rather than on an all-organisation scale. An example of this would be that although severe sepsis is thought to be responsible for the death of 37,000 people annually in the UK (Daniels and Nutbeam, 2010) an
individual healthcare worker may only see one or two cases during a year and so not appreciate the full scale of the problem.

**Tools**

- Root Cause Analysis
- 5 Whys
- Cause and Effect (Ishikawa, Fishbone) Diagram
- Safety Cross
- Run Chart
- SPC Chart

**Learning Opportunities**

*Investigate a critical incident to establish an understanding of the underlying causes.*
Putting it into practice

Improve your working environment

Healthcare teams work in an environment that has evolved over decades rather than being designed for purpose. In many cases this has led to the creation of more and more elaborate ‘work arounds’ that are deleterious to the receipt of safe and effective care by patients and waste staff time and effort.

Involvement in 1000 Lives Plus collaborative programmes, particularly Transforming Care, has enabled teams to re-examine the work environment and use human factors and ‘Lean’ principles to find better ways of working.

**Tools**

- Activity follow
- 5Ss
- Process Mapping
- Patient Status At a Glance (PSAG) board

**Learning Opportunities**

*Analyse how changing the systems and processes in the clinical environment can contribute to reductions in waste and harm.*
Embed improvement methodology

The Improving Quality Together framework helps organisations embed the improvement methodology in all they do. All levels of staff across all services will have a common understanding of quality improvement and how it is relevant to their daily work. Teams and individuals making small improvements together, demonstrated by measurement, will take those habits into other areas of work, ensuring all we do is based upon measurement and improvement. Improved systems and processes of working will become the norm, enabling us to achieve high reliability in patient care.

When using the Model for Improvement the question is asked ‘How will we know how we are doing?’ to which the only answer must be by measurement. Experience with 1000 Lives Plus has demonstrated to clinical teams that the reliability of healthcare delivery is always overestimated and that feedback of this in the form of a run chart or safety cross often leads to rapid improvement.
Putting it into practice

However, measurement carries with it a burden of extra time and effort and wherever possible measurement for improvement should be incorporated into the normal process so that it becomes ‘just the way we do it’.

Improvement teams have used human factors principles to devise checklists and care bundles documentation that are integrated into care planning. At the same time standard operating procedures, SBAR and safety briefing forms can be used as guidance but also become the permanent record for critical events whilst making data collection easier and automatic.

By continued reinvention and innovation clinical teams are able to integrate measurement into everyday activity and therefore ensure that quality improvement becomes established practice.

Tools

- Checklists
- Standard Operating Procedures
- Care bundles
- The STOP order
- 2 minute safety briefing

Learning Opportunities

*Debate methods for embedding measurement within daily activity so as to improve process reliability without increasing the burden of data collection.*

The tools mentioned in this section are available on the 1000 Lives Plus website www.1000livesplus.wales.nhs.uk
Putting it into practice

Common improvement questions
What is an audit?

Many staff take part in clinical audits as part of professional practice. Audits are essentially about comparing what should be happening with what has actually happened. This means that it is useful for governance and assurance, for example, in whether service standards or expected practice has been followed.

However, audits only provide a ‘snapshot’, which usually relies on an interpretation of notes or records originally compiled for a different purpose. At its best, an audit gives detailed knowledge of a process and can be helpful in setting improvement priorities.

Even when an audit results in specific recommendations for improvement, and a commitment is given to carry out another audit at a later date, too often the necessary change does not follow.

How does the Model for Improvement differ from traditional change methods?

The Model for Improvement requires the ongoing gathering of information and feedback, rather than periodically assessing progress. Improvement science encourages teams to know their systems and work to achieve better outcomes. If we know our system, and know where it is failing, we can choose and adapt an improvement idea from elsewhere (Greenhalgh, 2004).

As Shortell et al (1998) said: “The overall system of caring for patients must be transformed into a culture that emphasises integration and teamwork rather than individualism, measurement for improvement rather than judgement, and continuous learning from each other.”
Why focus on harm, waste and variation?

Harm

Evidence suggests that harm and death which can be avoided are a common side effect of healthcare provided in NHS Wales and beyond. In the UK, Sari et al (2007) found that harm had been caused to patients in 8.7 per cent of hospital admissions. The harm contributed to the person’s death in 10 per cent of these cases, and to disability in 15 per cent of the cases.

Waste

Once harm has happened, dealing with the consequences costs money and represents a large and avoidable cost. In 2001, harmful events were estimated to cost the UK NHS around £1 billion a year in extra bed days alone (Vincent et al, 2001).

In the US, it is estimated that $19.5 billion a year is wasted as a result of errors (avoidable mistakes). The three most expensive errors are post-operative shock ($93,682 per case), infection due to central venous catheter ($83,365 per case), and infection following infusion, injection, transfusion or vaccination ($78,083 per case) (Shreve et al, 2010).
Common improvement questions

Variation

There is often a difference between what we do and what we think we do and there is now a lot of evidence that best practice is not being delivered reliably and consistently.

This variation is not normally the result of individual competence or practice, but a result of the systems and processes being used. Berwick frequently quotes that: “Every system is perfectly designed to achieve exactly the results it gets”. It is through improving reliability in the systems and processes we use every day that there is the greatest potential for improvement.

Do care pathways and national service frameworks drive change?

These are both useful devices for agreeing models of service and setting out expectations for service users. But on their own, they are unlikely to drive change. The reasons why were described by Greenhalgh (2004) who researched the characteristics of effective changes. They are as follows:

- ‘It must have clear relative advantage’ - the people or teams (users) who are asked to make the change part of their work must be able to see that the new method is likely to be better.

- ‘It must have compatibility with the users’ values and ways of working’ - if users find it hard to incorporate the new method, they are unlikely to do so.
• ‘Complexity must be minimised.’

• ‘Users will adopt more readily if innovations allow trialability’ - can it be tested on a small scale to allow learning and familiarity before full commitment?

• ‘There must be observability, that is, it must be seen to deliver benefit’ - if the benefits are not obvious, or they take a long time coming, energy will be lost.

• ‘Reinvention is the propensity for local adaptation’ - this is the key to achieving sustainable improvement. A good improvement must be incorporated into the changing system and not preserved like a museum piece.
7

Examples of AHP quality initiatives using the methodology
Examples of AHP quality initiatives using the methodology

1) Physiotherapy orthopaedic transfer from inpatient to outpatient example.

Aim:
Improving the timely access to post-operative physio therapy at local hospitals following discharge from acute unit.

Measures:
Total waiting time for outpatient follow up, before changes it was 24.2 days.

Changes:
- New administrative process to move referrals from paper to electronic data.
- Referral data entered in once at acute unit and shared with local hospital (rather than repeated at local unit).
- Patients phone in three days following discharge to book appointment to book their own appointment.

Plan:
- Started with electronic recording of referral (stopped using paper referrals).
- Information developed and given to patients on the ward about when and where to contact for outpatient treatment.
- Change facilitated through meetings with Outpatient Managers and Team Leaders, who cascaded information to their staff.
Examples of AHP quality initiatives using the methodology

Do:
- Piloted with small group of patients

Study:
- The pilot study had to evolve during the process as alternative problems arose due to the changes
- Regular meetings and conviction helped resolve challenges
- Staff shortages lead to the pilots progressing more slowly than initially planned
- Need to start with a small pilot

Act:
- Investigate referral of certain post-operative patient groups direct to rehabilitation classes rather than to individual treatment sessions, where appropriate.
- Look toward further development of computerised referral as systems allow
- Following change the wait time was 16.4 days
2) Development of a New Administrative Pathway for Dietetic Case Notes

Aim
To develop a pathway of one dietetic case note per patient, across the UHB care settings. This minimises multiple ‘open’ episodes of care and provides a seamless timeline of patient care.

Measurement
A reduction in duplication of dietetic case notes by 50% within the first year and 100% compliance by year 2.

Changes
• Administrative process developed to document secure transfer and tracking of dietetic case notes to different care settings on a central database. This is accessible to all sites.

• Transfers to be undertaken by all sites on an agreed day of the week.

• Remove the requirement for clinician’s time to be spent writing referral letters / referral forms.

Plan
• Representatives from all care settings met to map the pathway.

• Database for tracking cards designed and set up.

• Pathway cascaded to all staff via a variety of methods/forums dependent on the care setting.
Examples of AHP quality initiatives using the methodology

**Do**
- Date agreed for implementation.
- Nominated lead identified in each care setting to support the transition.

**Study**
- Initial problems trouble-shooted by nominated clinical leads
- Transition was complicated by simultaneous changes to record keeping external to the dietetic service and within the community MDT. This was managed locally and impact on the wider care settings was minimised.

**Act**
A new pathway has been implemented which delivers one patient, one dietetic case note. Compliance is to be monitored in each care setting. The pathway will be formally audited at the end of the first year to assess if 50% compliance has been achieved.
3) Standardising Dietetic Assessment Approaches and Documentation

**Aim**
To standardise clinicians’ approaches to patient assessment to improve clinical efficiency and the confidence of junior team members in the dietetic assessment, care planning and discharge process.

**Measures**
- Enhanced quality and accuracy of assessment, with improved collation of both subjective and objective data.
- Improvement in compliance to professional and local standards of record keeping.
- Streamlining record keeping audit process to facilitate identification of variances.

**Changes**
- New referral equals new assessment - removing reliance on older data and assessments.
- Development of core assessment tools for use on all inpatient wards.
- Prompts for rapid data collection and all data fields completed by clinical team.
- New administrative process for patient demographics to reduce documentation time for clinicians. Up to date information printed not hand written.
- Reduction in clinician time for new assessments, whilst maintaining a thorough, high quality assessment.
- Reduced storage requirements for case notes.
- Reduction in printing and associated costs.
- Encouraging a culture of appropriate and timely discharge to accommodate increased demands on the service.
Examples of AHP quality initiatives using the methodology

Plan
- Small group of clinicians worked together to develop the initial tool.
- Consultation with staff to engage the team.
- Change facilitated through Clinical Governance and staff meetings.

Do
Small scale pilot was undertaken to prove efficacy of the assessment tool and to secure clinical feedback before larger scale launch.

Study
- Results of the pilot screened by senior clinician to identify if the tool was fit for purpose, accurately completed by clinicians and identified patients who deviated from the discharge pathway.
- Clinician feedback was sought and proved to be positive to the change implemented.
- Specific improvements were noted in the time taken to assess new patients and the ease at finding core clinical information within the dietetic case note.

Act
- The success of the pilot tool led to the development of a wider range of assessment tools suitable for use in specialist clinical settings.
- Clinician’s estimated a reduction of 10 minutes per new assessment indicating the tools improved efficiency.
- Improved ability to meet the rising demand for the service in the acute inpatient setting.
- Encourages a supportive environment of thorough assessment, appropriate care and timely discharge.
Summary
Summary

Providing good quality care is everyone’s responsibility. Experience has shown that through some simple principles and techniques, a shared understanding and language for improvement can be created.

The Model for Improvement provides a framework to structure improvement actions, but this is not enough by itself. Improvement work is about adopting and adapting evidence-based practice to the particular setting, and a well-defined outcome measure allows improvement to be tracked between sites over time.

Consult the best evidence to choose the most appropriate actions to achieve improvement and use a driver diagram to summarise the aim and actions. Make sure you consult an expert group to agree these. Use the ‘Plan-Do-Study-Act’ (PDSA) cycle as a way of trying a new technique, starting small and spreading to more sites only when the new technique is 90-95 per cent reliable.

To improve you need to use measurements to understand the problem and to measure the effect of a change. Study your system to see which action offers the most potential value. Use the Collect-Analyse-Review cycle to produce a baseline and use run charts or statistical process control charts to demonstrate how the process is performing. How often you collect, analyse and review information sets the pace for introducing change.

To put the Model for Improvement into practice, an understanding of the inevitable consequence of attempting to perform in a complex system with human limitations needs to developed. Clinical teams have used human factors principles to improve communication by adopting tools such as briefing and debriefing, SBAR, Patient Status at a Glance (PSAG) board and Simulation. These can be used in
education and as part of student improvement projects to help create an environment designed for purpose.

The Model for Improvement emphasises valuing the contribution of all stakeholders and it is noticeable that some of the most innovative and effective solutions have come from often overlooked team members such as domestic and reception staff or students.

Improving Quality Together will ensure that all staff at all levels across NHS Wales will have access to the quality improvement knowledge and skills to start making small scale improvements. Working on small scale changes as opposed to large improvement projects helps to build confidence with those tools, and will in turn support all NHS Wales to work towards a more reliable system of healthcare.
References
References

We referred to the following documents when producing this guide.


Appendix

List of Allied Health Professions represented on the Welsh Therapies Advisory Committee
Appendix

List of Allied Health Professions represented on the Welsh Therapies Advisory Committee

In Wales the Allied Health Professions as represented on the Welsh Therapies Advisory Committee include:

Art therapists:

Art Therapy is a form of psychotherapy that uses art media as its primary mode of communication. Clients who are referred to an art therapist need not have previous experience or skill in art, the art therapist is not primarily concerned with making an aesthetic or diagnostic assessment of the client’s image. The overall aim of its practitioners is to enable a client to effect change and growth on a personal level through the use of art materials in a safe and facilitating environment.

Dramatherapy is a form of psychological therapy in which all of the performance arts are utilised within the therapeutic relationship. Dramatherapy methods engage clients in effecting psychological, emotional and social changes. The therapy gives equal validity to body and mind within the dramatic context; stories, myths, playtexts, puppetry, masks, improvisation and movement with sound and touch are examples of the range of artistic interventions a Dramatherapist may employ. These will enable the client to explore difficult and painful life experiences through an indirect approach.

Music Therapy is a psychological therapy which uses the unique qualities of music as a means of interaction between therapist and client. Attentive listening on the part of the therapist is combined with shared musical improvisation using instruments and voices
so that people can communicate in their own musical language, whatever their level of ability.

**Chiropodists/Podiatrists**

Podiatry is defined as a field of healthcare devoted to the study and treatment of disorders of the foot, ankle, leg, knee and hip. The role of the Podiatrist is to maintain and improve the tissue viability and loco-motor function, to alleviate pain and reduce the impact of disability, increase and maintain mobility and independence promoting health and well being for a wide range of patients.

**Dietitians**

Registered Dietitians (RDs) are the only qualified health professionals that assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Uniquely, dietitians use the most up to date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.

**Occupational Therapists**

Occupational therapists enable people to achieve health, well-being and life satisfaction through participation in occupation. They provide practical support to people with physical and mental illness, disability, long term conditions, or those experiencing the effects of ageing, to do the things they need or want to do.
Orthoptists

Orthoptists assess, diagnose and treat visual and eye movement disorders with people of all ages and ability.

Paramedics

Paramedics are registered healthcare professionals who provide urgent and emergency care to acutely ill or injured patients. They can administer a range of drugs, provide advanced life support, and work closely with other healthcare professionals to ensure patients receive the optimum care for their condition.

Physiotherapists

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.
Speech and language therapists

Speech and Language Therapists are Healthcare Professions Council (HCPC) registered professionals responsible for the assessment, evaluation, differential diagnosis, treatment planning and implementation for people at risk from speech, language and communication and swallowing/feeding impairments.
Introducing Improving Quality Together

NHS Wales aims to provide the highest quality and safest care for the people of Wales.

Improving Quality Together is a standardised framework of core improvement skills for all NHS Wales’ staff and contractors, which builds upon recognised local, national and international expertise.

Taking part in Improving Quality Together will help you play a vital part in transforming NHS Wales into the service that people need.

The framework will give you an opportunity to develop your skills and gain accreditation in quality improvement methodology.

You will share a common and consistent approach to improving the quality of services that will help improvements take place much more quickly and spread effectively throughout the country.

“I think the course is excellent. It gives our frontline staff the skill-base to go into their own departments and say ‘I can make this improvement.’”
- Neil

“Improving Quality Together is patient driven. It’s also staff-driven. By improving quality, we can take away some of the stress and strains on staff.”
- Chris
What are the core skills?

The core set of skills are based on the Model for Improvement, looking at setting aims; measures; understanding your system; identifying changes; testing those changes and spreading improvements.

The skills focus on a person-centred approach in all we do, using measurement for improvement and small tests of change to achieve high reliability.

Improving Quality Together has three main levels - Bronze, Silver and Gold, complemented by a Board level.

Improving Quality Together will:

- Equip you to find new ways of working to save you time and reduce stress.
- Help you put the people you help at the heart of everything you do.
- Help you provide an even better service.

Find out more about Improving Quality Together at www.IQT.wales.nhs.uk
The Quality Improvement Guide

‘The 1000 Lives Plus Quality Improvement Guide’ brings together learning from around Wales - and further afield - to explain how a simple set of techniques can be applied to improve the quality of services provided. It will encourage everyone (the public, carers, managers, healthcare professionals, accountants, board members) to apply these techniques and be part of introducing change to bring about improvements.

Includes:

- Person driven care
- The Model for Improvement
- Putting it into practice
- Teamwork and leadership
- Measurement and reliability
- Common improvement questions

Also introduces Improving Quality Together, a national approach to improving standards and delivering care in NHS Wales.

Published by 1000 Lives Plus, the national improvement programme supporting organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales.