

# Why QI?

A guide to quality improvement  
from the Faculty of General  
Adult Psychiatry

# Why QI?

Put simply, the College believes quality improvement (QI) is the right thing to do – for service users and carers; for staff; for organisations; for commissioners; and for the NHS.



an interesting and informative read, we want it to be a call to action to try QI for yourself.

Firstly, we want to show that anyone can do it. The jargon can be off-putting, but anyone can have a go, from trainees to consultants. The fact is that fresh eyes and a breadth of experience are both equally valuable when doing QI.

Secondly, we want to inspire you, by showing you the range of QI projects taking place across the country, from huge organisational-level change, to small local projects. It's not just about using tools and techniques; it's about having a QI culture, ways of working and a 'can-do' mindset.

Thirdly, we want to share and spread our learning, creating a conversation across the faculty. We've recently updated our newsletter to include business updates and board meeting minutes so that you can read, reflect and feed back to us. We'd like you to do the same with this Guide, and help the faculty on its QI journey. This is the first time we've produced a document like this – tell us what you think!

I hope that you enjoy reading the Guide, and that it gets you thinking about QI.

There's lots of support to help you get started, within the faculty and outside it. Take a look at the information at the weblink (below), or you can contact:

**Dr Billy Boland,**  
Vice Chair of the Faculty of General Adult Psychiatry  
Consultant Psychiatrist in Community Psychiatry and Deputy Medical Director, Hertfordshire Partnership University NHS Foundation Trust

<http://www.rcpsych.ac.uk/workinpsychiatry/faculties/generaladultpsychiatry.aspx>



Dr Billy Boland

**A**s the largest RCPsych Faculty, we have a huge potential to affect positive change in the health service, in large part by getting on board with the national drive around QI. We must build quality and efficiency into everything we do. This was recognised in the 2016 King's Fund report 'Improving quality in the English NHS', the basic thrust of which was that if we don't focus on QI, the health service might fall over. Similarly, the 2016 Acute Adult Psychiatric Care Commission report, 'Old Problems, New Solutions: Improving acute psychiatric care for adults in England', included 12 recommendations, two of which were around QI: the need to embed a QI culture, and for an organisation to help its people develop

QI skills. The report authors found that places doing best in providing high-quality services had invested in quality improvement.

The College developed its QI strategy in response to this report, the implementation of which is being led by Dr Amar Shah, who is interviewed in this Guide. In turn, the Faculty's QI work is to enable the College strategy. But how do we turn good intentions into reality? Last summer, we carried out a survey asking you for your take on the report, and whether its recommendations were happening. Of the 500 plus respondents, just over 50 per cent told us their organisations were using or promoting QI for service development in some way – so 50 per cent were not. We

urgently need to close this loop.

The College's QI strategy will help to provide opportunities for members to build QI skills, but we also need to explain the principles of QI, and show that it really does work. This is why we've produced this Guide – to allow members, in their own words, to share their experiences of QI.

The fact that around 80 per cent of the people we spoke to in the creation of this guide named physical health checks for psychosis patients as one of their projects speaks to the commonality of issues facing the profession across the country – and shows the range of QI solutions, from large to small, that people have used to successfully tackle them.

While our hope is that the Guide will be

# Q&A

with RCPsych's QI lead, Dr Amar Shah

**A**mar Shah is the College's first-ever Quality Improvement lead. As Associate Medical Director (Quality) and a Consultant forensic psychiatrist at East London NHS Foundation Trust, he leads one of the largest mental health improvement programmes in the world, with the aim of providing the highest quality mental health and community care in England by 2020.



Dr Amar Shah

## How do you define QI?

I think of QI as the use of a systematic method to tackle a complex problem, which involves testing and learning, and is undertaken by those close to the problem. It should feel more engaging and can be more innovative than the traditional method of top-down decision-making.

## What skills do we need for QI?

All of us do QI all the time, even if we don't realise it, for example, in achieving personal objectives and goals, or in doing tasks like planning a holiday. We are constantly experimenting and learning about the best way of doing things. QI is about applying this same concept of learning and experimentation to solving problems in our clinical work. However, it's important to say that sustainable system-level changes can't happen by individuals working alone. It needs collaboration to succeed.

## Why is QI so important?

QI is a choice. In any organisation, particularly in the health sector, we recognise that our biggest assets are our people, both those providing and receiving services. For those in leadership roles, it's about realising you can't bring about change and solve problems by yourself – in fact, it's highly likely that you won't have all the solutions to our most complex problems. Our role as leaders becomes more about giving other people the chance to help discover the answers, provide them with the skills to improve the system and remove any barriers they face. For decades, the NHS has worked in a system of command and control, and it's not an easy task to change this culture. Sometimes a decision needs to be taken, but most of our really complex issues, such as improving quality while sustaining costs, can't be solved from the top of an organisation. Thinking that they can is an illusion. The solutions need to be identified in collaboration with those who receive care and those who deliver care.

## What's the difference between QI and assurance?

Assurance is something designed to give you reassurance that you are where you should be. It happens periodically, against a set of standards or best practice e.g. audit or inspections. QI, on the other hand, is about making continuous, iterative changes to the way your team functions towards reaching a shared goal.

## Why should psychiatrists be interested in QI?

As psychiatrists, we have a really important role in defining and shaping the culture in our teams. We are skilled in multi-disciplinary working, and at understanding and supporting change in human behaviour, so are in a great place to do QI. We have a responsibility to demonstrate that things can be better than the status quo, and that there are better routes to improving outcomes for those we serve.

## What are you asking the Faculty to do with regards to QI?

First of all, have a go at using QI with your team to solve a complex quality issue, and advocate within your organisations for a longer-term plan to build skills and support for this kind of work. The College is starting to think seriously about how to support psychiatrists in the application of QI in mental health services. We want to incorporate this into the events and training run by the College and faculties. We also want to share learning so we can also see the great work that's happening, and be inspired to try some of the new ideas in our own services.

Every Faculty has a QI rep, so please share your stories and QI ideas with me or with Billy.

<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement.aspx>

## CASE STUDY

## Cultural change in Chesterfield Community Mental Health Team (CMHT)

Dr Paul Rowlands is a Consultant Psychiatrist in the Chesterfield Community Mental Health Team, part of Derbyshire Healthcare NHS Foundation Trust, and Head of School for Yorkshire and the Humber.

Previously Vice Chair of the General Adult Faculty, he is a long-standing champion and practitioner of QI, and has worked with his team to create and embed a culture of continuous improvement, with impressive results - from introducing a 'same day' dispatch system for correspondence and increasing capacity through the creation of Recovery Clinics, to working with service users to co-produce a physical health programme.



Dr Paul Rowlands and the Team

I'm one of two consultant psychiatrists in the Chesterfield Community Mental Health Team. Our 15 staff have huge volumes of work to deal with – we look after a patient population of 106,000 – but our QI culture means that we're always striving to do things better.

The NHS needs more resources. We accept that, but we won't say we can't do something because of it. Things like identifying and cutting unnecessary tasks don't have to cost anything, and can make a huge difference. We have low bed occupancy and low use

of acute services, and this is all due to our embedded QI mindset and our collaborative approach, which is something we feel really makes us stand out in the Trust.

To my mind, there are two parts to QI: firstly, the development of a culture and a way of thinking, and secondly, the flexible use of QI approaches.

Our way of doing things is rooted in the Gemba Kaizen approach, which is about building quality into what you do from the very start. It was first developed to ensure consistent quality in manufacturing

processes, and because of this some healthcare professionals say, "this won't work for the NHS because we're about people, not car parts." In actual fact, it's completely applicable to healthcare. Some teams in the Trust have lengthy waiting lists for relatively simple interventions, and long waits for things such as psychotherapy. In my view, it's better to offer no service at all rather than one you need to wait three years for. It's just not acceptable. We knew there was no point in waiting for people to give us money to try to fix things, so instead we started by asking 'what can we do differently?' For example, using a Run Chart for referral numbers, we predicted numbers of how many patients would be referred to the service, and using flow charts identified the number of available slots we'd be able to offer, successfully eliminating a waiting list. To promote flow for people within the service, we created timely, clear pathways for particular diagnostic groups. We created alternative services to the traditional model of care co-ordination in the form of Recovery Clinics to increase capacity in the system, allowing step-down with an option of rapid step back-up if required. This sort of timely intervention is not only better for patients, it's better for the system because it helps us to avoid 'failure demand'. This is when something goes wrong because of a failure in the system that occurred at an earlier point. Healthcare is full of failure demand, and the cost of this can be huge. A lot of people end up in expensive, high-intensity parts of the system because they didn't get the resources they needed at the right stage, which would have meant they could have been treated in a less resource-intensive and expensive way. A week of acute in-patient care costs roughly the same as a year of CMHT care. It's not just clinical improvements that make a difference. One of our recent QI successes saw us drastically

improve our transcription processes. We found ourselves in an unacceptable situation where it could take up to a month from dictating a letter to it reaching the patient's GP. We began by mapping the transcription process to see where the delays were occurring, and to allow us to think about how we could improve each stage. We brought in digital dictation, uploading files directly onto the trust's computer system so the transcribers could access them immediately. We worked with the transcription team to consider how they could better organise their workload, by sharing with them our schedules and letting them know in advance when we needed them to be ready to transcribe. It really enthused them to get involved in the project and the solution truly was co-produced. Now, I check and e-sign letters on the same day I transcribe them, and most of the time, they're sent to the patient's GP the same day. My team and the transcription team have a running joke that our aim is to get the letter to the GP and patient before the patient has left the clinic! Because the waiting times for letters was so poor, the Trust agreed with GPs and commissioners a target that 90 per cent of letters would be sent out within ten days. But once you set targets you're moving away from a QI mentality. In the QI world, you do things when they need to be done. There's no need to have any wait if you have the right process in place. We should aim for improving a process for the long-term – not to hit targets or pass inspections. My team has the philosophy of 'inspect us when you like'. We're always ready to show what we're doing, what we're trying, and the issues we're addressing. The statistician and quality management consultant W. Edwards Deming said 'Cease dependence on inspection to achieve quality. Eliminate the need for inspection by building quality into the product in the first place.' I think that says it all.

### Hints and tips:

#### Paul's QI advice

It's important to develop a 'QI-eye', and ask yourself 'with the resources I have, what can I do?' A QI mentality doesn't start from 'we need more resources'. Assume those won't be coming any time soon. My team mentality is that we're incredibly can do. We're constantly thinking about how we can add value for the patient and maximise our effectiveness. The transcription project is a great example of how a simple mapping process completely transformed a way of working that was inefficient and causing problems. Throwing money at the issue wouldn't have solved it. And not only has working together to identify the blockages and address them removed the problem, but it has also increased morale and team working.



Dr Justin Earl and the Team

## CASE STUDY

# Helping to ensure continuous quality improvement and innovation

Justin Earl is Associate Medical Director for Quality Improvement & Innovation at South West London and St George's Mental Health NHS Trust, and a Consultant General Adult Psychiatrist in the Kingston and Richmond Assessment Team. The Trust is in the early phases of implementing its Quality Improvement & Innovation (QII) Programme, and has over 30 projects underway. Justin was introduced to quality improvement through his participation in the Darzi Fellowship in 2009. After completing his specialist training, he began applying QI methodology by making small-scale changes in the Community Mental Health Team in which he was a consultant. He joined Springfield Consultancy, a healthcare consultancy led by mental health professionals, as an associate in 2016 and was subsequently appointed to the QII post at South West London and St George's in February 2017.

The Board believe that the investment in quality improvement will support the delivery of the Trust's vision of "making life better together" through a mind-set of continuous quality improvement. We put forward an initial business case at the end of 2016 to create a Quality Improvement & Innovation (QII) Team, comprising 0.4 WTE of a consultant, a full-time admin role and a full-time Band 7 programme manager. Funding was agreed for the first year to enable the foundation work to commence with a full business case due in March 2018.

Springfield Consultancy was commissioned as our QI provider and partner. They have significant experience as they have worked closely with the Health Foundation, supporting over 150 health-related QI projects across the NHS. In addition, Springfield is led by two mental health professionals, which means they have a unique understanding of the mental health context in which we all work. Capability building is our current focus. We offer Foundation QI training, which is a blend of two half-day workshops plus eight e-learning modules (an e-Learning package called 'QI4U' which is purchased from the North West CLAHRC). In addition, we run an Intermediate training course for those with more experience of systems change and QI methodology. We are also setting up training for student nurses and Higher Specialist Trainees. Our initial training target was 140 staff in the first year of the programme. To date we've trained 180, and expect that number to rise to 200 by the end of the year. The training is voluntary so we've been very pleased at the response: there's definitely a hunger for it. At the same time the QII Programme was launched in the Trust, the organisation underwent significant re-structuring into a Service Line Management structure. Although this

was challenging, it also presented a unique opportunity to embed QI into the new service structures. QI is all about learning and adjusting in response to that learning, and that has been our approach to capability building. Feedback from staff was that the foundation programme was a significant time commitment, so we have introduced "Taster QI". This is a one-hour applied training session, where we train a whole team on how to use the Model for Improvement – the QI framework we have chosen – to address an issue they are currently facing. Teams can set up their QI project in the meeting with our support, and then have continued coaching as they lead on the delivery of the project. We currently have over 35 active projects taking place across the Trust. One that has shown great results has been the Cardiometabolic Assessment (CMA) project for patients with psychosis. Work is now focused on embedding the practices developed through the CMA project into the psychosis care pathway project. Other projects include 'Safer Care', which is focused on how we can enable teams to deliver the safest care to service users and includes reviewing risk assessment and risk management practice; projects to reduce violence and aggression and restrictive practice on acute and forensic wards; and a number of projects led by our pharmacists at reducing waste and increasing safer prescribing practice. We have a stratified approach to the projects we support in that we have a number of large scale projects focused on priority areas along with local projects developed and championed by staff in their teams – this is where a lot of the energy and enthusiasm is generated. For example, our core trainees are running a project to improve the experience and effectiveness on calls using new technology. The tech will make it safer for doctors to move around our large

and complex sites, especially at night. And QI is not just about clinical work; colleagues are considering how to streamline the process for mental health paperwork, and our HR department is looking at increasing the efficiency of recruitment processes. The great thing is that people aren't afraid of applying QI to their most intractable problems – they're realising that a different way of thinking is needed to bring about change.

### Further information

<http://www.springfieldconsultancy.co.uk>

## Hints and tips:

### Justin's QI advice

The important thing when introducing QI to an organisation is that staff need to be supported with time – not just time to do the training, but to actually work on QI projects.

Using your organisation's structures to embed the QI way of thinking is essential – senior leaders such as Clinical Directors and Heads of Nursing need to enable it and own it, supported by QI teams, where available. Often organisations undertake transformation programmes without a clear articulation of what will be different at the end. Having a shared vision of how your organisation will be different by embedding QI into everyday practice will help energise staff to get involved.

## CASE STUDY

## Supporting a trainee to take the lead in QI

Dr Mariam Omar is a Consultant Psychiatrist working across the Crisis Assessment and Treatment Team and Acute Day Treatment Unit at Hertfordshire Partnership NHS Foundation Trust.

Mariam was the supervising consultant on a QI project led by her former trainee, Foundation Doctor Dr Japna Satara. Using the Plan Do Study Act (PDSA) cycle, their team brought about a significant increase in the number of physical health checks carried out on their patients.



Dr Mariam Omar with the Crisis Assessment and Treatment Team at Hertfordshire Partnership NHS Foundation Trust



Dr Japna Satara and RCPsych Registrar Adrian James

In the crisis team, physical health monitoring was not optimal. Morbidity and mortality rates are higher for our patients than the general population, so we knew this was a need we had to address. Our QI project started off as an audit, led by Japna, but turned into something much more. We understood some of the reasons why physical health checks weren't being carried out – patients were only under our care for a very short period of time, we had limited access to treatment rooms, and a lack of basic equipment to hand. I supported Japna in turning the audit into a bigger project,

taking the opportunity to try something new by implementing a Plan Do Study Act (PDSA) cycle to tackle the problem head on. This was a big learning curve for both of us.

Japna led the three-month project, and our nine-strong team participated. We started from a baseline of zero, and our aim was to ensure that 100 per cent of our patients received physical health checks.

The PDSA cycle is a relatively straightforward process. Japna kicked things off by giving a presentation to the team, outlining the issue, getting them on board and assigning roles. We then looked at the physical health checks carried out during a one month period to see what problems were identified and why those were occurring. One of the nurses on the team came up with the idea of introducing a standardised template for physical health checks, because she said prompts would be helpful and would save time. The templates were filled in and submitted to Japna, who inputted the data into a spreadsheet. After one month, we re-audited. We decided that instead of shared patients across the acute day treatment unit and the crisis team being checked twice, the acute day unit would take charge of their physical health checks, to take the pressure off the crisis team. We found that by doing this our results improved.

Another intervention was to use our team budget to give each team member a set of equipment to allow them to perform physical health checks. They carried this around with them, so were always prepared. They were responsible for making sure they

had everything they needed, and that everything was in working order – this saved a lot of staff time.

The big advantage of using a PDSA cycle was that we could revisit the project at any point. Each intervention was a build on the problems faced with the one before. We tried something, audited it, discussed it with the team and then tweaked it, before starting the cycle over again.

We didn't manage to reach our 100 per cent target within the timespan of the project, but we did reach 60 per cent, which was a big improvement. Shortly after the project finished, Japna gave a poster presentation at the RCPsych's QI Conference in March 2016. She was the youngest participant to give a presentation, and she won.

Since then we've kept on using the templates, and we're keen to do even more. Japna has now moved on, but my new trainee has picked up the reins and we'd like to look at what else needs to be changed, using QI methodology.


While audits have their place, they can become tick box exercises. The big difference between auditing and QI, in my opinion, is that QI keeps people's interest. It's far more engaging. Doing a one-off audit is completely different from revisiting a project on a daily basis with your team. It keeps you on your toes by encouraging you to think about how things are going and how things could be made better, and everyone can contribute ideas.

**Further information**  
PDSA cycle (Plan-Do-Study-Act)

 Hints and tips:

**Mariam's QI advice**

QI facilitates team ownership, which is a big plus. The minute you mention an audit you see faces drop, but QI brings about enthusiasm. Everyone feels part of it because they have a role to play. That sense of ownership and being able to fully participate is key. Our project was a small one, led by the most junior member of the team, but it had a big impact. Team working can bring about amazing results. Don't be afraid to try things! There's no pressure to get it right first time – the important thing is that you're learning as a team, and eventually you'll hit on the right solution.

 Hints and tips:

**Japna's QI views:**

Leading the QI project was both challenging and invigorating. Being the most junior doctor on the team and its newest member, my biggest task was trying to get all the other members of the multidisciplinary team on board. Creating new work with a requirement to monitor physical health did not initially take off as well as I had hoped. By educating the team about the importance behind the project, and in staying determined, by the end of the three months I had made a vast improvement. I evaluated each intervention every month and discussed any difficulties the team faced. This allowed me to make changes and adapt the QI project to run more successfully. I thoroughly enjoyed leading this project, and it highlighted to me the importance of quality improvement in making positive changes for better practice and patient care.

## CASE STUDY

## Improving Physical Health Care for People with Psychosis (PHCP)

Dr Asif Bachlani is a consultant psychiatrist and Clinical Lead for Mental Health Tariff at South West London and St George's Mental Health NHS Trust. He currently works for the Kingston Recovery and Support Team, a community-based mental health service for adults between 18-65 years old. Asif is also the General Adult Psychiatry Regional Representative for South West London.

Previously, Asif worked at North East London NHS Foundation Trust (NELFT) as Associate Medical Director, and was co-founder and clinical lead for Improving Physical Health Care for Patients with Psychosis (PHCP), a Health Foundation Quality Improvement Project. The project is a collaboration with North East London Local Pharmaceutical Committee (NELLPC), which sees community pharmacists delivering health checks to patients with psychosis. Asif is now an external consultant on PHCP.



Dr Asif Bachlani and the Team

Since 2014 there has been an increased focus for mental health services, supported by the national CQUIN measure, to ensure that patients who are taking anti-psychotics have regular physical health checks, but there is evidence that the standard models of physical health care are not meeting the needs of these patients. The NAS Audit 2014 showed that only 32% had all five cardio-metabolic risk factors monitored, and that NELFT was in the bottom third of English mental health trusts nationally, having only 15% of cardio-metabolic risk factors. This

made it the poorest performer of London trusts for physical health monitoring. Around that time, I was invited to a talk held by North East London community pharmacists about models of self-care. They had started performing physical health checks for people with common mental disorders such as anxiety and depression, using a self-care model that aimed to support patients to self-manage and take control of managing their illness. It occurred to me that carrying out health checks in pharmacies for people with more severe mental health disorders might work for this difficult-to-reach population. I floated the idea

and received a positive response – local pharmacies had the capacity, and were happy to be involved in a pilot.

The first step was to get the necessary funding. I approached the CCG and my trust, but due to funding pressures neither was in position to assist. So, in late 2015, working with NELLPC we applied for a Health Foundation Innovation Award. It took 18 months for PHCP to be awarded funding, but while we waited, we tried various methods to improve the uptake of health checks for patients with psychosis, with variable levels of success.

Firstly, we trained the community team's psychiatric nurses to carry out the checks. This wasn't successful. They were asked to do this on top of their other work, and as they were already at maximum capacity they were understandably resistant to the idea. We also tried carrying out the checks while patients were attending depot or clozapine clinics, but as these were short appointments, this meant they had to make a separate appointment to come in for a health check, which few felt motivated to do. We then tried working with our colleagues from community services from the Walk in Centre in the same unit to carry out the health checks, but because the service was so busy they were only able to carry out the physical health checks during a set time. We encountered the same problem of patients having to come back to the hospital to have the health checks and only managed to achieve a 20% attendance rate. It was clear that we needed a specific intervention to allow us to meet the needs of our patients in the community, and to meet the CQUIN targets.

In July 2016, we were delighted to be awarded a Health Foundation Innovation Award of £75k. This allowed us to fund the pharmacists to carry out the health checks, and we were able to recruit ten pharmacies in the local community of Barking and Dagenham.

Patients were encouraged by the community mental health team to make an appointment with a pharmacy at a time and date that suited them. At the pharmacy, they underwent a comprehensive health check, including an ECG, blood pressure, cholesterol and

glucose checks with same day reporting of the results. Patients really liked it because the pharmacists spent up to an hour with them coaching and empowering them to self-manage their physical health, which is far longer than we could offer in the trust, due to other pressures.

One of the biggest challenges was to empower and motivate patients to take an interest in their physical health and to actually attend physical health checks. We achieved this by producing a patient information leaflet given to patients by their community nurse, explaining why these checks are important.

Another obstacle was that the trust and pharmacists use different EPR systems, and although the checks were being carried out and recorded by pharmacists on their system, we needed to record it on ours too, to show progress in meeting our targets. We initially explored using one IT system across the two organisations but this was not achievable within the time frame of the project. Instead, we created a post to act as a liaison between the trust and the pharmacies as well as support data entry and booking of physical health checks. This post was vital to the project and ensured close collaboration of the two organisations.

Now, over 18 months on, 140 patients (77%) of patients who were offered health checks in a community pharmacy have had one. In addition, 71% of attendees had all five Lester cardiometabolic risk factors monitored - significantly better than NELFT standard care in B&D (treatment as usual TAU), where only 36% of patients had all five checks. In addition, 100% of patients attending community pharmacy checks had health coaching to support them with smoking, diet and exercise, compared to 44% using TAU:

- 22 received support to stop smoking
- 56 received support for exercise
- 78 received support to eat healthier or lose weight.

Within the project team and NELFT talks are underway about how to continue the project past the end of the funding of the project. What is working

in favour of the project is that we now have evidence to support a business case – we can show that PHCP costs less money than providing the health checks within the trust, and that it frees up clinical staff time.

### Further information:

[www.health.org.uk/programmes/innovating-improvement/projects/improving-physical-health-care-patients-psychosis-phcp](http://www.health.org.uk/programmes/innovating-improvement/projects/improving-physical-health-care-patients-psychosis-phcp)

## Hints and tips:

### Asif's QI advice

I've always been interested in improving things. For me, QI is very similar to service improvement, but with added advantage of having measurable outcomes that can prove whether the project worked or not. The question you need to ask yourself is, is there anything within your service that needs to be improved? And if there are things that aren't working, are you going to complain about it, or do something about it? There are opportunities for us to do things better, and this is my way of thinking.

If you're interested in QI, my advice would be to develop good relationships with the people you work with, and form a gang of like-minded people who are keen to make services better. Often the start of a QI project is simply sitting down and having a chat and a moan about something that is not working, then coming up with a solution to try out and test. I would encourage others to be bold - don't accept the status quo and seize the opportunities that come your way to improve things!



Dr Rowan McClean

## CASE STUDY

### A Trust taking the lead in embedding QI

Dr Rowan McClean is a Consultant Psychiatrist at Belfast Health and Social Care Trust, and a Clinical Director of Community Mental Health Services. He is also Chair of the Northern Ireland division of the General Adult Faculty. Belfast Trust is focusing on QI as a core principal in improving services for patients. They are committed to growing a QI culture and embedding QI behaviours to sustain safety and quality, and in 2015 launched the 'Safety Quality Belfast' (SQB) programme, rolling out QI training across the Trust so that all staff, at all levels, can learn about QI methodology. They are aiming to train 1,000 staff by 2020.

I was on the SQB programme last year, and like other graduates of the scheme, am now a mentor for those about to undertake it.

The nine-month programme is a mix of workshops and lectures, and encourages you to undertake your own QI project to put what you're learning into practice.

There are numerous QI projects going on around the Trust, focusing on a wide range of topics, including ADHD medication, staff morale, reducing did not attend rates; making educational films for patients; and reducing the number of patients who go AWOL from inpatient units. It's becoming very embedded. We hold celebration events for those finishing their training and prizes are awarded, so there's a real feel-good factor, and it's a great way to share our projects with colleagues across the Trust.

My QI training project was to look at improving the quality of physical health-checks for patients on Clozapine. Our aim was that 95 per cent of patients would have greater than 70 per cent of recommended physical health measures recorded in their medical chart within an eight-month period. I worked alongside another psychiatrist, a trainee and colleagues from pharmacy and nursing to develop a proforma to help us improve recording of measures. Our last evaluation showed that we'd done this for 60 per cent of patients – considering our baseline was zero, we are getting close to our ambitious aim, and I think this is most definitely an improvement! There was also an improvement in communication

between the outpatient clinic and the Clozapine team, and with GPs. The training is delivered internally by a network of QI leads, alongside e-learning modules via the Institute for Healthcare Improvement's (IHI) Open School. The SQB is for permanent members of staff, but there is a separate programme for all trainees now under the STEP programmes. I think it really helps that senior members of the Trust, including the Medical Director, are big advocates of QI. It doesn't feel like something that's being imposed on us from top-down though. The training is not compulsory, and you need to volunteer to get a place, but people are increasingly keen to do it – so much so that this year's course is over-subscribed, having 350 applicants. One of the big benefits is that it's about multi-disciplinary involvement at all levels, across all specialties, and the fact that managers are involved as well as clinicians. QI provides a forum for sharing ideas and trying things out. In my role as Clinical Director managers have told me they feel more empowered now that they can try things out that may or may not work, instead of going to endless meetings to try to agree an approach. Also, collecting data allows us to have more robust evidence rather than the anecdotal data we've relied on in the past. Currently we're using QI methodology to look at GP referrals and patient flow through our systems, making use of real-time data and outcome data to try to improve things. In my view, the reason that the QI focus in our Trust is proving so

successful is because it allows the frontline to focus on things that are important in their day-to-day work and to their patients, rather than meeting sometimes arbitrary targets.

## Hints and tips:

### Rowan's QI advice

When we talk about 'Plan Do Study Act' cycles and run charts it can sound like there's a lot of new stuff to learn, but it's quite simple – it's just good practice. It was drummed into us that the key thing is to start small, and roll something out only when you know that it's working. If you think your project is too big, it probably is. Going on the training was the first time I'd used QI methodology. I'd tried to do improvement projects at various times but they'd never got off the starting blocks. QI made a difference because it gave us a framework to work within – and we knew we didn't need to have all the answers before we started. Good QI is about learning as you go along, adapting if you need to.





**Headquarters:**  
21 Prescot Street  
London  
E1 8BB  
020 7235 2351  
020 7977 6655

