An Introduction to Quality Improvement

16\textsuperscript{th} March 2013
Welcome

• Sally Davies @sally_bobs
  - Quality Improvement Fellow

• Tom Downes @sheffielddoc
  – Clinical Lead for Quality Improvement

• Steve Harrison @stevenbexsheff
  – Service Improvement Manager
Agenda – Morning

• 0900-0920 Introduction and physical demonstration of complexity
• 0920-1000 Delivering exceptional quality: focus, pull and standard work
• 1000-1005 Pull the Lever
• 1005-1045 Microsystem Redesign – An introduction and case study
• 1045-1100 Break
• 1100-1230 Paper Airplane Factory
• 1230-1330 Lunch + Tom Smith, Chief Executive BSG
Agenda – Afternoon

• 1330-1430 Workshop managing capacity and demand models for clinical services
  (Video link from IHI, USA with John Boulton)
• 1430-1445 Q+A
• 1445-1500 Break
• 1500 – 1510 Push the Fat Man
• 1510 - 1630 Interview fishbowls
• 16.30 Close
• 18.30 Dinner at Essence Restaurant, Stratford
Aim of Day

To prepare attendees for clinical leadership of complex health care systems
Activity

Please form a line in rank order of distance travelled to this event
Introduce yourself with:

• Name
• Place of work
• Role
• Expectation of the day
Exercise Debrief

- Physical demonstration of complexity
- The challenge of rapid problem solving in the absence of full information
- Novelty – a new problem
A patient story

- **Sunday**: Painful hand
- **Monday**: Surgery
- **Tuesday**
- **Wednesday**
- **Thursday**
- **Friday**
- **Saturday**: Discharge

- **IV antibiotics**
- **Oral antibiotics**
What is QUALITY IMPROVEMENT?
High Quality care is care that is:

• **Safe** – no needless deaths
• **Effective** – no needless pain or suffering
• **Patient-Centered** – no helplessness in those served or serving
• **Timely** – no unwanted waiting
• **Efficient** – no waste
• **Equitable** – for all
Improvement

The combination of a ‘change’ (improvement) combined with a ‘method’ (an approach or specific tools) to attain a superior outcome.
COMPLEXITY
Ford Mustang

1968

2013
Royal Hallamshire Hospital

1968

2013
Age-standardised five-year relative survival rate, female breast cancer, England and Wales, 1971-2009

% survival

Period of diagnosis


* England only
Health care: Good News / Bad News

Chance of Successful Outcome

Potential

Actual: Great

Actual: Poor

Surgery

Post-Op

Time

Sheffield Teaching Hospitals
NHS Foundation Trust
A patient story

- Painful hand
- Workaround admission
- IV antibiotics
- 3 hours to access
- Oral antibiotics
- No antibiotics
- Wound examined
- Wound redressed
- Antibiotics late
- Calls unanswered
- No antibiotics
- Second operation
- Staph / Strep mop
- No antibiotics

Timeline:
- Sunday
- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday

Sheffield Teaching Hospitals
NHS Foundation Trust
TOYOTA
1. Focus Factory
2. Pull system
3. Standardisation
1. Job shop to focus factory
1. Job shop to focus factory
2. Chaotic Push to Self Pacing Pull
Patient Cycle Times in DRU Falls Clinic

Split Start: 1
Median: 380.5, 155.0
3. Improvisation to Standard Work
Standard installation
# WHO Surgical Safety Checklist

## Surgical Safety Checklist (First Edition)

### Before Induction of Anaesthesia
- **Sign in**
  - Patient has confirmed:
    - Identity
    - Site
    - Procedure
    - Consent
  - Site marked/not applicable
  - Anaesthesia safety check completed
  - Pulse oximeter on patient and functioning
  - Does patient have a:
    - Known allergy?
    - No
    - Yes
    - Difficult airway/aspiration risk?
    - No
    - Yes, and equipment/assistance available
    - Risk of >500mL blood loss (7mL/kg in children)?
    - No
    - Yes, and adequate intravenous access and fluids planned

### Before Skin Incision

### Before Patient Leaves Operating Room

### Time Out
- Confirm all team members have introduced themselves by name and role
- Surgeon, anaesthesia professional and nurse verbally confirm:
  - Patient
  - Site
  - Procedure

### Anticipated Critical Events
- Surgeon reviews: what are the critical or unexpected steps, operative duration, anticipated blood loss?
- Anaesthesia team reviews: are there any patient-specific concerns?
- Nursing team review: has sterility (including indicator results) been confirmed? Are there equipment issues or any concerns?
- Has antibiotic prophylaxis been given within the last 60 minutes?
- Yes
- Not applicable
- Is essential imaging displayed?
- Yes
- Not applicable

### Sign Out
- Nurse verbally confirms with the team:
- The name of the procedure recorded
- That instrument, sponge and needle counts are correct (or not applicable)
- How the specimen is labelled (including patient name)
- Whether there are any equipment problems to be addressed
- Surgeon, anaesthesia professional and nurse review the key concerns for recovery and management of this patient

---

*This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.*
Surgical Safety Checklist

Full Implementation of Surgical Safety Checklist
“Over the next five years, competitive advantage will come from the ability to execute not create knowledge.”

Jim Easton,
Former Director for Innovation,
National Commissioning Board
An Introduction to Microsystem Improvement & The Cystic Fibrosis Project Brandon Case Study

Steve Harrison
16th March 2013
Content

• Define and introduce the concept of microsystem improvement

• Ownership vs. buy in

• Describe the microsystem improvement structure and some examples of results using a CF Case study
MICROSYSTEMS: AN OVERVIEW
Microsystems

• 1992 – Quinn – ‘Intelligent Enterprise’

• Studied the ‘best of the best’

• They are organised around the frontline interface with the customer

• ‘Smallest replicable unit’
“Why are some service organizations enjoying explosive growth and margins?”

He found that the “big” focus on the “smallest replicable units” AKA “microsystems”

• Front office fixated on front line perfection
• Quality, efficiency, timeliness, service excellence designed into front line
• Value and loyalty created at customer-provider interface
Microsystems

• Nelson, Batalden, Godfrey 2000 – 2007

• Looked at the characteristics of high performing clinical microsystems

• Formulated a curriculum to develop high performing microsystems
What is a Clinical Microsystem?

‘The Place where Patients, Families and Clinical Teams meet’

• The essential frontline building blocks of any healthcare system. **It is where the quality is delivered.**

*It’s where everything happens with, for and to the patient and family*
Microsystems

The small frontline units of healthcare

- A small population of patients
- A small group of doctors, nurses & other healthcare professionals working together – multidisciplinary team interdependent for a common aim
- Some administrative support
- Some information and information Technology

Can have clinical or supporting Microsystems
Supporting Microsystems

People with Healthcare Needs

- Access System
  - Clinical Issue
  - Enrollment And Assignment
  - Initial and Continuous Orientation
  - Assess & Plan Clinical Care

- Functional & Risks
  - Biological Expectations
  - Costs

- Information
  - Telephone
  - Web
  - Printed Material
  - Shape Demand

- Chronic
- Healthy
- Very High Risk

Other Care Locations
- Hospital
- Home Health
- ER/Urgent Care
- Nursing Home
- Other Clinical Offices

Prevention
Acute
Chronic
Palliative

People with Healthcare Needs Met

Access System
- Clinical Issue
- Enrollment And Assignment
- Initial and Continuous Orientation
- Assess & Plan Clinical Care

- Functional & Risks
  - Biological Expectations
  - Costs

- Information
  - Telephone
  - Web
  - Printed Material
  - Shape Demand

- Chronic
- Healthy
- Very High Risk

Other Care Locations
- Hospital
- Home Health
- ER/Urgent Care
- Nursing Home
- Other Clinical Offices

Prevention
Acute
Chronic
Palliative

Pharmacy
- Referrals
- Billing
- Physical Space

Functional & Risks
- Biological Costs
- Satisfaction
Supporting Microsystems Have Many Roles: 
*Within* their *own* microsystem and as *members of other* microsystems
Microsystems are the **building blocks** that come together to form Macro-organizations.

**System Levels**

- **Macrosystem**
- **Mesosystem**
- **Microsystem**

**Example**

- STH
- Chest Medicine
- Cystic Fibrosis Outpatient Clinic

The health system can be no better than the small systems ...
• Some of you have a card on your chair
• Read out in turn
• Hands up - Is this a Microsystem?
“The principal task of the mesosystem is to enable the work of the microsystems for the population(s) of patients served.”

Paul Batalden
High Performing Clinical Microsystems

- **Leadership**
  - Leadership
  - Organizational support

- **Staff**
  - Staff focus
  - Education & Training
  - Interdependence of care team

- **Performance**
  - Performance results
  - Process improvement

- **Patients**
  - Patient Focus
  - Community & Market Focus

- **Information & Information Technology**
“Every system is perfectly designed to get the results it gets.”

Paul B. Batalden, MD

Co-Founder The Institute for Healthcare Improvement
Founding Director, Center for Leadership and Improvement,
The Dartmouth Institute for Health Policy and Clinical Practice
THE MICROSYSTEMS APPROACH TO IMPROVEMENT
- ‘OWNERSHIP’ VS. ‘BUY IN’

These are not the same thing

Why?
‘Ownership’

• is where you share the ownership of an idea, a decision, an action plan.

• You have participated in it’s development, you have chosen it of your own accord and you endorse it.

• You understand it and believe in it and are willing to implement it
‘Buy In’

‘Buy – In’ is the opposite

• Someone else has done the development, the thinking

• They are now telling you or convincing you to implement their ideas
Microsystem improvement is about ownership

REDESIGN FROM THE INSIDE - OUT
‘If you want to make true and lasting change, ask the people who do the work how to go about it’

Daren Anderson, MD
VP/Chief Quality Officer
Community Health Center, Inc.
Based on experience, what is recommended for successful improvement work?

1. The need for **structure**
2. A **coach** to inspire and support
3. Must have senior management **leadership**
4. Must **spread** and share
Microsystem Improvement - The structure

SDSA 'Standardise'

Assess - 5Ps

Diagnose – Change Ideas

Treat - PDSA
The Dartmouth Microsystem Improvement Ramp

- Global Aim
- Specific Aim
- Measures
- Flowchart

5P Assessment

Effective Meeting Skills
A JOURNEY UP THE IMPROVEMENT RAMP

Cystic Fibrosis Outpatients
Northern General Hospital
Sheffield Teaching Hospitals NHS Foundation Trust
Context

• Cystic Fibrosis in Sheffield has 150 patients in their system

• Based at the Northern General Hospital

• Outpatients – 2 main clinics staffed by doctors, nurses, dieticians, physio, respiratory physiologists and other healthcare professionals
Cystic Fibrosis Outpatients

- Microsystems Improvement approach first tested in Falls clinic early 2011 (Project Evie)
- Consultant from CF contacted SI team, suggested by Service Manager
- Pressing Issues – Capacity & Demand
Pre Phase – The Work Before the Work

• March 2011

• Met clinical leaders – ‘challenging’ team dynamics

• Lots of time invested in discussing the approach with the Doctors, manager and senior nurses

• Sought support from Clinical Director

• Agreed expectations, set a regular weekly meeting, communication plan, who would be involved, Patient representation

• Coach – visit
Initial Meeting - April 2011

- Introduced what quality improvement is
- Introduced effective meeting skills and roles
- Set up the ground rules

There's so much talk about the system. And so little understanding

Robert Pirsig
Zen and the Art of Motorcycle Maintenance

Ground Rules

- You are all equal
- System, NOT individuals
- Treat others as you would expect to be treated
- All contributions are valuable
- Please don't interrupt
- Don't say it can't be done!
- If you oppose, you must propose
- No meddling
- Please have fun
The Dartmouth Microsystem Improvement Ramp

5P Assessment

Effective Meeting Skills

5P Assessment

Effective Meeting Skills

Global Aim

Specific Aim

Change Ideas

Measures

Flowchart

Cause & Effect
5Ps Data Collection April – May 2011

- Took place over several weeks – pieced together
- Staff & patient survey
- High level process map
- Patients timed clinic
- National Benchmarking reviewed
- Data from hospital systems
- Capacity and demand forecasting
The 5Ps develop.....
Purpose

• What is the purpose of the microsystem?
• Lots of debate!

‘To enable people with CF to live as normal a life as possible’
5Ps review – May 2011

- Meeting dedicated to reviewing the 5Ps
- Team stuck post its – where they saw something to improve for Brandon
- Grouped these to form ‘Themes’
The Dartmouth Microsystem Improvement Ramp

- Global Aim
- Change Ideas
- Specific Aim
- Measures
- Themes
- Cause & Effect
- Flowchart

Effective Meeting Skills
CF improvement Themes

- Capacity & Demand
- Adherence
- Clinic Process & Flow
The Dartmouth Microsystem Improvement Ramp

Global Aim

Specific Aim

Change Ideas

Measures

Flowchart

Effective Meeting Skills

Themes

Cause & Effect
CF Clinic Global Aim

• We aim to improve the efficiency and quality of the service of the CF outpatient clinic for staff and patients. The process begins with first contact with the patient and ends with them arriving back to their home after the visit. By working on the process we expect; the DNA rate to improve, for there to be less waiting for patients, improved efficiency for patients and staff and to achieve a greater standard of our quality markers. It is important to work on this to improve the clinic experience for patients, meet CF trust standards, and to provide an area of clinical excellence.
The Dartmouth Microsystem Improvement Ramp

**Global Aim**

We aim to improve the efficiency and quality of the service of the CF outpatient clinic for staff and patients. The process begins with first contact with the patient and ends with them arriving back to their home after the visit. By working on the process we expect the DNA rate to improve, for there to be less waiting for patients, improved efficiency for patients and staff and to achieve a greater standard of our quality markers. It is important to work on this to improve the clinic experience for patients, meet CF trust standards, and to provide an area of clinical excellence.

**Change Ideas**

**Specific Aim**

**Measures**

**Themes**

**Cause & Effect**

**Flowchart**

**Effective Meeting Skills**
Flowchart – A detailed process map

• Took three sessions
• Everybody understood the process by the end!
• Generated lots of change ideas – Car Park
The Dartmouth Microsystem Improvement Ramp

**Global Aim**

- We aim to improve the efficiency and quality of the service of the CF outpatient clinic for staff and patients. This process begins with first contact with the patient and ends with them arriving back to their home after the visit. By working on the process we expect the DNA rate to improve, for there to be less waiting for patients, improved efficiency for patients and staff and to achieve a greater standard of our quality markers. It is important to work on this to improve the clinic experience for patients, meet CF trust standards, and to provide an area of clinical excellence.

**Specific Aim**

- **Themes**

**Effective Meeting Skills**

**Measures**

**Change Ideas**

**Cause & Effect**
Specific Aim – June 2011

• After reviewing the 5Ps and the Flowchart the team chose to reduce Patient waiting as their first Specific Aim

‘We aim to reduce average total patient waiting time within the 2 CF outpatient clinics by 50% from our baseline measure of 40 minutes by the end of October 2011’
The Dartmouth Microsystem Improvement Ramp

**CF Clinic Global Aim:**
We aim to improve the efficiency and quality of the service of the CF outpatient clinic for staff and patients. The process begins with first contact with the patient and ends with them arriving back to their home after the visit. By working on the process we expect the DTA rate to improve, for there to be less waiting for patients, improved efficiency for patients and staff and to achieve a greater standard of our quality markers. It is important to work on this to improve the clinic experience for patients, meet CF trust standards, and to provide an area of clinical excellence.

**Specific Aim:**

**Measures:**

**Change Ideas:**

**Global Aim:**

**Themes:**

**Effective Meeting Skills**
Why are Patients waiting in the CF clinic?

- Late & early arrivals
  - Culture – it’s accepted
  - Mismatch of arrivals and resources
- Communication
  - Fax machine doesn’t work properly
  - Dictation delays clinic, always get out of sync
  - Communication breakdown
- Scheduling
  - Mismatch of arrivals and resources
  - Don’t know how long things take – cycle times
  - Non standardised – variation in content
  - Waiting for other professionals to finish
- Treatments
  - Patients don’t have own transport
  - Hospital transport is late
  - Reliant on others for lifts
- Finding Things
  - Going to find nebuliser from the ward
  - Going to the Pharmacy if patient too unwell
- Interruptions
  - X ray
  - Telephone Calls
  - Calls from the ward
  - Pharmacy
  - Taking patient off for a ward tour
  - Answering the doorbell
  - Notes
  - Scales
  - Trials
  - PEG changes, not planned into timings

Additional notes:
- Patients don’t have their own transport
- Hospital transport is late
- Reliant on others for lifts
- Trial
- PEG changes, not planned into timings
- X ray
- Going to the Pharmacy if patient too unwell
- Telephone Calls
- Calls from the ward
- Pharmacy
- Taking patient off for a ward tour
- Answering the doorbell
- Notes
- Scales

Sheffield Teaching Hospitals NHS Foundation Trust
Why are Patients waiting in the CF clinic?

- Communication
  - Fax machine doesn’t work properly
  - Dictation delays clinic, always get out of sync
  - Lots of paperwork - delays the clinic

- Late & early arrivals
  - Culture – it’s accepted
  - See early patients early (sometimes)
  - See patients even if late
  - Patients don’t have own transport
  - Hospital transport is late
  - Reliant on others for lifts

- Scheduling
  - Mismatch of arrivals and resources
  - Don’t know how long things take – cycle times
  - Non standardised – variation in content
  - Waiting for other professionals to finish

- Treatments
  - Trials
  - PEG changes, not planned into timings

- Finding Things
  - Going to find nebuliser from the ward
  - X ray
  - Going to the Pharmacy if patient too unwell
  - Pharmacy
  - Taking patient off for a ward tour
  - Answering the doorbell
  - Telephone Calls
  - Calls from the ward

- Interruptions
  - Lots of paperwork - delays the clinic
The Dartmouth Microsystem Improvement Ramp

Global Aim

We aim to improve the efficiency and quality of the service of the CF outpatient clinic for staff and patients. This process begins with first contact with the patient and ends with them arriving back to their homes after the visit. By working on the process we expect the DNA rate to improve, for there to be less waiting for patients, improved efficiency for patients and staff and to achieve a greater standard of our quality markers. It is important to work on this to improve the clinic experience for patients, meet CF trust standards, and to provide an area of clinical excellence.

Specific Aim

Change Ideas

Measures

Themes

Effective Meeting Skills

CF Clinic Global Aim

• Late & early arrivals
• Communication
• Treatments

Why are Patients waiting in the CF clinic?

• Finding Things
• Scheduling
• Interruptions

Mismatch of arrivals and resources

Don't know how long things take – cycle times

Non standardised

Answering the doorbell

Telephone Calls

Calls from the ward

Lots of paperwork

- delays the clinic
Change Ideas

• Review of Fishbone and Process map
• Brainstormed ideas to reduce waiting – top 4

- Reschedule the clinics
- Standardise the paperwork
- New Clinic Whiteboard
- Get everything we need
The Dartmouth Microsystem Improvement Ramp

**Global Aim**
We aim to improve the efficiency and quality of the service of the CF outpatient clinic for staff and patients. This process begins with first contact with the patient and ends with them arriving back to their home after the visit. By working on the process we expect the DNA rate to improve, for there to be less waiting for patients, improved efficiency for patients and staff and to achieve a greater standard of our quality markers. It is important to work on this to improve the clinic experience for patients, meet CF trust standards, and to provide an area of clinical excellence.

**Specific Aim**

**Change Ideas**
- Reschedule the clinics
- Standardise the paperwork
- New Clinic Whiteboard
- Get everything we need

**Measures**

**Themes**

**Effective Meeting Skills**

**Cause & Effect**

**CF Clinic Global Aim**

**Flowchart**

**Effective Meeting Skills**

**Sheffield Teaching Hospitals**
NHS Foundation Trust
Value Compass

We aim to reduce average total patient waiting time within the 2 CF outpatient clinics by 50% from our baseline measure of 40 minutes by the end of October 2011’

Time Spent Waiting in Clinic per patient

Attendances to CF Clinic

DNA rate

Number of staff in CF clinic

Quality/Cost = Value
The Dartmouth Microsystem Improvement Ramp

**Global Aim**

We aim to improve the efficiency and quality of the service of the CF outpatient clinic for staff and patients. This begins with first contact with the patient and ends with them returning to their homes after the visit. By working on the process we expect the DNAs rate to improve, for there to be less waiting for patients, improved efficiency for patients and staff and to achieve a greater standard of our quality markers. It is important to work on this to improve the clinic experience for patients, meet CF trust standards, and to provide an area of clinical excellence.

**Themes**

- CF Clinic Global Aim
- Effective Meeting Skills
- Yorkshire & Humber

**Change Ideas**

- Reschedule the clinics
- Standardise the paperwork
- New Clinic Whiteboard
- Get everything we need

**Specific Aim**

- Measures
- Flowchart
- Cause & Effect
- PDSA

**Capacity & Demand**

**Adherence**

**Clinic Process & Flow**

**CF Clinic Global Aim**

**Why are Patients waiting in the CF clinic?**

- Late & early arrivals
- Communication
- Treatments

**CF Clinic**

**Finding Things**

- Scheduling
- Interruptions

**Mismatch of arrivals and resources**

- Don't know how long things take – cycle times
- Non standardised paperwork

**-delays the clinic**

**Reschedule the clinics**

**Standardise the paperwork**

**New Clinic Whiteboard**

**Get everything we need**

**Attendance to CF Clinic**

**Time Spent Waiting in Clinic per patient**

**Number of staff in CF clinic**

**DNA rate**

**Stakeholder perspective**
PDSA

- Used PDSA worksheet to Plan changes
- Used timing data to reschedule clinic and devise an new Gantt
- New whiteboard introduced
- Standard Clinic Proforma devised
- Clinic rooms standardised – numbered, scales, BMI calculators
- Measures – Ongoing measurement
PDSA - Plan

4. **Plan** → How shall we **PLAN** the change? Who does what and when? With what tools or training?
- Baseline data to be collected? How will we know if a change is an improvement?

<table>
<thead>
<tr>
<th>Tasks to be completed to run test of change</th>
<th>Who</th>
<th>When</th>
<th>Tools/Training Needed</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrange for installation of clinic whiteboard</td>
<td>Claire W</td>
<td>Start Aug 2011</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Clearly number all Clinic rooms</td>
<td>Claire W</td>
<td>Next Week</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Set up excel sheet to capture patient timing data</td>
<td>Sally D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure all patients complete a cycle time form</td>
<td>Yvonne</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create new ideal clinic template based on cycle times</td>
<td>Yvonne with MS team</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

![Graph showing patients' information]

Sheffield Teaching Hospitals NHS Foundation Trust
PDSA – Do & Study

[Graph showing data with annotations]

Sheffield Teaching Hospitals
NHS Foundation Trust
The Dartmouth Microsystem Improvement Ramp

Global Aim
We aim to improve the efficiency and quality of the service of the CF outpatient clinic for staff and patients. This process begins with first contact with the patient and ends with them arriving back to their homes after the visit. By working on the process we expect the DNA rate to improve, for there to be less waiting for patients, improved efficiency for patients and staff and to achieve a greater standard of our quality markers. It is important to work on this to improve the clinic experience for patients, meet CF trust standards, and to provide an area of clinical excellence.

Specific Aim

Measures

Change Ideas

Themes

Effective Meeting Skills
Improvement – multiple ‘ramps’

Themes

Capacity & Demand

- Global Aim
  - Specific Aim 1: Increase nurse-led activity
  - Specific Aim 2: Reduce Variation in follow up frequency

Clinic Process & Flow

- Global Aim
  - Specific Aim 1: Reduce Waiting
  - Specific Aim 2: Reduce DNA
  - Specific Aim: Shorten Annual Review

Adherence

- Global Aim
  - Specific Aim 1: Increase use of iNebs
  - Specific Aim 2: Increase use of MI

5Ps
‘Improvement in health care is 20% technical and 80% human’

Marjorie Godfrey, MS, RN
The Dartmouth Institute
Some staff reflections

We now have better, smoother, unhurried clinics, shorter waiting times, happier patients, happier staff - more efficient

The team ethos has changed with the patient more firmly at the central point. The OP processes have been streamlined and are much better. Patient adherence has been accepted by all the team as important and a workstream is developing this. Previously some people gave this lip service.

We are blessed with a strong and effective team but having a coach has tapped this and encouraged us to run rather than take over or steer too much - the ownership is ours.

Lots has improved - clinic running much better, focusing on improving patients outcomes.

The coaches enthusiasm, patience and support were invaluable. He helped us to understand. His experience was invaluable.
Some staff reflections

I have enjoyed this experience immensely and have a passion for making things better for the patients. It has been satisfying for me personally to be able to do this with a system that I thought we were stuck with and that we all hated - staff and patients. It will be interesting to see if we have more patients attending their appointments now that clinics are improved.

We now have a re-energised team no longer daunted by increasing work load but motivated to find ways to work more effectively - and seeing them work

Has been really inspiring. For the first time I have felt that I've been able to implement changes to help the service run more efficiently for patients and staff

We now have a head of steam and the application of taught techniques in processing data allows us freedom to try something, look at it change it and try again without relying on the coach doing the analysis.
Managing Capacity and Demand models for clinical services

Dr John Boulton
The Health Foundation Quality Improvement Fellow
Institute for Healthcare Improvement
Cambridge, Massachusetts
USA
EVALUATION

What went well?

What could be improved?