Learning & Sharing Together

A series of posters showing how Primary Care in Scotland is responding to the Quality Strategy
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Introduction
The Delivering Quality in Primary Care (DQPC) Action Plan is clear about the challenges facing the NHS in Scotland, whether public health, demographic or financial and about our response to those challenges. The Scottish Government’s ambitious ‘20:20’ Vision for sustainable quality puts the emphasis on anticipation, prevention and a shift towards more integrated care delivered close to or at home. Driving Quality through Innovation in Primary Care is central to delivering that 20:20 Vision for NHSScotland.

The DQPC steering group, made up of representatives from the Royal Colleges, contractors, secondary care, NHS boards, the Scottish Government as well as others from the primary care team has exemplified a mutual, collaborative NHSScotland working together towards a common aim.

The following posters are a selection from those displayed at our National Event. They reflect diverse activity across NHSScotland, the length and breadth of the country; they celebrate success, share good practice and highlight the innovation, creativity and achievements of a talented and passionate Scottish Primary Care workforce.

I would like to thank all those who have contributed to this book.

Could the quality improvements described in the posters make a difference where you work?

Derek Feeley
Director-General Health and Social Care and Chief Executive of NHSScotland
“This is Scotland Today”

There is a great deal to be proud of with NHSScotland’s provision of care. We recognise, however, that we should go further to ensure consistently good outcomes for patients, service users, carers and families. We likewise recognise the pressures which will continue to challenge our attempts to deliver the highest quality of healthcare services and ensure that NHSScotland remains recognised as one of the best healthcare systems in the world.

For instance, Scotland’s population has seen a continuous increase in recent years, partly because there have been more births than deaths, but mainly because more people have moved to Scotland than have left. At 5,254,800 the population of Scotland is now the highest ever recorded.

Births still outnumber deaths, although there were fewer births in 2011 than in 2010. In 2011, the number of deaths in Scotland dropped to 53,661, the lowest annual total since registration began in 1855.

As a result, the number of older people has increased and this has also contributed to a rise in the number of households. This is likely to continue, with an anticipated increase of 63 per cent in the number of people aged 65 or over by 2035. This all brings increased pressures which NHSScotland will have to deal with.

Despite these pressures, outcomes are improving: life expectancy in Scotland has improved greatly over the last 25 years, increasing from 69.1 years for men and 75.3 years for women born around 1981, to 76.1 years for men and 80.6 years for women born around 2010. Despite recent improvements, Scottish men and women have poor life expectancy compared with most of the European Union – 3.6 years lower for men and 4.7 years lower for women compared with the countries where life expectancy is highest.

Alongside this, other challenges across the NHS in Scotland are also rapidly escalating: an increase in the proportion of the population who are living longer with multiple long-term conditions, public health imperatives including reducing health inequalities, balancing the use of new technologies and tight financial constraints.

The vision for NHSScotland therefore remains ambitious; it has the person at the centre and seeks to build on the significant progress made over the course of the last three years. Rather than focusing on products and technology, we will instead look to the benefits and outcomes experienced by the people of Scotland flowing from service re-design and quality improvements.

The articulation by the Scottish Government of a “20:20 Vision” for sustainable high quality healthcare and in particular its straightforward recognition that healthcare cannot carry on being provided as it always has been. We strongly support the vision’s emphasis on anticipation, prevention and a shift towards more care at home or closer to home. These are also the priorities articulated in the Scottish Government’s proposals for integration of adult health and social care.

Scottish Government
Better Together
Scotland’s Patient Experience Programme

The NHS Scotland Healthcare Quality Strategy has given us a clear direction of travel in making sure that treatment and care is person-centred as well as being safe and effective. Patient experience is a key quality outcome indicator and is often an early warning sign of emerging challenges in the quality of care. Listening to what patients have to say is therefore an important part of efforts to improve the quality of care.

Scotland’s Patient Experience Programme, “Better Together”, was launched in February 2008. It has an important role to play in “shining the light” on patient experience as a driver and measure of quality. The initial focus has been on the quality of healthcare experience for inpatients and users of GP services in Scotland. In 2013, we will run the first national patient experience survey for maternity services.

To date, we have published results from five national surveys – three Inpatient Patient Experience Surveys and two focusing on GP and local NHS services. Interest in the use of this data is growing rapidly with many boards working in partnership with GP practices, patients and the public to identify areas where there is a common desire to see change.

The latest GP and local NHS services results were published in May 2012. Over 1000 GP practices have their own reports with hundreds of invaluable comments also contributed by respondents to the survey – all coming together with local information to paint a compelling picture of the quality of care and experience provided by staff every day.

The programme also has a significant role to play in encouraging and supporting NHS boards and their partners to use a range of approaches to gather the experiences of their patients. This allows us to better understand where improvements can be made as well as supporting the sharing and learning where examples of good practice are highlighted.

The national Person Centred Health and Care Programme will launch later this year and will continue the pursuit of our ambition to provide the best possible experience for patients, carers and staff. The national survey programme will continue with a continued and growing emphasis on the use of nationally and locally gathered information on patient experience to drive improvement.

Visit our website
www.bettertogetherscotland.com

For GP, CHP NHS Board results from the Scottish GP and local NHS services survey visit:
www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey
Scottish Practice Management Development Network

There are over 1000 GP practices in Scotland, from the Borders to the Shetland Islands. Practices consist of a multidisciplinary team and the Network provides support to develop practice managers through a vocational scheme and a development network.

Practice Managers play a central role in meeting the changing demands within Primary Care.

The Scottish Practice Management Development Network and the Practice Managers Vocational Training Scheme, enhance the quality of educational provision, and provide services for a wide group of stakeholders in Scotland.

The Scottish Government supports the work of the Network in a variety of ways. This year saw the first National Poster Awards. The GP Practices that submitted the best posters were rewarded with a staff development day financed by the Primary Care Development Fund.

A poster about the work of the Network and a sample of the excellent contributions follow.
Learning and Sharing Together
Scottish Practice Management Development Network

Advancing the role of General Medical Practice Management through the development of high quality, easily accessible and locally relevant networks providing information, support, education and representation for practice managers.

"If Practice Managers are to meet the new challenges of the ever-changing NHS and General Practice, they have to be more competent than ever before and have the knowledge and skills to deal with the quantity, chaos and complexity of information relevant to the Practice Manager's eclectic role and responsibilities."

Category: Scottish Practice Management Development Network
Name(s): Elizabeth Williamson and Lynn McGowan.
Main Contact: Marion MacLeod
Email: marion.macleod@nes.scot.nhs.uk
### Aim
To highlight the development opportunities for Practice Managers in Scotland.

### Content
Practice Managers (PMs) value locally relevant networks which provide information, support, education and resources to support their Continuous Professional Development (CPD). A range of the options available to help develop, promote and support PMs across Scotland is highlighted.

### Relevance:
We have developed an educational network to provide the knowledge and skills required for PMs to deliver high quality GMS for the future.

### Outcomes
We have developed educational resources to support a career in practice management and an accredited programme of education, completed by eighty nine trainee PMs, together with guidance for appraisal and recruitment of PMs.

### Discussion
Scotland has taken the lead in PM development. Several studies in England into the availability and relevance of CPD opportunities, networking or professional support for PMs concluded that PMs needed a supportive network, induction into their role, resources and learning opportunities, and PDP/appraisal. Our educational programme would be transferrable across the UK.
All Under One Roof
The Surgery, Larkhall

Category: Scottish Practice Management Development Network
Name(s): Michelle Fitzpatrick and Sarah Moyes
(with input from whole practice team)
Main Contact: Michelle Fitzpatrick
Email: michellefitzpatrick@nhs.net
**Aim**

Reduce patient waiting times within the surgery for appointments. Also to offer a complete patient service from start to finish, including a comprehensive review for housebound patients.

**Methodology**

The practice employed a Nurse Practitioner to reduce GP appointments. We also negotiated in-house services; Physiotherapy, Clinical Psychologist, Phlebotomy, Treatment Room, Midwife. We also fully utilised our practice nurse team, who now carry out house calls to housebound patients for annual reviews of their chronic diseases. Our nurses also carry out 24 hour blood pressure monitoring and ECG reporting, again reducing the wait and travel to a hospital appointment.

**Results**

Patients can now be seen on the day for minor complaints by the Nurse Practitioner. We now have an average wait of 2 days to see a GP. We have also been able to offer a wide range of different appointments and times for both GP’s and Practice Nurses. We can offer appointments from 8.00am to 8.30pm throughout the week. We also offer telephone consultations and an advice line from the Practice Nurse.

Patients can be seen within the week in the practice if they require physiotherapy services, this includes injections.

We are also able to offer counselling within the practice and patients can usually be seen within 4 weeks of referral. We also have the benefit of group therapy which has proved popular with our patients.

**Conclusion**

Patients are now extremely happy with the exceptional service we provide “all under one roof”. Our waiting times have dramatically reduced. Patients do not have far to travel to be seen and don’t have to wait for the usual waiting times at the hospital.
Health Checks For People With Learning Disabilities
The Fullarton Practice

ANNUAL HEALTH REVIEWS FOR PEOPLE WITH LEARNING DISABILITIES

“two-thirds of GPs think people with learning disabilities receive poorer healthcare than other patients…” GMC Survey

✓ Appointment made by telephone
✓ Carers & support workers invited to attend
✓ Appointment reminder in writing
✓ Telephone reminder the day before
✓ Records updated with Next of kin details
✓ Compliance with Adults with Incapacity (Scotland) Act 2000
✓ Practice Nurse & Liaison nurse for Learning Disabilities offer 40 – 60 minute appointments
✓ Complete keepwell template
✓ Patient anxiety is reduced by increased familiarity with the practice
✓ Early intervention and robust referral process
✓ Increase in clinical knowledge
✓ Increased awareness of specialist nursing role
✓ Carers supportive and enthusiastic

Category: Scottish Practice Management Development Network
Name(s): Joanne Gibson, Practice Manager
Mary Gallery, Practice Nursing Sister
Hilda Griffin, Primary/Acute Care Liaison Nurse, LD Team

Main Contact: Joanne Gibson
Email: Joanne.gibson@aapct.scot.nhs.uk
Aim

“Two-thirds of GPs think people with learning disabilities receive poorer healthcare than other patients. The poll found that 64% of GPs agreed that people with learning disabilities receive a poorer standard of care than those without ... “ GMC survey

To offer patients with learning disabilities (LD) an annual health check with chronic disease screening to meet their specific health needs; inviting patients, support workers and or parents/carers to attend.

Methodology

- Appointment booked by telephone initially.
- Appointment confirmed in writing.
- Telephone reminder 24 hours before.
- Length of appointments 40 – 60 minutes.
- Review undertaken jointly by the practice nurse and liaison nurse.
- Referral to appropriate primary and secondary care services.

Results

Patients:

33 patients from a practice LD register of 42 have attended.

- 1 admission and referral to urology, 3 podiatry referrals and surgical appliances.
- 1 patient with a history of falls and cataract diagnosis followed up.
- 1 patient suffering social isolation was referred to occupational therapy.
- 1 given additional support hours
- 1 GP referral

Practice:

- updated patients’ records with next of kin/carer Adults with Incapacity (Scotland) Act 2000 information.

Nursing Team:

- Liaison nurse and practice nurse increased understanding of their respective roles.

Conclusion

- development of this service will provide equitable service provision.
- early intervention, as problems hitherto unknown are diagnosed.
- develop their knowledge and understanding of the needs of this vulnerable group.
- practice and the liaison nurse working together ensures referral processes are more robust.
- As patients becoming more familiar with the practice team anxiety may reduce.

Carers: Anecdotal evidence:

One of the mothers at a recent carers’ meeting was enthusing to other carers about how beneficial the appointment had been.
Introduction of a Surgery Pod
Tranent Medical Practice

Our aims ...
- To improve patient care
- To provide a convenient and efficient service
- To provide a timeous recall system for our patients
- To increase availability for Practice Nurse appointment

We were looking for a way to improve patient care for those on our hypertension register as we were finding it increasingly difficult to recall all 1754 patients when due. After investigating the possibilities available, the Practice agreed to purchase the Surgery Pod (Telehealth 2009). This offers a more convenient service to the patients as there is no need for an appointment. It also links directly into our clinical system.

Methods
We looked into the possibilities available for stand alone BP monitors which could be located in our waiting area. This involved looking on line and also in medical equipment catalogues. On finding out about the ‘Surgery Pod’ and it’s capabilities, we arranged a demonstration.

Outcome and Result ...
- Improved recall system for our hypertensive patients
- Convenient for all patients
- Used by 1110 patients in the first 6 months
- Reached maximum points in all areas involving BP within the Quality and Outcomes Framework (QOF)

Conclusion ...
- Teamwork required
- Practice purchased scales, which now allows BMI/weight to be recorded
- All results are recorded instantly which is beneficial to patients and Practice

“... an excellent example of local innovation ...”
Scottish Government

Category: Scottish Practice Management Development Network
Name(s): Jill Thomson, Dr Alyson McClure & Dr Alastair Clubb
Main Contact: Jill Thomson
Email: jill.thomson@lothian.scot.nhs.uk

Delivering Quality in Primary Care – Progress Report
New Quality and Productivity indicators which were agreed nationally and included in the GP contract in 2011/12. These focused on prescribing, emergency admissions and outpatient referrals by GPs.
Aim

To improve the service available to Patients on the Hypertension register and to offer the best service possible. As a team we decided to look into the introduction of BP monitor within our waiting area. On investigating the possibilities we heard about the ‘surgery pod’ (Telehealth solutions 2009) which would connect to our clinical system, instantly record results, alerting the practice immediately if a result was out of range.

Methodology

We looked into the possibilities for stand alone BP machines, which involved looking online and in medical equipment catalogues. On finding out about the ‘surgery pod’ and its capabilities, we arranged a demonstration.

The whole team was to be involved as the Admin staff were required to assist patients using the pod, if necessary and the Nursing team to encourage patients to use the pod and educate them on the benefits.

We looked at our practice polices and protocols and ensure that a robust system was in place for the management of results out with normal range.

Results

During the first 6 months of use, 1,110 patients had used the pod. The practice was able to measure the achievements and usage via Clinical Audit and a practice search. The practice reached maximum points in all areas involving BP within the QOF.

The team work within the Practice was of huge benefit and helped make this a successful service for our Patients.

Conclusion

We believe the above results prove that this has been a good investment for our Practice, Patients and their care, allowing regular BP monitoring at the patients’ convenience. We have increased the option availability on our pod and now, in addition to BP we now also capture smoking status, alcohol consumption and weight/BMI.

References:

The Introduction of the Nuka Alaskan System of Health Care
Muiredge Surgery, Buckhaven

“... some real insights into the practicalities and philosophy of SCF ...”
Scottish Government

Category: Scottish Practice Management Development Network
Main Contact: Maxine Jones (Practice Manager)
Email: maxine.jones@nhs.net

Delivering Quality in Primary Care – Progress Report
For 2012/13 changes have been introduced to the Scottish Enhanced Services Programme (SESP) to enhance local autonomy and the sustainability of the services its supports.
Aim

The Nuka Alaskan\textsuperscript{[1]} system of health care is a relationship-based system of care which offers a new model of delivering primary care services. This innovative model is being piloted at a “proof of concept” stage at Muiredge Surgery to address an unsustainable crisis in demand management and increasing workload currently being experienced throughout primary care in Scotland and to identify new ways of matching resources to community need.

Methodology

A dedicated team within the practice, comprising general practitioner, case manager (nurse practitioner), practice nurse, and administrator, with input from a psychologist, has been established to implement the Nuka system. This will support 1,350 patients for six months and a number of outcomes will be measured.

Results

The Nuka system has achieved considerable success in Alaska as assessed by outcome measures.\textsuperscript{[2]} In particular, the number of A&E and OP attendances, admissions, length of admission and associated costs, have fallen dramatically and quality indicators have all improved. The model has successfully addressed demand management issues, has improved health outcomes and has achieved greater patient and staff satisfaction.

Conclusion

The model has the potential to transform the way primary care is delivered in Scotland. A successful mini-pilot in Muiredge surgery will enable a full-scale pilot to be carried out and evaluated in different settings throughout the country. If this in turn is successful, it could be rolled out across Scotland.

References

\textsuperscript{[1]} Southcentral Foundation [homepage on the Internet]. Anchorage, Alaska; 2012.

Available from: https://www.scf.cc/


Available from:
Learning and Sharing Together

The Scottish Government & NHSScotland

Scottish Centre for Telehealth & Telecare

Led by Professor George Crooks, OBE, the SCTT (part of NHS 24) has supported a number of key activities over the past few years resulting in:

- **People within 11 out of 14 territorial Health Board areas having access to 24/7 stroke thrombolysis treatment** providing local clinical teams with access to immediate stroke specialist support using video conferencing and PACS imaging. Board areas who implemented telestroke had a 151% increase in treatment rates compared to a 23% increase in treatment rate for Boards not using (or not requiring) telestroke (based on the national stroke audit figures for 2011).

- **Significant improvements have been made in the quality and reliability of video conferencing** across NHS Scotland, through the national programme led by NSS, the North of Scotland Planning Group and SCTT. All 14 territorial NHS Boards have migrated onto the new service.

- **Successfully securing £10 million funding** as part of the UK wide Technology Strategy Board’s DALLAS (Delivering Assisted Living Lifestyles At Scale) competition. The ‘Living It Up’ Project aims to provide improvements in health, well being and lifestyles for over 55,000 people living in 5 geographic areas across Scotland over 3 years (2012-15).

- **Patients in three Health Board areas accessing pulmonary rehabilitation classes** via the use of video conferencing. By the end of March 2012, 179 patients in Dumfries and Galloway, Lothian and Tayside had participated in such classes.

The forthcoming National Telehealth and Telecare Strategy identifies a number of key Priority Objectives for Scotland, including:

- Contributing to Integrated Care by embedding Telehealth and Telecare within improved and efficient whole system, citizen centred pathways.

- Utilising Telehealth and Telecare to empower people with long term conditions to live independently at home for as long as possible.

- Making greater use of new technologies to improve mental health.

- Improving access to customisable health, care and support services via the use of familiar, everyday technologies and multiple channels e.g. telephone, television and the internet

- Improving access to rapid, safe and appropriate treatment and support.

- Health, care and support organisations systematically considering telehealth and telecare solutions in local service redesign, in order to co-produce and deliver safe, effective and person centred care in a way that is both sustainable and value for money.

- Expand the use of telecare and telehealth in promoting wellbeing, choice, independence and control for service users and carers.

- Promote strong leadership across the public and private sectors to support our transformational vision on the role telehealth & telecare can play in reshaping care services.

For further information please contact Professor Crooks on 0141 337 4501 or george.crooks@nhs24.scot.nhs.uk. View our webcasts at http://www.video3uk.com/sctt
“The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.”

**What we were looking for**

Innovative examples of services, initiatives and activities that seek to ensure that appropriate and effective care is provided consistently for every person, every time.

This is a wide-ranging Quality Ambition which includes cost reduction (without quality reduction) and efficiency of service delivery. This includes the different stages along the age continuum for positive health and well-being; from early years through to adult health improvement and health maintenance and prevention of the population involving responsibility for one’s own health, and to complex needs as well as older people and supported self management.
"...the longevity, results and conclusions speak volumes as to how useful this programme is ...”

*Scottish Government*
**Aim**

The Heart Manual, NHS Lothian, is a person-centred, home-based cardiac rehabilitation programme that, in conjunction with facilitation by a registered healthcare professional, provides highly effective support for individuals recovering post cardiac event. This includes: psychological and practical support; information; behavioural activities to promote self-management.

Grounded in psychological theory, the innovative programme has been used to deliver effective rehabilitation for the past 20 years and its continual development sees its expansion into other service delivery models, such as telehealth and internet-based applications.

**Methodology**

Effectiveness of the Heart Manual has been evaluated, most notably in two randomised controlled trials comparing the Heart Manual to hospital-based cardiac rehabilitation. It has been included in two systematic reviews and is recommended in both SIGN and NICE guidelines.

**Results**

The evidence base that has increased since the Heart Manual’s launch has resulted in its use by over 200 NHS boards, with more than 2500 registered healthcare professionals trained as facilitators. International collaboration has taken the form of translated manuals in five international countries, with interest from three others. Similarly, the Heart Manual’s content and approach has been harnessed in an ongoing European-funded trial employing telehealth in the rehabilitation and support of people with heart failure and coronary heart disease (CHD).

**Conclusion**

In conclusion, the Heart Manual has continued to develop and strengthen its contribution to people with CHD. With future projects already in the pipeline, the Heart Manual will continue to provide robust support for patients for a long time to come.
Audit into Reduction of Do Not Attend Appointments
NHS Tayside

BACKGROUND
Previous publication in Pulse magazine suggested a reduction of do not attend appointments (DNAs) can occur by implementing cheap and simple measures.

Idea of this audit was to see the impact of these measures when applied to the Arbroath Medical Centre which has a practice population of around 10,000 patients.

INTERVENTIONS
Getting support from all GPs and practice manager.

Allowing notice board in waiting room. Previously had a list of numbers of missed appointments – this can normalise not attending.

Changed to percentage of patients who do attend (rounded up).

Reception staff to ask patient on phone to repeat back appointment.

Reception staff ask patient if they would be willing to call back if they are delayed/need to cancel (as opposed to informing them this).

Reception staff are to ask patient to write down appointment themselves.

METHOD
Retrospective audit of number of DNAs from 1/6/11 until 15/9/11. Interventions above occurred from 1/6/11. Re-audited number of DNAs 16/9/11 until 31/12/11. The numbers where obtained from Vision GP appointment software.

RESULTS
From the 1/6/11 until the 15/9/11 there were 896 DNAs. This represents 5.9% of appointments.

On comparison from 16/9/11 until the 31/12/11 there were 920 DNAs - this represents a small reduction to 5.5% of appointments.

<table>
<thead>
<tr>
<th></th>
<th>DNA</th>
<th>Attend</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Intervention</td>
<td>920</td>
<td>15672</td>
<td>16592</td>
</tr>
<tr>
<td>Pre Intervention</td>
<td>896</td>
<td>14275</td>
<td>15171</td>
</tr>
</tbody>
</table>

Contingency table analyzed with Chi-square with Yates correction. Chi squared equals 1.331 with 1 degrees of freedom. The two-tailed P value equals 0.1736 NOT statistically significant. Null hypothesis = No difference in DNAs can be rejected.

RECOMMENDATIONS
Due to non statistically significant improvement and other factors potentially confusing data (such as flu clinics occurring during re-audit) the authors would not recommend these measures to be introduced routinely in other general practices.

The Arbroath Medical Centre has decided to allow receptionist to choose themselves whether to adopt these slight alterations to booking style and has decided to keep the alteration to the notice board.

Contact: christopherweatherburn@nhs.net

Category: Efficiency
Main Contact: Christopher Weatherburn
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Aim
Do not attend (DNA) appointments cost the NHS large amounts of money and can lead to frustration from all members of staff as these wasted appointments could potentially have been used by others. Previous publication in Pulse magazine (September 2011) suggested simple non costly measures have been performed in England with reductions of DNA rates of over 30%. The idea of this audit was to assess whether these strategies could be utilised in Arbroath Medical Centre, Scotland to decrease the DNA rate.

Methodology
GP appointment system was retrospectively audited for 3 months to assess rate of DNAs for all healthcare professionals at the Arbroath Medical Centre. Subsequently strategies where taken including:

- Altering notice board sign from number of DNAs to percentage of patients who attend.
- Subtle differences in the way that reception staff communicate with patients when they are booking appointments.

The following 3 months from the intervention the GP appointment system was re-audited.

Results
Rate of DNAs overall was reduced from 5.9% to 5.5%. This could be portrayed as a 7% reduction in DNA rates. However on statistical analysis this reduction was not statistically significant.

Conclusion
After this audit it was decided to give the reception staff freedom in how they book appointments and the new notice board sign highlighting the percentage of patients who attend appointments was left in place.

Delivering Quality in Primary Care – Progress Report
This new service-based approach has been introduced through a phased implementation programme and covers four core services: Minor Ailment Service, Public Health Service, Acute Medication Service and Chronic Medication Service.
Identifying Patients in the Community Who Are at Risk of Pressure Ulcer Development Who Have Diminished Ability to Self Care

NHS Greater Glasgow and Clyde

“Identifying patients in the community who are at risk of pressure ulcer development who have diminished ability to self care”

Lynne Watret, TVN Primary Care & Fiona Muddler, Clinical Effectiveness Co-ordinator

If risk of pressure ulcers is minimised it can “help individuals live with greater independence; to promote the client’s optimal level of well being; and to assist the patient to remain at home, avoiding hospitalisation or admission to long term care institutions”.

Introduction

A Pressure Ulcer Prevalence Study of patients on the district nurses caseload across NHS Glasgow and Clyde was carried out in January 2011. A sample size of 5,698 patients was reviewed.

To prevent pressure ulcers, it is essential to determine the factors which place the patient at risk; put strategies in place to minimise this and support the individual to self manage as long as is possible.

The study highlighted the challenges experienced by patients and carers with chronic diseases and co-morbidity factors resulting in a greater reliance on formal and informal carers to maintain the patient’s quality of life.

Patient co-morbidity

Cancer, coronary heart disease and diabetes accounted for 43% of the total group with some patients having more than one co-morbidity (Fig 1). These conditions can lead to a degeneration in the patients physical condition and result in a gradual or rapid loss of patient independence with subsequent reliance on others to assist whole or in part with ability to self care.

Ability to self care: Reliance on others to remain independently at home

56% of patients were believed to be self caring; 46% required the support of relatives or informal carers; 56% relied on social care. (Fig 2)

There is obvious overlap in care input, which can result in variations in practice.

53% of the sample was viewed as having challenges with mobility.

Lack of mobility and co-morbidity problems can be a contributing factor in the development of incontinence.

67% of patients were incontinent. This can lead to a downward spiral of issues that affect quality of life (Fig 3).

In conclusion

The study identified varying levels of self care deficits in 66% of patients on the DH caseload; the vital role of carers as major care providers must be recognised at all levels in the NHS and staff must work closely with carers as partners in providing care.

This study demonstrates the benefits that can be made in Productive Community Services: Release time to care providers to provide high quality, effective and patient centred care. Time spent working with the patient to deliver care based on the anticipated and perceived needs of the patient will ensure that resources are focused on preventative care rather than becoming involved in care when treatment of pressure ulcers is required.

References:


Acknowledgements: All District Nursing Staff GCC

Category: Effective

Main Contact: Lynne Watret

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Aim

NHSGG&C, aims to reduce the incidence of preventable pressure ulcers by 50% by April 2013. In order to provide a baseline, a prevalence of all patients on the District Nursing caseload was carried out.

Methodology

- Determine severity and origin of pressure ulcers
- Collect information on intrinsic factors which may predispose to pressure ulcer development
- Collect information on patient dependency on carers (informal and formal) to carry out the activities of daily living
- Determine if any conclusions can be made which highlight where future resources may be focussed to prevent pressure ulcer occurrence.
- District Nurses completed data forms on all patients currently on their caseload. (n=5,633)
- Survey was created and data analysis and graphical output was carried out.

Results

For the purposes of the poster application results to be discussed pertain to patients pressure ulcer risk assessment scores (Waterlow risk assessment score). 73% of patients were at risk of developing a pressure ulcers.

The study highlighted the challenges experienced by patients and carers with chronic diseases and co morbidity factors resulting in a greater reliance on formal and informal carers to maintain the patient’s quality of life.

Cancer, coronary heart disease and diabetes accounted for 43% of the District Nurses caseload.

- 34% of patients were believed to be self caring.
- 48% required support of relatives or informal carers
- 56% relied on social care.
- 53% of the sample had challenges with mobility. “Lack of mobility and co-morbidity problems can be a contributing factor in the development of incontinence”
- 67% of patients were incontinent.

Conclusion

The study highlighted the complexity of the District Nurses caseload. It demonstrated the challenges for patients and informal carers in maintaining self care.

Pressure ulcer prevention is a quality indicator and if we can support the patient to self care and optimise mobility through health promotion and anticipatory care we will in turn reduce the incidence of pressure ulcers and “help individuals live with greater independence; to promote the client’s optimal level of well being; and to assist the patient to remain at home, avoiding hospitalisation or admission to long term care institutions”
Improving Substance Misuse Service Access in South East Edinburgh

NHS Lothian

Improving substance misuse service access in South East Edinburgh

<table>
<thead>
<tr>
<th>Aims</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and drug services in Edinburgh are provided by NHS Lothian, City of Edinburgh Council, Third Sector and Primary Care. Each organisation in South East Sector has its own separate assessment and stage process. This means that clients accessing more than one service receive more than one assessment.</td>
<td>Tools used in the pre-work stage of the project included:</td>
</tr>
<tr>
<td>Waiting times for drug services were in line with the national target requirements (currently 5 weeks, RTT). However, waiting times for alcohol services were much higher; for instance there was a 22-week wait between referral and treatment. The government targeted for RTT to three weeks by March 2013. The aim of the project was to:</td>
<td>- 55 Stakeholder interviews (including patients)</td>
</tr>
<tr>
<td>- Ensure patients don’t wait longer than three weeks for the offer of treatment to start.</td>
<td></td>
</tr>
<tr>
<td>- Patients get the right service at the right time and therefore are more likely to achieve their desired goal.</td>
<td>- Data collection and analysis</td>
</tr>
<tr>
<td></td>
<td>- Value stream mapping of nine services</td>
</tr>
<tr>
<td></td>
<td>- Time value analysis.</td>
</tr>
</tbody>
</table>

Outcomes

- The longest wait for alcohol treatment is now three weeks.
- One Triage assessment form and recovery plan developed and agreed across all agencies, reduction in duplication. Standardised forms across all services.
- Co-location of Health, Social Work and Third Sector staff (8 agencies) at one single point of access for SE Edinburgh in Cramond. New centre opened on 19th January 2012.
- Saving of wasted appointments through drop-in clinics – estimated at approx. 500 hours per year.
- Same day triage assessment and recovery plan via Drop-in at Recovery Hub Monday – Friday, 10am – 4pm.
- Agreement to develop a drop-in service at the single point of access between 8am and 4pm, Monday to Friday. Only clients with extenuating circumstances would receive a home visit for their assessment.
- Agreed on joint assessment and stage process across all alcohol and drug services (eight services). A joint assessment form and recovery plan were developed in parallel.
- A staff role agreed to ensure the service was fully covered, this would be staffed by any competent worker from NHS, Council or Third Sector Services.
- Management arrangements were agreed and a steering group set up to monitor progress and drive forward the action plan.
- A service directory was developed.

“Coming together of multi-agency, multi-disciplinary practitioners and management greatly increased knowledge and understanding of service transition in South East Edinburgh.”

Kaizen participant

Staff co-located to the new premises in December 2011 and the service started for patients in January 2012, after being officially opened by Kenny MacAskill MSP.

Recovery Hub: mission statement
“We strive to offer the right service at the right time to support your recovery.”

Progress against the 3 week target – data covers all Edinburgh’s sectors

Conclusion

The organisation is now equipped to meet the new HEAT A11 target (3 weeks from referral to treatment) and patients now receive an improved service with clear guidance. There will be a six-month evaluation of the assessment and stage process to ensure there is improved access to service. This model of working has been implemented in the North East of Edinburgh and it is hoped that the other two sectors will follow soon.

Category: Effective
Main Contact: Libby Tait
Email: libby.tait@nhslothian.scot.nhs.uk
**Aim**

Edinburgh’s alcohol and drug services are provided by NHS Lothian, City of Edinburgh Council, the Third Sector and Primary Care. Each organisation in the South East sector has its own separate assessment and triage process; consequently teams were failing to meet the upcoming three-week referral to treatment HEAT target. This project aimed to establish a multi-agency single point of access in South East Edinburgh and develop pathways to achieve the new HEAT target.

**Methodology**

Tools used in the project’s pre-work stage included 55 stakeholder interviews; data collection and analysis; value stream mapping of nine services; time value analysis; voice of customer. 26 third sector, health and social work staff attended a three-day kaizen in August 2012.

**Results**

Agreement was reached at the kaizen to co-locate as a multi-agency team offering a single point of access and drop-in service for clients in SE Edinburgh. It was agreed to have one assessment and triage process across all eight alcohol and drug services in SE Edinburgh. A triage assessment form and recovery plan were developed during the kaizen. Management arrangements for the set up and ongoing co-location of services were agreed and a steering group established to monitor progress and drive forward the action plan. A service directory and information leaflets were developed. The service opened in January 2012.

**Conclusion**

The organisation is now equipped to meet the new HEAT target and patients receive an improved service with clear guidance. A six-month evaluation of the assessment and triage process will ensure improved access to the service.

"... an example of innovative practice developed to help reduce waiting times and improve opportunities for people with drug and alcohol problems ...

*Scottish Government*

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**Delivering Quality in Primary Care – Progress Report**

The directed enhanced service for extended hours has been extended; the new Quality and Productivity indicators for 2012/13 which aim to reduce avoidable Accident and Emergency
Childsmile

Childsmile is a national programme designed to improve the oral health of children in Scotland. The main elements are:

- **Childsmile Core** - the distribution of free dental packs and supervised toothbrushing programmes.
- **Childsmile Practice** provides a universally-accessible, child-centred NHS dental service.
- **Childsmile Nursery and Childsmile School** provide clinical prevention programmes offering twice-yearly fluoride varnishing.

The Scottish Government set a target for 60 per cent of primary one and seven children to have no obvious signs of tooth decay by 2010.

The target for Primary 7 children was exceeded one year ahead of target and in 2011, the dental health of P7’s had further improved to 69.4% having no signs of obvious decay.

In 2010, 64% of Primary 1 children were found to have no obvious dental decay experience.

For further details about Childsmile visit [www.child-smile.org.uk](http://www.child-smile.org.uk)

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**NHS Education for Scotland**

**Key achievements**

- Continuing Professional Development is now available for the whole dental team. In-practice education and training in decontamination has been delivered to over 95% of practices.
- Final year dental students spend 50% of their time in outreach placements in a primary care setting. 17 centres have been built throughout Scotland.
- Dentistry has fully embraced IT in training and development for example, e-learning, preparing personal development plans and e-portfolios.

Over 25% of graduates now complete a two year foundation training period.

For further details about NES, visit [www.nes.scot.nhs.uk/education-and-training/by-discipline/dentistry.aspx](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/dentistry.aspx)
SDCEP is a guidance development initiative within NHS Education for Scotland that contributes to the Healthcare Quality Improvement Strategy for NHSScotland by:

- developing user-friendly, evidence based guidance in a variety of formats to support the delivery of safe and effective, patient-centred healthcare
- conducting knowledge translation research to understand how best to support implementation of best practice recommendations
- informing educational initiatives and health policy

While primarily directed towards primary care dental practice, SDCEP's work is also relevant to other healthcare settings, including general medical practice and community pharmacy.

For further details about SDCEP guidance and related research visit

www.scottishdental.org/cep

Oral Health Improvement Strategy for Priority Groups

- Effective preventive healthcare care should be achievable for all who are dependent on others for support.
- Preventing oral disease keeps treatment simple.
- More people are keeping some of their natural teeth as they enter old age.
- The two most common oral diseases, dental decay and gum disease are largely preventable.

- The strategy sets out measures to prevent oral disease in adults who are particularly vulnerable to poor oral health.
- It identifies ways in which people across health and social care can work together to improve oral health in the people they care for or support.
- Oral health support that people receive is personalised to meet their own assessed needs, safe and evidence-based.

For further details about this strategy visit

Just in Case: Anticipatory Prescribing for Palliative Care Patients

NHS Fife

"...Anticipatory prescribing in is a key component of good palliative care and enshrined in the Liverpool Care Pathway. This is best practice. ...”

Scottish Government

Category: Effective
Main Contact: Andrea Smith
Email: andrea.smith5@nhs.net
Aim

Living and Dying Well (SGHD 2008) recommended that NHS Boards implement systems to ensure timely and easy 24-hour access to medicines for patients with palliative care needs.

The aims of anticipatory prescribing via “Just in Case” boxes are to:

- Improve access to medicines
- Enable patients to die in their preferred place of care (90% wish to remain at home)
- To reduce or avoid hospital admissions
- To improve palliative and end of life care

Methodology

- JIC boxes are provided by the established network of specialist palliative care pharmacies
- Medicines prescribed reflect the Liverpool Care Pathway and NHS Fife guidance
- A Standard Operating Procedure describes the role of all healthcare professionals
- Guidance was developed for the prescribing and administration of medicines

Medicines are recorded on kardex which served two purposes - ensuring standardisation of drug choice/dose and triggering the pharmacy to initiate JIC.

Results

An audit tool was developed to ascertain when a box was used, who used the box and in what circumstances:

Of 131 boxes issued, 61 (47%) were used, 26 (43%) during normal hours and 35 (57%) out of hours (See AS graphic 1).

In 60 cases it was felt JIC enabled the patient to remain at home, in 30 cases an OOH doctor visit had been avoided and in 35 cases a hospital admission had been avoided (AS graphic 2).

Conclusion

Patient wishes are respected, with more effective, better planned end of life care. Unnecessary hospital admissions are also avoided.
Reviewing long-term antidepressants can reduce drug burden

Chris Johnson, Antidepressants Lead, Clinical Governance, NHS Greater Glasgow & Clyde

Email: c.johnson2@nhs.net

Summary

Antidepressants are a first-line treatment for depression and are prescribed in the long term for patients who continue to suffer from chronic depression. Long-term treatment can lead to drug burden, potentially increasing patients’ risk of adverse drug events and interactions. Reducing the risk of adverse drug events in long-term treatment can be achieved by reviewing the need for long-term antidepressants. This can be done by identifying patients who no longer need their medication or those who can be switched to a less potent alternative.

Methodology

A review of long-term antidepressant treatment was conducted in the four hospitals in NHS Greater Glasgow & Clyde. This review aimed to identify patients who could continue on their current treatment or who could be switched to a less potent alternative. The review process was supervised by a clinical pharmacist and involved the participation of medical and nursing staff.

Results

A total of 801 patients were reviewed, of whom 34% were prescribed an antidepressant in the long term. Of these, 21% were prescribed an antidepressant at a high dose, which was reviewed and reduced in 13%. In addition, 10% of patients were prescribed a medication that was not appropriate for their condition. These patients were switched to a less potent alternative.

Conclusion

The review process showed that long-term antidepressant treatment can be reduced. This reduction can lead to a decrease in drug burden, resulting in fewer adverse drug events and increased patient safety. The review process also identified patients who were prescribed inappropriate medications, which were switched to a less potent alternative.

Table 1: Medications reviewed and changed (n=801)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Reduced</td>
<td>340</td>
</tr>
<tr>
<td>switched to Less Potent Alternative</td>
<td>281</td>
</tr>
<tr>
<td>Not Appropriate</td>
<td>80</td>
</tr>
</tbody>
</table>

Further reading


Acknowledgements

This project was conducted in collaboration with the clinical governance team of NHS Greater Glasgow & Clyde. The authors would like to thank all the staff who participated in the review process for their contributions.
Aim

Antidepressant prescribing continues to rise. Contributing factors are increased long-term prescribing and possibly the use of higher selective serotonin re-uptake inhibitor (SSRI) doses. In 2007 the Scottish Government set targets to reduce antidepressant prescribing. Aim: to review general practice patients prescribed the same antidepressant long-term (≥2 years) and evaluate prescribing and management pre- and post-review.

Methodology

All practices were invited to participate. All patients prescribed antidepressants (excluding amitriptyline) for ≥ 2 years were identified from records November 2009 to March 2010. Amitriptyline was excluded due to non-mental health use. GPs selected patients for face-to-face review of clinical condition and medication, December 2009 to September 2010. Pre and post-review data were collected; average antidepressant doses and changes in prescribed daily doses were calculated. Onward referral to support services was recorded.

Results

71 of 97 practices participated. 8.6% (33,312/388,656) of all registered patients were prescribed an antidepressant, 47.1% (15,689) were defined as long-term users and 2,849 (18.2%) were reviewed. 811 (28.5%) patients reviewed had a change in antidepressant therapy: 7.0% stopped, 12.8% reduced dose, 5.3% increased dose and 3.4% changed antidepressant, resulting in 9.5% (95% CI 9.1% to 9.8% p<0.001) reduction in prescribed daily dose and 8.1% reduction in prescribing costs. 6.3% were referred onwards, half to NHS Mental Health Services. Pre-review SSRI doses were 10-30% higher than previously reported (3-4).

Conclusion

Almost half of all people on antidepressants were long-term users. Appropriate reductions in prescribing can be achieved by reviewing patients. Higher SSRI doses may be contributing to current antidepressant growth.

Delivering Quality in Primary Care – Progress Report

NHSScotland has mainstreamed the Keep Well programme of targeted health checks. The programme offers a systematic cardiovascular disease risk assessment and management programme for people aged between 40 and 64.
WHOLE SYSTEMS WORKING AND GENERAL PRACTICE

From 2009 General Practitioners in Forth Valley have taken part in redesign and improvement work to improve the quality and consistency of services for patients across the Board area. Work has focussed on developing a more integrated single system, particularly addressing interface issues between primary and secondary care, and supporting initiatives to ensure safe and rational prescribing behaviour.

Work carried out from 2009 around integrated care pathways around referrals and emergency admissions using comparative data and current evidence and guidelines has been taken forward through QIP QOF from 2011.

The project provides GPs and the wider system with opportunities to reflect on clinical behaviour using comparative data. In turn prioritised work is put into context through promotion and provision of best practice guidelines.

Supported by protected learning time GPs are enabled to understand and manage variability, work more consistently to evidence-based practice and develop a broader perspective of an integrated system and use resources effectively.

Priority areas for Whole System Working for 2011/12 were
- Rationale use of laboratory and radiology services
- Falls pathways
- Polypharmacy
- Cancer pathways

For 2012/13 prioritised areas are
- Appropriate use of diagnostic services to support new pathways
- Anticipatory Care Planning for patients with complex needs
- Improving rational pain management prescribing choices using a Pain Management toolkit.

Although initiated within primary care, whole system improvement relies on productive joint working and engagement with a broad stakeholder group.

Some positive quantifiable outcomes include:
- Reduction of > 50% in lumbar spine and CT head investigations as a result of GPs being more informed and working within agreed criteria.
- Compliance with SIGN guidance for MSU reducing the number of samples received by 33%.
- Introduction of B12 testing guidelines resulted in a 30% reduction in tests
- PSA testing was reduced by 16%.
- Prescribing work has reduced quinolone prescribing in primary care by > 50% and ezetemibe prescribing by 60%.
- 1250 polypharmacy reviews were carried out with 1500 medicines stopped. 94% remained discontinued.

There is a need to develop measures that quantify the influence of the project on referral and admission rates and the reported qualitative influence on improving the interface between primary and secondary care. Forth Valley does have the lowest admission rate for LTCs and Care Home admissions have reduced to 0.2% of total admissions. The project has also influenced development and use of an improved and consistent discharge planning process.

Dr Stuart Cumming, Clinical Lead, Stirling CHP
01786 442860 stuart.cumming@nhs.net
Reshaping Care for Older People: A programme for Change is a multi-agency improvement programme at national scale that aims to transform care and support for older people in Scotland. The Joint Improvement Team (JIT) is supporting health, social care and housing partnerships to work with their Third and Independent sector partners to use £300 million (existing funding ring fenced 2011-2015) as a Change Fund to shift the balance of care towards more care at home and to shift the distribution of their total spend on adult health and social care. Partnerships are applying the Integrated Resource Framework as they develop local Joint Commissioning Strategies to redesign services to deliver high quality care and support across a whole system pathway.

The Reshaping Care Pathway was developed in 2010 by JIT and the Long Term Conditions Collaborative as a set of interventions that reflect the evidence based Chronic Care Model. They span preventative and anticipatory care, proactive, coordinated and integrated primary and community care, and actions that promote independence and effective care at times of transition. Collectively these interventions and enablers will improve outcomes, reduce future demand and make best use of public resources.

Improvement Network

This national Network is engaging all sectors and disciplines to exchange learning, drive the spread of key actions and increase the pace of local improvement through:

- WebEx virtual meetings, e-bulletins and web site*
- Exchange of good practice, evidence, resources and improvement tools
- Learning events - over 1000 people and more than 140 presenters exchanged learning at regional and national events in 2011/12
- Support for embedding integrating personalised outcomes-based approaches
- Training on improvement methodologies, measurement and evaluation

A suite of measures and indicators help partnerships chart their local progress in delivering improved outcomes for people who use services and their carers. From 08/09 to 2011 there has been around reduction in the days people over 75 spent in hospital as an emergency.

For further information contact: Anne.Hendry@scotland.gsi.gov.uk

http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/change-fund-library-of-resources/
Supporting Integration through Action Learning
NHS Grampian

AIM
To create opportunities for GPs, healthcare managers and practitioners from health and social care to come together to constructively challenge and improve practice, behaviours and pathways of care for older people, towards a shared outcome of shifting the balance of care.

Method
11 sessions, ranging in size from 15 – 25 people
One facilitator, two hours every six weeks
Over 140 people actively engaged

Achievements include:
- Changes to system and processes – reduction in barriers, duplication, variation and waste;
- Greater understanding and appreciation of the challenges, priorities, constraints, frameworks and drivers that impact on each service and result in the patterns and behaviours observed;
- Sharing, understanding and respect for personal values and drivers;
- Improved communication;
- Greater understanding of the impact of actions by one part of the service on another, and so on the entire system;
- Increased desire to work together as a team to resolve issues;
- A reduced tendency to describe something as “a Health” or “a Care” issue;
- and fewer references to “historically” ...

Membership:
Local GPs, Clinical Lead, Hospital Medical Director, Home Care, Care Management, Nursing, Community Nursing, Occupational Health – Hospital and Community, Physiotherapy, NHS Area Manager (Pharmacy, Housing, Telehealthcare, Information & Independent Sector)

Next Steps...
- Moving to a phase of multiagency improvement methodology (MMIO)
- External evaluation planned for late 2013

caring • listening • improving

Category: Effective
Main Contact: Fiona Soutar
Email: fionasoutar@nhs.net
Aim

Action Learning Sets (ALS) were established in 11 geographical areas of Aberdeenshire to create opportunities for GPs, local team managers and practitioners from health and social care to come together to constructively challenge and improve practice, behaviours and pathways of care for older people, towards a shared outcome of shifting the balance of care.

Methodology

The ALS include representation from all services with a key role to play in providing health and care services to older people (GPs, Health Area Managers, Home Care, Care Management, Ward Nursing, Community Nursing, OT, Physiotherapy, Hospital Medical Directors and Area Clinical Leads). At times, Housing, Pharmacy and Telehealthcare services also contribute to the discussion.

The smallest ALS has 10 core members, the largest has 23. Around 170 individuals are involved.

All 11 Action Learning Sets are facilitated by one facilitator, with a background in organisational development and Service Improvement, using a variety of tools and methodologies to build on existing relationships and good work already happening to: support and engage participants; encourage honesty and reality in discussion and reflection; provide the opportunity to challenge and be challenged in a safe and supporting environment; and enable participants to develop safe, affordable and sustainable solutions which meet the challenges of the local area.

Results

Achievements include:

- changes to systems and processes to reduce barriers, duplication, variation and waste;
- greater understanding and appreciation of the challenges, priorities, constraints, frameworks and drivers that impact on each service and result in the actions and behaviours observed;
- sharing, understanding and respect for personal values and drivers;
- improved communication;
- greater understanding of the impact of actions by one part of the service on another, and so on the service users;
- increased desire to work together as a team to resolve issues;
- a reduced tendency to describe something as “a Health” or “a Care” issue;
- and fewer references to “historically ....”.

External evaluation of the work is being organised and is planned for later in 2012.

Conclusion

- increased sharing of information;
- greater understanding and clarity between services and professions of each others roles and responsibilities;
- increased ability and opportunity to signpost service users appropriately between services;
- reduced confusion;
- fewer assumptions;
- increased trust and confidence in the systems and processes;
- a more integrated approach to service provision.

As the ALSs move in to a phase of problem solving using structured improvement methodology the impacts will be measurable and measured in terms of: time, finance, people, quality and safety.
Family Nurse Partnership Programme (FNP) in Scotland.

FNP is now firmly embedded in Scottish Government policy with the intention to ‘roll out’ the programme across Scotland over the next few years. As a preventative early intervention programme for our most vulnerable first time teenage parents there are early signs that this approach is making a significant difference in the lives of the parents enrolled on the programme and to the babies born into FNP families.

The aims of the programme are to improve maternal health and pregnancy outcomes, improve child health and increase parent’s economic self sufficiency.

The FNP approach is underpinned by the principles of developing self-efficacy, attachment and human ecology. It works on a mother’s intrinsic desire to do the best for her baby and uses the window of pregnancy as an ideal opportunity to work with the mother and her family. The programme builds on the mother’s strengths and resilience and helps her look towards a positive future as a parent. It is an intense programme and the therapeutic relationship between the Family nurse and client is key to the successful outcomes we are seeing in UK. Despite being a voluntary programme for parents we are seeing over 80% of clients who meet the programme criteria enrol and very low attrition rates. Family Nurses report high levels of job satisfaction in the role despite working with some of our most challenging families.

The programme costs approximately £3000 per family per annum for its 2.5 year duration and there is a potential for significant financial savings in the long term as the families graduate from the programme and the children grow up and become parents themselves. General Practice plays a pivotal role in identifying and supporting families on the programme, and, more importantly, supporting them once they graduate at 2 years. Being able to work in a way that recognises the strengths that these parents have makes a major difference to their long term outcomes. We are learning that as young people graduate they are less deficit focussed and in time are expecting us all to recognise, with them, the potential that they bring as parents.

FNP Information

- FNP pages on SG website: www.scotland.gov.uk/family-nurse-partnership

Contact: Gail Trotter – Tel: 0131 244 4007, e-mail: gail.trotter@scotland.gsi.gov.uk
Efficiency

“As a publicly funded service, NHSScotland has a duty to ensure value for money and to provide person-centred, safe, effective and efficient services to the people of Scotland. There is evidence of the human and high financial cost of poor quality and therefore improving both quality and cost is essential across NHSScotland.”

What we were looking for

Innovative examples of services, initiatives and activities that seek to improve quality and efficiency through improving experience, reducing unwarranted variation, removing waste and eliminating harm. We were particularly interested in examples where demonstrable benefits in terms of quality and efficiency have been achieved and are clearly described.
Development of a Bench Project to Implement Diabetes Teleconsultation

NHS Highland

**Category:** Efficiency

**Main Contact:** Astrid Lefevre

**Email:** astrid.lefevre@nhs.net
Aim

Delivery of a high quality specialist service to patients with long term conditions is particularly challenging across sparsely populated geographical areas. Diabetes was chosen as an exemplar specialty to examine the use of videoconference consultation to overcome these difficulties.

Methodology

- A project team led by eHealth was established to oversee implementation of a videoconference clinic between Inverness and Thurso in the North of Scotland
- A system for downloading blood glucose results from self monitoring devices was used by the diabetes nurse in the remote site, Thurso.
- Patient and staff satisfaction questionnaires were completed to inform the ‘Toolkit’ and assess acceptability of the service

Results

- A diabetes Video Consultation clinic ‘Toolkit’ was developed to facilitate effective delivery of further clinics
- Both patients and staff expressed high degrees of satisfaction with the service
- The approach confirmed consultant travelling time could be reduced by half and in doing so increase access to specialist services by a third

Conclusion

An enhanced mixture of face to face and VC consultation out-patient services has been established for diabetes patients in Thurso. This has led to improved appointment options for our patients and decreased consultant travelling time. This service has now been rolled out successfully to all diabetes clinics in Highland. The use of a remote blood glucose monitoring device was considered fundamental to wider roll out. The ‘Toolkit’ has application across other specialities and given that consultants in Highland spend over 5,000 hours travelling, the potential benefits are significant.

“...very good example of local innovation using eHealth and telehealth technologies...”
Scottish Government
Developing a Professional to Professional Line Between the Scottish Ambulance Service and the Borders Emergency Care Service

NHS Borders

Direct telephone access to Out of Hours GP = A safe alternative to admission for 85% of patients discussed

Aim
- To maximise safe treatment in the community
- Avoid unnecessary ambulance transfer and hospital admissions

Method
- We measured that patients regularly transferred from ASE to BCEC having presented in an ambulance. It was realised that if an SAS crew felt that a patient would benefit from an alternative to hospital they could discuss this with an Out of Hours GP whilst still in the patient's house

Results
1. Admissions & other outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>50</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>Other Outcomes</td>
<td>10</td>
<td>15</td>
<td>20</td>
</tr>
</tbody>
</table>

2. Interventions that prevented admissions

- Prevented unnecessary admissions
- Keeps patients safe at home with appropriate support
- Could potentially be rolled out across Scotland
- Potentially 24/7

Category: Efficiency
Main Contact: Laura Ryan
Email: laura.ryan@borders.scot.nhs.uk
Aim

The aim of the project was to maximise the timely, safe treatment of patients within their homes and communities as an alternative to transfer to A&E Borders General Hospital when they phoned 999. This in turn reduced unnecessary attendance at A&E at Borders General Hospital and maximised efficient use of that service.

Methodology

- Identify that there were patients arriving in ambulances that were subsequently discharged back into the community.
- Identify that these patients could be managed safely via a direct line between SAS professionals and GPs of the Borders Emergency Care Service.
- Meetings with GPs/management/paramedics to plan a pilot.
- Development of paperwork to ensure high standards of clinical governance.
- Regular review of the cases to ensure patient safety.

Results

Between 85% and 90% of patients were managed at home in the pilot phase rather than being transferred to A/E by this collaboration between the OOH service and the SAS. This was measured by looking at the total conveyances in the year of the pilot and taking those admissions prevented as a percentage of the total.

Conclusion

This positively influenced the Shifting the Balance of Care initiative, further improved T10 HEAT targets and most importantly improved the patient experience by ensuring they were getting the right treatment at the point of access to NHS services in Borders.

Delivering Quality in Primary Care – Progress Report

National quality indicators will support the delivery of consistent care, allow comparison between different NHS Board areas, and enable continuous improvement within local primary care Out of Hours services.
A&E Attendances Included in the QP QOF

The Scottish Government HEAT Target on reducing A&E Services aims to ensure that patients who could be equally well or better cared for elsewhere are aware of the alternative services and access these. A range of milestones have been developed to help Boards and partners focus on the key actions. Engagement with NHS 24, Scottish Ambulance Service and practitioners across the service will be critical for successful delivery. It is important that when patients access the health service the information they receive is consistent – regardless of whether they contact their GP Practice, local pharmacy or specialist services in secondary care.

During 2012/13 A&E attendances are included in the QP QOF – with practices being encouraged to focus on children with minor illnesses or injuries older patients with co-morbidities at high risk of admission and frequent attenders. Full details of the QP indicator and the associated information to be shared with practices is in the process of being shared through NHS Boards.

To continue engagement across the system in supporting patients to get to the right place first time a networking event is being held at the Scottish Health Service Centre on Thursday 14th June. This will be Chaired by Mr. Frank Strang, Deputy Director, Scottish Government Primary Care Division and will include a series of workshops led by clinicians and practitioners from the Service.

For further details contact Lorna Hall: lorna.hall@scotland.gsi.gov.uk
Access to Local Information to Support Self Management

Contact:
Dr Graham Kramer
National Clinical Lead for Self Management and Health Literacy Self Management, Scottish Government: graham.kramer@scotland.gsi.gov.uk  0131 244 3291
Spread and Benefits of Implementing Productive General Practice and Releasing Time to Care in the Community

Healthcare Improvement Scotland

Releasing Time to Care

Quality is everybody’s responsibility and Releasing Time to Care is a key programme of work that NHS Scotland and Scottish Government are investing in that benefit staff and patients alike.

Two key strands of the Productive Series for Primary Care teams are:

- Releasing Time to Care Community Services and,
- The Productive General Practice.

Together, they are enabling staff in Primary Care settings within NHS Scotland to embrace the challenge of providing improved quality of care, whilst managing increased demand and achieving best value for every pound of public expenditure. This current challenging context of healthcare Releasing Time to Care provides healthcare teams with permission to pause and be curious about their current practices and together make positive changes. Implementation involves a lot of energy, commitment, enthusiasm and hard work, but the benefits outweigh the challenges.

Releasing Time to Care Community Services was introduced to NHS Scotland in 2011 and all NHS Boards are now actively engaged with the process of planning and implementation. Working through the modules systematically empowers teams to make decisions that benefit patient care.

Conclusion

The integration agenda with health and social care partners is a strategic objective for all NHS boards. Working in collaboration in community settings GP Practices and Community Nursing Teams have unique opportunities not only to work together to implement RTC principles to enhance safer, effective and efficient patient care, but as highlighted in Delivering Quality in Primary Care Progress Report also begin to work with other community partners in service redesign and workforce planning in support of this objective.

Productive General Practice

The Productive General Practice (PGP) programme is designed to help general practices continue to deliver high-quality care whilst meeting increasing levels of demand and diverse expectations.

The latest in the NHS Institute for Innovation and Improvement’s nationally and internationally renowned Productive Series, Productive General Practice developed in partnership with NHS Scotland, co-designed, and tested by GPs, practice managers, nurses, receptionists and patients, as well as improvement experts from industry.

Through investment from the Scottish Government PGP is free to all practices in Scotland. Implementing the programme will engage all staff in the practice to improve their working processes, making it possible to release time to invest in improving patient outcomes and staff wellbeing whilst putting the needs of patients first.

The design and delivery of training is being facilitated through a team from the Royal College of General Practitioners and Quality and Efficiency Support Team in Scotland.

PGP Programme Structure

Click to see PGP Programme Structure

For more information please contact pgp@nhs.scot

Category: Efficiency
Name(s): Janet Harris and Fiona Cook
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Aim

A range of products from the Productive Series has been implemented in NHSScotland since 2008 to deliver on the quality agenda; specifically the Effective Quality Ambition alongside efficiency and value for money. In 2010 NHS Boards began to implement Releasing Time to Care (Community Services) which empowers community nursing teams to explore current work related systems and processes and refine in order to provide an evidence based, efficient quality of service to patients and families.

More recently Productive General Practice (PGP) was developed through a unique rapid innovation partnership with General Practices, the Quality and Efficiency Support Team (QuEST) and the Institute of Innovation and Improvement. It is currently being rolled out to practices throughout NHSScotland.

The implementation and spread of both resources in primary care yields many mutual potential benefits and opportunities for working together in healthcare and with other partners.

Methodology

Initial training was offered to RTCC Facilitators for RTCC in all NHS Boards.

GP Practices can independently work through the PGP material or can attend an awareness or training session delivered by a joint RCGP/QuEst team.

Data of current uptake for both programmes are available

Results

All NHS Boards in NHSScotland are beginning to implement RTCC and are beginning to see the impact. Spread of PGP is beginning to gain momentum across Scotland. work is underway to identify impact measures. Early benefits are materialising from the work currently being undertaken with work underway to identify impact measures.

Conclusion

Enhanced efficient quality of service provided for patients and families

Delivering Quality in Primary Care – Progress Report

Change Fund for older people’s services is a partnership resource for health, social care and the third and independent sectors, which is expected to act as a catalyst for more radical, innovative redesign of older people’s care and support.
The Patient Held Record. Your Health in Your Hands
The Digital Pen Project
NHS Western Isles

The Patient Held Record - Your Health in Your Hands
Digital Pen Project

The reason for the introduction of the Digital Pen

With the aim of improving patient care and reducing errors, the digital pen project was launched to revolutionise the recording of patient information. A digital pen was developed to allow for the secure and efficient input of patient information, making the process more accurate and accessible. The project was aimed at improving the efficiency of the healthcare system and providing patients with greater control over their health information.

What benefits do we hope the pens will achieve?

- Reduced errors in patient information
- Improved patient care
- Increased patient satisfaction
- Enhanced data accuracy
- Streamlined administrative processes

How was the digital pen expected to improve things?

- Reduced time for staff to input data
- Enhanced communication between healthcare professionals
- Improved patient understanding of their health information
- Increased efficiency in patient care

Category: Efficiency
Main Contact: Christine Chlad
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## Aim

The project was undertaken following a review of our Community Nursing Service. The results highlighted the fact that nurses had to complete the Patient Held Record in patients’ homes and then spend a large proportion of their time on data entry, often having to duplicate the data in multiple systems once they travelled back to base. We made the decision that the digital pen would be an ideal solution.

## Methodology

A standardized set of forms that make up the Patient Held Record were agreed. Each community nurse now has a smart phone which is paired with a digital pen, and there is also a docking station alternative at each base for transmitting the data in areas where there is little or no mobile signal.

These forms are now digitised and once a nurse has completed the relevant forms, they tick the “send” box printed on the form, and this sends a signal to the pen, which transmits the data to the mobile phone, all via Bluetooth technology. The phone then sends the data back to the system server, where the relevant data is converted from handwriting to text.

## Results

The project is just about to go-live and our aim is that the following will be achieved:

- ‘Releasing Time to Care’ by increasing time for additional patient visits and patient enhancing activities.
- Reduction in time spent on administration.
- Direct flow of data, reducing duplication of data entry.
- Improved documentation and standardization of forms.
- Reduction in time for data entry and increase in quality of data.

## Conclusion

- Reduction of 50 -70% in staff time spent on admin and inputting data, which will give nurses a substantial increase in hours per day available for patient facing activity, with the aim of maintaining people safely in their own homes.
- Removal of the need for data entry and duplication of data into multiple systems.
- Continuing the improvement in the quality of patient care, streamline community nursing processes and provide additional management information.
- Significant improvements in non-cash releasing efficiencies and productivity.
20:20 Workforce Vision

Demand for healthcare and the circumstances in which it will be delivered in Scotland will be radically different in future years. There will be a continuing shift in the pattern of disease towards long-term conditions, growing numbers of older people with complex needs such as dementia. Over the next 20 years demography alone could increase expenditure on health and social care by over 70% based on current service delivery patterns.

NHSScotland aims to become a world leader in healthcare quality with 3 priorities of person centred, safe and effective care. Achieving sustainable quality in Scotland’s Healthcare: an agreed 20:20 vision provides the context for taking this forward and to improve efficiency and achieve financial sustainability, within integrated health and social care provisions.

That vision is that by 2020 everyone is able to live longer and healthier lives at home, or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re admission.

The workforce is central to achieving the 2020 vision and that is why we are developing the 2020 Workforce Vision for NHSScotland together with policy, service and partnership colleagues. We are focusing on 3 key themes

- Modernisation and Capacity - the changing size and shape of the workforce needed to deliver different models of care in the future
- Leadership and Capability - leadership is central to improving performance, redesigning services and securing better outcomes for the people of Scotland.
- Governance and Engagement - improvements in staff engagement impacting positively on the care experience

We will thread through this the work on integration describing how to prepare the workforce to deliver different models of care which cross boundaries in organisations and provide seamless care. We will base our work on strengthened values, culture and behaviours.

The role of GPs in achieving the 2020 Vision is very much recognised and needs to be considered alongside workforce and capacity issues in a collaborative way.
Quality Infrastructure

“The Quality Strategy recognises that there are a number of areas of work which support and facilitate NHSScotland and its partners to have the maximum impact on the three Quality Ambitions. At a national level these include: measurement; information technology; workforce, education and training; communication; and governance - collectively referred to as Infrastructure.”

What we were looking for

Innovative examples of services, initiatives and activities from one of the Infrastructure strands. There are other areas of work that support and facilitate the achievement of our Quality Ambitions too, e.g. administration where improvement methodologies have been used to achieve greater efficiency.
Augmenting Rural Midwifery Services Training Tools: RRHEAL & SMMDP

NHS Education for Scotland

Augmenting Rural Midwifery Services training tools: patient centred and service focussed
Fiona Fraser, Project Lead/RRHEAL, Helena Marshall, SMMMDP Director/RES
Theresa Chivers, Midwife/ NHS Shetland, Sarah MacLeod, Midwife/ HHS Highland

- Remote and rural midwifery service teams face challenges in maintaining a broad range of skills in the context of isolated clinical practice and leading to a dispersed patient population.
- Training exists to support such teams but ways were sought to compound clinical effectiveness and prepare the period of skill maintenance between training sessions.
- RRHEAL (1:(m) collaboration with SMMDP(2) developed two educational tools to compound existing training delivery and present practical guidance within the context of remote Midwifery care.
  - Short training films were developed, demonstrating scenarios in simulation within a remote clinical context for Pregnancy induced hypertension (PPIH) and post partum haemorrhage (PPH).
  - These audio visual resources include detailed narrative, highlighting key learning points.
  - The tools are accompanied by supportive workbook materials including references to further educational resources and linked national guidance.
  - Enactment of the scenarios is realistic to the rural context and as a result engaging and effective for the focused audience.
  - These resources demonstrate an inclusive approach to both contextually appropriate educational delivery and efficiencies in extending the period of skills maintenance whilst reducing lost clinical time and the impact of unnecessary travel.
- This approach is being replicated for other subject matter.

The resources are hosted on the RRHEAL education platform / www.rrheal.scot.nhs.uk (9).

For Reference

RRHEAL
The Remote and Rural Healthcare: Educational Initiative First tool was developed by NHS Forth Valley in 2005 in response to a need for simulation and support for rural and remote Midwifery teams as well as for neonatal and postnatal care. Newfoundland Island.
- RRHEAL provides accessible to remote and rural NHS Regions and is a result of the collaboration between National Health Service and the local NHS regions.
- RRHEAL, available from the education resources for Midwifery education, using technology assisted learning on the platform, the tool delivers the tool.
- RRHEAL, available from the education resources for Midwifery education, using technology assisted learning on the platform, the tool delivers the tool.
- SMMDP
The Scottish Multi-Media Development Programme (SMMDP) was established in 2004 in response to recommendations made by "Expert Group on Acute Material Services" (EGAMS) 2003.
- The SMMDP through a network of regional facilitators aims to provide broad access to educational resources for all professionals in the Midwifery domain, and educators & managers to them in a variety of roles and settings. It supports the development of educational resources for midwives and midwife educators.

Post Partum Haemorrhage (PPH)

- Pregnancy induced hypertension

The PPH resource has been used to support a distributed branch of the new guidance for early recognition and management. This supports the guidance on remote and rural midwifery services teams, making sure that midwives have a consistent understanding of key national level accessible knowledge and principles without need for travel.
- To provide an educational resource for midwifery teams in remote, rural and island settings, clothing options for managing a woman presenting with pregnancy induced hypertension.
- To accompany the newly developed guidance for PPH (RRHEAL have collaborated with SMMDP/HHI).
- An audio visual resource has been produced which uses simulation to depict the rapid assessment, recognition and early intervention required for a woman presenting with pregnancy induced hypertension in a rural setting.
- The context depicted references the challenges and possible courses for treating and transferring on such a patient.

- The resource for PPH will support training already delivered to rural teams and consolidate learning, in addition to providing a resource for newly accessed remote training.
- This tool augments the existing and national delivery of training for PPH. This tool may assist with skills maintenance as basic, but additionally as a tool for small group teaching and to support clinical decision making.
- The resource defines clinical presentation of primary and secondary post partum haemorrhage.
- Approaches to assessing the woman and defining the cause of PPH are outlined, using the-ETTS, pain, lesions, trauma, thrombus.
- The need for prompt recognition and early intervention is highlighted.
- The procedures for initiating is manual compression is illustrated.

- Further direction is offered regarding ongoing assessment and intervention with need for additional support.
- Emphasis is made in the need for readiness for transfer and the need for team liaison and acknowledgement of local to national guidance to support this.

Category: Infrastructure
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Aim
Remote and Rural midwifery service teams face challenges in maintaining a broad range of skills in the context of isolated clinical practice and tending to a dispersed patient population. Training exists to support such teams but ways were sought to compound clinical effectiveness and prolong the period of skill maintenance between training sessions.

RRHEAL in collaboration with SMMDP developed reusable educational tools to compound existing training delivery and present practical guidance within the context of remote Midwifery care.

Methodology
Short training films were developed, demonstrating scenarios in simulation within a remote clinical context for post partum haemorrhage (PPH) and Pregnancy induced hypertension (PIH).

Enactment of the scenarios is realistic to the rural context and as a result engaging and effective for this focused audience.

The resources are hosted on the Remote and Rural Healthcare Educational Alliance (RRHEAL) education platform.

Results
The PIH resource has been used to support a distributed launch of the new guidance for early recognition and management. This supported at distance engagement by remote and rural midwifery services teams; making both educational content and engagement with national leads accessible and inclusive without need for travel.

The resource for PPH will compound training already delivered to rural teams and consolidate learning, in addition to providing a resource for ready access/team training.

Conclusion
These resources demonstrate an inclusive approach to both contextually appropriate educational delivery and efficiencies in extending the period of skills maintenance whilst reducing lost clinical time and the impact of unnecessary travel. This approach is being replicated for other subject matter.

Delivering Quality in Primary Care – Progress Report
Healthcare Improvement Scotland’s (HIS) development of the Patient Safety in Primary Care programme objective is to reduce the number of events which could cause avoidable harm to people from healthcare delivered in any primary care setting.
Developing a National Improvement Network for Community Hospitals

Scottish Association of Community Hospitals

Category: Infrastructure
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Delivering Quality in Primary Care – Progress Report

The Scottish Government will be promoting the development of community hospitals and community hospital staff through the creation of an Improvement Network and a short life working group.
**Aim**

In 2010 the Scottish Association of Community Hospitals (SACH) embarked on an educational project in partnership with NHS Education for Scotland (NES) to undertake and give feedback on a survey of the self-assessed learning needs of staff in Community Hospitals across Scotland.

**Methodology**

Between 2010 and 2011 the SACH and NES conducted focussed Learning Needs Analysis studies of the Community Hospital workforce in Scotland via:

- an overview of Community Hospital development needs by the SACH
- an electronic questionnaire to all territorial NHS Boards
- focus group discussions with staff
- listening visits to six community hospital sites

**Results**

These activities culminated in the following joint SACH and NES Learning Needs Analysis reports:

- Bridging the Gap 2010
- Identifying the Learning Needs of Community Hospital staff in Scotland 2011
- Sharing the findings via the SACH website and individual copies emailed to all Community Hospitals in Scotland

**Conclusion**

The Learning Needs Analysis combined report directly influenced the Scottish Government’s ‘Community Hospital Strategy’ (published in April 2012). This identifies the strategic intention for NES to host the SACH to develop a central resource for Community Hospitals through a National Improvement Network to help facilitate education, sharing good practice, exchange of knowledge and clinical skills, and establish an improvement forum.

This National Improvement Network would provide a unique opportunity to build on existing partnership working between NES and the SACH to support the learning needs of community hospital workforces in Scotland, in association with the health and social care integration agenda.
Scottish GP Rural Acute Care Competencies and Educational Needs

NHS Education for Scotland

Introduction

The Scottish Government and NHS Scotland established the Remote and Rural Implementation Group (RRIG) to oversee the implementation of the Delivering for Remote and Rural Healthcare (DfRRH) Action Plan (March 2019). The purpose of the DfRRH was to improve access to primary and secondary care services for remote and rural populations. To support this, the Scottish Executive funding was made available for postgraduate education (PGE) for General Practitioners (GPs) in remote and rural areas.

This paper describes a pilot project to develop a new educational pathway to support Scottish GPs working in rural and remote settings.

Method

The Scottish GP Rural Acute Care Competencies and Educational Needs project was led by Fiona Fraser, Peter Nicol, Greg DeMello, Ronald Macvicar, Elaine Pacitti, Gillian Needham, and Julie Milne. Fiona Fraser is the project lead.

Findings

The competencies for rural GP services identified the need for additional skills and competencies over and above those covered in GP training. The competencies are as follows:

1. Life support
   a. Emergency Medicine
   b. Cardiac Care
   c. Trauma

2. Acute care
   a. Acute Medicine
   b. Surgery

3. Primary care
   a. Primary Care
   b. Pharmacy

4. Health and social care
   a. Health and social care
   b. Care of the elderly

5. Public health
   a. Public health
   b. Health promotion

6. Leadership
   a. Leadership
   b. Teamwork

The competencies were designed to help to develop a new educational pathway for GPs working in rural and remote settings.

Conclusions

The project has identified several key themes:

1. The importance of rural GP services
2. The need for additional skills and competencies
3. The development of a new educational pathway

The project has led to the development of a new educational pathway for GPs working in rural and remote settings.

Category: Quality Infrastructure

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**Aim**

The Remote and Rural Implementation group (RRIG) Scotland, highlighted the sustainability of services and workforce in remote Community Hospitals as a priority issue.

The most pressing of these reasons centred on the recruitment, education, skill acquisition and maintenance, appraisal and revalidation of General Practitioners (GPs) providing acute medical care in remote Community Hospital settings across Scotland.

The Remote and Rural Healthcare Educational Alliance (RRHEAL) co-ordinated work identifying affordable, accessible and sustainable education pathways supporting Rural Practitioners providing care in acute settings.

**Methodology**

RRHEAL convened a short-life working group under the chairmanship of the NES North of Scotland Director of Postgraduate GP Education.

General Practitioners in remote Community Hospital settings and related areas across Scotland provided expertise by defining competences and educational requirements.

**Results**

The key steps:

1. Identification of core competences for a general practitioner providing care in Acute Settings in the remote hospital context
2. Identification of current education and training already delivered and its suitability for this group of R&R general practitioners.
3. Identification of gaps in educational provision
4. Description of an education pathway to support General Practitioners in remote Community Hospital settings.

**Conclusion**

The short life rural general practitioner advisory group defined the additional skills and competences over and above those covered in GP Speciality Training that a GP would require to undertake work in the rural acute care setting.

This extensive list of competencies was refined and categorised into 11 clusters. These formed the basis of a national structured education programme for general practitioners practising in rural acute care settings.
Scottish Community Hospital Improvement Network


The current strategy refresh provides a renewed focus for community hospitals and highlights their key contribution to sustainable quality through their role in delivering safe, effective and person centred care closer to home. In order to achieve this aim, each NHS Board now has a nominated Community Hospital Lead with responsibility to ensure that each community hospital has a clear service plan that identifies their role and maximises their contribution to developing and improving outcomes within specified care pathways.

To support this process NHS Education for Scotland (NES) has been commissioned to develop a national Community Hospital Improvement Network, working with the nominated Board Leads, and building on previous partnership working with the Scottish Association of Community Hospitals (SACH). The purpose of this Network is to support the learning needs of the community hospital workforce through facilitated education, exchange of knowledge and clinical skills and to provide an improvement forum to share and spread good practice.

The Network will offer support to the community hospital workforce through facilitated webex sessions, regional and national learning events, and opportunities for practitioners to exchange knowledge through an online forum which will be hosted by NES. Learning and improvement themes will be informed by the analysis of the Scottish community hospital workforce learning needs undertaken between 2010 and 2011.

Through this support the Network will help NHS Boards to deliver a comprehensive system of intermediate care and will strengthen local progress on integration of health and social care, reshaping care for older people, palliative care and dementia care standards and redesign of care pathways in remote and rural settings.

Please contact NHS Education for Scotland for further details and/or information (CHIN@nes.scot.nhs.uk).
“There will be mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.”

**What we were looking for**

Innovative examples of services, initiatives and activities that seek to put people at the heart of decisions about their care and that involve people in how services are shaped and delivered. This includes activities that support staff, patients and carers to create partnerships which result in shared decision making or initiatives that inform and support people to manage and maintain their health, and to manage ill-health. It also involves involving service users to report and share accounts of their experience of a service as a whole or an intervention and how this is used as feedback into the service to adapt and improve.
Do 'Just in Case' Boxes, Improve Access to End of Life Medications
NHS Lanarkshire

Anticipatory prescribing for dying patients -
A pilot study of Just in Case boxes in NHS Lanarkshire

Introduction
Many people nearing the end of life have a strong desire to remain in their own home for as long as possible. Ensuring timely access to medicines can prevent unnecessary distress (e.g., emergency admission to hospital) and distress for patients and their families. The publication of Living and Dying Well by the Scottish Government in October 2008 led the NHS Lanarkshire Managed Clinical Network for palliative care to consider just-in-case boxes as a way to facilitate anticipatory prescribing and further enhance patient care. Within NHS Lanarkshire Patient Group Directions (PGD) for four palliative care medications (barbiturates, hypnotics/benzodiazepines, inotropes and inhaletable oxygen) are currently reimbursed in practice. These medicines can be administered by community nurses working out-of-hours in accordance with the PGD. Audit findings have revealed that the most common reason for a medicine to be administered under a PGD is lack of anticipatory prescribing or sudden deterioration in a patient’s condition. To ensure 24-hour access to end-of-life medicines, it was necessary to take further steps to support anticipatory prescribing and have medicines available in the home before a patient enters their final days of life. Subsequently, a short life working group was set up and tasked with the development of a policy to ensure patients within NHS Lanarkshire who wanted to die at home would have medicines immediately available to them.

A pilot study was commenced in 2010 to assess the value of placing a stock in Care box into a patient’s home, with the patient’s consent, a few weeks prior to their anticipated death. Medicines are prescribed for the patient by their GP 'Just in case', and are sourced in a ready-to-administer box along with needles and syringes, a syringe driver, disposables, and a prescription and administration record. This ensures that symptoms can be managed effectively and without delay. The prescribed medicines have been aggregated into a single box, which is easy to transport and includes a pharmacy prescription label. Following the pilot study, the care for wider implementation was made and accepted by NHS Lanarkshire and a full roll-out took place in January and February 2012.

Recommended Medications for Just in Case (JIC) prescription

<table>
<thead>
<tr>
<th>Indication</th>
<th>Medication</th>
<th>Route</th>
<th>Dose instructions</th>
<th>Recommended supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain relief</td>
<td>Opioids/sedatives (or current opioid)</td>
<td>SC</td>
<td>Opioids to be determined by prescriber</td>
<td>Sufficient supply to cover the immediate out of hours period</td>
</tr>
<tr>
<td>Antiflux/and/or anxiety</td>
<td>Midazolam injection</td>
<td>SC</td>
<td>2.5 mg, 5 mg, 10 mg (or as required)</td>
<td>10 ampoules of 10mg/2ml</td>
</tr>
<tr>
<td>Anti-emetics</td>
<td>Non-specific (Bupropion)</td>
<td>SC</td>
<td>20mg orally as required</td>
<td>10 ampoules of 20mg/1ml</td>
</tr>
<tr>
<td>Neurological</td>
<td>Lorazepam (or current opioid)</td>
<td>Intravenous injection</td>
<td>2.5 mg, 10mg, 30mg (or as required)</td>
<td>15 ampoules of 10mg/2ml</td>
</tr>
<tr>
<td>Confusion/ delirium</td>
<td>Haloperidol injection</td>
<td>SC</td>
<td>2.5 mg once or twice daily as required</td>
<td>5 ampoules of 5mg/1ml</td>
</tr>
<tr>
<td>Distoct</td>
<td>Water for injection</td>
<td>SC</td>
<td>10 ampoules of 10ml</td>
<td></td>
</tr>
</tbody>
</table>

Prescribing and Administration
- All GP practices within NHS Lanarkshire using the JIC prescribing system have the JIC prescription available automatically.
- The CPD prescription is taken to the patient’s nominated community pharmacy for dispensing.
- Community nurses take an empty JIC box from the nursing home, add the required medicines and place in the patient’s home. The dispensed medications are then added.
- A prescription and administration record is signed by the prescribing doctor and placed in the JIC box.
- Community nurses record administration of JIC medications on the prescription and administration record.
- If 1 or more doses of any one medicine are required within 24 hours a CPD refill is made for consideration of a syringe pump.

Audit Findings
- 219 audits forms evaluated
  - Average length of time the JIC box was available for use was 1 day (range 1-21 days)
  - 180 patients (82.5%) required medication from the JIC box
- 153 respondents stated that a call to the out-of-hours service was not made. Of these 114 (73.7%) claimed that use of the JIC box had prevented the call.
- 131 respondents stated that the patient was not admitted to hospital. Of these 69 (53%) claimed that use of the JIC box had prevented an unneeded hospital admission.

Implementation
- Initially pilot sites (17) within NHS Lanarkshire
- Recently extended to 4 pilot sites
- A care is being developed for area-wide implementation
- To be presented to NHS Lanarkshire local committee Autumn 2011

Comments from district nurses
- Just in case box benefits the patient as drugs can be given instantly saving a visit for GP
- Requests from families that comfort in the home can be maintained without delay on transfer
- Drugs were not used in emergency but were used to initiate medications in a synergy effect
- Very useful in preventing admission to hospital/palliative
- GPs, patients, relatives, all nursing staff involved in care reassurance
- Family expressed their reassurance at having box at home
- Care family, patient and staff reassurance that symptoms could be managed quickly

Education
- Scheduled information sessions were delivered by the community liaison nurse and the clinical lead for the palliative care managed clinical network
- Sessions were held in each pilot area and aimed at district nurses and GPs
- Individual meetings with GPs from participating practices took place on an ad-hoc basis

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**Aim**

Many patients nearing the end of life wish to remain in their own home for as long as possible. Ensuring timely access to medications can prevent unnecessary crises and distress for both patients and their carers; preventing hospital admissions and calls to out of hours.

**Methodology**

We report on a study of 'Just in Case' (JIC) boxes to facilitate anticipatory prescribing and improve access to medications. Each box contains medications that are commonly required to manage symptoms at the end of life-namely pain, anxiety/terminal restlessness, chest secretions, nausea/vomiting and confusion/delirium. The medications are prescribed ‘Just in Case’ by the GP, dispensed by the community pharmacist and put in a readily identifiable box by the community nurse along with the necessary sundries and prescription/administration record. Amongst the aims of the study, we wanted to understand whether or not ‘Just in Case’ boxes improve patient care.

**Results**

In order to measure the outcomes, such as hospital admissions, out-of-hours calls and patient being able to stay in their preferred place of care, each box has come with an audit form which should be completed for all patients by the team who looked after them.

Using this data, we have been able to identify that 149 of 180 boxes were used (at least one drug administered) as of December 2011. This resulted in 71 hospital admissions being avoided and 102 OOH calls being avoided due to the box being in place. These results come after an approximate period of 18 months data collection with regular reporting to the Palliative Care MCN.

**Conclusion**

The availability of the box has been welcomed by patients and their carers. Community nurses have stated that the accessibility of the medications provide reassurance, allow symptoms to be managed promptly and prevent hospital admission. Based on these findings, the case for wide area implementation has been made.

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*Delivering Quality in Primary Care – Progress Report*

**DALLAS** (Delivering Assisted Lifestyles At Scale) initiative will examine the use of new technologies to support people in their own homes and find out which innovative products, systems and services work best.
Developing a system of direct access to Out of Hours GP services improved the experience of the patient and those caring for patients with severe learning disabilities when they had acute health while GP surgeries were closed.

**NHS Borders**

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**Improving the experience of patients with severe learning disabilities and those caring for them when they have acute health needs out of hours.**

**Providing direct phone access to NHS Borders Out of Hours Service**

**Method**
- An appropriate form was developed by the Learning Disability Team with which to share valid information with the BECS Out of Hours team.
- The Learning Disability Team ensured the Adult with Incapacity forms were shared with the out of hours service.
- An education session for OOH GPs was delivered by the Learning Disability team prior to a 9 month pilot in 2000.
- A list of the relevant syndromes affecting patients who were likely to access the service was shared with the GPs.
- An information booklet was developed to give carers explaining the service, the direct access telephone number.

**Results**
- The learning disability team have twice measured feedback from the carers who have accessed the service. The carers express much satisfaction with this way of accessing care. A few examples of the comments are shared below.

  *Extremely helpful, eternally grateful that the service is in place and hard to describe the psychological reassurance it gives us especially OOH and at weekends.*

  *Never had a profit. Very reassuring service. Reassuring that it is there.*

  *The whole weekend experience was “excellent” everyone did their very best for us and it was much appreciated.*

**Conclusions**
- Carers of patients with multiple complex needs have a less stressful way to access a prompt, safe, effective service. The primary care GPs and nurses delivering the care, out of hours are well equipped with up to date information which is maintained by excellent communication with the Learning Disability team. The service is now embedded in the Borders Emergency Care Service and regular contact is made with the Learning Disability Team to ensure information is kept up to date.

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**Category:** Person Centred

**Main Contact:** Laura Ryan

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**Delivering Quality in Primary Care – Progress Report**

Childsmiile adopts a multi-agency approach to improving children’s oral health through dental practice, community, and education settings and has a holistic approach to healthy living and health improving life skills.
Aim
The aim was to expedite advice and delivery of required care by ensuring those with the most complex needs had relevant information formulated by the Learning Disabilities Team and carers that was then shared with the Borders Emergency Care Service (OOH GP Service). A pilot of a direct access line was developed with a view to making this a permanent facility if it worked.

Methodology
- An appropriate form was developed by the Learning Disability Team with which to share valid information with the OOH team
- The Learning Disability Team ensured the Adult with Incapacity forms were shared with the out of hours service
- An education session for OOH GPs was delivered by the Learning Disability team prior to the pilot in February 2009
- A list of the relevant syndromes affecting patients who were likely to access the service was shared with the GPs
- An information leaflet was developed to give to carers explaining the service and the number to give them direct access

Results
The learning disability team kept a record of feedback for the carers who had accessed the service during the pilot. The carers expressed much satisfaction with this way of accessing care. A few examples of the comments are shared below. The service is now embedded in the Borders Emergency Care Service and regular contact is made with the Learning Disability Team to ensure information is up to date.

"This experience in comparison to previous experiences was like night and day. I hope this service continues"

"This service was in contrast to the service we accessed in the past. The whole weekend experience was "excellent" everyone did their very best for us and it was much appreciated".

"Never had a problem. Very reassuring service. Reassuring that it is there"

Conclusion
Carers of patients with multiple complex needs have a less stressful way to access a prompt, safe, effective service. The primary care clinicians delivering the care out of hours are well equipped with up to date information which is maintained by excellent communication with the Learning Disability team.
Delivering Quality in Primary Care – Progress Report

The Modernising Nursing in the Community Programme Board was set up to support NHS Boards in their workforce planning and development by developing and testing a framework which will assist NHS Boards to carry out this work in a Scotland-wide co-ordinated approach, while enabling local solutions. The online interactive toolkit resource that was launched in January 2012 assists NHS Boards in service redesign and workforce planning/configuration.
Aim
Improving access to primary care services and consistency of access were recurring key themes during the development of NHS Ayrshire & Arran’s primary care strategy Your Health – we’re in it together. In partnership with the public we took forward the challenge to develop a set of standards that can clearly set out what people can expect from their local health services.

Methodology
Linking with local groups and organisations a continuous programme of public engagement ensured stakeholders had the opportunity to comment on and be part of the creation of the Rights and Responsibilities initiative.

A one day large scale public event held in May 2011 gave event delegates an opportunity to work in partnership with healthcare professionals to look at setting standards across primary care services. Delegates attended workshops themed by contractor group and at the general practice workshop worked jointly with a GP and Practice Manager to consider the issues of accessibility and consistency.

A graphic facilitator recorded what the public told us pictorially ensuring that the information was more accessible.

Presenting all findings and public expectations to both the GP Sub Committee and Local Medical Committee (LMC) for consideration meant that public and professionals were fully involved in the development and evolution of the initiative which was endorsed by both committees.

When launching Rights and Responsibilities it was vital to present to the public the collaborative nature of this work at all levels. The GP Sub Committee played a key role at the launch event by ensuring a representative from the committee presented to the public what the initiative meant from the GP and committee perspective.

Results
Rights and Responsibilities in General Practice fully reflects not only what the public want as patients from local healthcare but also sets out professional views by displaying what local General Practice can expect from patients.

The initiative was officially launched in June 2012 at a public event.

Conclusion
With joint support from the Associate Medical Director and the secretary of the LMC, Rights and Responsibilities posters have been cascaded to all practices. Uptake of the initiative will be assessed in late summer/early autumn 2012.

By widely promoting this initiative all stakeholders know what to expect and what is expected of them when accessing local health services.
### Maternal and Child Health

#### The Policy Context for Primary Care in Scotland

Everyone gets the best start in life, and is able to live a longer, healthier life.

Giving every child the best start in life is a national quality outcome for the Scottish Government. Maternal and child health services are the cornerstone of this ambition. In order to achieve the ambition, the Scottish Government has worked collaboratively with NHSScotland, the Royal Colleges and other stakeholders to develop a suite of strategic frameworks and guidance for maternal and child health services.

These frameworks are aimed at strengthening the role of the NHS and other public services in delivering early intervention and preventative services during the pre birth period and the earliest years of children’s lives. Central to this work is reducing the inequalities in outcomes for children. We know that this inequality is not inevitable – many contributing factors are modifiable and amenable to reduction. Strengthening universal health services and in particular primary care services' ability to identify risk factors and to intervene as early as possible, is critical to improving outcomes and reducing inequalities in outcomes for women and children.

The **top 10 actions for primary care teams** in implementing maternal and child health policy in Scotland are:

1. Ensuring all women of reproductive age are given proactive advice and support in relation to their contraceptive and family spacing needs.
2. Seeing all primary care contacts with women and their families as an opportunity to promote pre-conceptual health and in pregnancy promote early access to antenatal services.
3. Ensuring effective communication and collaboration with maternity services and other agencies for vulnerable mothers so as to reduce avoidable maternal and infant morbidity and mortality.
4. Identifying and responding effectively to health and social risk factors, which may have an adverse impact on maternal and infant health.
5. Identifying and supporting parents to develop their parenting skills, particularly where there are concerns about maternal and infant attachment, through either self-help or structured interventions.
6. Promoting and supporting good maternal and infant nutrition, including breastfeeding.
7. Utilising support from specialist services when screening and assessment processes identify vulnerable babies, with particular awareness that babies under 1 year of age are going through the period of greatest brain development whilst also being at increased risk of abuse.
8. Ensuring that all in the practice team use the Getting it Right for Every Child Practice model6 and the revised Child Protection Guidance6 and the Getting our Priorities Right Guidance7.
9. Using routine antenatal contacts, immunisations and the refreshed Hall 4 child health programme as critical points for primary care to identify concerns and opportunities to work with families using strength-based approaches.
10. Ensuring that the Primary Care workforce are confident and skilled in the recognition of illness that needs specialist opinion and that practitioners have links to specialist services and their local Community Child Health services.

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1. [Scotland Performs](http://www.scotland.gov.uk/About/Performance/scotPerforms)
2. [A Refreshed Framework for Maternity Care in Scotland](http://www.scotland.gov.uk/Publications/2011/02/11122123/0)
3. [Improving maternal and infant nutrition - A Framework for Action](http://www.scotland.gov.uk/Publications/2011/01/13095228/4)
4. [A new look at Hall 4 - the early years - good health for all children](http://www.scotland.gov.uk/Publications/2011/01/11133654/0)
5. [Getting it Right for every Child](http://www.scotland.gov.uk/Topics/People/Young-People/gettingright)
6. [National Guidance for Child Protection in Scotland](http://www.scotland.gov.uk/Publications/2010/05/27095252/0)
7. [Getting our Priorities Right](http://www.scotland.gov.uk/Publications/2012/07/9484)
Care Information Scotland is for anyone seeking information about community care for older people. Research identified that many people don’t know where to turn when they are looking for care services - quite often at a time of crisis.

The service has been designed as a central point to help guide people through the maze of resources to ensure they have access to comprehensive, accurate and up to date information, either for themselves, a relative or friend.

The service is also a helpful source of information for care professionals who are able to direct people to the information service as required. As well as containing core information for the whole of Scotland, such as what different types of care exist; charging policies; free personal care; and care standards, the service also provides information about specific local services and support groups and how to access them.

The telephone help line is available from 8am-10pm, 7 days per week on 08456 001 001. Call charges may vary depending on the service provider. Outwith these hours, people can still access the website www.careinfoscotland.co.uk which contains a range of information on care services, presented under clear categories. The service is also available through the TV using Sky, Freesat for Sky (channel 539) and Virgin (interactive channel).
How ACAP United Practitioners Across Scotland
NHS Lanarkshire

Introduction
Advanced practice in its current concept is reasonably new in the UK. It has evolved from the nurse specialist in the 1970s and 1980s to the level of last responders to some of the most acutely unwell patients. Advanced Practitioners are at the forefront of making complex decisions, providing independently, changing or implementing treatment plans and often without experienced medical staff to support them. This can often create a feeling of vulnerability resulting in APs questioning their own ability.
Fragmented throughout Scotland, with regional differences and service demands influencing practice, many APs lack a community, a sense of belonging, have a voice, be given a platform, have ownership and empowerment and of course improve knowledge and skills to provide the very best of care for patients.

Method
July 2010 saw the inception of ACAP Scotland. Initial questionnaires proved many Scottish-wide communities but also showed a lack of diversity within the role. Just ten APs from various regions in Scotland took the first step in providing APs with a voice, build on communities and address diversity.

Result
ACAP Scotland now links practitioners from Involve to Extremes & Galleys, providing educational conference events; a platform for practitioners to be heard and develop, facilitates networking on a Scotland-wide basis, encourages members to present, write and publish in the Advanced Nurse Practitioner (the ACAP journal); share good practice and link with major stakeholders, but ultimately the main aim is to enhance care delivery for patients.

Conclusion
This is a pioneering new initiative, there has never been anything quite like ACAP Scotland. It is an organization for all the practitioners, by the practitioners. ACAP is now Scotland’s largest independent networking group for APs, and aims to link APs nationally whilst providing education, promotion of sharing of best practice and ultimately pushing the boundaries of advanced practice.

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### Aim

Prior to the inception of ACAP (acute care advanced practice) Scotland, there was no organisation in Scotland to provide a link with all practitioners working in the field of advanced practice.

Despite the escalation of advanced practice in Scotland, there was a clear lack of unity for those working in this service across all of Scotland. So in June 2010 the idea of having a national forum was discussed among a few practitioners across, initially just 2 NHS regions. The need for a forum like this was recognised, but until then no-one had taken the first steps to allow this to happen. With positive responses from initial enquiries to clinical leads and educationalist, the founders had the encouragement to continue.

### Methodology

Just a few ANP’s from various regions in Scotland took the first step to provide ANP’s with a link to produce that commonality. Initial questionnaires proved many Scottish wide commonalities but also showed areas of diversity within the role.

### Results

Linking 164 practitioners across Scotland; providing educational conference events; a platform to be heard and develop; facilitates networking; encourages members to present, write and publish in the ACAP journal; shares good practice and links with major stake holders, but ultimately enhance better care for our sick.

This is a pioneering new initiative. It is an organization for the practitioners, by the practitioners. Achievement were measured & tracked through testimonials from members, support from major stake holders and Scottish Government and 2 surveys providing new and crucial evidence of practice.

### Conclusion

Linking ANPs whilst providing education, sharing of best practice, providing a commonality for all members, recognizing educational needs to enhance the care for our patients and facilitate professional development for ongoing care needs and ultimately pushing the boundaries of advanced practice.
Its Good to Talk and Even Better to See You!!
Dumfries & Galloway Royal Infirmary

Maureen MacRae, Wilma Frew, Scott Taylor, Gwen Baxter, Calum Murray

AIM
Communication is often challenging especially at end of life (1). The introduction of technology has improved verbal communications especially when long distances are involved. If we are to practice person centred care then we also need to think about non verbal communication and facilitate that not just for Health Care Professionals but for the patient their family and friends.

This poster describes how staff of a rural NHS DGH used technology to support the delivery of person centred care (2), enhance a patients experience and help them achieve their wishes and goals.

METHODOLOGY
Discussion with IT about setting up SKYPE with relatives living abroad.
Agreement and co-ordination for this unusual visit between NHS staff, the family living abroad and local friends.
A ward owned laptop computer was used with Skye to facilitate the communication.

RESULTS
Positive experience for
- patient
- family living abroad
- local friends
- staff involved with patient care

CONCLUSION
There is an excellent potential use for SKYPE within the NHS for enhancing patient care and experience.
The use of technology in medicine is mainly associated with diagnostics and treatments.
However this poster highlights how technology can have a positive outcome for person centred quality care in a palliative care environment.
Apart from the direct benefit for patient to achieve their goals and wishes there was a positive experience for their family and friends.
The opportunity to deliver a good patient experience had a profoundly positive effect on staff and has significantly improved staff morale in a palliative care environment.

REFERENCES
2. Geoffrey Mitchell , Palliative care – a patient centred approach, 2008 chpt 1 pages 1-5

Category: Person Centred
Main Contact: Maureen MacRae
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## Aim
Communication is often challenging especially at end of life\(^1\). The introduction of technology has improved verbal communications especially when long distances are involved. If we are to practice person centred care then we also need to think about non verbal communication and facilitate that not just for Health Care Professionals but for the patient their family and friends.
This poster describes how staff of a rural NHS DGH used technology to support the delivery of person centred care\(^2\), enhance a patients experience and help them achieve their wishes and goals.

## Methodology
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Apart from the direct benefit for patient to achieve their goals and wishes there was a positive experience for their family and friends.
The opportunity to deliver a good patient experience had a profoundly positive effect on staff and has significantly improved staff morale in a palliative care environment.

## References:
1. Robert Twycross, Introducing Palliative Care, 2003 Chpt 2 pages 21-60
MAXIMISING RECOVERY, PROMOTING INDEPENDENCE
AN INTERMEDIATE CARE FRAMEWORK FOR SCOTLAND

NEW INTERMEDIATE CARE FRAMEWORK IS LAUNCHED.
The Scottish Government’s new Framework for Intermediate Care – Maximising Recovery, Promoting Independence – was published in June 2012.

The Framework provides Health and Social Care Partnerships, and third sector organisations with a guide to developing Intermediate Care within their localities.

KEY FEATURES OF THE FRAMEWORK
The Framework includes:
❖ A working definition of Intermediate Care;
❖ The principles and outcomes which should underpin Intermediate Care;
❖ The reasons for the development of Intermediate Care in Scotland looking at the policy context and the evidence of its impact and effectiveness;
❖ The components of an effective and coherent Intermediate Care system, drawing on good practice examples.

WHAT IS INTERMEDIATE CARE?
The key components of Intermediate Care are:
❖ Clear agreed scope, focused on prevention, rehabilitation, reablement and recovery.
❖ Time limited, based on individual needs, linking to, and complementing, existing services.
❖ Accessible, flexible and responsive through a single point of access, 24 hours 7 days a week.
❖ Based on an outcomes focused, person centred, assessment
❖ Co-ordinated, and able to draw on multi-professional and multi-agency skills.
❖ Managed for improvement.

Copies of the new Intermediate Care Framework are available to download from the Scottish Government’s website – www.scotland.gov.uk/Publications/2012/07/1181
Integration of Adult Health and Social Care

The Scottish Government and its partners – statutory and non-statutory – are committed to putting in place a system of health and social care that is robust, effective and efficient, and which reliably and sustainably ensures the high quality of support and care that is right for the people of Scotland.

What are we trying to achieve?

The integration of adult health and social care represents the radical reform that is needed to improve care, particularly for older people, and to make better use of the substantial resources that we commit to adult health and social care.

Integration will ensure that:

- Health and social care services are firmly integrated around the needs of the individuals, their carers and other family members
- That they are characterised by strong and consistent clinical and care professional leadership
- That the providers of services are held to account jointly and effectively for improved delivery
- That services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve – rather than the organisations through which they are delivered.

Integration of Adult Health and Social Care Bill

The Integration of Adult Health and Social Care Bill will bring forward legislation to create Health and Social Care Partnerships, which will replace Community Health Partnerships and will be the joint and equal responsibility of Health Boards and Local Authorities.

The Bill will put in place:

- nationally agreed outcomes, which will apply across adult health and social care, and for which Health Boards and Local Authorities will be held jointly accountable
- a requirement on Health Boards and Local Authorities to integrate adult health and social care budgets
- a requirement on Partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services.

The Bill aims to ensure that adult health and social care budgets are used effectively to achieve quality and consistency, and to realise a shift in the balance of care from institutional to community based settings.

Partnerships will be jointly accountable to Ministers, Local Authorities, Health Board Chairs and the public for delivering the nationally agreed outcomes.

The consultation on proposals for the Bill closed on 11 September and work is currently ongoing to analyse the responses to help inform policy development.
The Impact of a Tertiary Centre Patient Support Intervention, ‘Navigation’ on Primary Care: A Qualitative Evaluation

NHS Lothian

Introduction:
For the development and delivery of appropriate patient care, effective communication from the patient service-recipient and provider (PSR-P) is key.

The purpose of this support intervention was to improve the quality of care delivered by the Scottish Health Services (NHSScotland) for patients with neurological conditions and their family members.

Method:
The context of the study was the delivery of a patient support intervention. A qualitative evaluation was conducted to explore the perceptions of patients, family members, and healthcare professionals. The intervention was implemented in six clusters across the country, and the research team analyzed the data using a thematic approach.

Results:
Four themes were generated from the data:
- **Time:** It was important for patients to have access to timely information and support.
- **Access to Information:** Patients and family members appreciated having easy access to information and resources.
- **Communication:** Effective communication was a critical factor in the success of the intervention.
- **Support from Professionals:** Healthcare professionals were crucial in providing emotional and practical support.

Conclusion:
The intervention showed promising results in improving patient outcomes and satisfaction. Further research is recommended to explore the long-term impact of the intervention.

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Delivering Quality in Primary Care – Progress Report

NHSScotland and the NHS Institute for Innovation and Improvement, in partnership with general practices designed and tested a new innovative programme, **The Productive General Practice**, which is now being used in practices across Scotland.
Aim

Navigation helps patients prepare for oncology consultations and provides an audio-recording and summary letter of the appointments. The summary letter details the key points spoken about in the consultation and is also sent to the patient’s GP. This project assessed the impact of ‘Navigation,’ particularly summary letters, on communication between primary and tertiary care and provides recommendations in keeping with the person-centred ambition of the quality strategy.[1]

Methodology

Semi-structured interviews with 4 GPs and 2 oncology consultants were conducted to explore their views on the current system and how ‘Navigation’ impacted patient care. Interviews were analysed using the framework approach,[2] and six key themes emerged.

Results

GPs expressed a need to receive concise communication as soon as possible in order to have an informed consultation with patients; consultants recognised this need. All GPs stressed the importance of knowing exactly what the patient had been told in oncology consultations, often finding the ‘Navigation’ summaries more enlightening than clinic letters. GPs found this extra information helped ease communication, and reported: ‘It’s just so much easier to talk to him knowing exactly what he’d been told.’ (GP2). Opinions on the usefulness of the ‘Navigation’ summaries were divided; some reported its length a drawback to its usefulness.

Conclusion

This study highlighted holes in the current communication system between primary and tertiary care, which Navigation potentially fills. The existing clinic letter system could be improved by introducing a standardised letter format and adopting electronic communication to improve speed. These changes may be more sustainable long term.

References

The Rosewell Story! Frail Older People Managing Their Own Medicines

NHS Grampian

Enabling frail older people to manage their own medicines

Category: Person Centred
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### Aim
Ensuring that frail, older people can safely manage their medicines is vital.

Rosewell House is a 60 bedded Aberdeen City Council (ACC) facility. Twenty beds are Intermediate Care re-enablement beds for the elderly and NHS Grampian (NHSG) staff are involved in their care. Rosewell promotes independent living.

Rosewell had no robust system to assess service-users’ ability to manage their medicines, allow self administration during their stay or ensure support post-discharge.

### Methodology
We:
- created a simple yet robust assessment tool that would identify whether service-users could safely manage their own medicines
- created a system that would enable service-users to manage their own medicines, where appropriate, whilst at Rosewell
- ensured that medicines management was considered before and at ‘discharge’
- promoted partnership working between ACC and NHSG staff
- ensured a person-centred approach was maintained

The Community Health Partnership (CHP) Pharmacy team created an assessment tool tailored for Rosewell and designed a system for allowing self administration. Managers and care staff supported and assisted the pharmacy team in implementing the new system.

### Results
- An assessment tool was created that identifies who could self medicate (+/- supervision) during their stay in Rosewell.
- Suitable service-users are now able to self medicate
- Medication problems are identified and resolved in time for ‘discharge’ home
- ACC and NHSG staff work together to implement the system

### Conclusion
Encouraging independence with medicine management is now part of the service-user’s re-ablement process. Medication management solutions tailored to the individual person is now standard practice.
Public Involvement – ‘Your health – we’re in it together’

In June 2008, Ayrshire and Arran NHS Board gave its approval for the development of a primary care strategy, known as ‘Your health – we’re in it together’. The project engaged and involved local communities to find out what people wanted from their local health services.

This programme of extensive public engagement, involvement and discussion put the public at the heart of healthcare and led to the development of the Your Health strategy. The project won recognition from Consumer Focus Scotland as an example of best practice in consumer engagement.

However, public involvement is not new to the NHS. Large scale events were often held in cinemas and public venues to let people know about health campaigns such as the TB screening programme of the 1950s. Here the emphasis was on information giving not information seeking.

As well as using traditional ways of reaching people, we also use a range of social media including facebook, YouTube, twitter and our public website. Social marketing techniques are also used to aim health messages at specific groups of people - for example recent work with football teams and players to target young men aged between 17 and 35 years old.

As a direct result of public involvement and collaborative working, NHS Ayrshire & Arran has now developed a set of rights and responsibilities for patients accessing local primary care services. These rights and responsibilities have been developed in response to feedback from the public for General Practice, Dental, Community Pharmacy and Optometry and aim to improve the consistency of our patients’ experience.
Evidence shows that work is a key social determinant of health\(^1\). High quality systematic reviews\(^2\) conclude that:

- **Work is generally good for individuals health and wellbeing;**
- **Unemployment is generally harmful to health and can lead to increased morbidity and poorer physical and mental health;**
- **Work can be therapeutic and helps to promote recovery and rehabilitation.**

Patients of working age value a discussion on how their condition impacts on their ability to work and want advice on how to remain in or get back to work.

Return to work can be part of the recovery or rehabilitation process and can lead to faster and fuller recovery. Make use of the fit note (or e-fit note if your practice has been enabled) to have the conversation with a patient to help them get back to work.

Free and confidential advice on using the fit note, on workplace adjustments and other aspects of occupational health is available from the Scottish Centre for Healthy Working Lives – a directorate of NHS Health Scotland. Call 0800 019 2211 or visit www.healthyworkinglives.com. The Department for Work and Pensions website also has advice on the fit note www.dwp.gov.uk/fitnote

If you consider your patient requires additional support or advice that you are unable to provide, the following pathway may help you to signpost them to the most appropriate service.

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2. Is work good for your health?, Waddell G and Burton K, TSO, 2006
The 'Teach-Back' Technique
Improving Communication, Patient Safety, Self-Management and Health Literacy
NHS Lothian

Teach–back technique

Improving communication | Improving patient safety
Improving self management | Improving health literacy

Clear communication is essential for effective healthcare relationships and patient safety. Yet patients remember and understand less than half of the information they are given.

Poor understanding can lead to serious health problems.

Simply asking 'is that clear?' or 'have you understood everything?' doesn’t work.

Use teach-back, it’s an easy and effective way to check patient’s understanding.

Teach-back is a really simple way to check patient’s understanding.

It involves asking patients to explain or demonstrate, in their own words, what you’ve discussed with them – for example:

“To be sure I’ve explained this consent form clearly, can you tell me what you are agreeing to?”

Or

‘Please show me how you will use the asthma inhaler, so I can be sure I have given you clear instructions.’

Or

‘We discussed a lot today. Can you tell me what you found most important?’

• If patients don’t restate the information correctly, then try explaining again using different words, drawing a diagram or simplifying instructions, then use teach back again.

• If, after two or three attempts, the patient still does not “get it,” then ask a colleague for help or look for another explanation such as the need for an interpreter.

Further copies of this postcard are available from:
knowledge@nes.scot.nhs.uk

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Aim

The NHS Healthcare Quality Strategy is committed to delivering person-centred healthcare, enabling patients to share in decision-making about their care and treatment. Improving the communication skills of NHS staff and the health literacy of patients is key to achieving this.

Our aim is to encourage NHS staff to use the ‘teach-back’ technique, a simple way of checking patient’s understanding, enabling patients to become more actively involved in decisions about their care and treatment, as well as managing and maintaining their health and the health of their families.

Methodology

- A postcard promoting the teach-back technique was designed and distributed to NHS Lothian staff to support implementation of a new COPD self-management plan.
- Teach-back awareness-raising sessions were developed for staff.

Results

A review of the effectiveness of teach-back in primary care in NHS Lothian is planned for later in 2012. Evidence from the USA demonstrates its effectiveness in relation to informed consent; cancer screening; diabetes disease management; chronic disease management and promoting effective transitions of care at hospital discharge.

GPs in Lothian report that teach-back is easy to carry out, effective in identifying when patients have misunderstood information and reduces consultation time.

Conclusion

Poor understanding can lead to serious health problems. Evidence clearly shows that teach-back could have a major impact on improving health outcomes for patients by improving their understanding and health literacy. Embedding teach-back across all NHS services in Scotland would enable patients to become more actively involved in decision-making about their healthcare and treatment, contributing to person-centred, quality care.

Delivering Quality in Primary Care – Progress Report

The Better Together Programme has now led delivery of two national surveys focusing on primary care including GP services as well as three national inpatient surveys. In general, most GP practices report that patients experience good or excellent care.
Virtual Ward; Outcome of a Six Month Pilot
NHS Highland

Title: Virtual Ward; Outcome of a six month pilot

Name(s): Dr. Shahid Barlas (Belford Hospital, Fort William), Dr Andrew Wilmington, Dr Morag Calder, Rona Yard (Ballachulish Medical Practice, Argyll), Morven McPhillips (District Nurse South Lochaber), Iain MacInnes (Health Project Manager, NHS Highlands)

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Aim
To improve patient centred care, more efficient working by improving communication between primary and secondary care and reduce hospital admissions and re-admissions.

Methodology
During a six month period patients were selected by GPs for admission through the use of SPARQA-ES data and personal GP practice intelligence. Enhanced level of care was provided to the patients in their homes termed as virtual ward.

The virtual ward team comprised of a hospital based consultant physician, two GPs, district nurse and GP practice manager. District nurse paid daily home visits to the patients and discussed them with the GPs. A weekly teleconference was held among virtual ward team to discuss patients. Integrated Digital Dictation, SCI-STORE and EDT technologies were used for virtual ward documentation.

Results
There were twelve admissions. There were no unscheduled admissions of virtual ward patients into the hospital. Eleven admissions were stabilised/improved and were discharged from the virtual ward. One patient died at home.

Conclusion
We felt that all patients benefitted from the virtual ward admission. The patient care improved with more timely and appropriate intervention. More effective communication between nurses, GPs and consultant made clinical decision making easier. Virtual ward activity was easily accommodated within the current working schedule.

Patents felt that they benefited from increased nursing input but not all understood the concept of virtual ward.
We will need to compare hospital admissions data for this six month period to the same period in previous years when it is available. It was a zero finance pilot.

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“... using a 'virtual ward' model of care shows how effective teamworking across hospital and community settings can deliver an enhanced level of care to people in their own homes and avoids unnecessary or unplanned admission to hospital ...”
Scottish Government
Aim
To improve patient centered care, more efficient working by improving communication between primary and secondary care and reduce hospital admissions and re-admissions.

Methodology
During a six month period patients were selected by GPs for admission through the use of SPARRA-65 data and personal GP practice intelligence. Enhanced level of care was provided to the patients in their homes termed as virtual ward.

The virtual ward team comprised of a hospital based consultant physician, two GPs, district nurse and GP practice manager. District nurse paid daily home visits to the patients and discussed them with the GPs. A weekly teleconference was held among virtual ward team to discuss patients. Integrated Digital Dictation, SCI-STORE and EDT technologies were used for virtual ward documentation.

Results
There were twelve admissions. There were no unscheduled admissions of virtual ward patients into the hospitals. Eleven admissions were stabilised/improved and were discharged from the virtual ward. One patient died at home.

Conclusion
We felt that all patients benefitted from the virtual ward admission. The patient care improved with more timely and appropriate intervention. More effective communication between nurses, GPs and consultant made clinical decision making easier. Virtual ward activity was easily accommodated within the current working schedule.

Patients felt that they benefited from increased nursing input but not all understood the concept of virtual ward.

We will need to compare hospital admissions data for this six month period to the same period in previous years when it is available. It was a zero finance pilot.

Delivering Quality in Primary Care – Progress Report
The RCGP and NES have begun a collaborative project on developing and implementing a leadership programme for primary care practitioners.
The Scottish Primary Care Research Network (SPCRN), funded by the Scottish Government’s Chief Scientist Office is part of NHS Research Scotland’s (NRS) clinical research infrastructure. Its role is to increase the amount of high quality research relevant to patient care that is undertaken in the primary care setting.

The SPCRN helps to ensure the timely, appropriate and effective recruitment and follow-up of patients in research studies and, in doing so, works with primary care health professionals and researchers as well as other parts of NRS clinical research infrastructure and UK-wide Networks.

By supporting high quality primary care research relevant to the needs of patients and the NHS, the SPCRN contributes to all 3 Quality Ambitions of the Healthcare Quality Strategy for Scotland - Person-centred, Safe and Effective

Contact details for more information can be found at: http://www.sspc.ac.uk/spcrn/

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**Primary Care Development Fund**

The objective of the Primary Care Development Fund (PCDF) is to take forward activity which will go on to develop or enhance NHS primary care services in Scotland in line with the NHSScotland Quality Strategy and the priorities that emerged from the Delivering Quality in Primary Care National Action Plan and the Progress on Actions Report.

Priorities for new projects in 2012-13 should focus on, although are not necessarily restricted to, the following areas:

- Whole system working and approaches across primary care to the Health and Social Care Integration agenda
- Activity which looks to develop leadership skills across the primary care workforce
- Primary care workforce planning
- Person centred care
- Innovation in primary care
- Data collection and use

For more information contact: John Alvin at the Scottish Government; john.alvin@scotland.gsi.gov.uk

Current and previous projects include:

- Eyecare Integration, Patient Safety Programme, Primary Care Out of Hours Services, RCOP Productive General Practice and Living Well Projects, Scottish Association of Community Hospitals, Community Pharmacy, Framework for practice nursing, Practice Managers Network, Practice Nurse Network, Dental Action Plan, Development of Eye Care Services in the Community; Modernising Nursing in the Community.
Carers & Young Carers: A GP Resource

Scottish Government worked with the Royal College of General Practitioners Scotland and other partners to produce a guidance for all GPs in Scotland on identifying and supporting carers and young carers. This was launched in October 2011 by Michael Matheson, Minister for Public Health.

We also provide funding to NHS Boards for their Carer Information Strategies. Some of the Health Boards are using this funding to work with GPs and other partners to identify and support carers and young carers.

An example of this work is the launch of NHS Forth Valley’s GP Resource Pack “Supporting Carers in Primary Care” which Michael Matheson launched on the 9 August. The pack was developed in partnership with carers’ organisations, community workers, health professionals and carers. This resource is a collection of resources which helps GP practices identify, inform and refer carers on for support locally.

This pack will dovetail with the Royal College of GPs Resource Pack which was launched nationally on 12 October 2011.

There will be support to carers through the Change Fund. Some partnerships are using their Change Fund to provide GP health checks for older carers of older people.

We have been working with NHS Boards on the extension to Keep Well and carers’ health checks. Health Boards have to target those aged 40-64 living in the most deprived areas for health checks. Reporting and monitoring process are in place that will allow us to identify how many carers have been provided with health checks by Health Boards.

We are also piloting a Young Carers Authorisation Card within six Health Board areas. This card will enable health professionals to better take account of young carers’ knowledge about the person they care for and share appropriate information with them.

A link to the guidance as can accessed here
www.rcgp.org.uk/college_locations/rcgp_scotland/about_us/patients_p3/carers_resource.aspx

Delivering Quality in Primary Care – Progress Report

… through a short-life task and finish group unscheduled care pathways for people with long-term conditions were considered and a set of transferable principles developed which could be applied across a range of common presentations.
Scottish Patient Safety Programme in Primary Care
Regional 1 Day Multi-disciplinary Workshops from October – December 2012

Healthcare Improvement Scotland is running a number of regional workshops throughout Scotland, aimed at preparing staff to support and implement the national Scottish Patient Safety Programme in Primary Care.

Aims:

These interactive workshops will allow delegates the opportunity to:

- Learn more about the Scottish Patient Safety Programme in Primary Care in preparation for formal launch in March 2013.
- Learn about the improvement tools developed to support the Scottish Patient Safety Programme in Primary Care, including:
  - Trigger Tool Review of Electronic Patient Records;
  - Clinical Care Bundles;
  - Safety Climate Surveys, and Human Factors
  - Training materials and resources
- Explore other approaches that align to SPSP – PC, including Productive General Practice
- Reflect on how the programme will be supported and rolled out locally.

Target Audience:
Primary Care Medical Directors & Clinical Leads, Nursing Directors and Pharmacy Leads, CHP Leads, Pharmacy Facilitators, GP Appraisers & GP Associate Advisers, Practice Manager Leads, Practice Managers, Health Board SPSP Programme Managers, Facilitators and Quality Improvement Leads

The workshops will be run in the following regions on the dates listed below and will take place from 10.00 – 4.00pm. For further information on Island workshops, please contact us on 0131 623 4321

<table>
<thead>
<tr>
<th>Region</th>
<th>Date</th>
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<tbody>
<tr>
<td>Dumfries</td>
<td>6 November 2012</td>
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<tr>
<td>Aberdeen</td>
<td>13 November 2012</td>
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<tr>
<td>Dunfermline</td>
<td>22 November 2012</td>
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<td>Inverness</td>
<td>29 November 2012</td>
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<tr>
<td>Glasgow</td>
<td>4 December 2012</td>
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</tbody>
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All workshops will be EPASS and CPD Accredited and a limited number of locum fees will be paid for those requiring clinical cover. Further details can be found throughout the registration process.

To book your place, please visit [http://spspa.instantreach.biz/forms/2Y337GC9K1](http://spspa.instantreach.biz/forms/2Y337GC9K1) and follow the onscreen instructions.
Safe

“There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.”

What we were looking for

Innovative examples of services, initiatives and activities that seek to ensure that the environment as well as the regard and care people receive are clean and no harm is incurred when they come into contact with the health service. This Quality Ambition also acknowledges that patients are vulnerable when in need of healthcare and includes children’s services and mental health too.
Safety Improvement in Primary Care: NHS Forth Valley

NHS Forth Valley

Delivering Quality in Primary Care – Progress Report

The Scottish Government in collaboration with stakeholders through the SGPC … has developed a fit for purpose best practice access toolkit that can help those practices for whom access is a problem to improve access levels equivalent to that already enjoyed by many patients in Scotland.
### Aim
The national Safety Improvement in Primary Care (SIPC) programme was developed to enable primary care teams to improve reliability of care and identify/reduce risk and harm to patients.

### Methodology
Twelve Forth Valley practices were introduced to new methodologies specifically adapted for primary care, these included:
- Condition specific bundles of care for high risk medications and heart failure
- Trigger Tools (structured case note review) looking for harm
- Practice Safety Culture
- Patient involvement techniques

### Results
Two year 1 teams have achieved reliability (i.e. 80% compliance over 6 data points) on the heart failure bundle. Bundles have revealed unreliable practice indicating areas for improvement.

This graph demonstrates year 1 practices compliance with the heart failure bundle, reaching 100% during February 2012.

The Trigger Tool has sensitised practices to harm leading to increased significant event analysis where avoidable harm was identified.

The Safety Culture survey was useful in facilitating difficult conversations between team members and empowered administrative staff to voice concerns previously unheard.

As a result of patient focus groups some practices now display ‘You Said, We Did’ posters in waiting areas to feedback in house improvements. Clinicians have expressed this process as more rewarding than initially anticipated.

### Conclusion
SIPC has directly influenced the development of local GP Enhanced Services for Near Patient Testing and Anticoagulation.

The programme has raised awareness of patient safety and enabled Forth Valley to build knowledge and skills in improvement methodologies identifying experts to support implementation of the national Patient Safety in Primary Care Programme in 2013.
**Safety Improvement in Primary Care: NHS Grampian**

**NHS Grampian**

**Category:** Safe

**Main Contact:** Louise Black

**Email:** louise.black@nhs.net
Aim

NHS Grampian is participating in a national pilot – Safety Improvement Primary Care looking at “communication” from Outpatients Department to General Practice and back to patients.

Moray leads this locally with 5 Practices participating in the pilot. Process mapping helped set aims and objectives for patients to have timely, clearly communicated and well implemented treatment plans following Outpatient clinic attendance.

Methodology

Snapshot audits in primary/secondary care on processes and final typed letters from Medical Outpatient clinics showed:

- Letters took 3–4 months to reach GP; in some cases 6–8 months
- Letters didn’t include patient demographics or consultant contact details
- Practices took up to 2 weeks to review typed letters
- No evidence that management plans were implemented

Results

- From these audits, measures were implemented and monitored on a 2-weekly basis:
  - Patient demographic/Consultant contact detail labels used on immediate clinic letters
  - Structured format for immediate communication to GPs from Neurovascular clinics
  - 14 day standard agreed for clinic letter turn around in secondary care
  - Practices collect data on the timeliness of clinical review of letters; evidence of management plan implementation and communication of this to patients.

Conclusion

Small changes occurred in Practices with 75% of typed letters now reviewed within 2 working days by an appropriate health professional.

Continuing improvement in measures of communication showed: timely distribution of clinic letters from secondary care; patient and Consultant details always present; improved internal processes within Practices leading to a reliable system for implementation and communication of patient treatment plans.
Safety Improvement in Primary Care: NHS Tayside
NHS Tayside

Safe & Reliable Monitoring of High Risk Medications in General Practice

Dr Andrew Marks, Deirdre Cameron, Arlene Bryce
Safety Governance & Risk Department, Ninewells Hospital, Dundee. Contact: 01382 424819

Patient Safety Medication Issues
- Approximately 5% of hospital admissions are due to adverse drug reactions.
- 9.8% of drugs involved are preventable.
- Toxicity of less commonly prescribed, cytotoxic drugs, like Methotrexate and Cyclophosphamide, can cause severe harm, including death, although this is rare.
- These are the subject of regular National Patient Safety Agency (NPSA) alerts.
- Improving the safety of prescribing of these drugs is likely to have considerable benefits for safety and health. Particularly as 11% of patients currently being prescribed cytotoxic medications have not received the minimum recommended monitoring.

Background
This Safety Improvement in Primary Care Programme (SIPC) is a two year programme funded by the Health Foundation to test the use of patient safety tools within a Primary Care environment.

Fourteen practices in NHS Tayside have participated in the programme which commenced in June 2010 along with practices from NHS Forth Valley, NHS Lothian and NHS Highland.

Practices in Tayside have focused upon safety of prescribing cytotoxic medications.

Three monitors of the practice team including a GP, pharmacist and practice nurse or pharmacist are supported by a Clinical lead and Safety Governance & Risk Facilitators from NHS Tayside.

Immunosuppressive Care Bundle
- A care bundle with six measures for immunosuppressive medications. Methotrexate and Cyclophosphamide was developed by the Clinical Lead GP for Tayside.
- The bundle is undertaken twice a month for a sample of five patients. Measures include:
  - Full blood count undertaken in the last six weeks?
  - Abnormal results in the last 12 weeks actioned and recorded?
  - Documented review of blood tests prior to issue of the last prescription?
  - Has patient had a pneumococcal vaccination?
  - Documented review the patient has been asked about side effects of medications?
  - Compliance with all measures?

Composite Measures

Patient Involvement within the SIPC programme
Involving patients in changes is an important work Stream within the Safety Improvement in Primary Care Programme. Patients from practices in Waves 1 were invited to participate in focus groups to share their experiences of taking immunosuppressive medications on a long term basis.

Improvements made with patient involvement have included:
- Blood monitoring results shared with patients.
- Development of credit card sized information leaflets explaining possible side effects of medications.
- Patients comments included “It was a useful reminder of symptoms to look out for and when to contact the practice for advice”.

Category: Safe
Name(s): Safety Governance & Risk Team NHS Tayside
Main Contact: Deirdre Cameron
Email: deirdre.cameron@nhs.net
**Aim**

NHS Tayside were one of six health boards involved in the Safety Improvement in Primary Care pilot which commenced in June 2010.

Approximately 6% of hospital admissions are due to adverse drug reactions (ADRs), and 3.7% are drug related and preventable (Howard 2007).[1]

Much less commonly prescribed, cytotoxic drugs like methotrexate and azathioprine do not cause emergency hospital admissions on the same scale as other drugs, but their inherent toxicity means that they are relatively common causes of severe harm including death (NPSA, 2004).[2]

Improving the safety of prescribing for these drugs is therefore likely to have considerable benefits for safety and health.

**Methodology**

Fourteen Practices in Tayside focused upon improving safety and reliability of care for patients taking high risk medications (Disease Modifying Ant-Rheumatic Drugs – DMARDs).

A Care bundle for patients prescribed methotrexate and azathioprine was used by practices to sample five patients every fortnight.

**Results**

Data from the care bundles was recorded on a specifically designed website which created run charts.

Care bundles enabled practices to identify areas for improvement which were shared with other practices using Improvement Methodology (PDSAs).

Improvements by practices included:

- Development of a patient safety checklist
- Restrictions on prescribing of medications
- Development of a credit card sized leaflet with advice regarding potential side effects of medications
- Development of a VISION guideline

**Conclusion**

The care bundle has led to more reliable and safer systems being implemented for patients prescribed Methotrexate and Azathioprine with reliability achieved for four of the five measures in the bundle.

**References:**

[1] Pirmohamed et al; Adverse drug reactions as cause of admission to hospital, British Medical Journal, 2004

Safety Improvement in Primary Care: Results Handling
NHS Borders

INTRODUCTION
NHS Borders is participating in a national pilot until July 2012. Safety Improvement in Primary Care (SiPC) was asked to look at the results handling strand, in particular looking at the interface of results handling across the interfaces of primary and secondary care. The pilot has been expanded to include all NHS Scottish boards to look at the handling of results across all boards.

METHOD
Baseline data was collected in each of the practices and in the laboratories. This showed that:

- The system was not fully integrated and communication regarding investigations ordered and results between primary care and laboratories was poor.
- Practices were not fully aware of the timeframes and expectations for processing results.
- There was no formal system in place to track results back to the practice.
- Results were not being returned to the practice in a timely manner.
- Some results were not being communicated to the practice.

MEASURES
Other changes involved the use of a new system to track results back to the practice. This was done through a combination of

- A daily review of results returned to the laboratory
- A weekly review of results returned to the practice
- A monthly review of results returned to the practice

CONCLUSION
Over the past five months, a steady improvement in the handling of results has been shown. The pilot has been extended to include all NHS Boards in Scotland and is now being rolled out across the country.

ACKNOWLEDGEMENTS
All participating practices in NHS Borders, Secondary Care colleagues, Healthcare Improvement Scotland, and the local health boards are thanked for their support.

Category: Safe
Main Contact: Julia Scott
Email: julia.scott@borders.scot.nhs.uk
Aim
The Safety Improvement in Primary Care programme, funded by the Health Foundation, aims to identify and reduce harm in primary care by developing more reliable systems within practices and at the interface with secondary care. The NHS Borders SIPC2 group have recognised that more reliable systems are required to be developed for the management of blood results. The group aims to optimize safe management of blood results handling, thereby reducing harm to patients.

Methodology
- A comprehensive literature search
- Recruitment of 5 general practices
- Formation of a project team with representatives from primary and secondary, and patient involvement
- Low and high level process mapping events
- Formation of a bundle of measures test reliability of results handling across the interface
- Concurrent 'global trigger tool ' reviews of random case notes to detect harm

Results
- Measures per month per practice, aggregated centrally showing that processes are improving and becoming more reliable.
- Methodology shows that and IT system is required for sample reconciliation between primary and secondary care.
- GTT showing a variety of incidental findings and potential harm (polypharmacy errors) on differing cohorts of patients.

Conclusion
To be involved in this pilot programme has paved the way for formalising a culture of patient safety in General Practice, which could, with planning and appropriate resource then be rolled out across NHS Borders.

Delivering Quality in Primary Care – Progress Report
The Key Information Summary (KIS) is a summary of medical history and patient wishes which will replace paper-based faxing of patient information between GP practices and Out of Hours.
Safety Improvement in Primary Care
NHS Tayside

NHS Tayside are one of six health boards who participated in the two year Safety Improvement in Primary Care Programme. Practices from Tayside focused upon improving safety and reliability of care for patients taking high risk medications (Disease Modifying Anti-Rheumatic Drugs – DMARDS), patients with Heart Failure / LVSD and effectiveness of medication reconciliation using the care bundle approach.

DMARDS Bundle
The DMARDS bundle comprised six measures:
1. Full blood count in the last 6 weeks
2. Action from abnormal results recorded
3. Documented review of blood tests prior to issue of last prescription
4. Documented review the patient has been asked about any side effects of their medication at last blood test
5. Patient ever had pneumococcal vaccine
6. Have all measures been met

Between Aug 2010 and June 2012 there was a gradual increase in compliance from 47% to 86% by eight Wave 1 practices and 0% to 80% for six Wave 2 practices (June 2011-June 2012). Improvements included updating of registers, development of a DMARDS checklist, VISION guideline, restrictions on repeat medications and information leaflets regarding potential side effects of medications.

LVSD Bundle
In year 2 (June 2011-June 2012) practices from Wave 1 undertook an additional LVSD bundle with measures:
1. Appropriate medical therapy - Current use of licensed B Blocker Bisoprolol, Carvedilol and Nebivolol
2. Maximise medical therapy - B blocker prescribed at target or max tolerated dose
3. Functional Assessment Documented - NYHA recorded in last year
4. Record patient given information about the recognition of worsening of heart function
5. Pneumococcal vaccine given
6. Have all measures been met

Improvements over time were slower, mainly as this is a condition that requires active management over a longer period of time. The data demonstrated a gradual improvement from 3 % to 45% by the end of the project, with measure 3 presenting some challenges as this was new to practices.

Medication Reconciliation Bundle
A Primary Care Medicines Reconciliation Bundle was developed with the following measures:
1. Has the Immediate Discharge Document (IDD) been work flowed on the day of receipt
2. Has medicines reconciliation occurred within 2 working days of the IDD being work flowed to the GP/Pharmacist
3. Is it documented changes to medications have been acted upon
4. Is it documented changes to medications have been discussed with the patient or their representative
5. Have all measures been met

Four practices collected data from Oct 2011-June 2012. Indications showed 3/5 measures on tract to demonstrate reliability (consistently above 80%). Improvements included a practice protocol for medicines reconciliation, process for patients to inform the practice if their repeat medications are incorrect and a patient questionnaire to ascertain patients’ understanding of medications.

Contact Details: Safety Governance & Risk Team, Dundee. Telephone: 01382 424169
MODERNISING NURSING IN THE COMMUNITY

Community nursing is at the heart of the Scottish Government’s vision for high quality health care. The Modernising Nursing in the Community (MNiC) programme was established to provide support and direction for community nursing to realise its full potential in providing safe, effective and person centred care and support to people in Scotland. Achievements to date are highlighted here and on our website www.mnic.nes.scot.nhs.uk.

- Vision for community nursing in Scotland
- MNiC Framework
- MNiC interactive website
- Career and Development Frameworks for Community Nursing
- Universal care pathways for children, young people and families
- Evidence based summaries
- Education provision for community nursing practice

We are now building on the achievements and taking on the important challenges of the next couple of years. Examples of work in progress include:

- Children’s Continuing Healthcare Assessment Tool
- Quality indicators for DN and PHN
- Improving accuracy of community nursing workforce data and development of minimum data set for community nursing and AHP activity
- eHealth scoping to gain baseline of community nurses use and access to ICT
- eHealth strategic leadership programme
- Scoping of occupational health nursing workforce
- Scoping of DN workforce requirements and options for education provision
- Review of PHN and DN caseload size
- Work and wellbeing

It brings together evidence from research, practice and policy for quality improvement in service provision. www.mnic.nes.scot.nhs.uk

The MNiC interactive website was launched by Michael Matheson, the Minister for Public Health at an event at Queen Margaret University in January. The event aimed to engage as many people as possible and was streamed live to community nurses in their bases across Scotland. An on line question and answer session followed the formal presentations and the Minister answered questions from community nurses in real time assisted by Karen Wilson, Deputy Chief Nursing Officer and Jane Harris, Programme Manager.

For more information please contact Jane at 0131 244 3253 jane.harris@scotland.gsi.gov.uk