Can we embed improvement science across the organization in four years?

Adopting a single methodology, focusing on co-production, data literacy, targeted training and a communication strategy to celebrate success.

**Methods**

Our theory was, if we focused on the following four areas from the outset we would be successful at embedding improvement science.

1. Worked with service users and carers to design, develop and deliver our strategy
2. Changed how we use data (RAG reporting to SPC charts) in all board reports.
3. Developed a dosed training programme as well as targeting key influential leaders
4. Celebrated success, generated improvement stories and developed an annual conference with poster presentations and prizes

We also set ourselves a target of achieving 80% service user and carer involvement (in four years).

**Results**

Some of our results:

- 2548 staff trained in QI methodologies (36% of the workforce)
- 64% of our QI projects now have service user and carer involvement
- 283 active projects
- 90% of our committee papers contain SPC charts
- Improved staff satisfaction and morale

Putting co-production at the forefront of our roll-out has changed the dial on service user/carer involvement across the organization with significant improvements demonstrated in previously difficult to improve areas. Our first ever annual conference attracted 430 people and 170 posters, evidencing the enthusiasm for sharing their improvement across the organization.

Following this success, we developed an Improvement Academy.

**Discussion**

Co-production on delivery, design and implementation is pivotal to success. Nile Ward Psychiatric Intensive Care Unit, London, gives an example of how it used co-production to develop a set of mutual expectations between staff and patients to reduce violence on the unit. Developing bespoke training to meet needs of key staff groups has enormous impact. Prioritise embedding SPC charts into board reports from the start. In Making Data Count, S. Riley writes, ‘There is strong evidence that better decisions are made when using SPC rather than ‘simple’ techniques such as the popular RAG approach.’ Opportunities for staff to share their work at a conference generates organizational enthusiasm for QI.

**REFERENCES**


**5 PHYSICIAN PARTICIPATION IN QUALITY IMPROVEMENT WORK INTEREST AND OPPORTUNITY: A CROSS-SECTIONAL SURVEY**

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**Introduction**

Lack of physician involvement threatens the success and sustainability of quality improvement work (QIW). Few studies have assessed physicians’ interests and opportunities to be involved in QIW. It is therefore important to do so, both in hospital and general practice.

**Methods**

Our aim was to determine the prevalence of physicians reporting active participation in QIW and the prevalence reporting an interest (without participation) in QIW. To understand the potential for improvement, we also needed to assess whether physicians’ opportunity and designated time to participate in QIW had an effect on their interest and active participation in QIW. Our hypothesis was that designated time promotes participation in QIW. This resonates with Donabedian’s structure, process and outcome framework. We conducted a cross-sectional postal survey on a representative sample of physicians in different job positions in Norway in 2019.

**Results**

The response rate was 72.6% (1513 of 2085). A large proportion (85.7%) wanted to participate in QIW, and 68.6% had actively done so in the last year. Physicians’ active participation in QIW was significantly related to the designated time for QIW in their work schedule (p<0.001). Only 16.7% reported designated time for participation in QIW. Among those with designated time 86.6% participated in QIW, while 63.7% among those without designated time participated.

**Discussion**

Physicians want to participate in QIW. They participate to a higher degree when they have designated time. Leaders can increase QIW participation from physicians by ensuring that time for this is part of the work schedule.

**REFERENCES**


**6 UNPLANNED MEDICINES-RELATED READMISSIONS TO MENTAL HEALTH WARDS AND CRISIS RESOLUTION HOME-TREATMENT TEAMS (CRHTTS)**

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**Introduction**

Hospital readmission is common in mental health. Unplanned readmission within 30 days of discharge is considered a poor indicator of quality of care provided. In 2011, unplanned readmission rates for schizophrenia and
bipolar disorders in 15 OECD countries were reported as 13% and 11% respectively\(^1\) and worldwide, over 14% admitted with a mental health illness are readmitted within 30 days.\(^2\)

We investigated the potential role of medication related factors in unplanned readmissions to mental health wards and CRHHTTs and whether a collaborative multidisciplinary Quality Improvement (QI) approach helps to reduce medicines-related readmissions.

**Methods**

Notes for patients admitted to 16 wards and 6 CRHHTTs over a 2-week period were checked to identify a previous admission. For the 213 cases identified, notes were reviewed and GP practices and patients interviewed to assess if medication contributed to readmission either ‘significantly’, ‘partly’ or ‘not’. Where readmission was identified as medicines related, we identified whether:

- patient received discharge medication at previous discharge and left with their medication;
- discharge notification was sent and received by patients’ GP;
- post discharge follow-up was completed.\(^3\)

Subsequently, collaborative multidisciplinary QI methodology was adopted to assess impact of systemwide changes on medicines-related readmissions.

**Results**

- 82 out of 126 readmissions were considered to be related to medicines.
- 14 out of 82 had no medication on discharge. For the remaining 68, 8 patients did not receive or collect their discharge medication at last discharge. Medication partly (n=5) or significantly (n=3) contributed to all 8 readmissions; 2 of these readmissions occurred within 60 days of discharge.
- Out of the 126 previously admitted patients, 86 (68%) had their last discharge notification sent to their GP; 40 (32%) did not. Of these, medication was significant to readmission in 17 cases and ‘partly’ in 11 cases. 7 of these 28 patients were readmitted within 60 days of discharge.
- Of the 86 patients whose last discharge notification was sent to their GP, practices confirmed receipt in 95% of cases. All four whose discharge notification were not received by GP had a medication-related readmission.
- 24 patients did not receive post discharge follow-up, medication was significant to readmission in 9 cases and partly in 6. Of these 15 patients, 4 were admitted within 30 days and 3 within 31–60 days of discharge.
- QI methodology reduced medicines-related readmissions from 58% to 2 - 5% in 6 months.

**Discussion**

Readmission is distressing to patients and their families and has a negative impact on the health economy.\(^4\) Medicines are the most common healthcare intervention. Medication changes during admission are common and timely communication to GP post-discharge is essential to avoid discrepancies.\(^5\) QI methodology can significantly reduce medicines-related readmissions by adopting a multidisciplinary approach to discharge planning and continuity of care.

**REFERENCES**