

Annual Report 2014

Reporting on the Quality and
Efficiency Support Team

Annual Report 2014

Reporting on the Quality and Efficiency Support Team



Scottish Government, Edinburgh 2015

© Crown copyright 2015

You may re-use this information (excluding logos and images) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit <http://www.nationalarchives.gov.uk/doc/open-government-licence/> or e-mail: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This document is also available from our website at www.gov.scot

ISBN: 978-1-78544-091-5

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Published by the Scottish Government, June 2015

TABLE OF CONTENTS

PART:		PAGE:
1	FOREWORD	1
2	INTRODUCTION	3
3	QuEST PORTFOLIO OFFICE	5
4	WHOLE SYSTEM PATIENT FLOW	25
5	OUTPATIENTS, PRIMARY AND COMMUNITY CARE	48
6	MENTAL HEALTH	64
7	CANCER	81
8	PRESCRIBING	91
9	PROCUREMENT	102
10	SHARED SERVICES: HARD FACILITIES MANAGEMENT	118
11	SHARED SERVICES: SOFT FACILITIES MANAGEMENT	133
12	HR SHARED SERVICES	141
13	PERFORMANCE SUPPORT	151
14	APPENDIX	155



FOREWORD

NHSScotland is an enormous force for good across Scotland; as well as requiring the highest levels of professionalism and competency in its management and delivery of services, it is also one of our public bodies with which everyone in our country feels a personal relationship and shares a commitment to its success. It is, alongside other public bodies and our partners, a crucial contributor to achieving our Priorities for Government; it directly impacts on reducing inequalities as well as providing jobs and growth in our local economies.

In addition, it is crucial that NHSScotland continues to improve its already high-quality services ensuring patients and their carers get the best possible outcomes. However, in order to do this in times of financial, demographic and other pressures, NHSScotland must also ensure that it provides the best possible value for money and reassure all of its users, staff and the wider public that it is spending your money wisely and effectively. This supports our wider commitment to developing, preserving and reforming the public sector.

That is why I am delighted to introduce the latest Annual Report from the Scottish Government Health Directorate's Quality and Efficiency Support Team (QuEST). In this and its previous two reports, QuEST highlights the excellent work being done by NHS Boards to maximise the value of the resources they receive. And the figures are not small; in the last five years, NHS Boards have saved over £1.5bn, all of which has been reinvested in the delivery of services. Those savings are paying for more clinical staff, improved facilities and, ultimately, better outcomes for the people we serve.

The administrative and managerial costs of delivering NHSScotland are some of the lowest in the world, comparing extremely favourably with other public systems and with the private sector. What many of the case studies in this report show is the importance of the true 'multidisciplinary team' that delivers the NHS; after all, the doctors, nurses and physiotherapists cannot provide their expert care if their equipment and buildings are not maintained and their salaries are not paid.

I welcome all of the excellent work highlighted in this report and commend the good practice NHSScotland continues to demonstrate. Our commitment to ensuring the lessons learned are spread widely will be taken forward by a future programme of activity where those things that are proven to improve the quality of outcomes as well as deliver greater efficiencies will be rolled out across NHSScotland. I look forward to sharing future successes with you.

Shona Robison, Cabinet Secretary for Health, Wellbeing and Sport



INTRODUCTION

Welcome to the third Annual Report of the Scottish Government Health and Social Care Directorate's Quality and Efficiency Support Team (QuEST).

Over the last five years, NHS Boards in Scotland have successfully delivered £1.5bn of savings through increasing efficiency and productivity and reducing waste and duplication. Many of the innovative ways in which they have done this appear in QuEST's Annual Reports as they are supported by one of our ten thematic programmes. The 36 case studies in this report bring our grand total across the three years of QuEST's formal reporting to over 120. As always, all of these case studies are worthy of consideration; as a minimum, we recommend that Boards consider them in the context of what they are doing, adopt where appropriate and/or utilise them to identify areas for focused activity.

A further highlight of this year was the publication of our [2020 Framework for Quality, Efficiency and Value](#). Cutting through the often somewhat 'fuzzy' rhetoric around the Quality Improvement (QI) agenda, QuEST simplified what we know about approaches to QI, identified the steps on the critical pathway and outlined a number of key tools and techniques that anyone can use. Backed up with the 'real' examples in the case studies, this framework gives NHS Boards – and their partners – a firm foundation upon which to build their QI infrastructure development and activity.

So what next for QuEST?

Our website (<http://www.qihub.scot.nhs.uk/quality-and-efficiency.aspx>) will continue to be updated with relevant case studies, tools, tips and techniques as and when they become available. But, more importantly, we are moving into a new and exciting phase of activity across NHSScotland.

We firmly believe we now have a major repository of good practice; that evidence from NHS Boards is supplemented by work directly delivered by QuEST such as the Whole System Patient Flow programme and our Facilities projects. Where there is overwhelming evidence that there are clear improvements in outcomes as well as reductions in cost and/or increases in efficiency, there should be a 'presumption of adoption' unless there is clear evidence of a locally-implemented solution that has better outcomes, savings etc. Such good practice will be supported by a new national programme that will seek to help Boards and their partners benefit from this wealth of material. In addition to this, there will be further work to deliver accelerated outcomes in shared services. QuEST will be central to the success of this refreshed programme.

QuEST is staffed by highly-skilled individuals, many of whom are on fixed-term contracts, secondments or Service Level Agreements from NHS Boards or partners, supported by civil servants. This unique approach ensures we remain very close to healthcare services while ensuring implementation of Scottish Government policy. Everyone in QuEST is committed to continuous quality improvement in public services and the results of this commitment are clearly highlighted by the range of achievements to date.

We look forward with anticipation to our next challenges.

Linda Semple, Head of QuEST



QuEST PORTFOLIO OFFICE

ABOUT THE PROGRAMME

Shona Cowan
t: 0131 244 6911
e: shona.cowan@scotland.gsi.gov.uk

drivers

The QuEST Portfolio Office (QPO) ensures the efficient coordination and focus of a range of projects across QuEST programmes.

aims

The QPO supports improved service delivery in NHSScotland by providing a national overview of quality, efficiency and value across all NHS Boards and programmes.

workstreams

- Design programme and project management resources that can be flexed across our Programmes of work to ensure that priorities are met and resources are standardised and utilised to best effect.
- Developing an approach to delivering improvements based on quality, efficiency and value, including innovative tools and resources. These are shared widely across our stakeholder groups and are made publicly available on the Quality Improvement Hub website.
- Identifying areas with the greatest potential productive opportunity through benchmarking, data analysis and application of health economic approaches to all improvement work.
- Coordinating networks across NHSScotland to encourage sharing of learning, resources and expertise.
- Identifying up to date research, capturing and sharing knowledge and learning, and spreading good practice.
- Participating in strategic partnerships such as the Quality Improvement Hub, the Joint Improvement Team (JIT) and the Quality Unit.

achievements 2014

.....

In March 2014 the QPO delivered two regional QuEST roadshows in Edinburgh and Glasgow. These events provided NHS Boards with an opportunity to showcase their achievements and share their learning in relation to improving quality and efficiency.

The QPO led the refresh of the NHSScotland Efficiency and Productivity Framework through the development of the 2020 Framework for Quality, Efficiency and Value, a dynamic web-based resource that provides practical tools and guidance to support NHS Boards.

The QPO has supported NHS Boards to develop their capacity and capability for continuous quality improvement through specific allocations ring-fenced for this purpose. NHS Boards are continuing to build their infrastructure for quality improvement through local quality improvement hubs and portfolio offices.

The QPO has contributed significant knowledge management resources to the Quality Improvement Hub website, including over 100 case studies, produced in partnership with NHS Boards. These case studies demonstrate how quality improvements and efficiency savings have been achieved.

The QPO continues to lead QuEST's involvement in the Quality Improvement Hub partnership.

The QPO has supported tests of change where these do not logically fit within one of the larger QuEST programmes, for example using health economics to quantify the benefits of improving diabetes care in Scottish hospitals.

Health economics can inform and improve decision-making about the allocation of scarce healthcare resources. The QPO in partnership with NHS Health Scotland has developed a Health Economics Network to facilitate collaboration between the health economics academic, policy and practice communities across Scotland to encourage the application of health economics evidence.

The QPO held a major event which focused on the use of data and information to drive quality, efficiency and productivity and brought together colleagues working in the fields of quality improvement, efficiency and productivity, health intelligence, health economics, finance, performance management and planning.

The Health Services Journal (HSJ) acknowledged the excellent work undertaken by QuEST and NHS Boards and QuEST was shortlisted for an HSJ Efficiency Award.

priorities 2015

.....

In 2015 the QPO will:

- Identify and publish a range of quality and value case studies from across NHS Boards.
- Host a 'Business Case for Quality' event which will bring together a wide audience to identify priority projects for a pan-Scotland approach.
- Form a key part of the team QI Hub team progressing the NHS Board Quality Improvement Infrastructure visits.
- Support the development of the UK Improvement Alliance, a network of quality improvement organisations across the UK, taking the lead on Quality as a Business Strategy.



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/quality-efficiency-and-value.aspx>

Programme Case Study

Health Economics Network for Scotland (HENS)

Background and context

Health economics can help to achieve value for money by informing and improving decision-making about the allocation of scarce healthcare resources. Population, preventive and healthcare interventions can all be prioritised through the analysis of their costs and benefits to increase the benefits achieved with the finite resources available.

In the current climate of tight public spending as well as policy emphases on prevention and shifting the balance of health and social care, there has been a renewal of interest in what health economics can offer public health and healthcare policy and practice in Scotland. However, the full potential of health economics to influence policy and practice has not yet been realised due in part to the need for stronger links between the producers and users of health economics evidence and analysis.

Problem

There is substantial health economics capacity in Scotland in academic departments, Scottish Government and NHS Boards. However, policy makers and practitioners often cannot or do not access this capacity when they need it. There are a number of issues that need to be addressed. These include:

- the availability, accessibility and relevance of health economics evidence
- skills and knowledge required to interpret available evidence
- differences in the priorities of academic, public health and health service organisations in relation to health economics.

The Health Economics Network for Scotland (HENS) is providing a forum for debating these issues and identifying solutions, a network for bringing users and producers of evidence together and, with resources from QuEST, funding activities that will address evidence and skills gaps.

Aim

HENS aims to facilitate collaboration between the health economics academic, policy and practice communities across the health and social care with a focus on:

- the shift to prevention and changes in the balance of health and social care
- improving quality, sustainability and effectiveness in healthcare services

Action taken

HENS is undertaking the following activities:

- Increasing existing capability for using health economics concepts, evidence and tools in the health and health care sectors in Scotland by funding training and development opportunities delivered by academic partners with health economics expertise
- Developing and supporting the evidence for, and application of, health economics approaches and tools through undertaking projects to test the collaborative approach and demonstrate how HENS should work
- Organising events to bring together producers and users of health economics evidence to discuss ways of promoting the translation of health economics evidence into practice
- Providing a forum on the Scottish Public Health Network (ScotPHN) for sharing knowledge and skills amongst HENS members.

HENS is led by a Steering Group, chaired by NHS Health Scotland and comprising members from ScotPHN, Scottish Government, NHS Boards (change and innovation, and public health), Glasgow Centre for Population Health and academia.

The network now comprises over 80 members from Scottish Government, NHS Territorial and Special Boards, universities and local government.

Results

It is too early to identify outcomes in the sense of improvements in the efficiency of resource use resulting from HENS. However, the actions taken highlight a number of outputs that have been produced or are currently being organised:

- An inaugural network meeting took place in February 2014 bringing together users and producers of economics evidence/analyses and identifying activities that users wanted HENS to undertake.
- A conference was organised for December 2014 bringing together users and producers of evidence to discuss the translation of economics evidence into practice.
- A forum has been established on a HENS website with papers and reports for discussion.
- Development opportunities for non-economics specialists to understand and apply economics evidence are being set up by the University of Aberdeen and the University of Glasgow.

These outputs have raised the profile of health economics and its potential to help with current resource allocation challenges. The network has increased engagement between academic producers and policy and practice-based users of economics evidence.

Staff experience

HENS has improved staff experience in the following ways:

- HENS has provided a forum for health economists and others to come together, creating a supportive environment for this group of professionals to discuss challenges and share learning
- The existence of HENS means that staff within NHS Boards requiring support in the

practical application of health economics tools, techniques and evidence can now access guidance from professionals

- Academic partners have recognized the value of the network, engaging actively in planning and delivery of outputs to date
- Network members are actively engaging with the network

Efficiency savings and productive gains

Whilst it is too soon in the life of HENS to identify quantifiable efficiency gains from changes in work practices or business processes, it is anticipated that the network will help to support the more efficient use of health economics resources.

By sharing resources, knowledge and skills, and health economics evidence and analyses, HENS will help to reduce duplication and will support the 'Once for Scotland' agenda.

Sustainability

The emphases on networking and training are both aimed at sustainability. Health economics expertise is scarce – it is important that the results of health economics analyses are used as widely as possible to maximize their reach and impact in line with the 'Once for Scotland' agenda.

Better networking will help optimise the use of available health economics expertise by better matching demand and supply. Training opportunities will increase capacity to access, understand and use economics evidence.

Longer term, the aim of HENS is to contribute to the financial sustainability of the health and social care system by identifying more efficient approaches to prevention and by encouraging the use of health economics tools to inform shifts in resources into a more preventative health and social care system. By encouraging more consistent use of health economics evidence and tools, the aim is that efficient solutions will be identified and adopted more widely and consistently.

Lessons learned

Producers and users of economic evidence want the same thing – the efficient use of limited resources in health and social care – but they use different language to frame and answer questions about resource use and prioritisation. They also have different expectations regarding the use of economics evidence and tools. A key lesson from the HENS work so far is the importance of dialogue to narrow some of these differences, so that producers of evidence better understand what users want, and users of evidence better understand what producers are able and what they are incentivised to provide. A second lesson is that this takes time.

Next steps

A HENS event was held in December 2014. This event focused on how health economics can help meet current challenges in public health and health policy, including the shift to prevention and the reduction in health inequalities. The event used a number of case studies including economic analysis of public health measures such as smoking ban or minimum unit pricing.

Completion of the two test projects: Economics of Prevention and Programme Budgeting and Marginal Analysis (PBMA). The evidence and learning from these projects will be shared with the network and the broader health economics community.

HENS are working with the Health Economics Research Unit (HERU) at the University of Aberdeen to develop a course for healthcare planners, finance directors and other health care managers working in NHS Boards who have no prior experience in economic evaluation. The course will provide an introduction to the identification, appraisal and application of economic evaluation for policy-making in population health.

HENS are working with the Health Economics and Health Technology Assessment team at the University of Glasgow to design and deliver a professional development opportunity that will help participants identify and use suitable health economics tools for the translation of economic evidence into practice.

NHS Board Case Study NHS Dumfries and Galloway

Area Clinical Activity Committee

Background and context

The Area Clinical Activity Committee (ACAC) was set up to review clinical effectiveness and possible over-treatment across both primary and secondary care, including mental health.

Problem

There has been increasing concern over recent years that not enough focus is applied to clinical effectiveness. Management traditionally ensures that clinical activity is delivered in a timeous way at the least possible cost – there is insufficient focus on whether the clinical procedures are effectively meeting patients' needs. Early evidence was provided to the Committee of over-treatment in terms of cataract removal, cystoscopy and upper GI (gastrointestinal) endoscopy. It was noted that the rate of cataract extraction was 80 per cent more than the Scottish average (even when weighted for age/sex distribution) and similar 'excess' activity was found in relation to cystoscopy, upper GI endoscopy and colonoscopy. While all of these procedures carry undoubted benefit for patients, they also all carry a degree of risk. Where the procedure is carried out at a low threshold there is a danger that the risk/benefit balance is tipped towards low benefit and the same degree of overall risk.

In addition, while there is evidence of overtreatment of some clinical issues, there is also evidence of under-treatment of other issues: It must be remembered that there is always an opportunity cost attached to any activity. In the case of ophthalmology there was evidence of an 'excess' of cataract

extractions co-existing with extreme waits for patients requiring review of glaucoma – a sight-threatening condition.

Aim

The remit of ACAC was to ensure that sensible steps were taken to maximise clinical effectiveness by ensuring that evidence-based interventions were directed at those patients who would derive most benefit. In many cases this involved re-setting the clinical thresholds for the intervention. In addition, ACAC felt it appropriate to challenge various aspects of medical care with particular emphasis on the number of review appointments in secondary care, the number of new outpatient referrals from General Practitioners, and the number of emergency admissions to both medical and surgical specialties.

Action taken

- Reorganisation of minor surgery in General Practice, with elimination of procedures of limited clinical value
- Review of the threshold for removal of cataracts – threshold now 6/12 and agreed with all high street optometrists
- Review of arthroscopic wash-outs of the knee (no evidence of benefit)
- Tonsillectomy and adenoidectomy indications brought in line with SIGN guidelines resulting in significant decrease in activity
- Review of the rate of cystoscopic examinations: indications changed and intervals for review cystoscopy brought in line with best guidance
- Review of the high rates of colonoscopy procedures: review scopes now done in line with best guidance
- Review of the high rate of upper GI endoscopy: agreed referral protocol change so all patients treated for helicobacter prior to endoscopy consideration

- A pilot scheme in which 15 GP Practices agreed to review – by all partners – all referrals before they were sent to Dumfries and Galloway Royal Infirmary

Results

In most cases we have seen a positive result due to the interventions of the ACAC group – bringing performance closer to the Scottish average. This has reduced unwarranted interventions, reduced costs (e.g. extra scope lists at treble time) and helped address under-treatment – e.g. glaucoma.

Patient experience

The remit of ACAC was to ensure that sensible steps were taken to maximise clinical effectiveness by ensuring that evidence-based interventions were directed at those patients who would derive most benefit. The Kings Fund study on patient preferences (2012) indicated that often patients regret having treatments – up to 20+ per cent in some instances.

Staff experience

The main driver to deliver these changes has been to challenge individual clinician behaviour. It is appropriate that a committee composed primarily of clinicians should exert peer pressure to reduce variation amongst individual clinicians as this generally leads to considerable improvement in the quality of care.

Efficiency savings and productive gains

By moving activity to the Scottish average or upper quartile we have freed up capacity in the system. This has avoided costs such as waiting list initiatives which otherwise may have been necessary.

Sustainability

The continuing existence of the ACAC group is key to sustaining these changes as it ensures an ongoing level of monitoring and scrutiny.

Lessons learned

Apart from the formal meetings it is essential to support the work of the group with appropriate levels of health intelligence input.

Leading the Scottish Patient Safety Paediatric Programme

Background and context

QuEST monies were used to fund a 0.6 WTE Patient Safety Co-ordinator 2013-2014 to lead SPSP within the nursing team across Combined Child Health (CCH) which includes Royal Aberdeen Children's Hospital (RACH).

Problem

CCH nursing management recognised that there was a need for dedicated time to ensure positive progression of the SPSP across the service. Previously, this role had sat with clinical nurse managers and senior charge nurses who found it difficult to dedicate adequate resources to make significant changes or enable effective learning and/or awareness within their teams of the aims of the programme.

Aim

The Patient Safety Co-ordinator will develop care bundles and a structured approach to measurement and data display.

Action taken

The following care bundles have been developed:

- Combined insertion and maintenance peripheral venous catheter (PVC)
- Indwelling urinary catheter
- Central venous catheter (CVC)
- A daily huddle has been introduced at RACH

- Senior charge nurses have been supported in the delivery of SPSP within their wards/departments
- Introduction of Lanqip and BOXI reporting of SPSP measures
- Standardised display of SPSP data across all areas
- Structured ward rounds being tested

Results

Work is continuing to embed actions taken within practice, ensuring a sustainable ethos of patient safety for children in CCH's care.

Further improvement work has also been being undertaken within CCH, for example, Improvement Tree, Leading Better Care (LBC), Caring Behaviour Assurance System (CBAS) and participation in the Person-Centred Collaborative.

Efficiency savings and productive gains

The daily huddle has contributed to improving patient flow within RACH. The aims of the structured ward round are to:

- Improve eIDL completion times
- Improve multidisciplinary team communication
- Ensure take home medicines are available when a patient is ready for discharge
- Reduce time to discharge
- Improve patient flow and experience

Sustainability

Developing a workforce with improvement skills is the key. This has been achieved by:

- NHS Education for Scotland/Healthcare Improvement Scotland training
- In-house training and workshops
- Attendance at learning sets
- Raising awareness through mandatory training, use of storyboard and having this on meeting agendas
- QuEST monies are being used to fund this post for another 12 months

Lessons learned

.....

Having dedicated time to develop and support the SPSP has enabled the work to gather pace.

Development of a Rapid Access Frailty Service

Background and context

With an ageing population the hospital inpatient service was seeing more and more patients who are frail with complex needs. Although we have a lower rate of hospital admissions for over 65 years in Forth Valley, we also know that there is variation in patient length of stay for a variety of reasons including demand into and flow out of the hospital system. It is well documented that extended lengths of stay can have a significant detrimental effect on long term care needs and patient outcomes. Having undertaken a review of frail elderly inpatients, we believed that there was scope to develop a service to address some patients needs in an ambulatory setting reducing the need for an unnecessary hospital admission. This project sits at the heart of inpatient capacity and flow, health and social care integration and community services, and is part of the whole system working required to provide better outcomes for older people through collaborative working to achieve shared goals.

Problem

Frail elderly patients frequently have period of decline where specialist review and intervention is required. During these periods they are often admitted to hospital either following a fall or for review. Diagnostics and treatment plans can take some time and during this time, in the hospital setting, they may lose further mobility and reduced nutritional intake and are exposed to the risk of hospital associated infections (HAIs).

Built on the back of work undertaken by Dr Tom Downes in Sheffield, we developed a proposal to test the provision of the required

assessment and treatment within a specialist, multidisciplinary ambulatory setting.

Aim

The aim of this project is to improve outcomes for frail elderly patients by reducing avoidable hospitalisation and supporting patients to be cared for in their own home/communities with the following key objectives:

- provision of timely comprehensive geriatric assessment – allowing streamlining of patients to an inpatient or ambulatory pathway
- reduce avoidable admissions through rapid access clinic assessment and treatment
- timely discharge from inpatient pathway as soon as possible when acute care no longer adds value
- reduce avoidable disability/harm – with potential associated on-going burden of care and loss of independence
- optimise partnership approach between the NHS, patients, carers, primary care, social care, community service, mental health, other specialties
- improve patient and carer experience

Results

Outcome Measures

- improved timely access by primary care team to specialist review
- reduce avoidable admissions (min of 50 per cent) from rapid access frailty ambulatory care
- improved patient and carer experience
- greater involvement of carers in assessment and pathway
- reduced wait for specialist assessment with associated improvement in quality of care
- rapid access to 'one stop' diagnostics
- improved communication and planning with social work service
- reduce length of stay in inpatient ward
- rapid access to allied healthcare professional assessment and community rehab services

Patient experience

The benefits for patients and carers are numerous:

- Patients can be seen as a day patient allowing them to return home at night.
- Patients are encouraged to come with a family member or carer which gives them support and often means the patient feels more relaxed and better information can be shared with the team.
- Access is timely and a review will be carried out with a plan before the patient leaves.
- Where follow up is required there is continuity of care as the patient is brought back to the clinic area.
- Feedback has been extremely positive and patients and families have embraced the concept.

Staff experience

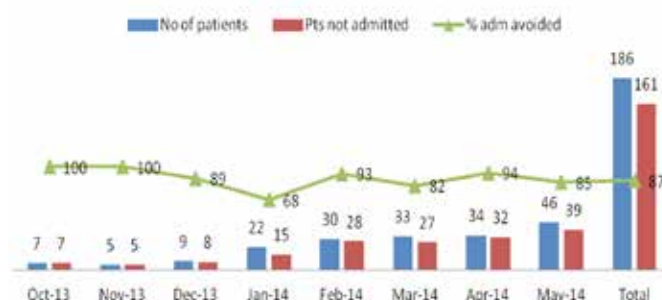
The staff involved in the service find it very rewarding as the patient is seen quickly, has an excellent quality of review by a multidisciplinary team and leaves with a holistic package to meet their medical, physical and social needs.

Again, staff feedback from the service and from NHS staff referring to the service has been very good.

Efficiency savings and productive gains

The primary benefit for the patient is that their treatment plan and additional support are put in place in a very timely manner. This improved the quality of care and improves the outcomes for that patient. The associated benefits of this are numerous including admission avoidance, potential complications related to a protracted hospital stay and onward support packages or care needs required. On a basic level the service is seeing approximately 40 patients per month with admission avoidance at 87 per cent (average) as seen above.

Rapid Access Frailty Clinic 7th October - 31st May 2014



This benefit can be considered in two ways, either as a reduction in bed costs, or as added resilience to enable flow within the acute setting with increasing demand. We assessed that all patients who avoided admission would have otherwise required admission. If we assume that 50 per cent of patients would have had a length of stay of 50 per cent at 14 days this equates to a bed saving of approximately 14 beds per day. However, our overall admission levels have remained relatively static which suggests that this saving is in effect offsetting the expected demand due to demographic changes as predicted from ISD prediction information below:

Predicted Monthly Admissions >75 years Actual v Prediction (ISD FV 2011 - 2016)



Sustainability

Change Fund monies have been used to aid redesign of service, however it is planned to bring this into core funding. It is also planned to develop this from a five day to a seven day a week service.

Lessons learned

Good approach taken with key outcome measures. Used weekly 'Oobeya - Big Room' approach which helped to land team ownership and involved a wide number of stakeholders in the development. Challenges – not to underestimate the need for communication across a whole system.

NHS Board Case Study

Scottish Ambulance Service

Improving Care for Older People who Fall and Present to SAS

Background and context

The Scottish Ambulance Service (SAS) responds to circa 25,000 calls for people aged 65+ who have fallen. SAS clinicians are largely unable to consider an alternative outcome to the emergency department for this group due to a lack of developed pathways and partnerships with local integrated care services.

Problem

Patients often do not receive the care and service which best meets their needs which can result in an unnecessary attendance at the emergency department (increasing the pressure on that area) or, if the patient is well and uninjured, they remain at home without any on-going referral or notification to their primary care team (the risk of future falls is not addressed).

Aim

Across Scotland the SAS aims to develop partnerships/pathways with local integrated care services to enable our clinical staff to offer the patient an outcome which better reflects their need.

Action taken

- SAS operational managers supported by SAS service improvement facilitators have been engaging with local authority based integrated care teams.
- Through a multi-disciplinary task and finish group SAS has produced a toolkit to support our frontline managers to build sustainable partnerships and care pathways ('Making the Right Call for a Fall' booklet).
- Through a collaboration with NHS Education for Scotland (NES) a short film has been produced aimed at raising awareness and supporting a change in practice by Paramedics and Technicians.
- Applying quality improvement methodology, SAS managers and local partners have been undertaking tests of change to develop concepts into business as usual practice.

Results

The SAS has around 25 active partnerships with integrated care service providers. While, for a national service, this provides significant complexity and challenge those partnerships who are undertaking tests of change have evidence which indicates:

- Reduced conveyance to the emergency department from this patient group evidenced nationally by a 10 per cent reduction since April 2012 and further supported by local data. Please [refer to page 20](#).
- Increased instance of referral to falls prevention services evidenced, for example, in Edinburgh by 14 referrals in three months during our PDSA test (please [refer to graph on page 21](#)).
- Reduction of repeat calls to SAS.
- Indicative cost benefits from reduced conveyance and emergency department attendance (circa £400 per case).
- Improved identification and management of patients at risk.

Patient experience

.....

Early informal feedback strongly suggests high levels of patient satisfaction with the outcomes provided from these partnerships.

A more formal approach is planned to be undertaken.

Staff experience

.....

Significant cross system engagement, feedback and more formal review has been undertaken prior to and during any test of change. Consequently staff involved in the development of pathways have contributed positively.

Efficiency savings and productive gains

.....

Evidence indicates a reduction in SAS journeys and emergency department attendances. Work is required to understand any associated change in in-patient stays off set against community health and social care costs.

Sustainability

.....

The partnerships and pathways themselves are fairly simple to sustain however the ability of the whole system to move resource from secondary care to community models will be challenging.

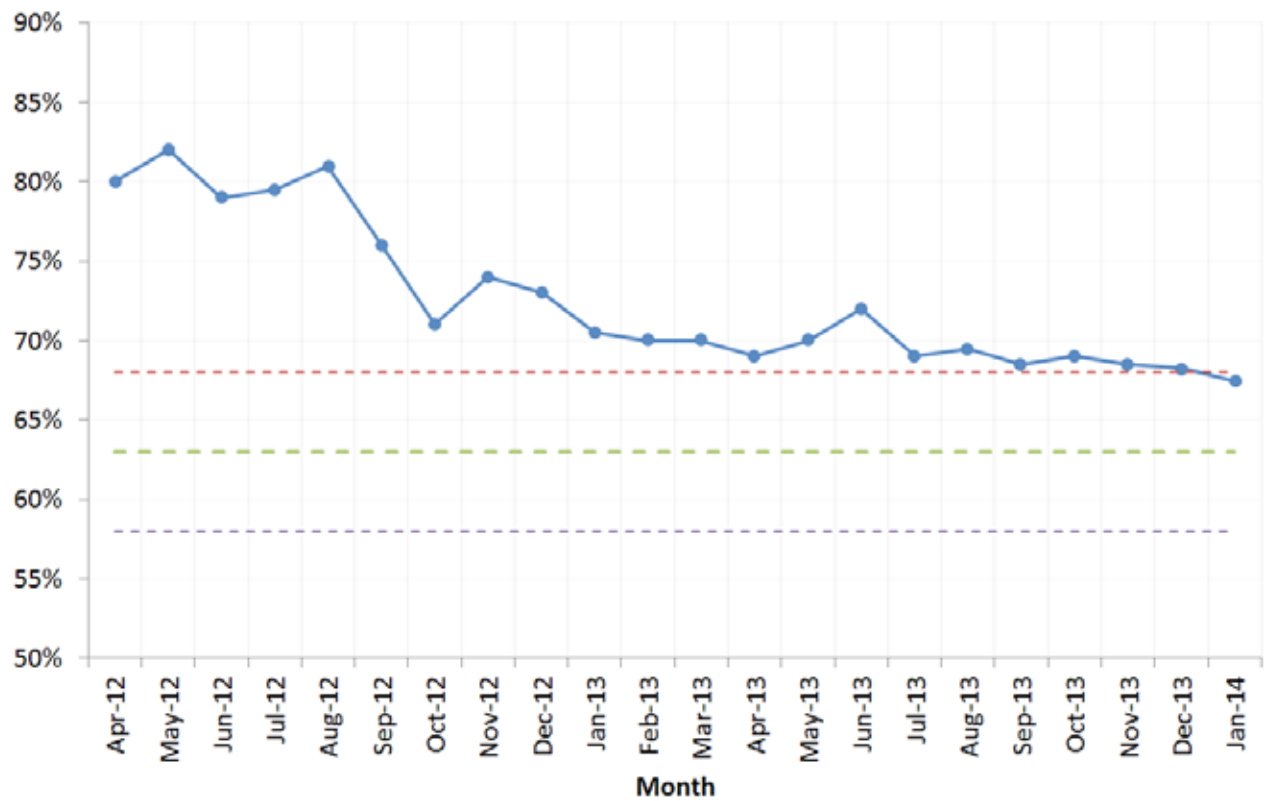
Lessons learned

.....

- The models developed are more responsive, safer and more appropriate for this patient group than attendance at the emergency department.
- Developing partnerships across 32 areas is labour intensive and complex.
- Local partner capability and capacity is varied.
- Front line staff have relished the opportunity to develop effective systems and processes.

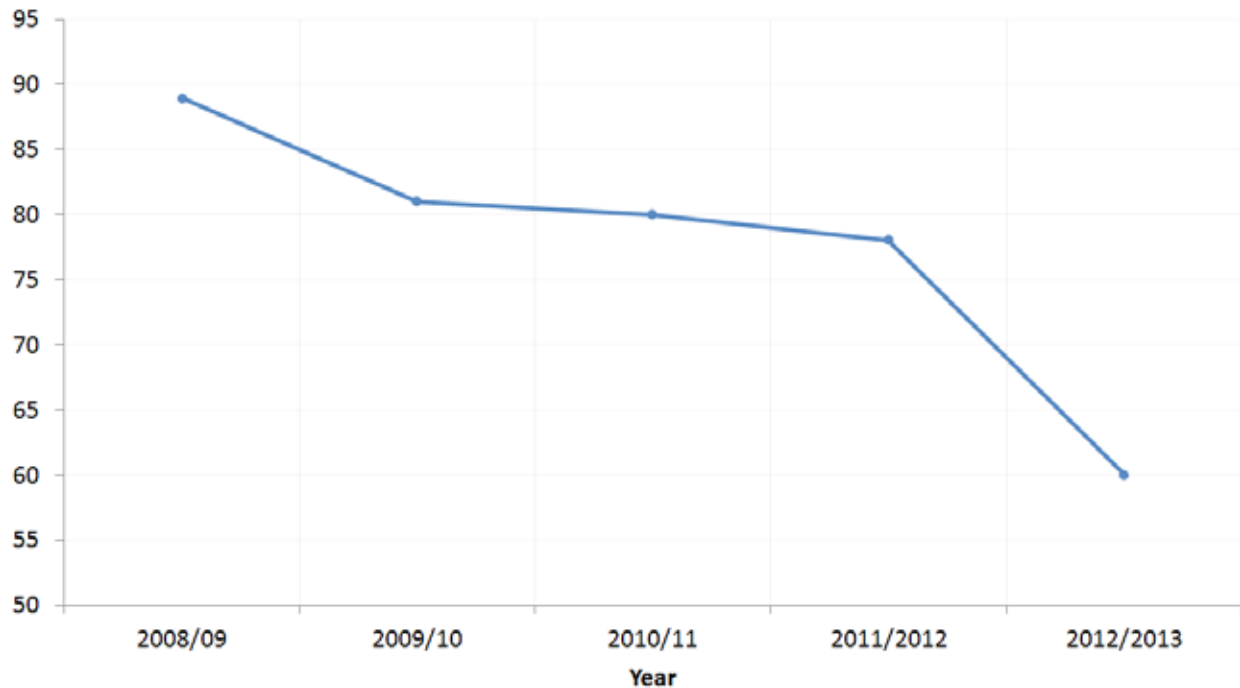
Conveyance of Elderly Patients to Hospital (Monthly Total for Scotland; April 2012 - March 2015)

Elderly Conveyance



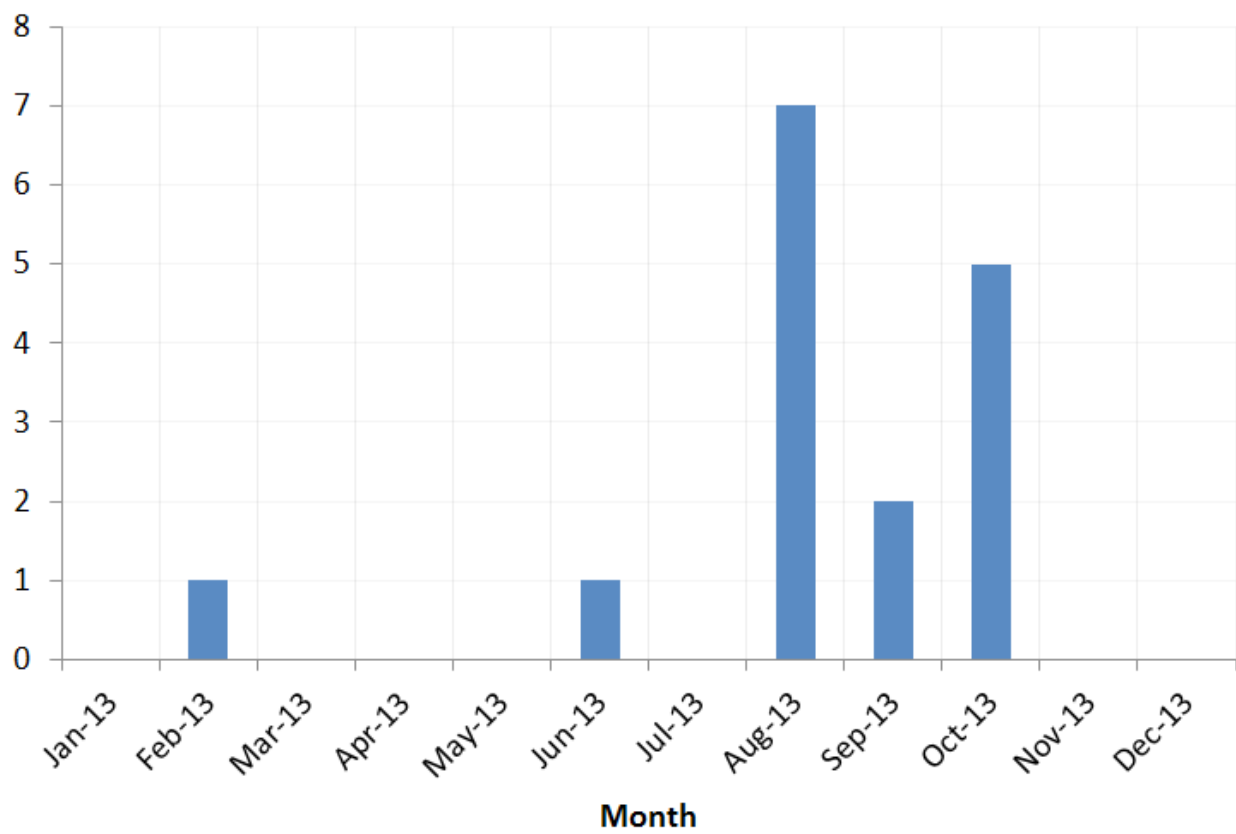
SAS 'Non-dangerous' Falls Incidents (% Conveyed to Emergency Department, Argyll & Bute CH)

Conveyed (%)



Referral to Falls Prevention Services (Edinburgh)

Number of Referrals



NHS Board Case Study

NHS Board Scottish Ambulance Service

SAS Paramedic Practitioner in support of Hospital at Home

Background and context

Scottish Ambulance Service (SAS) Practitioners work as part of an integrated team supporting the delivery of NHS Lanarkshire's Age Specialist Service Emergency Team (ASSET) providing care at home to patients aged 75+ who required complex disease management and are of moderate to high acuity.

Problem

An evidence-based recognition of improved outcomes for older patients when managed at home.

Aim

A reduction in attendance and admission at hospital for this patient group when presenting via primary care to the SAS, 999 and NHS 24.

Action taken

Two SAS Paramedic Practitioners are undergoing development which will allow them to operate as ASSET Practitioners. This partnership will improve the resilience and capability of ASSET and will allow patients who present to SAS to be considered for redirection away from the emergency department to ASSET.

Results

A combination of an evidence and reflective study has indicated, for patients within this group, a potential shift in care:

- Reduction in emergency department presentation from SAS to 0 per cent which would represent a shift of 47 per cent from the current practice, with ambulance crews being able to access not only a wider range of outcomes for the patient but also a greater degree of clinical decision support.
- Indications are that outcomes delivered exclusively by an SAS Paramedic Practitioner would occur for 33 per cent of cases. The Practitioner would also be instrumental in a further 25 per cent of cases by facilitating a referral to other services.
- NHS Lanarkshire's ASSET would provide the outcome for 20 per cent of cases which would represent an increase from 6 per cent.
- Primary care would require to accommodate 47 per cent of cases which represents an increase from 9 per cent.

The shift in care indicated by the on-going test of change of this model is substantial. The role of the Paramedic Practitioner is also clearly crucial as it provides:

- A point of support and referral for ambulance crews
- A source of capacity e.g. ASSET at times of demand surge
- A conduit for the patient to access services appropriate to their need following a detailed and clinically informative assessment.

Patient experience

A focused exercise of the patients' experience requires to be undertaken, however, a comparison of service provision for this patient group, when presenting to the NHS via 999, within the North Lanarkshire test area and South Lanarkshire has evidenced a more appropriate, holistic care package is offered to patients in the North Lanarkshire test area.

Two example patient stories which describe this experience are below:

Patient A Jan 2014 – supported by integrated services

- Paramedic Practitioner on duty in the Monklands area (SAS/ASSET).
- Referral request from Coatbridge PRU ref elderly male/frequent faller. Seeking advice as patient is uninjured however PRU Paramedic suspects underlying infection and patient remains unsteady on his feet.
- Background: Gentleman does not suffer from any diagnosed LTCs and has no home support package. He has been falling in his home for four weeks approximately with no injury but finds it difficult to get up from the floor (no walking aids). He stays with his elderly wife and they have no home support. He would normally be the main carer for his wife and also dispenses her medication via a blister-pack which gets delivered to them weekly. On-going falls with multiple A&E admissions with discharge same day (x 6 in last 4 weeks).
- Assessment: Recent discoloured, smelly urine. Chesty productive cough / widespread wheeze on right side. Abdomen SNT. Memory test 4/10. FAST test negative. No ankle swelling or calf pain. Temp increased other obs within normal parameters. Low mood.
- Recommendations: Paramedic Practitioner discussion with senior clinicians within ASSET and referral agreed. First ASSET assessment undertaken by Paramedic Practitioner (Obs, ECG and bloods, urine sample and clerk in). Consultant review within one hour of call. Bloods suggest high inflammatory markers. Blood++ and high white cell count in urine. Diagnosed with LRTI and UTI. Antibiotics prescribed by COE Cons.
- Other requirements followed 1 day later to compliment patient centred care:
- On-going ASSET follow up

- CPN review (low mood)
- Physio review (mobility issues / walking aids)
- CXR arranged with transport to and from hospital
- Social work (medication prompts and personal care x 4 daily)
- Patient maintained at home and discharged from ASSET after 4 days.

Patient B Jan 2014 – no service integration in place

- No Paramedic Practitioner on duty in the Hamilton area (SAS/ASSET).
- 999 call attended by Paramedic/Tech ambulance for 82 year old male in distress and fear.
- Background: Gentleman lives with dementia and has alerted police a number of times over two weeks complaining of being 'held hostage' by wife. Wife is single carer, has not involved primary care and believes behaviour is solely due to dementia. Patient requests to be sectioned under Mental Health Act and wife portrays severe levels of 'carer strain'
- Assessment: Obs normal, cough and chest wheeze, polyuria, recent history of falls, memory test 2/10, does not recognise family or surroundings. No homecare in place. Medications taken (dispensed by wife).
- Recommendations: Contact NHS 24 to arrange GP visit. Return call from NHS 24 after 40 minutes to inform GP advice to transport to A&E.
- Outcome: Patient transferred to A&E by SAS (total SAS case time 2.5 hours). Patient waited seven hours in A&E side room diagnosed with delirium related to chest inf. Discharged next morning with Paracetamol and antibiotics.
- No short or long term care package in place on discharge.

Staff experience

.....

The SAS Practitioners have found the experience challenging but extremely positive. The wider SAS clinical group have welcomed the opportunity to offer patients within this group access to care and services which is more consistent with their need.

Efficiency savings and productive gains

.....

This model undoubtedly offers patient-centred care however the efficiency gains are complex to determine and this is currently work in progress. There is however a likely clear shift from institutional to community delivered care and from a single disease management approach to the management of co-morbidities.

Sustainability

.....

The clinical model is consultant led and there may be an opportunity to review and redesign this which would improve its sustainability.

Lessons learned

.....

- Recognising and understanding prior training and education across different services is a challenge.
- Patients are less concerned about the individual clinician who provides their care than we think (as long as it is appropriate and the clinician is competent).
- Conflicting priorities between partners can be a challenge or potential barrier.
- Shifting the balance of care and identifying a cashable benefit is very complex.



WHOLE SYSTEM PATIENT FLOW

ABOUT THE PROGRAMME

Martin Hopkins

t: 0131 244 5178

e: martin.hopkins@scotland.gsi.gov.uk

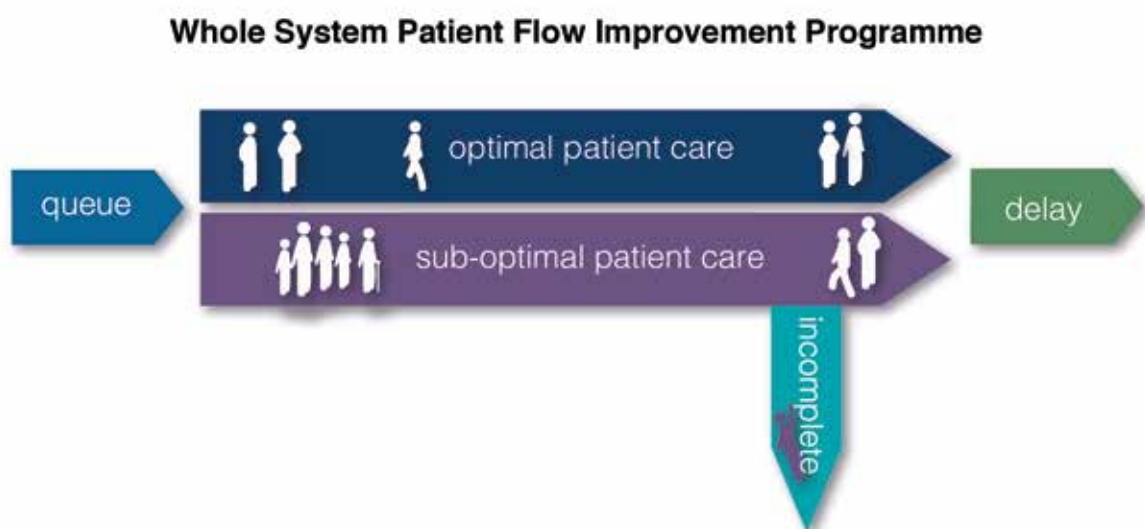
drivers

Designing care systems with effective patient flow is critical to the delivery of NHSScotland's Quality Ambitions of safe, person-centred and effective health care.

Poor patient flow means reduced quality which may result in patients:

- waiting for treatment
- possibly not receiving as effective care or perhaps waiting longer
- not receiving all the care they need
- being delayed once their treatment is completed

Good patient flow supports optimal care for patients' needs and contributes to safe, person-centred and effective care. It also eliminates or reduces inefficiencies.



aims

- Adopt a whole systems approach to patient flow, designed to ensure patients receive the right care, at the right time, in the right place, by the right team
- Promote the bringing together of both elective and unscheduled workstreams to support a whole system approach
- Test new and innovative approaches to improving patient flow
- Reduce artificial variation in health care
- Develop a culture of sharing and continuous improvement across NHSScotland

workstreams

- Proof of Concept – testing new and innovative approaches to improving patient flow
- Day and Short Stay Surgery
- Enhanced Recovery
- Fracture Clinic Redesign
- Criteria Led Discharge (established in 2014-15)
- Hospital Huddles (established in 2014-15)

As well as focusing on the above workstreams the programme aims to support NHS Boards to have effective infrastructure in place to enable:

- Frontline administrative, clinical and managerial staff to optimise the management of pathways and queues on a day to day basis, further embedding monitoring and management tools and real time pathway management reports
- The development of an embedded approach to Demand, Capacity, Activity, Queue (DCAQ) analysis and the operational application of it
- The use of prediction tools to plan emergency capacity and real time demand and capacity management techniques
- To further build a system across acute sites to assess the balance of resources across both emergency and elective care with a view to maintaining effective flow both at strategic and operational level

achievements 2014

- Proof of concept – procurement of a technical partner to test an innovative approach to improving patient flow. Our technical partner is the Institute for Healthcare Optimisation (IHO). The work has commenced in NHS Forth Valley, NHS Borders, NHS Greater Glasgow and Clyde and NHS Tayside. The basic principles of the model are the application of queuing theory, separation of flows (unscheduled and scheduled), and the use of variability methodology.

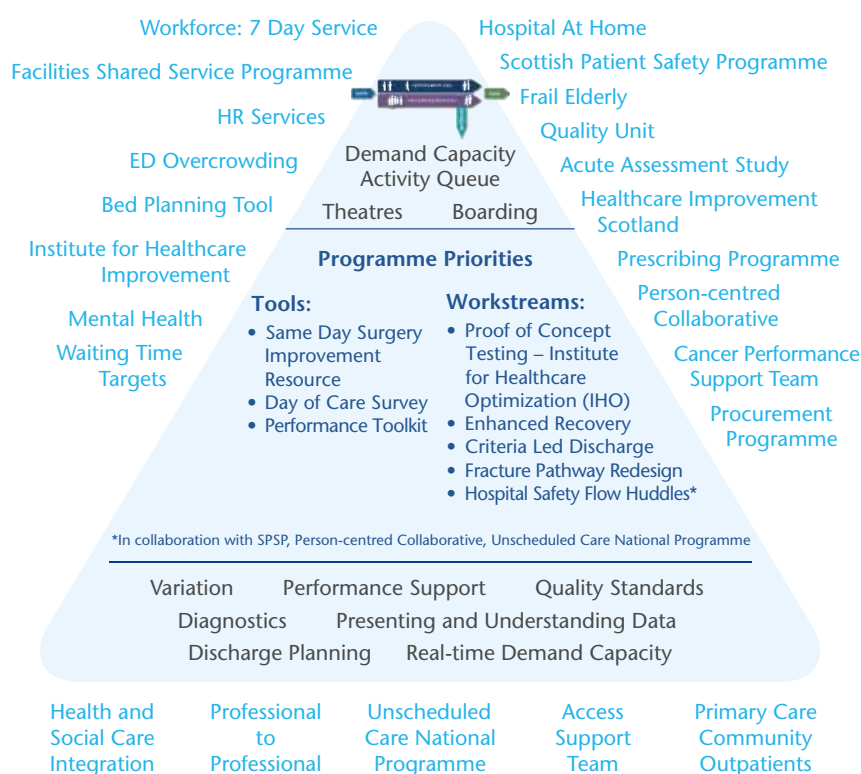
Delivery of two national events focused on patient flow, engaging staff from across NHSScotland:

- The first event focused on exploring the relationships and interdependencies between flow, patient safety and our Quality Ambitions and showcased best practice in improving patient flow.
- The second event, held jointly with the Royal College of Physicians of Edinburgh (RCPE) reached a consensus on how to reduce unnecessary bed moves for patients and improve patient flow, so as to ensure that there is sufficient capacity in hospitals and the community for patients' needs including in times of winter pressure.
- The Fracture Redesign Model originating in NHS Greater Glasgow and Clyde has further spread across Scotland and England, and has been recognised internationally. Support for NHS Boards in implementation and spread continues.
- Development of a set of measures to enable measurement for improvement in respect of Enhanced Recovery. Regular reporting to commence in 2014-15 to aid spread and sustainability.

priorities 2015

Taking a whole system approach to patient flow will influence how healthcare is delivered in all areas. It is recognised that there is a great deal of work being progressed both locally and nationally that has a bearing on patient flow. Those within the pyramid are specifically related to the Whole System Patient Flow Improvement Programme and its priority areas.

Influencing Patient Flow



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/whole-systems-patient-flow.aspx>

Programme Case Study

Enhanced Recovery After Surgery

Background and context

Enhanced Recovery after Surgery (ERAS) is an evidence-based approach that helps patients to recover more quickly after surgery. It focuses on ensuring that patients are active participants in their recovery process, and it is important that all staff have knowledge of the evidence supporting Enhanced Recovery so that their relationship with the patient is built on mutual trust and respect.

The underlying principle behind Enhanced Recovery is to minimise the physical and mental stresses the patient goes through, so that they can recover more quickly, have a reduced stay in hospital, and are able to return to normal activities earlier. The pathway starts in primary care, moves through pre-operative, admission, operative and post-operative stages, and ends with the follow-up stage.

Enhanced Recovery involves a number of evidence-based interventions which individually have been shown to be beneficial, however when used together in a protocol they have been shown to result in substantially improved outcomes.

Enhanced Recovery is the sum of marginal improvements – if 1 per cent improvements are made in all areas, this adds up to make a significant improvement for patients and their carers.

Problem

Enhanced Recovery has been delivered in the UK since the early 2000s. In early 2012 a baselining exercise was undertaken by QuEST (formerly Improvement Support Team) to establish the position for Scotland. It was identified that, while Enhanced Recovery was

being carried out in some areas, this was not standard practice or consistent between or within NHS Boards.

Through establishing the Enhanced Recovery Programme (now part of the Whole System Patient Flow Improvement Programme), QuEST provided an overarching structure and national coordination for the implementation and spread of Enhanced Recovery.

Aim

QuEST aims to support NHS Boards to achieve a reduction in variation in the delivery of Enhanced Recovery principles across NHS Scotland, ensuring reliable implementation and spread to improve quality of care and patient and carer experience.

The Enhanced Recovery programme aims to:

- Bring together the best practice in organisation of care and clinical management, so that patients receive evidence-based care use patients and families as a resource in planning and managing the patient's recovery and care
- Focus on less invasive surgical techniques, optimised pain relief and management of fluids and diet, in order to mobilise patients more quickly post-operatively
- Make the patient's time in hospital as normal as possible
- Promote a wellness, rather than an illness, model of care.

Action taken

In order to achieve the aim of reduced variation and reliable implementation and spread of Enhanced Recovery principles QuEST has supported NHS Boards by:

- Providing one-to-one Service Improvement Manager support to Enhanced Recovery Coordinators within NHS Boards.
- Establishing an Enhanced Recovery Forum for NHS Boards Enhanced Recovery Coordinators and Analysts to come together to share best practice, successes

and challenges, in addition to shaping the future requirements for support from QuEST.

- Establishing an online Enhanced Recovery Network to support individuals leading/working on local programmes of work and to encourage the sharing of best practice across NHSScotland.
- Developing an National Enhanced Recovery Data Analysis Toolkit which provides NHS Boards with a national dataset of up-to-date information for improvement. This information allows NHS Boards to identify where the opportunities for improvement exist (through highlighting of variation) and identifies areas of best practice.
- Developing a LearnPro eLearning module (in partnership with NHS Boards) to raise awareness of Enhanced Recovery principles and ways of working across all staff groups.
- This eLearning module underwent user testing in various NHS Boards during August 2014.

Providing financial support to enable NHS Boards to:

- establish an infrastructure, across the organisation, to coordinate improvement activities in this area
- secure clinical champions to lead and support this work across the organisation and within priority specialities
- embed data collection processes to ensure the agreed bundle of improvement measures are consistently collected
- embed Enhanced Recovery into the core clinical service delivery

Results

To date there has been a lack of robust data which describes the level of Enhanced Recovery implementation across Scotland.

QuEST has developed a National Enhanced Recovery Data Analysis Toolkit which contains clinical data elements submitted by NHS

Boards. This is the first time that Enhanced Recovery clinical data has been available for this number of specialties across NHS Boards in the UK. We are now moving towards being able to demonstrate evidence-based care for all elective admissions.

Collating a national dataset of information for improvement allows NHS Boards to understand where the opportunities for improvement exist. The use of real-time clinical data enables an understanding of how systems are currently delivering services and the level of variation that exists. As a result, systems will be able to continuously monitor and improve services when redesigning care pathways and thereafter measure the impact of these changes.

QuEST will engage with NHS Boards to identify variation in compliance with Enhanced Recovery principles and to support NHS Boards to develop:

- plans to tackle challenges in further roll out
- a plan for spread and reliable implementation and ensure sustainability

Patient experience

Enhanced Recovery provides a way of managing care and rehabilitation that improves patient outcomes and speeds up a patient's recovery after surgery, enabling them to return to normal activities more quickly.

There are a number of benefits to patients which align to our Quality Ambitions:

- Person-centred – patients and carers are active partners in their own care and recovery process. Patients are more informed and have more choice about the management of their care which improves their experience and clinical outcomes.
- Safe – patients on an Enhanced Recover pathway have fewer complications and readmissions. Patients have a reduced length of stay which improves patient safety from reduced risk of hospital associated infections.

- Effective - patients receive improved pre-operative care, reduction in the physical stress of the operation and increased comfort post-operatively. In addition, Enhanced Recovery can aid early detection of complications and additional care interventions can be given earlier if required (e.g. chemotherapy, radiotherapy).

Staff experience

There are a number of benefits to staff working with Enhanced Recovery pathways, including:

- improved multidisciplinary experience
- team building opportunities
- education and training opportunities
- improved focus on use of technology
- recognition for achieving improvements in quality and patient experience

Efficiency savings and productive gains

Implementation of Enhanced Recovery has the potential to deliver significant productive gains through reduced length of stay and bed days saved, including:

- potential to treat more patients within same resources
- increased bed capacity for hospitals to support optimum patient flow

Enhanced Recovery also provides the opportunity to harmonise care across the NHS to support optimum patient pathways and to assist NHS Boards in meeting operational performance standards (e.g. 18 Weeks and Treatment Time Guarantee).

Sustainability

QuEST has supported NHS Boards to develop an infrastructure to ensure that Enhanced Recovery is the default approach to managing care before and after surgery. The new ways of working are being embedded within NHS Boards and QuEST continues to support implementation and spread.

Lessons learned

Key lessons learned include:

- It is critical that NHS Boards have dedicated resource to 'pump prime' the move to Enhanced Recovery and embed the new ways of working
- The establishment of networks to support individuals delivering Enhanced Recovery in NHS Boards is important for sharing best practice and addressing challenges
- Communicating opportunities within NHS Boards is vital – for example ensuring staff are aware of training opportunities such as the LearnPro eLearning module
- Providing networking opportunities is key to support cross NHS Board working

Next steps

Good progress has been made in NHS Boards in colorectal, urology, gynaecology, orthopaedics and breast surgery and the next stage is to test and spread the approach to other specialties.

Next steps for the QuEST national team include:

- Supporting an Enhanced Recovery pilot in obstetrics for planned caesarean section procedures
- Providing on-going support for the National Enhanced Recovery Data Analysis Toolkit
- Launching the newly developed LearnPro eLearning module to raise awareness of NHS staff of Enhanced Recovery principles
- Contributing to a national Whole System Patient Flow event in October 2014 through delivery of Enhanced Recovery workshops
- Continue to engage with local teams and understand further opportunities for spread to other specialties and support as appropriate.

NHS Borders

Improving the Emergency Access Standard

Background and context

Since September 2013 the national Emergency Access Standard (EAS) has stipulated that 95 per cent of all patients presenting to UK Emergency Departments (EDs) should be seen, treated and admitted or discharged within four hours.

Problem

It is extremely challenging to achieve the Emergency Access Standard consistently.

Aim

This study aimed to address the on-going problem of Emergency Access Standard breaches at a district general hospital.

Action taken

Senior managers and senior clinicians met weekly for fifteen minutes in the ED. Using improvement methodology, tests of change were devised to address recurring causes for breaches in each patient flow group:

- flow 1 – minor injuries
- flow 2 – acute illness
- flow 3 – medical admissions
- flow 4 – surgical admissions

Each test of change was implemented on a plan-do-study-act (PDSA) basis and data was displayed on statistical process control charts. Data interrogation identified recurring reasons for breaches and specific PDSAs were devised to address these. The impact of each PDSA was then analysed, discussed and refined at the weekly meetings.

Results

Over an eight-month period (July 2013 - February 2014) initial testing focused on flow groups 1, 2 and 3 which in turn all demonstrated reduced variation in performance evinced as a significant reduction in patient waits. The greatest impact was on breaches in flow 1 which were reduced from 1.31 per cent (July 2012 - February 2013) to 0.5% (July 2013 - February 2014). Over the study period the Borders General Hospital averaged 98 per cent on the Emergency Access Standard whereas for the same period in 2012-2013 performance averaged 96 per cent.

Patient experience

NHS Borders is now consistently meeting the Emergency Access Standard. 98 per cent of patients are seen, treated and admitted or discharged within 4 hours, thereby improving the patient experience at the 'front door' of the hospital.

Staff experience

Staff have gained a greater understanding of why breaches occur and have the confidence to employ PDSA cycles to address any future issues. Up to date performance data is visually displayed in the department which helps engage staff and ensures a focus on quality.

Efficiency savings and productive gains

NHS Borders has consistently achieved and exceeded the Emergency Access Standard averaging 98 per cent over the study period. This was achieved within existing resources.

Sustainability

The weekly 15 minute 'Alpha Zone' meeting is now thoroughly embedded in the department ensuring on-going scrutiny of the performance data and providing a forum to introduce further PDSA cycles as necessary.

Lessons learned

.....

This study has shown that the application of improvement methodology, using PDSA iterative cycles, and a patient safety approach, can address special cause variation in patient waits in a district general hospital. Furthermore, a joint working partnership between clinicians and managers allowed PDSAs to be implemented and spread across the wider hospital community. The authors would recommend that a similar team-based, patient safety approach be adopted in other NHS Boards.

NHS Board Case Study

NHS Dumfries and Galloway

Pilot of a Surgical Assessment Unit

Background and context

NHS Dumfries and Galloway was struggling to achieve the interim four hour waiting times target (95 per cent) within the emergency department at Dumfries and Galloway Royal Infirmary (DGRI).

The opening of the Acute Medicine Unit with access to assessment beds had improved the medical flow of patients providing better experience for the patient and improved performance against the target for this flow. However, traditionally Flow 4 – the surgical admissions flow – was the lowest performing flow for the four hour emergency access target (appendix 1). This performance led to slow assessment and poorer care of patients. As such the Board agreed to the trial of a Surgical Assessment Unit (SAU).

Problem

Traditionally all surgical patients referred for emergency admission by GPs, or assessed as requiring emergency admission by the emergency department, were managed within the emergency department.

The assessment of the patient followed a very traditional pattern with the junior undertaking an initial clerk-in followed by a hierarchy of assessment. This assessment could be delayed because the senior medical staff were in theatre or otherwise busy within the ward.

Aim

NHS Dumfries and Galloway was keen to deliver high quality assessment, treatment and diagnosis for all acutely ill surgical patients with prompt access to decision maker followed by rapid initiation of treatment

and investigations and either admission or discharge as appropriate. It was anticipated that the introduction of a Surgical Assessment Unit would support these goals and improve performance against the four hour target.

Action taken

A five bed area (one single and one four bedded room) was identified within one of the general surgical wards to support development of a Surgical Assessment Unit.

The surgical assessment area was provided with dedicated nursing staff, being sited within the ward area itself provided improved access to medical staff within the ward.

The unit was opened on 2 December 2013 although initially (until 6 January 2014), due to recruitment difficulties, was only open between 8am and 8pm. The unit is now fully functioning and is open 24 hours per day, seven days per week and receives adult surgical emergency admissions with the exception of orthopaedic and gynaecology presentations.

The surgical admissions flow was redesigned so that GP referred patients received a quick initial assessment in the emergency department before going on to be formally assessed in SAU. The self-presentations or 999 ambulance patients are assessed in the emergency department before being referred on to the unit. The unit was provided with dedicated nursing input, FY1 and middle grade cover, access to a range of diagnostic tests and a single room where treatments could be carried out.

The unit has functioned well since opening.

Results

Impact on the Emergency Department

The SAU has undoubtedly had a beneficial impact on the emergency department. Firstly, since opening there has been a step change improvement in our emergency department four hour performance (appendix 1). This has gone from achieving around 70 per cent to 90 per cent performance, including one week where we reached 98 per cent. Secondly, the length of time our patients are

spending in the emergency department has reduced dramatically (appendix 2). Finally, the emergency department staff have found that the unit helps to improve their working as the surgical patients move from the unit much faster.

Impact on General Surgery

The General Surgery staff are finding the unit beneficial as the patients are easier to manage once in the SAU. In addition, the patients are being looked after by trained surgical nurses rather than emergency department staff who are working with a range of patients.

Performance of SAU

The SAU is showing strong performance against its original measures. We are currently using a manual input for data collection the information which suggests that 21 per cent of patients are being discharged directly from the SAU. Work is currently underway with information services to capture this data using existing systems.

Efficiency savings and productive gains

.....

As already outlined the aim of this pilot was to improve the quality of patient journey for the surgical flow of patient. This also forms a key component of the of our improvement towards the four hour emergency department waiting times target and early steps towards the development of our combined assessment area in the new District General Hospital. No cash releasing savings were envisaged.

However as can be evidenced by the mean waiting times in the emergency department (appendix 2) the impact of this investment has been to improve the efficiency of flow in the emergency department.

Sustainability

.....

The pilot is designed to inform the development of a combined assessment unit for the new District General Hospital and has been extended for another year.

Lessons learned

.....

Key to the success of this pilot has been the high level of engagement of the wider team throughout.

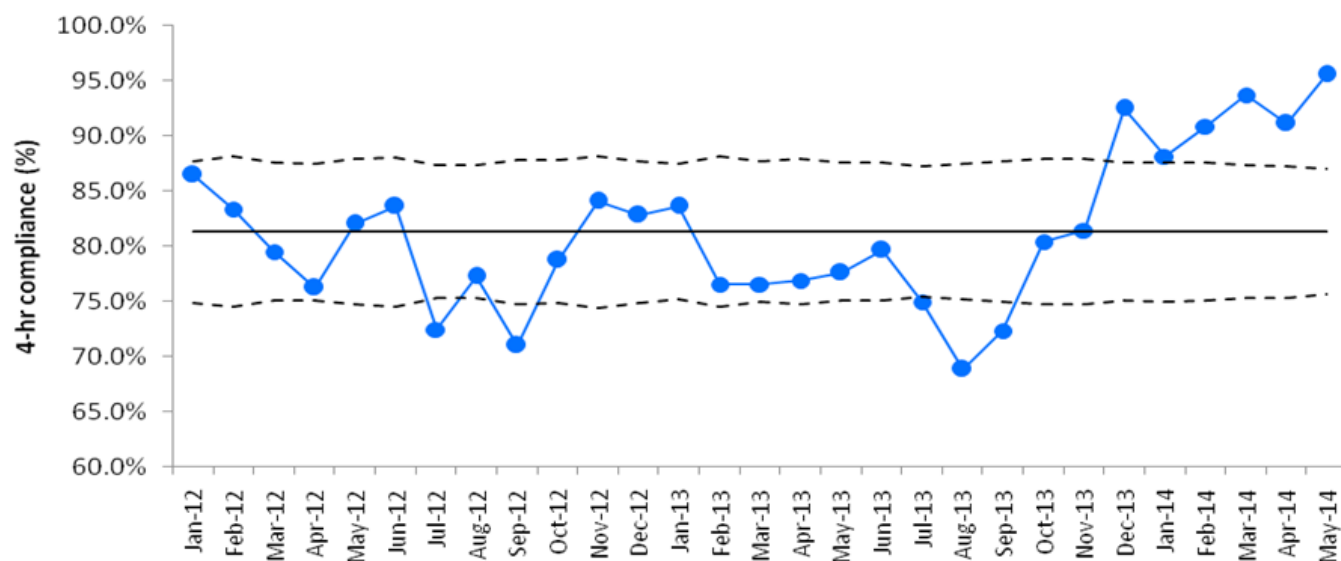
In the initial planning stages a there was a weekly meeting of key staff to develop and agree the operational policy and detail of the patient flow.

During the initial weeks of the unit opening there was a daily huddle to identify and resolve issues as they developed.

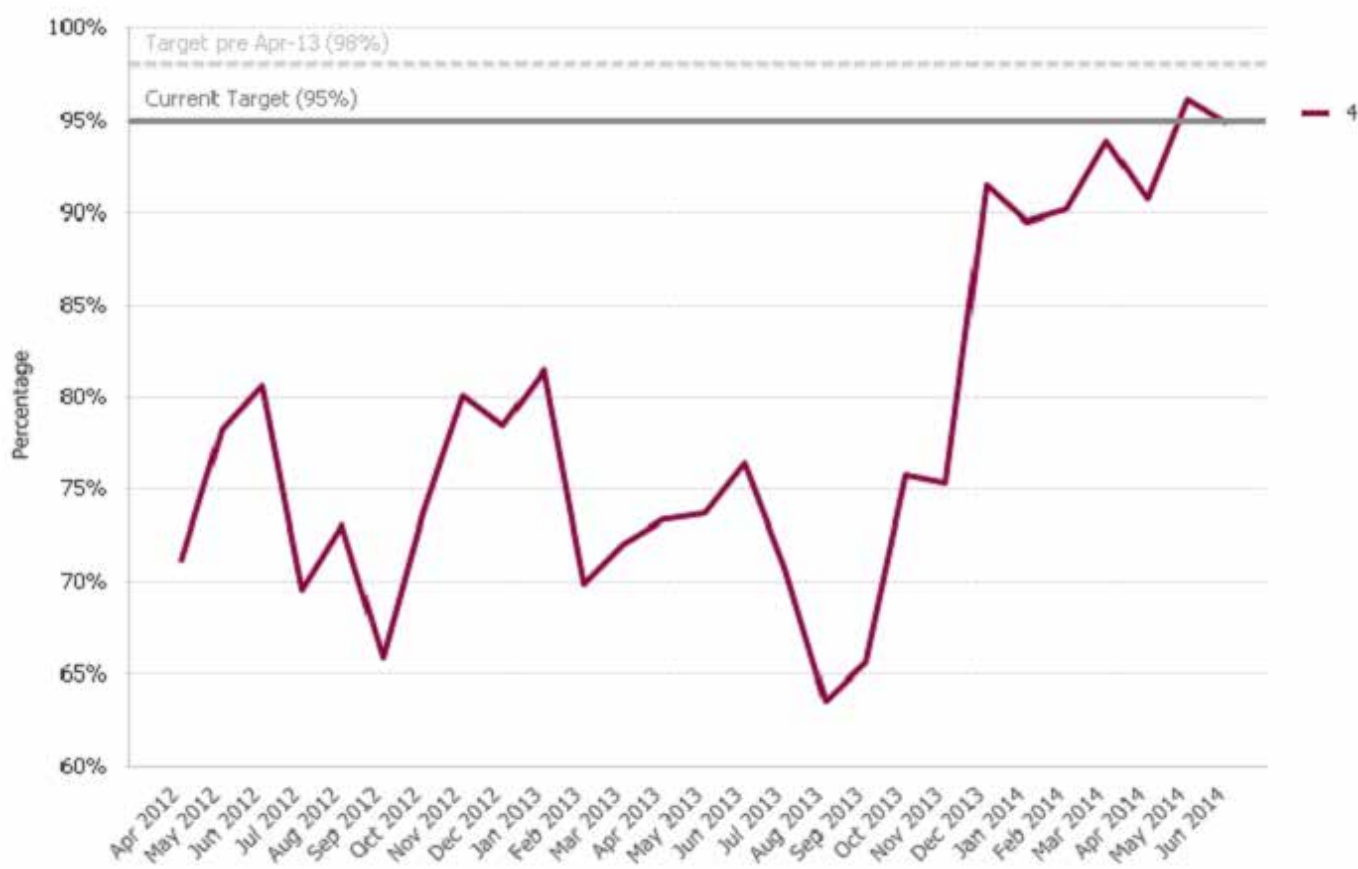
This high level of engagement has continued with a weekly ward huddle and until recently a two weekly steering group meeting. The steering group meeting has dropped to monthly in the last week.

Appendix 1

Performance against the four hour target for surgical emergency admission flow (includes gynaecology and orthopaedic admissions)

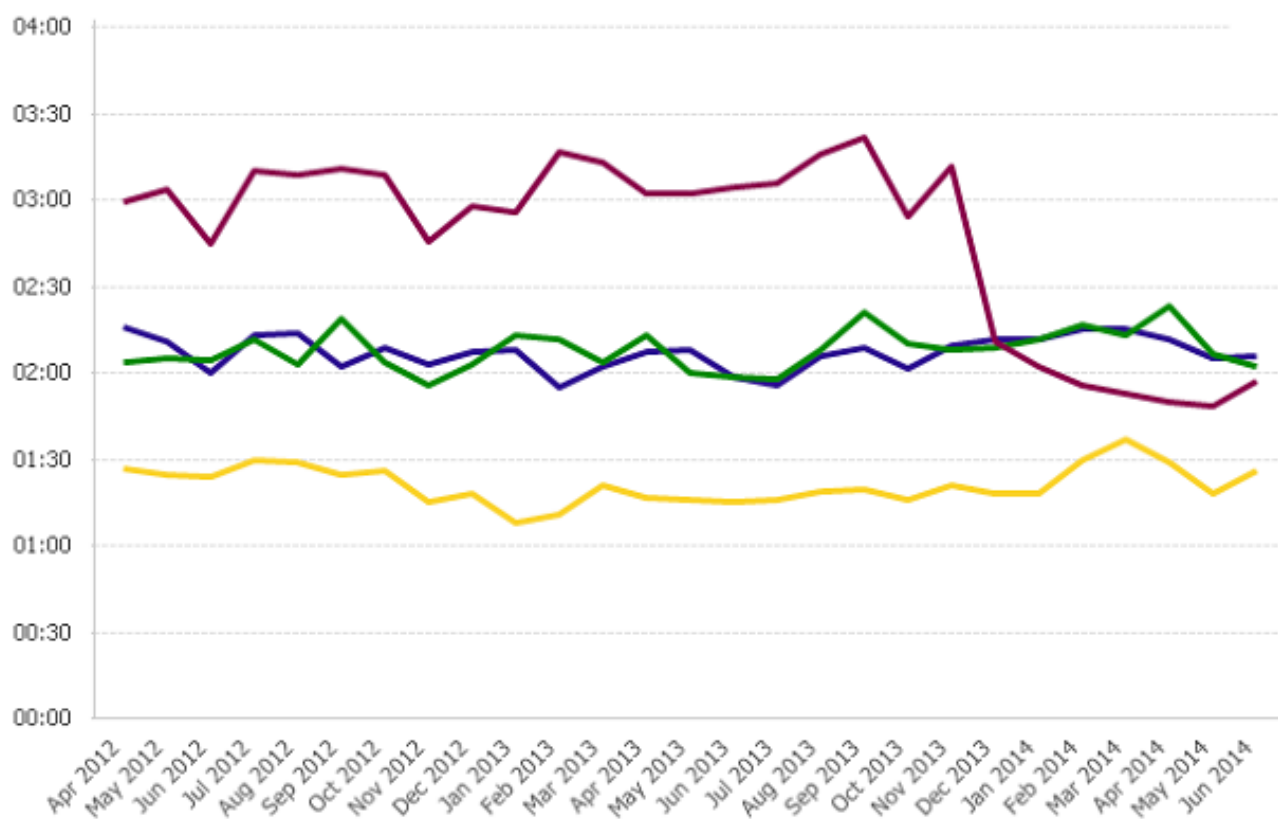


Performance against the four hour target for general surgical emergency admission (general surgery only)



Appendix 2

Median wait times in the emergency department for all patients



Coloured lines represent different patient groups admitted to the emergency department.

Median wait times in the emergency department for patients admitted as a general surgical emergency



NHS Board Case Study

NHS Shetland

Orthopaedic pathway for pre-operative assessment – surgeries off-island

Background and context

The NHS Boards' corporate objectives are to provide quality, effective and safe services, delivered in the most appropriate setting for the patient. Several NHS Shetland pathways were identified as potentially having challenges and variation within them; pre-operative assessment for off-island procedures was identified as one of the priorities. It was therefore this pathway that was chosen as a project to identify the current state so the challenges could be identified from within pre-operative assessment.

Problem

The main problem was that the staff members working within this pathway were voicing confusion and finding it stressful working within the current system. Initial conversations with staff members revealed variation, duplication and ambiguity and it was decided to map the current state so the problem could be identified and future recommendations suggested.

Aim

The aim over a four month period was to identify the current pathway for patients and their clinical information for pre-assessment for planned hip and knee joint replacements

off island. This would take into account both the staff and patient experience.

By the end of the four months, the current pathway would be identified and shared with the staff members (on Shetland, Elgin and Aberdeen) involved. On-island, Shetland staff members will be aware of their own and each other's roles within the current system and future recommendations will be made.

Action taken

Initially a project initiation document, contract, charter and driver diagram were drawn up. Then, interviews were held with staff members involved in the current system (10 members of staff on island) and telephone/email conversations with staff members off-island (five in Elgin, six in Woodend) and the current system was drawn up as a process map. This map was sense checked with all staff members to ensure it was accurate. Data was collected to find out how many patients went through the system. Patient stories were collected using emotional touch points.

Following collection of this information, a facilitated discussion was held on Shetland with the NHS Shetland staff members involved. During this session staff members measured their understanding of each other's roles at the beginning and end of the session on a scale 1-10 (1 being they do not understand the role at all, 10 being full understanding of the role). The beginning of the day saw scores varying from 1-10, the end showing variation of 8-10. This session also allowed future recommendations to be set.

During the project, there were several risks identified that were resolved. Procedural errors were highlighted where staff were unaware around policy sharing and this was addressed immediately. There was also ambiguity of words on documents being shared with across NHS Boards which was highlighted and changed. It was highlighted that there was variation in how patient information was being sent to the mainland (posted recorded delivery and scanned and emailed) and this was streamlined to be the same system for all hospitals.

Results

Attached at the end of the case study are three figures which show the pathways for Shetland, Elgin and Aberdeen as they currently stand.

This work benefits patients as staff are now aware of the current process they follow so can better inform them of their journey which leads to less confusion. Staff members appear happier in their work and have a clearer understanding of their role and each other's, thus enhancing working relationships. This work has raised the profile of NHS Shetland within mainland NHS Boards. Organisationally staff are compliant with policies within the pathway and variation has been reduced, thus lowering associated costs.

Efficiency savings and productive gains

Productivity has been improved because staff are now fully aware of the system they work within, they are able to provide the same service within existing budget but are able to inform the patients better around their journey. Costs have been lowered by scanning and emailing pre assessment pack to the mainland rather than sending recorded delivery which has led to a more efficient and cost effective means of producing the same results with less input.

The future recommendations this project has identified will further add to the efficiency and productive gains by further reducing variation and streamlining the system to ensure faster throughput of patients.

Sustainability

A local working orthopaedic group has been established on-island to take forward to recommendations from this project. All key stakeholders have been identified and invited. This will ensure regular and effective communication links are maintained between key staff members, which will also ensure sustainability of the current changes.

Lessons learned

The main lesson learned from this work was the time it took to extract the information from all stakeholders and the complexity of working across NHS Boards. It highlighted the importance of having a clear working pathway which everyone is aware of and understands. Challenging assumptions was another learning point, as these assumptions are often not factual and can further lead to confusion. The local orthopaedic working group will take forward the recommendations which have been identified by completing this work. Others looking to map similar pathways could use this as a means of demonstrating the benefits of this type of analysis – without mapping these pathways, it would have been impossible to find where the variation and ambiguity was and therefore identify solutions.

Figure 1 – Shetland Pathway

Please see [page 40](#).

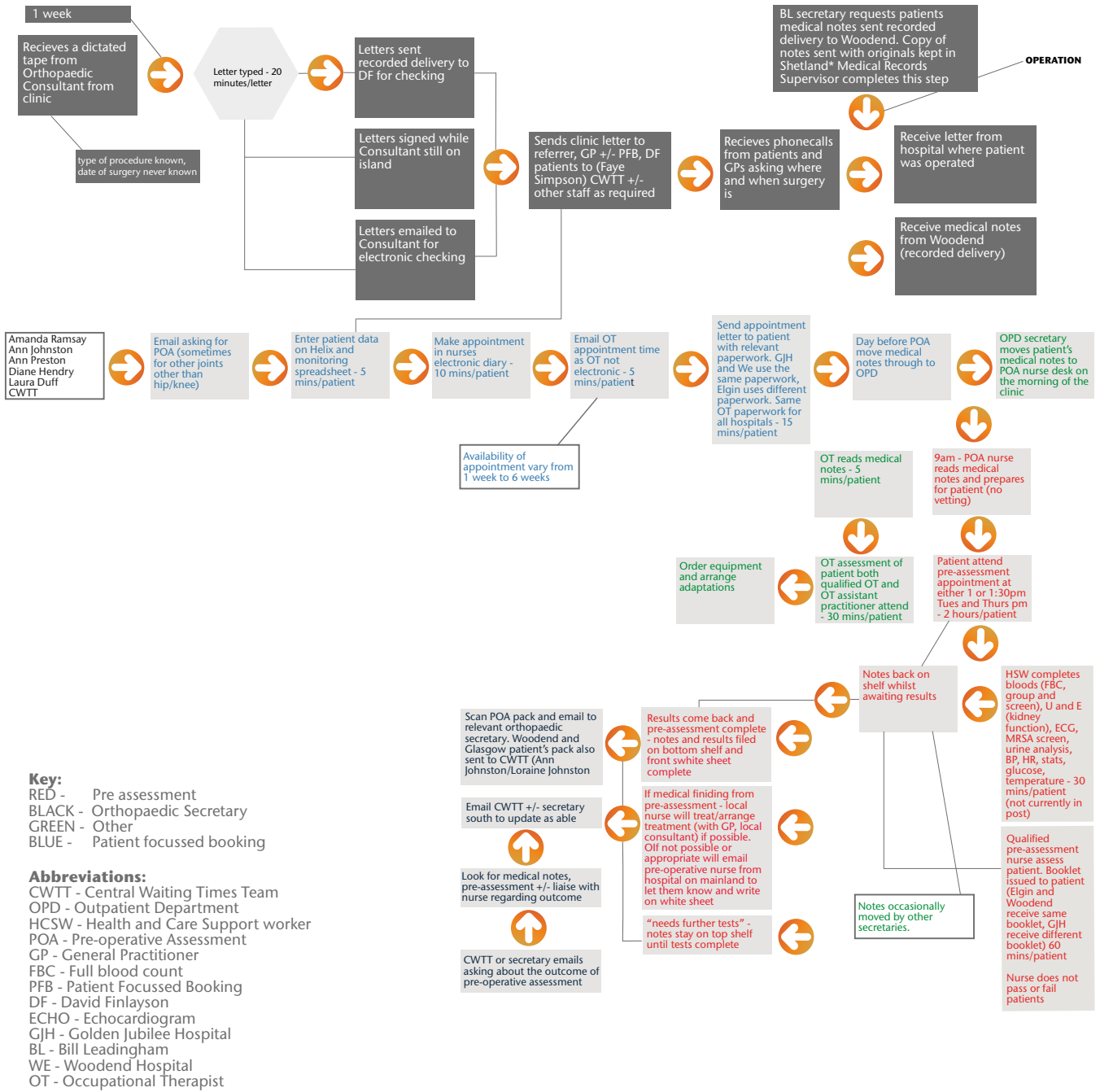
Figure 2 – Elgin Pathway

Please see [page 41](#).

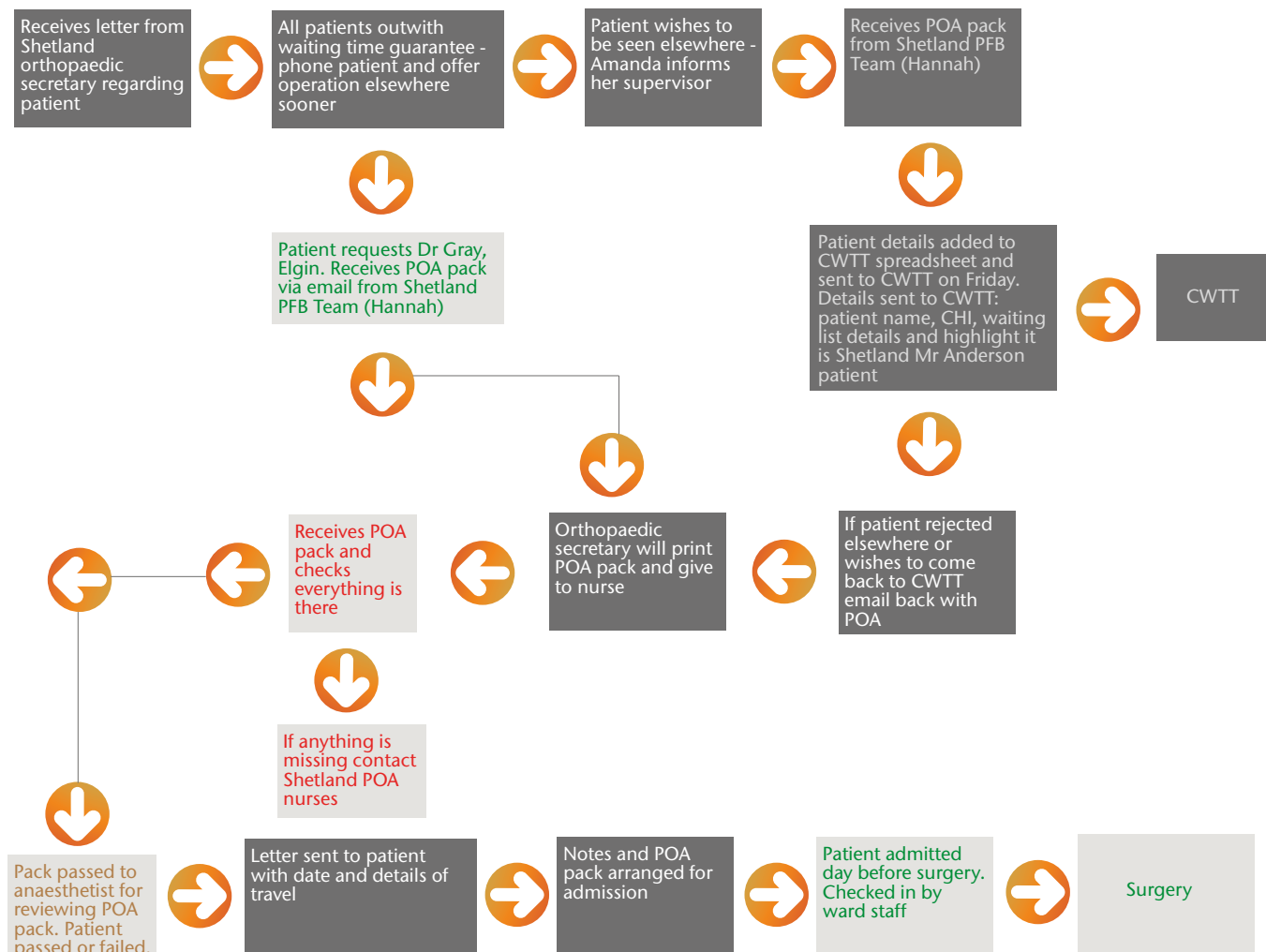
Figure 3 – Aberdeen Pathway (Woodend)

Please see [page 42](#).

The Pathway for Patients and their Clinical Information for Planned Hip/Knee Replacements - Shetland



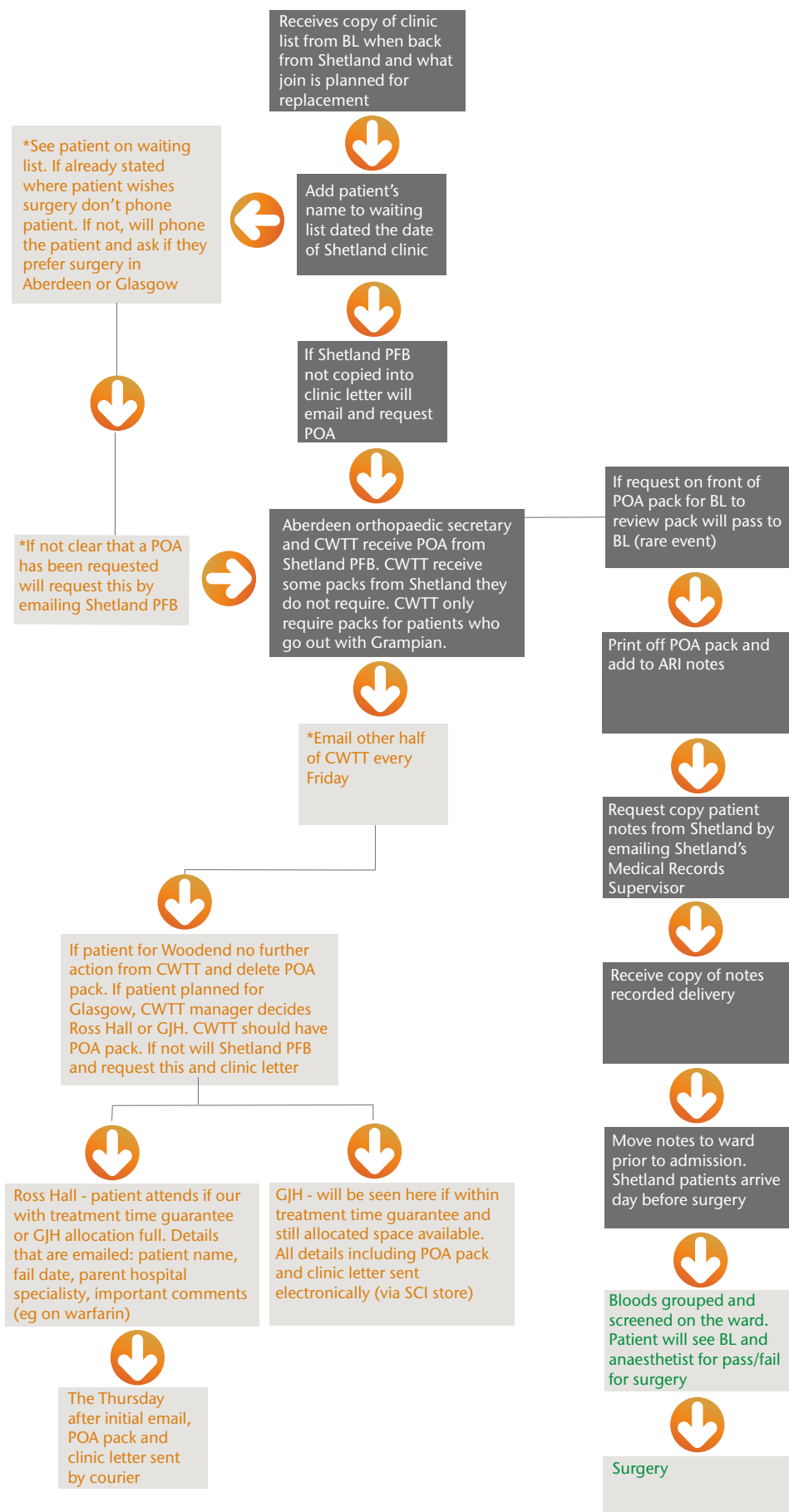
The Pathway for Patients and their Clinical Information for Planned Hip/Knee Replacements - Elgin.



Key:
 BLACK - Orthopaedic Secretary
 GRAY - Medical Secretary Supervisor/Trainer
 RED - Pre assessment NURSE
 BROWN - Anaesthetist
 GREEN - Other

Abbreviations:
 CWTT - Central Waiting Times Team
 POA - Pre-operative Assessment
 PFB - Patient Focussed Booking

The Pathway for Patients and their Clinical Information for Planned Hip/Knee Replacements - Woodend.



Abbreviations:

ARI - Aberdeen Royal Infirmary
 BL - Bill Ledingham (Consultant Orthopaedic Surgeon)
 CWTT - Central Waiting Times Team
 POA - Pre-operative Assessment
 PFB - Patient Focussed Booking
 GJH - Golden Jubilee Hospital

Key:

WHITE - *Ann Johnson/Lorraine Johnston from CWTT Orthopaedic secretary -
 ORANGE - CWTT (all components of CWTT)
 GREEN - Other

NHS Board Case Study

NHS Western Isles

Real-time DCAQ Data Dashboards

Background and context

The QuEST Efficiency and Productivity Report identified NHS Western Isles as outlier in the number of measures of mental health delivery while national benchmarking products continued to place Western Isles Hospital as an outlier for a number of efficiency measures most notably around average length of medical stay. Key to improving these metrics has been a recognition of the need to apply DCAQ information to redesigning system processes and embed its use in operational management. While collection of DCAQ data has seen developments, these were not yet fully realised while there is a real need for support to facilitate the use of such information within the operational service planning of these services. It has recently been a critical time for these services in Western Isles as we undertake a full mental health redesign and wider hospital modernisation programmes. There will be a key requirement when implementing new models that the principles and applications of improvement advice and key role for DCAQ metrics are at the centre of operationalising this model.

Problem

Past attempts to redesign processes or services have tended to rely on reactive responses to particular situations and utilised ad hoc information. This information was more often than not unclear on its links to the problem, out of date once utilised and did not form part of the on-going management and monitoring of the process/service redesign. The result often was that when addressing issues such as peaks in demand, loss of capacity, activity build-ups and waiting time pressures there was a deficit in timely information available to either anticipate or alert immediately

when processes/services were out of balance. In addition the use of such information did not form part of the on-going routine operational management to ensure such balance once re-established was sustainable and maintained.

This situation was a product of both lack of manager engagement with such data and the deficiencies in the data itself.

Aim

The aim of project was to develop and introduce a suite of electronic DCAQ dashboards for use by operational managers beginning with identified key needs for referrals/activity and waiting lists by end of March 2014.

Action taken

The aim was to be delivered via a change in both the content and delivery mechanism of data to provide managers with a more self-serve approach to intelligence required. An initial gathering of information requirements and user engagement was carried out both pre and post introduction of the change in information delivery. Training in use and interpretation of the new information dashboards was arranged which included a move to more statistical process control trending and benchmarking information outputs to measure progress over time and comparatively with peers.

Results

Dashboards were developed and trained in primary care (referrals/activity), out of island referrals (SCI Gateway and ECR referral analytics), waiting lists and theatre utilisation.

Efficiency savings and productive gains

It is early days yet in evaluating the impacts on the service improvements from such new tools and DCAQ approaches. Examples of gains have been described by Theatre Administrators as improving theatre utilisation, and by GPs as an increased ability to track their referrals/admissions over time and benchmarked to their peers. Alerts for acute admission enable care planning and discharge.

Sustainability

.....

This is now the primary method of data delivery for our operational teams. A programme of future planned developments is underway into Clinical Quality which will replicate similar analysis techniques for this area around hospital mortality, average length of stay, A&E waiting times, DC rates and selected metrics from Patient Safety programme. The regular awareness raising and training of staff in this approach to data delivery is planned alongside developments.

Lessons learned

.....

Key lessons from learning were twofold:

1. Engagement with key staff at outset to get their requirements and sign-up to change to new way of data delivery and its utilisation.
2. Availability of right data at right time was key to success of take up. Data therefore needed to be as near to real-time as feasible and relatively straightforward to interpret (which is where use of run charts and benchmark comparisons were effective). The early developments suffered from being perhaps over complex while gradually have simplified to focus on these key data outputs that can be used relatively easily.

NHS Board Case Study

NHS National Waiting Times Centre Board

Orthopaedic

Pathway

Improvement

Background and context

The Orthopaedic service within the Golden Jubilee National Hospital (GJNH) has been established for ten years and has strived to be a centre of excellence for lower limb arthroplasty which incorporates two differing referral flows: 'treat' (patients who have previously been assessed for surgery by a consultant or extended scope practitioner at their host NHS Board) and 'see and treat' programme (patients who are assessed for surgery and treated as appropriate by a consultant within GJNH). Since 2008 it has led the way in developing a designated Enhanced Recovery Programme (ERP), and the CALEDonian® Technique, which has resulted in improvements in patient outcomes whilst reducing length of stay following surgery (McDonald et al, 2012).

From 2010, a national programme to establish ERP as the normal pathway of care for all patients undergoing joint arthroplasty has been developed. This has improved patient care throughout Scotland and has led to reductions in:

- Catheterisation rates
- Blood transfusions
- The mean post-operative length of stay for patients around Scotland (MSK Audit 2013)

Problem

Although the GJNH outcomes from the ERP programme have remained consistent, they have now become the norm. To sustain the hospital's position as the centre of excellence

for lower limb arthroplasty, it was necessary to review the whole patient journey from referral to follow up. This review had to:

- Take into consideration the impact that the steep rise in the number of 'see and treat' referrals was having on service delivery
- Help establish where further improvements could be made that would benefit the patient and provide the highest quality of care
- Provide increased capacity to accommodate the demand

Aim

To achieve this it was decided that a clear quality improvement methodology was necessary which would help to structure, analyse, implement and sustain the proposed improvement. The objective of the programme was to maximize capacity in order to service the increasing demand in Scotland for lower limb arthroplasty.

From this, the Orthopaedic Improvement Group decided on the following two aims:

1. To ensure all patients are pre-assessed and fit for surgery two weeks prior to their operation
2. To reduce average length of stay for primary Total Hip Replacements and Total Knee Replacements by two days

Action taken

A series of workshops was arranged with all relevant stakeholders and a decision was taken to use a natural variance model which:

- Focused on the management of variability within healthcare processes
- Provided a structured process to follow
- Used data to support findings and facilitated the development of measurable outcomes

By following this model, the groups were able to identify what would prevent the two aims being achieved. Data was collected to support these findings and then objective changes were made along the whole patient pathway to improve service delivery.

As well as following this model, the input of an external expert with experience in both quality improvement work and service delivery in orthopaedics helped to:

- Provide constructive challenges for the staff
- Bring ideas and examples of alternative ways of working
- Instil a discipline of following a quality improvement model
- Make the team focus on the key areas to be improved
- Monitor these improvements

Results

One of the main challenges identified that would prevent the achievement of the first aim was the lack of a robust waiting list management system. This has been addressed and there are now electronic referrals being received from NHS Lanarkshire, NHS Lothian, NHS Greater Glasgow and Clyde, NHS Ayrshire and Arran, NHS Dumfries and Galloway and NHS Forth Valley.

Data collected would suggest that this work has been successful with the majority of “treat” patients being received early in their nine week treatment pathway (Figure 1).

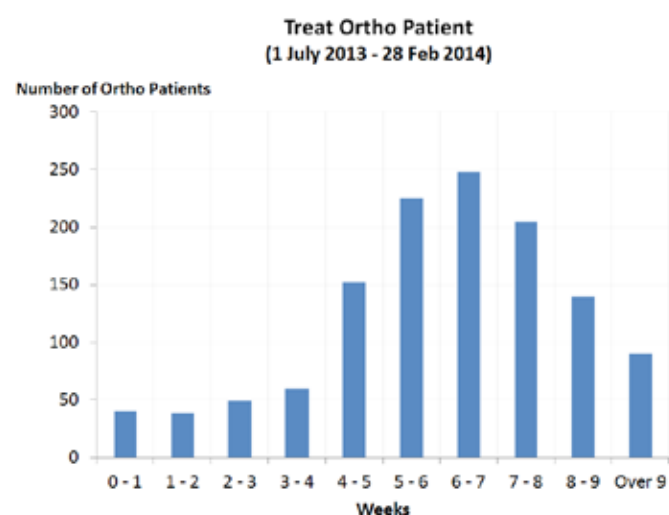


Figure 1: Wait times from referral to admission in weeks

Clinic activity has also increased since the redesign released capacity with the average monthly attendance now averaging 500 patients (Figure 2).

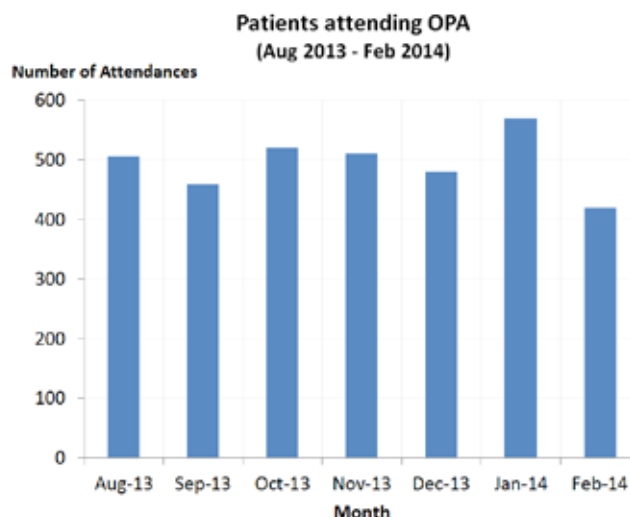


Figure 2: Clinic activity from August 2013 - Feb 2014

Prior to the implementation of the improvement work, there were a high number of patients attending clinic less than two weeks before their pre-booked theatre date. This would often lead to theatre slots not being filled, as there was insufficient time to contact other patients to replace anyone who was unfit for surgery. This programme has resulted in improvements in the referral management systems and new Service Level agreements with other NHS Boards which has led to:

- Reduced ‘batching’ and a smoothing out of booking office activity with patients being referred earlier in the pathway
- Improved and timely population of the pre-operative assessment clinics
- Better theatre utilisation because of the increased time between pre-operative assessment and procedure date (Figure 3/ Table 1)

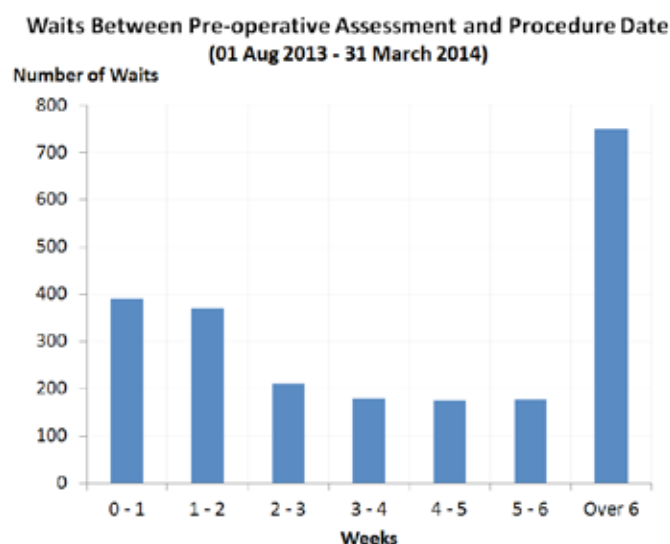


Figure 3: Wait time for patients between pre-assessment and procedure

Weeks	Number	%
0-1	347	17
1-2	349	16
2-3	210	10
3-4	167	8
4-5	146	7
5-6	149	7
Over 6	757	35
TOTAL	2,152	100

Table 1: Percentage waits between pre-operative assessment and procedure date

Efficiency savings and productive gains

The changes made to the patient pathway following this improvement work have clearly demonstrated that:

- The vast amount of patients are being seen within nine weeks of receipt of referral.
- Attendance at outpatient clinics continues to rise.
- Patients now attend for their pre-operative assessment in a timely fashion that allows for any challenges such as patient's being unfit for surgery to be managed appropriately.

- Nurses now pre-assess patients independently of the surgeon's consultation which has increased the capacity and greatly improved the patient flow through the clinic.

Sustainability

The monitoring of the new Service Level Agreement with other NHS Boards ensures that referrals are received in a timely fashion. Data relating to pre-operative assessment activity is now reported monthly and meetings with relevant stakeholders are held weekly to review waiting times.

Lessons learned

The Orthopaedic Improvement programme has, from the start, showed encouraging results. It has also clearly demonstrated the benefit of following a quality improvement methodology which is

- Simple
- Based on data which is continually reported
- Used to monitor, modify and sustain improvement



OUTPATIENTS, PRIMARY AND COMMUNITY CARE

ABOUT THE PROGRAMME

Susan Bishop
t: 0131 244 2019
e: susan.bishop2@scotland.gsi.gov.uk

drivers

There is increasing demand on health and social care services; in order to meet this demand it is necessary for more people to get the right care, from the right person, at the right time, in the right place.

We can create more opportunities for self-management, giving control to individuals over their own conditions. Shifting the balance of care and reducing unwarranted variation and waste allows resources to be better utilised for those most in need and achieve best value.

aims

The overall aim of the Programme is to move care closer to home and enable more people to receive the right care, from the right person, at the right time, in the right place.

This overall aim is supported by the following supplementary aims to:

- support teams, services and networks across outpatient services, primary and community care to:
 - work together to understand and diagnose system issues
 - systematically use quality improvement methodologies to deliver safe, person-centred and effective care
 - make best use of resources including the time of patients, the public and staff
- work in partnership with clinicians, managers, other improvement partners, patients and the public to generate new concepts, design and test new and innovative models of care and implement changes that improve the quality of service delivery
- increase the quality and use of data to help reduce variation, waste and harm

workstreams

- Transforming Outpatient Services – implementation of five change concepts as outlined in the driver diagram (see [page 55](#))
- Primary Care – designing and testing new models of service delivery to improve the flow of patient pathways through the health and social care system
- Community Care – designing and testing new ways of working to reduce unwarranted variation and waste, and to release time to reinvest in patient care

achievements 2014

Transforming Outpatient Services

- Patient Reminder Services Change Package to support NHS Boards to reduce the number of Did Not Attends (DNAs)
- Pathfinder projects to use advice instead of referral, optimise outpatient clinic resources, test digital technology prototype and use of alerts and video to support self-management
- National Return Outpatients Data Group to increase the quality and use of data for peer review to understand and reduce unwarranted variation and to inform and test improvements

Primary Care

- Design and delivery support for anticipatory care planning within General Practice and development of primary care indicators
- First phase of Managing Patient Flow – Shaping Our Future Practice (testing and extending the use of data and tools to improve patient flow within primary care)

Community Care

- Transition of the use of Releasing Time to Care to business as usual for NHS Boards and continuing development of the facilitator network
- Completion of phase one testing of Releasing Time to Care to support the process of integration of health and social care teams

priorities 2015

Transforming Outpatient Services

- Design new and sustainable person-centred models of outpatient services
- Adoption and spread of five high impact changes: use of advice only, clinical dialogue and referral feedback, centralised and e-triage, improved booking practices and use of reminder services, direct access to diagnostics and musculoskeletal redesign
- Increase the quality and use of data for peer review to understand and reduce unwarranted variation and to inform and test improvements

Primary Care

- Supporting delivery of General Practice access indicators
- Second phase testing of the Managing Patient Flow – Shaping Our Future Practice project

Community Care

- Releasing Time to Care for integrating health and social care teams
- Collaborative design of Telehealth and Telecare Improvement Programme



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/outpatient-primary-and-community-care.aspx>

Programme Case Study

Patient Reminder Services

Background and context

In 2013-2014 just under 5 million 'consultant led' outpatient appointments were recorded. 1.5 million of these were new outpatients. Traditionally outpatients are classified as patients who are referred to a consultant or other hospital-based specialist for further assessment, advice, diagnosis or treatment. The current 'traditional' model for the provision of outpatient services is that patients will be referred and subsequently offered appointments with hospital based consultants at clinics usually based within hospital premises. Overall demand for traditional 'consultant led' outpatient services is increasing. However, it is increasingly recognised and evidenced that not all outpatients need to be seen in this traditional manner.

The Transformation of Outpatient Services (TOPS) programme of work supports NHS Boards and local Health and Social Care Partnerships to move care closer to home and to enable more people to get the right care, from the right person, at the right time.

TOPS aims to identify suitable alternative options for outpatient services, which improve quality and safety of care and to support clinicians to transform the service.

It supports teams working together with patients and the public to understand and diagnose system issues, to design and innovate and to use continuous improvement to deliver high quality person centred care and best value for money.

Problem

The overall average 'Did Not Attend' (DNA) rate for new outpatient appointments across NHS Boards in 2013-14 was 9.8 per cent. Extrapolated to the 4.6 million total outpatient

appointments, this equates to 460,000 lost outpatient appointments across NHSScotland in one year. These wasted appointments and the resulting, irretrievable loss of capacity and specialist resource adversely impacts on patient waiting times. It also equates to an estimated £61 million net total unutilised outpatient appointment cost to NHSScotland, which is potentially lost to the service and cannot be reinvested.

The existing and expanding evidence base (encompassing research and experiential) demonstrates significant advantages to the individual patient, to specialties, and also to the wider NHS organisation in systematically implementing and utilising patient reminder services (PRS).

Aim

The TOPS programme of work aims for all patients to be seen in the right place, at the right time and by the right person.

In order to achieve this overall aim there are five high impact change concepts (see driver diagram below), one of which is to 'Reduce DNAs through using patient reminder services'.

Refer to image on [page 55](#).

The aim of the PRS change concept is to:

- Help patients to keep appointments, meaning that more people will arrive for their planned outpatient appointment
- Help reduce DNAs and release outpatient clinic capacity
- Provide advance notification of cancelled appointments that can be reused by other patients on waiting lists
- Enable recycling of released capacity to reduce overall outpatient waiting times and realise the subsequent health benefits to patients by reducing waiting times
- Reduce 'new' outpatient waiting lists
- Ensure best use of staff and resources through optimising clinic utilisation and where appointments need to be cancelled, the released appointments are made

available for other people to use thus more efficient use can be made of available resources

- Provide safe, effective and person-centred appointment booking
- Improve patient flow and capacity management
- Reduce health inequalities – through utilising DNA propensity software, we can identify patients or patient groups most likely to DNA and communicate with them in the most effective way to improve attendance.

Action taken

Extensive evidence and literature review was undertaken (encompassing research and experiential), leading to the identification and development of each of the high impact changes.

Between 2012 and 2014, QuEST commissioned three NHS Boards to use three different approaches to transforming outpatient services, one of which was rapidly testing changes and contributing to the development of change packages that help spread reliable improvements. Through this process PRS (incorporating telephony and digital systems and services) have been tested in a range of NHS Boards, sites and specialties.

During 2013-14, Chief Executives of all NHS Boards agreed to support rapid adoption and spread of five evidence-based, high-impact change concepts including implementation of PRS.

QuEST, in collaboration with NHS Boards and partners developed the PRS change package, as a resource to support NHS Boards to implement and spread the PRS change concepts. The change package is designed as a web-based resource which describes in detail the steps needed and how to plan for, adopt, implement and monitor effectiveness of PRS. It includes direct links to evidence, resources, and examples of good practice, information and contacts for teams to use and also provides information and resources to enable planning for spread.

The PRS change package and readiness assessments were issued to NHS Boards via a Chief Executive Letter (CEL).

Baseline readiness assessments have been completed for all NHS Boards.

Development and production of PRS evaluation matrix, core data set and productivity tool for use by NHS Boards.

Collaborative development of 'Once for Scotland' PRS proof of concept proposal.

Commissioning and development of national PRS procurement framework.

Patient experience

The following patient benefits are anticipated:

- patients will be seen in right place, at right time by the right healthcare professional
- increased health benefits to patients by reducing waiting times
- improved patient experience, fewer delays and increased patient satisfaction
- safe, effective, person centred appointment booking

Staff experience

From a staff perspective the following indicates some of the benefits that can be realised:

- professional satisfaction of seeing patients, at the right time
- opportunity to reduce harm to patients by reducing waits
- release of clinical capacity, enabling optimal use of clinical time
- ability to innovate, design and deliver outpatient services which meet the health needs of the future

Efficiency savings and productive gains

By achieving the overall aim of reducing DNAs to 7 per cent by 2016 (which represents achievement of the 2013 upper quartile) and

taking activity projections into consideration (an increase of about 3 per cent by 2016) around 41,151 new outpatient appointments alone could be released back into the system with a productive opportunity of between £4.3 million (total direct cost) and £5.5 million (net total cost).

Benefits realisation through utilisation of released capacity and consequential cost reduction through a decreased requirement for additional clinics and minimal use of waiting list initiatives.

Release consultant time and improve utilisation of released clinician/clinic capacity for which there is an indicative productivity gain.

Optimise utilisation of clinic resources and maximise opportunity of filling cancelled slots.

Sustainability

The identification of key enablers (local and national) in relation to all aspects of the Programme and the engagement and collaborative working with patients, NHS Boards, and partners to develop easily accessible comprehensive resources for use by NHS Boards will support implementation, spread and sustainability.

Key enablers across the TOPS programme of work include:

- Chief Executives of all NHS Boards agreed to support rapid adoption and spread of the five existing interdependent, evidence based change concepts.
- All fourteen territorial NHS Boards, with their partners, are beginning to take the necessary strategic actions to create the contextual, cultural and leadership conditions to enable staff, practitioners and patients to achieve their 2020 vision.
- Some NHS Boards have already formalised outpatient transformation as a strategic priority and integrated or adopted TOPS high impact changes into their local programme.

Planning for spread and sustainability are integral elements within each of the change packages and as such significant evidence and resources are made available.

- A key point is to truly understand capacity and demand for new and return outpatients.
- Development/commissioning of national PRS procurement framework.
- Development of PRS evaluation matrix, core data set and productivity tool.
- Supported implementation and evaluation of the PRS change package.

Lessons learned

The following key lessons have been learned:

- The development and implementation of the PRS change package focuses on improved quality of service for patients, but clear efficiency savings and productivity gains can be realised.
- Recognise the value and learning from what does not work well, as well as what does.
- Provide non-prescriptive guidance to NHS Boards to enable implementation and sustainability at local level.
- Keep the patient at the centre of every discussion and involve them in implementation.
- Ensure that the right clinicians and staff are involved from the start – this should include medical, nursing, primary care and medical records staff to ensure buy-in, stakeholder engagement, and identification of win-win solutions.
- It is critical to ensure joint working at Scottish Government level to enable connections between initiatives to be made, ensure consistent messages and increase visibility of the Programme.
- Plan for implementation, spread and sustainability from the start.

Next steps

.....

A further evaluation of implementation of the PRS change package will be undertaken.

All NHS Boards implementing PRS will use common criteria and a core data set to evaluate the impact of PRS, which will enable useful qualitative and quantitative cross NHS Board comparisons.

The TOPS Programme team in collaboration with NHS Boards and other partners will review the PRS change package and update to include current research and experiential learning and newly developed resources.

Chief Executives of all NHS Boards will continue to support the rapid adoption and spread of the five existing interdependent, evidence based change concepts.

Transforming Outpatient Services



NHS Board Case Study

NHS Ayrshire and Arran

Co-production for the Design and Delivery of Personal Footcare

Background and context

The demographic changes facing Scotland are well known; the number of people aged over 65 is projected to increase by 22 per cent by 2020 and by 63 per cent by 2035.

Good personal footcare such as toenail cutting helps older people to remain active, well and independent for as long as possible (Managing Falls and Fractures in Care Homes for Older People, Social Care and Social Work Improvement Scotland (SCSWIS) and NHSScotland, 2011).

In the past NHS podiatry services provided personal footcare. Within NHS Ayrshire and Arran the consequence in reshaping the service around need was that many older people were no longer eligible for NHS services yet still required help with their personal footcare to keep well and active (NHSScotland National Personal Footcare Guidelines, 2013).

Problem

Demand on service and capacity to deliver.

Aim

- For NHS and third sector to work with the public to develop and deliver an asset-based personal footcare service.
- To develop a sustainable model that utilises skills existing in the community.
- Through the above to enable NHS podiatry services to be able to meet demand and deliver an enhanced service.

Action taken

Using the experience of the third sector in delivering community projects a range of delivery models was explored. A social enterprise model was supported by the main features which were:

- recruit people with experience in health care and/or volunteering
- recruit a coordinator for admin and team lead role
- pump prime then charge small amount for service (£5)
- provide training and mentorship model
- pay people to deliver footcare to ensure motivation

Results

- First 10 months 1,200 people seen by third sector = 3,200 NHS Podiatry appointments saved
- This equates to two WTE NHS podiatrist time reinvested
- This has led to a reduction in waiting times from 16 weeks to three weeks in podiatry musculoskeletal service
- This has enabled the development of a foot protection programme for people with diabetes
- Third sector see people within two weeks compared to 10 week wait in NHS
- Person-centred – 100 per cent of people booking appointments between 6-9 weeks compared to 'enforced' 12 -14 week return times in NHS
- Social enterprise model with full sustainability within three years

Patient experience

- 99 per cent highly satisfied with the service, due to appointment availability and frequency
- 99 per cent of the public attending are agreeable to paying £5

- 100 per cent found it very easy or easy to make an appointment
- 100 per cent found the staff very helpful
- 100 per cent would definitely recommend the service to a friend
- Service able to be delivered within heart of communities in locations easily accessible
- Five NHS Board areas have been to visit the project; two with their third sector partners with a view to reproducing model in their areas

Staff experience

.....

- 18 volunteers trained age range 21 years – 73 years
- 100 per cent of volunteers rated the training and experience to date as positive
- 12 volunteers delivering personal footcare as interested in contributing to their community, six volunteers are delivering footcare with an aim to gaining full time employment
- Two volunteers have gained full time employment due to this volunteering experience

Efficiency savings and productive gains

.....

Productive gains are:

- First 10 months 1,200 people seen by third sector = 3,200 NHS Podiatry appointments saved
- This equates to two WTE NHS podiatrist time reinvested
- This has led to reduction in waiting times from 16 weeks to three weeks in podiatry musculoskeletal service
- This has enable the development of a foot protection programme for people with diabetes
- Third sector see people within two weeks compared to 10 week wait in NHS

Sustainability

.....

The on-going costs for the third sector personal foot care service are demonstrated by the east project projections which shows sustainability by year three.

Lessons learned

.....

This is an example of a co-produced and sustainable model of care delivery which has had a direct and positive impact on the public and on NHS services.

Lessons:

- How to work in partnership with individuals and communities to deliver and improve services.

NHS Board Case Study

NHS Ayrshire and Arran

Musculoskeletal

Service Redesign

Background and context

Within NHS Ayrshire and Arran, musculoskeletal (MSK) services have been redesigned in order to consistently deliver an evidence-based, streamlined and timely service for patients. The MSK service is community-based using a single point of contact to access the services of a core range of allied health professionals (AHPs), with there being no need for re-referral between specialties.

Problem

MSK conditions account for one in four GP consultations in Scotland. Historically in Ayrshire and Arran, patients with MSK conditions were referred into acute services, in part driven by lengthy waits for AHP services. Unsurprisingly more than 40 per cent were discharged from their first orthopaedic appointment with no need for further follow-up, many then added to the waiting list for AHP services. Lack of clarity on the patient pathway resulted in uncoordinated activity, often with expensive duplication and intervention which added no meaningful value to management.

Aim

To improve access to MSK services with patients being seen by the most appropriate clinician at the right time closer to their home with care delivered by an integrated team of AHP practitioners.

Action taken

A series of redesign events, engaging all stakeholders and utilising lean methodologies informed the MSK pathways of spinal, shoulder, elbow wrist and hand, hip, knee, and foot and ankle. Pathways inform and prompt best management from initial

presentation, need for referral, triage, appointing, management and onward referral as indicated. Patients can self-refer via the national Musculoskeletal Advice and Triage Service (MATS) hosted by NHS 24. Reconfiguration of electronic referral process has enabled a single point of access, a single waiting list and efficient electronic triage for a core team of AHPs including physiotherapists, occupational therapists, podiatrists and orthotists. Implementation of TrakCare patient management system also supports clinical outcome recording and evaluation. Advanced practitioners who previously worked in acute services now deliver clinics across all primary care sites, a successful shift in the balance of care. A robust process of clinical supervision and escalation ensures patients can access specialist opinion, further investigation, including diagnostic tests, and referral on to acute services as and if required, with there being no need for referral back to GPs. This avoids over-medicalisation, reduces risk of chronicity and promotes a culture of self-management and enablement. On-going developments will improve management options for patients, for example, through engagement with third sector and voluntary organisations. The identified need for alternative management options has driven improvements in pain pathways enabling patients with persistent pain to access specialist management encompassing a multidisciplinary approach and pain management programme.

Evaluation includes business measures, e.g., orthopaedic waiting time, quality measure, EQ5D5L, person-centred, including staff and patient surveys, patient stories and focus groups. Safety evaluation has included clinical presentation mapping as well as review of any adverse incidents and complaints. Continuous improvement is supported by regular programme board meetings, incident log and route cause analysis.

Results

Implementation of the low back pain pathway alone resulted in significant improvement in orthopaedic outpatient capacity. Low back pain previously accounted for 40 per cent of advanced practitioner capacity and now

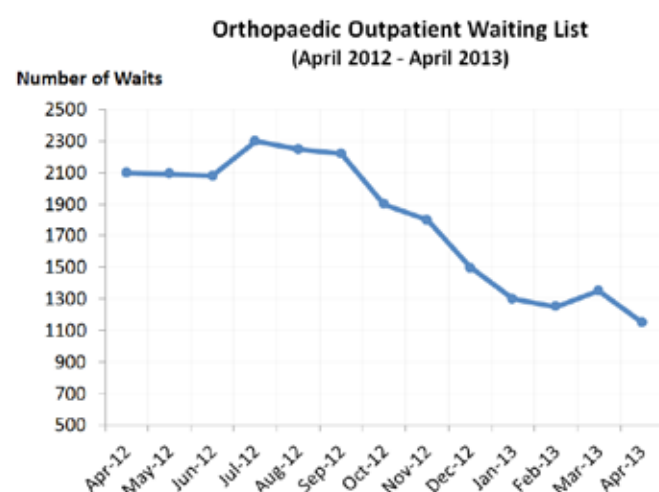
accounts for less than 10 per cent. Over the first six months this accounted for 945 saved orthopaedic appointments. The success of the low back pain pathway provided confidence for stakeholders to support the roll-out of all other pathways.

"In general, MSK pathway is better than hospital consultants and GPs at delivering well thought out cases for surgery"

(Consultant Orthopaedic Spinal Surgeon)

The clinical pathways have demonstrated a significant impact on orthopaedic waiting times. The figure below clearly demonstrates the impact on the orthopaedic waiting list. Since implementation in October 2012, a 20 per cent reduction in total orthopaedic demand has been sustained.

Significant improvements in surgical conversion rates have been reported with pre MSK rates of 25-35 per cent and post redesign 74-80 per cent.



Patient experience

Patient focus groups and stories have been integral to the redesign from the outset. Patients have reported improvements in ability to access services, with no need for repeat visits to GPs and patients felt more informed and involved in decision making. Patient story recordings are available.

Staff experience

Following the implementation of the low back pain pathway a staff survey and focus groups helped inform the on-going pathway and service developments.

In May 2014 further staff focus groups were conducted.

Efficiency savings and productive gains

The redesign was delivered cost neutral but by continuing to save approximately 150 Orthopaedic clinic appointments every month an estimated minimum financial saving of £325,000 per annum has been achieved. However consultant time was able to be effectively reinvested in theatre time to facilitate improvements in Treatment Time Guarantee performance.

Sustainability

On-going work will develop improvements in management options for patients to deliver MSK management that fulfils the changing needs of patients and our communities. Test of change initiative identified that 27 per cent of the MSK patient population have a low risk of on-going symptoms and best care is supported by self-management. With less than 4 per cent of this patient cohort opting back in for treatment, significant improvements in capacity have been achieved. This along with other co-production initiatives should ensure the long term sustainability of the redesign.

Lessons learned

The MSK redesign has come about with a radical change in working practice. The process has been supported by the programme board which continues to meet regularly. Critical to success has been the engagement of stakeholders which has been achieved in a number of ways. A clear communications strategy has supported the workstream, with regular activity reports and updates, including face to face contacts, provided for all stakeholders. Our greatest challenges were around the implementation of patient management system and without dedicated commitment from eHealth team this would not have been achievable.

Anticipatory Care Planning in NHS Lanarkshire

Background and context

The essence of Anticipatory Care Planning (ACP) is to help people with long term conditions to have the confidence, control and choice that comes with knowing what might happen, spotting small indications of change and being ready to do the right things with the right support from the right people. It should be tailored to the stage of the patient's condition and as such exemplify person-centred and holistic care, and respect for the individual's goals, wishes and choices (NHSScotland 2013). It's also about collectively managing risk by working with individuals to help them adopt a 'thinking ahead' approach to have greater control in the event of a flare up of their condition or carer crises.

Within the context of palliative care where the person's condition is expected to deteriorate, the term anticipatory care fits under the umbrella of advance care planning. The aim of advance care planning is to develop better communication and recording of decisions, thereby leading to provision of care based on the needs and preferences of patients and carers.

Problem

The results of an NHS Lanarkshire review of Health and Social Care pathways for the over 65 year olds (June 2013) showed that there was little evidence of anticipatory/advanced care planning and that had this been in place as an alternative, a number of hospital admissions could have been avoided.

An evaluation of Phase 1 of the ACP project in Lanarkshire also showed:

- A lack of relevant knowledge and skills by health care staff, patients and carers to effectively undertake self-management (red flags/alerts) and condition management (GPs) steps to avoid unnecessary acute admission
- Unnecessary admissions which could have been avoided if symptoms or changes in health condition or patient needs had been met earlier thereby de-escalating any deterioration at an early stage
- The above factors causing undue demand and therefore increased workload on acute services and staff with subsequent impact on efficiency and costs and negative impact on patient and carer experiences
- Evidence from patients and carers of a negative patient and/or carer experience following a change or deterioration in health, with dissatisfaction being expressed with regard to lack of dignity and respect shown to individuals and ignorance of preferred wishes and choice

Aim

To firmly embed ACP into practice using improvement methodology approach.

ACP is a collaborative, person-centred self-management approach to facilitating control and choice in personal health. In Lanarkshire, we introduced ACP to improve patients' experiences by respecting individuals' preferred wishes and goals for their care, reducing avoidable admissions and reducing length of hospital stay.

To establish project key performance indicators (KPIs) and track patients in, through and out of hospital, using care homes in the Monklands Hospital catchment area as a focus for the initial work.

Action taken

.....

- The development and introduction of an ACP, guidance notes on the use of ACP for health and social care professionals and an information leaflet for families
- The introduction of ACP throughout the 84 care homes in Lanarkshire, within community nursing, within GP practice, our acute hospitals, carer networks and patient advocacy groups
- Introduced training for ACP champions within care homes to ensure sustainability, identification of ACP champions in the acute division and wider carer groups
- Promotion of ACP at a variety of stakeholder events, multi-agency learning and sharing events, and the introduction of ACP within post graduate educational programmes
- Tracking and follow up patients referred to hospital via the ERC (Emergency Response Centre) who either have, or could benefit from an ACP
- DVD developed to demonstrate the interaction between a service user and service provider during the anticipatory care planning process – used for education purposes/wider promotion of ACP process

Results

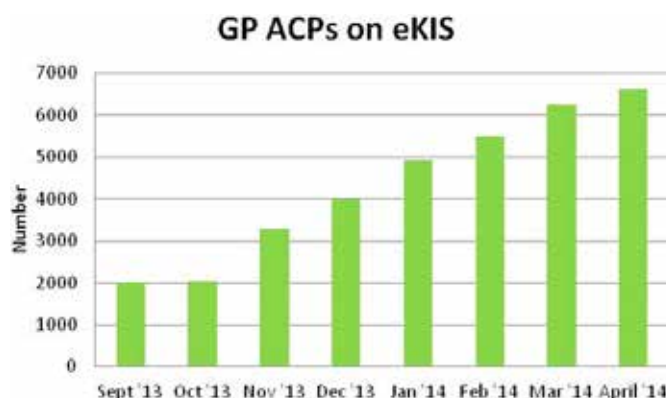
.....

A significant increase in the number of ACPs being shared by care homes in Lanarkshire

Please refer to graph on [page 63](#).

Increase in sharing and communicating relevant care home ACP information with GP practice from baseline

Improved communication of patients preferred wishes/key information available to health care staff at point of need or at change in care needs.



Voice of the customer and employee feedback:

- *"Residents who have completed an ACP with their family, have done so in the knowledge that their wishes are valued and respected"* (care home staff)
- *"An ACP is very beneficial to patients, carers and those that are involved in their care"* (care home manager)
- *"Our resident came back from hospital recently and the ACP had been updated by staff on the ward this is an example of good communication with regard to person-centred care"* (care home manager)
- *"We have engaged with service users and their families in an attempt to promote the advantages of ACPs in a more positive way... We have initiated a programme of ACP training within our home which is proving to be successful."* Feedback from ACP questionnaire (care home manager, North Lanarkshire)
- *"ACP is recognition of empowerment for all our residents. We need to ensure choices and preferences are recognised"* (care home manager, Lanarkshire)
- *"Anticipatory Care Planning made me think about my own health and writing down my preferences and wishes gave me a feeling of control. This enabled discussions with my partner with regards to my health needs and the relevant signs and symptoms to look*

out for which may indicate a change in my condition” (service user)

- “Completing an ACP is like a wakeup call to take ownership of my own health and inform others with regard to my wishes/choices” (service user/patient advocacy)

Efficiency savings and productive gains

.....

The table below shows data from the audit of residents from participating Care Homes (n = 73) in the Monklands Hospital catchment area who avoided hospital admission as a result of an ACP being in place i.e. remained in their preferred place of care. The audit began in January 2014 and is on-going on a monthly basis.

	No. of patients	* Ave LoS (days)	Cost per day (£)	Occupied bed days	Cost avoidance
Jan 14	38	5	350	190	66,500
Feb 14	20	5	350	100	35,000
Mar 14	16	5	350	80	28,000
Apr 14	18	5	350	90	31,500
May 14	30	5	350	150	52,500
Total	122	5	350	610	213,500

*NB: Average Length of Stay – 5 days at £350 per day

(<http://www.isdscotland.org/Health-Topics/Finance/Costs>)

Sustainability

.....

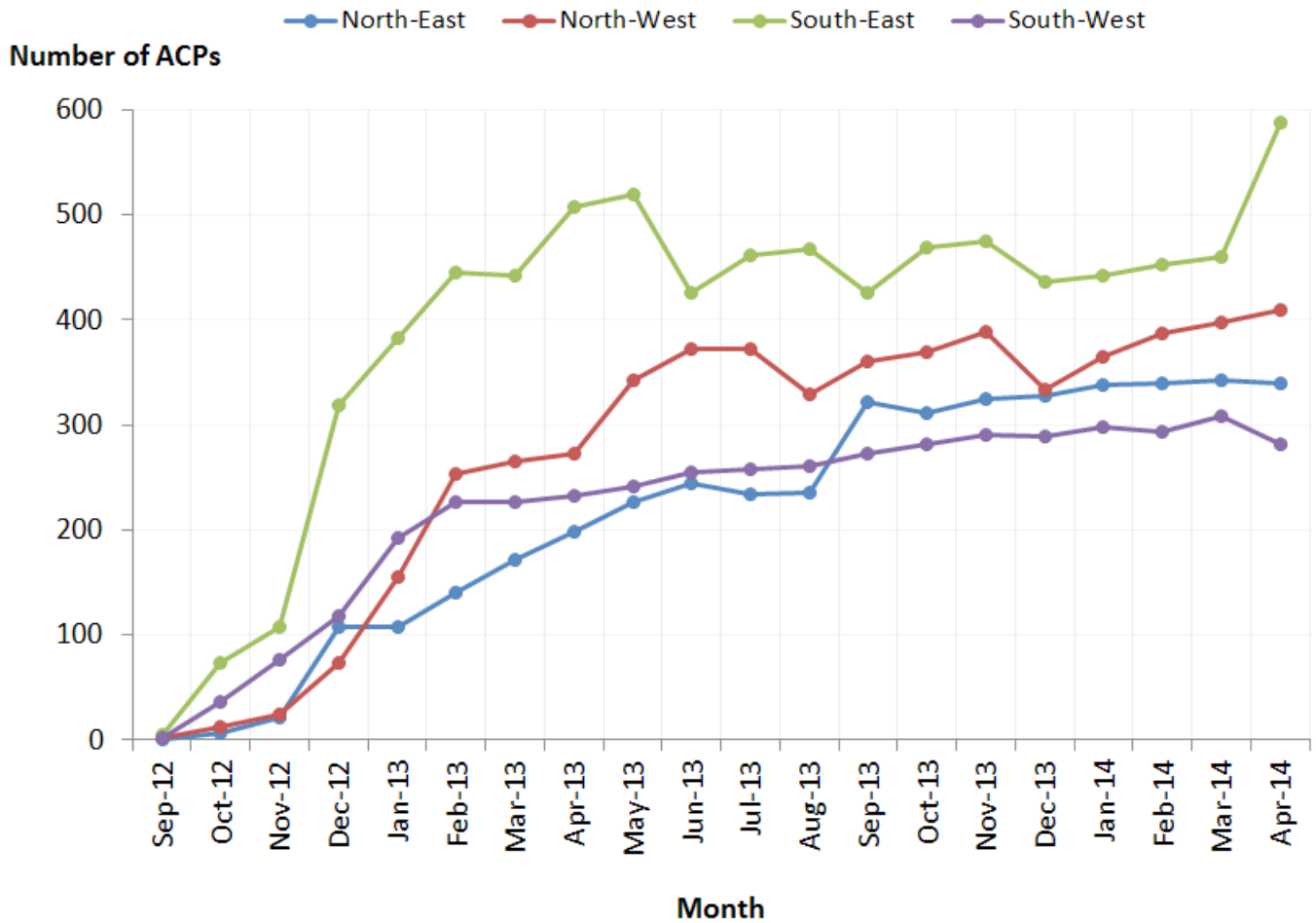
Whilst there has been very significant progress in embedding ACP within NHS Lanarkshire, it is acknowledged that further work is required to ensure that the necessary infrastructure is in place to sustain the ACP ethos. The necessary elements to ensure that ACP is sustainable have been identified and are being implemented in phase two of the project. ACP champions have been identified and trained in both the care home, community and secondary care sector and they will be a cornerstone for ensuring sustainability in the future.

Lessons learned

.....

- Remember to factor in time – cultural change will not happen overnight
- The goals of staff/patients/carers/stakeholder groups all vary even though the overall objective is shared – adapting to change needs to take cognisance of individual and group priorities
- Resistance to change/barriers – can be overcome once benefits are realised
- Momentum for change builds once benefits become demonstrable – difficult to plan ahead for resource needed to deliver the improvements once late adopters come on board (i.e. difficult to predict pace of change and demand for support can outstrip the initial planned capacity to deliver it)
- Relying on external partners to collect and report performance data to quantify benefits is problematic.

Number of NHS Lanarkshire ACPs in Care Homes



ACPs Signed off by GPs in Care Homes





MENTAL HEALTH

ABOUT THE PROGRAMME

Mental Health

Fiona McMahon

t: 0141 2420317

e: fiona.mcmahon@scotland.gsi.gov.uk

Focus on Dementia

Amanda Johnson

t: 0141 2421237

e: amanda.johnson@scotland.gsi.gov.uk

Michelle Miller

t: 0141 2425643

e: michelle.miller@scotland.gsi.gov.uk

drivers

- Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services. Early action is more likely to result in full recovery and in the case of children and young people will also minimise the impact on other aspects of their development such as their education, so improving their wider social development outcomes.
- Mental Health Strategy for Scotland: 2012–2015
- Scotland's National Dementia Strategy 2013–2016

aims

- Support NHS Boards to deliver a maximum waiting time of 18 weeks from referral to treatment for psychological therapies and Child and Adolescent Mental Health Services (CAMHS) by December 2014.
- Establish a National Dementia Care Improvement Programme to support services in their work to improve the care and treatment provided to individuals with dementia and their families.

workstreams

- Mental Health
 - Psychological Therapies Referral to Treatment
 - Child and Adolescent Mental Health Services Referral to Treatment
 - Effective and Efficient Community Mental Health Services

- Dementia
 - Timely Diagnosis
 - Post Diagnostic Support
 - 8 Pillar Post Diagnostic Support Test Sites
 - 10 Key Actions in Acute Care
- Using Data to Drive Improvement (an enabling workstream supporting the two main workstreams)

achievements 2014

- The Improving Access to Psychological Therapies: Early Implementer Event was held in May 2013. The aim of this national event was to share key lessons learned from the DCAQ Early Implementer work by QuEST and NHS Lothian and to provide an opportunity for those doing similar work in NHS Boards to consider the implications for their own workstreams.
- The Improving Efficiency Without Compromising Quality Event was held in October 2013. This event, jointly hosted by NHS Education for Scotland, focused on delivering the Psychological Therapies HEAT Target.
- Finalisation of the Effective and Efficient Community Mental Health Services (CMHS) Toolkit which provides guidance on application of improvement methodologies in the CMHS setting. This reference toolkit was coproduced with NHS Boards and is available at the QI Hub website.
- Dementia Post Diagnostic Support (PDS) One Year On event was held in March 2014 and resources from that day are available on the QI Hub website.
- Delivered a series of WebExs on a variety of topics such as: planning and running activity audits, using CORE-Net and information flow mapping.
- Developed the Mental Health Data for Improvement Network running workshops on run charts and SPC charts.
- Provided ongoing support to Health Boards around Psychological Therapies, CAMHS and Dementia.

All resources are available on the QuEST Mental Health section of the QI Hub Website.

priorities 2015

- Supporting NHS Boards to deliver a maximum waiting time of 18 weeks from referral to treatment across psychological therapies and CAMHS by December 2014 through:
 - enabling the use of system improvement techniques in mental health including Demand, Capacity, Activity and Queue theory
 - ensuring clinical outcomes and service user experience data are routinely used to drive improvement
 - developing and implementing mechanisms to monitor overall risk to delivery and highlight to the Mental Health Delivery Team Boards where risks are elevated
 - developing the Mental Health Data for Improvement Network.

- Leading the development of the National Dementia Care Improvement Programme by working with a range of partners to ensure a programme of support is designed and initiated that will enable local health and social care services to:
 - Ensure individuals receive a timely diagnosis
 - Provide person-centred post diagnostic support to ensure future care provision is in line with the person's own wishes
 - Test the 8 Pillars post diagnostic support model to Improve dementia care in acute hospitals
- Using data to effectively drive improvement – leading effective programme closure for the National Dementia Demonstrator sites, working with a range of partners including the Health Economics Research Unit (HERU), Integrated Resource Framework (IRF) Team, Information Services Division (ISD), Blake Stevenson, Joint Improvement Team (JIT) and the sites to produce both site level and national evaluation reports.
- Designing and implementing an effective spread strategy – supporting NHS Boards to release efficiency and productivity savings in mental health services whilst maintaining or improving the quality of care by developing the second edition of the Effective and Efficient Community Mental Health Services Toolkit.
- Providing performance support as required.



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/mental-health.aspx>

Programme Case Study

Testing the “8 Pillars” Model of Community Support

Background and context

In June 2013, Scottish Government and the Convention of Scottish Local Authorities (COSLA) published Scotland’s second 3-year National Dementia Strategy. A major part of implementing the strategy is supporting better community-based, integrated health and social care (including housing) support for those people whose dementia has advanced to the extent that they need intensive interventions to stay living at home for as long as possible. This will increasingly take place within the context of local partnership work to develop joint commissioning plans that seek to shift the balance of care towards community-based support, as part of service re-design to provide better integrated care and support.

Commitment 3 of the National Dementia Strategy is intended to complement this partnership activity and states that the Scottish Government will, in partnership with the Joint Improvement Team (JIT), COSLA, Scottish Social Services Council (SSSC) and Alzheimer Scotland, test and evaluate a range of approaches to providing better integrated care and support, on the basis of Alzheimer Scotland’s “8 Pillars” model of community support.

This partnership approach, which forms part of the Focus on Dementia Programme, is testing this innovative, world-leading, model which focuses on improving the support and care for people with dementia and their carers.

Problem

There are currently around 80,000 people with dementia in Scotland and this number is set to double in the next 25 years. Currently around 36 per cent of people with dementia receive their care in an institutionalised setting (this can be as low as 10 per cent in other countries such as Japan).

The current model of care is not sustainable. People with moderate to severe dementia need to be supported to stay at home for as long as possible with high quality support which helps to avoid the need for hospital admission and institutionalised care.

People with dementia currently receive a minimum of one year post diagnostic support with a link worker to enable them to move to a period of self-management. However, as people with dementia deteriorate and dementia becomes more severe they are often admitted to hospital or care home due to crisis. The “8 Pillars” model provides a comprehensive, integrated, coordinated approach to support people with dementia and their families and carers. By tackling a full range of factors that influence the experience of the illness in a coordinated way, this work takes a therapeutic approach to enhancing the resilience of people with dementia and their families and carers; equipping and supporting them to cope with the symptoms of the moderate to severe stages of the illness.

Aim

The aim of the Focus on Dementia Programme is to improve experience, safety and coordination of care for people with dementia, their carers and staff by January 2016, through testing and evaluating a range of approaches to providing better integrated care and support in the community using the “8 Pillars” Model.

The Programme will:

- Test different models and approaches to delivering the key role of the Dementia Practice Coordinator within the “8 Pillars” model

- Assess the costs and benefits of implementing the “8 Pillars” model including the Dementia Practice Coordinator role.
- Better understand which groups of individuals might benefit from a Dementia Practice Co-ordinator and demonstrate those benefits in practice in test sites
- Assess the helpfulness of the other seven pillars in directing the development of integrated care and support and, where appropriate, develop a better understanding of the distribution of need/ demand across each of the pillars
- Engage wider community planning partners in testing how their services can contribute to the other seven pillars through responding better to the needs of people with dementia.

The output of the programme will be used to inform the Dementia Strategy for 2016.

Action taken

.....

The Focus on Dementia Programme has established a series of learning sessions, WebEx calls, peer support and improvement expertise:

- An introductory event was held in January 2014, to enable test site teams to meet each other and to learn from other related dementia workstreams, including dementia demonstrator sites and post diagnostic support test sites.
- A Knowledge and Skills Needs Analysis has been carried out to identify individual requirements in order to design effective support for individuals and teams.
- To date, four out of eight planned national learning sessions have been held (each learning session focuses on one of the pillars). Learning sessions have been supported by WebEx calls to ensure continuous engagement and shared learning.

- A ‘Managing Qualitative Data’ session was held in September 2014 to build capacity and capability in this area.
- Test site visits, telephone support calls and tailored educational sessions have been made available to support test sites. In addition, JIT Associates also provide ‘critical friend’ support to the test sites and attend and contribute to local steering groups.
- Existing change package material including the Post Diagnostic Services test sites toolkit is available for test site teams to use and adapt to fit with their local context.
- Funding for improvement capacity locally has been made available to test sites.
- External evaluation is currently being commissioned to work closely with the test sites to support the evaluation of the different models.
- A measurement framework, change package and qualitative data framework has been developed and test sites are beginning to gather both quantitative and qualitative data from people with dementia, carers and staff.

Results

.....

- Each of the five test sites have identified a Dementia Practice Coordinator who will ensure access to the other seven pillars of support on an on-going basis as appropriate to each individual, and will coordinate between all the practitioners delivering care, treatment and support.
- Each of the five test sites have submitted flash reports and driver diagrams to share learning, progress, highlights and challenges.
- Data collection to provide evidence of improvement has commenced at each of the five test sites.
- Evaluations from the learning sessions held to date demonstrate an increase in knowledge and understanding of the

pillars within the “8 pillars” model, and improved knowledge and understanding of improvement methodologies. Delegates have valued the opportunity to share learning with the other test sites.

- As a result of attending Learning Session 3, on average 89% participants believe their knowledge and understanding of a variety of therapeutic interventions had improved.
- As a result of attending the Managing Qualitative Data session, 100% of participants believe their understanding of how to analyse and report on personal outcomes data had improved. Participants also reported increased confidence in their ability to do this.
- The following qualitative feedback has also been received:
 - *“Thanks for the opportunity to attend a really interesting day - I will use the learning in many areas of my work.”*
 - *“Good day, time well spent.”*
 - *“All really positive, energising and uplifting.”*
 - *“Good wide ranging exploration of the variety of specific interventions, encouraging open mindedness in this respect.”*

Person with dementia/ carer experience

Whilst it is too early in the programme to have evidence of improved outcomes, improvements are anticipated in the following areas:

- Improved experience – both people with dementia and their carers should have increased satisfaction with the service received. What is important to the person with dementia is central to their personalised plan. Carers feel supported in their role.
- Improved safety – crises should be averted and/or managed leading to reduced emergency call-outs, reduced

A&E attendance and reduced emergency admissions. People with dementia and their carers feel safe.

- Improved coordination – People with dementia and their carers have access to the right support at the right time. It should be easier to access multiagency interventions (with fewer steps required to access support). The experience of working across a range of professions and services should be improved, with effective partnership working arrangements, processes and shared responsibility. People with dementia and their carers feel responded to.

Staff experience

Whilst it is too early in the programme to have evidence of improved outcomes, improvements are anticipated in the following areas:

- Improved experience – staff should have the necessary skills and support in order to deliver the highest quality care.

Efficiency savings and productive gains

Whilst it is too early in the programme to have evidence improved efficiency, benefits are anticipated in the following areas:

- Through averting/managing crises there should be a reduction in emergency call-outs, A&E attendances and emergency admissions. As such time should be released that can be used to deliver care elsewhere.
- There should also be a reduction in the number of preventable GP contacts (it is noted that people with dementia may have multiple comorbidities which necessitate frequent GP attendance which is unavoidable).
- By shifting the balance of care into the community, ensuring that people with dementia can stay at home for longer, the number of care home admissions should also be reduced.

Sustainability

.....

The programme will test the model until 2016 when a recommendation will be made about whether it should be rolled out across Scotland or modified to ensure spread and sustainability.

Lessons learned

-
- Partnership working has been key to the success of the Programme to date. Working with people with dementia, carers, staff and key agencies (JIT, COSLA, SSSC and Alzheimer Scotland) has enabled relationships to be built and has provided a richness to the work.
 - Evaluation planning should be undertaken from the start of a programme to ensure this is embedded in the programme from an early stage.

Next steps

-
- Learning session five focused on the General Care Health and Treatment pillar will be held in February 2015
 - Test sites will continue to gather and report data
 - An interim report on the work will be published in May 2015

NHS Board Case Study

NHS Dumfries and Galloway

Outcome Measures and Qlikview Connection

Background and context

Previously very little outcome measure data was collected. It was essential to collect data on the efficiency and effectiveness of clinicians.

Problem

Engaging staff to collect data and complete “even more paperwork” was the main challenge. It was crucial to be able to produce meaningful data quickly to prove the benefit of the data. Being funded to employ an assistant psychologist dedicated to this project allowed sufficient planning, training and support during the initial set up. This assistant is reporting manually to clinicians until the Qlikview data is ‘live’. He is training staff, both psychologists and other teams, i.e. occupational therapists, inpatient and community nurses. These teams are starting to collect data in a comparative fashion. This assists in the development of other DCAQ work.

Aim

To demonstrate the effectiveness of the psychological intervention to all stakeholders, as well as utilise data for reflective practice, management purposes and service planning, and professional development. To monitor the service aim that the throughput of the department is efficient as well as effective.

Action taken

Data has been collected for one year now. (Not all the data has been entered yet due to the previous assistant being accepted on a course and delay in recruiting to the vacancy).

Work has been undertaken with IT to enable the creation of the data via Qlikview which in the longer term will save on analysis time.

We are just about at the stage where we can use the data:

- for reflective practice via individual reports
- for governance purposes related to the quality of service provided
- to consider development needs of clinicians
- to highlight areas for service development
- to inform the targeting of resources to enhance quality.

Results

Staff have been impressed by the amount of data we can now easily report on.

The next stage is to develop routine individual and aggregate service reports and organise access for managers and clinicians to live data which can inform development review, individual reflective practice and highlight service quality issues requiring strategic planning.

Efficiency savings and productive gains

The next stage will be to review efficiency and productivity gains such as identifying where we are most effective and to shape working practices as well as guiding individual and service development plans. Qlikview reporting will streamline this process, allowing for live data and a growing evidence base.

Sustainability

Sustainability is an issue as in the longer term we will not have funding for an assistant psychologist.

Qlikview will help towards the sustainability of the data analysis.

We are just about to pilot electronic data entry by clinicians of one small team. If this is successful, it would remove the longer term need to have someone manually entering data.

Lessons learned

.....

- Having an assistant psychologist dedicated to implementing the project has been a key factor in the success so far.
- Data entry has been more time consuming than anticipated.
- It was essential to have a structured programme of training for clinicians to ensure engagement of those completing the data collection.
- Having an assistant psychologist to scrutinise the data for anomalies/errors close to the time of clinician data recording on paper is crucial, since missing data can easily be retrieved from currently open files.
- Value of Qlikview for timely reports for efficiency/quality monitoring.
- Potential for usefulness of data produced to:
 - Identify training needs
 - Focus on areas most efficient - identify where not so efficient and work out why
 - Look at outcomes with clients from particular referring agents and action feedback to them if there are referrer-specific patterns. Also value for informing wider service training needs, outcome patterns per type of problem, clinician training needs.
- In relation to the HEAT target, potential to understand pattern of resources needed to achieve certain outcomes with certain problems (e.g. look at patterns in numbers of sessions offered using different models for same problem – would any more resource be more efficient than others?)

NHS Board Case Study

NHS Greater Glasgow and Clyde

Achieving and Sustaining CAMHS Referral To Treatment HEAT Targets

Background and context

NHS Greater Glasgow and Clyde (GG&C) Specialist Children's Services established a programme of work to deliver the 26 Week Referral To Treatment Target for access to Child and Adolescent Mental Health Services (CAMHS) by March 2013 and the future target of 18 weeks by December 2014.

The programme was designed to deliver improvement in the waiting times for CAMHS services at Tier 3 as well as improving the patient journey and service provided to ensure consistency across NHS GG&C CAMHS teams.

Problem

In order to achieve the RTT targets within current resources, and faced with excessive waiting times as part of the work to redesign and develop the NHS GG&C CAMHS Service Framework, a number of key areas have been identified for improvement:

- Gaining a better understanding of our demand and capacity within teams and the projected capacity within our new CAMHS workforce model by introducing Lean methodology.
- Improving service efficiency, by improving our referral and administrative processes within teams.
- Reducing the inequalities in access,

structure and quality of service delivery and reducing the variations in workforce and practice across NHS GG&C CAMHS teams.

- Delivering quality outcomes as defined by children and families.

Historically NHS GG&C CAMHS had significantly long waiting times from referral to treatment. The graph below demonstrates the problems which were faced in 2010 and 2011. In April 2010, the longest wait for RTT was 123 weeks and this figure remained extremely high until nearer 2012.

Please refer to the graph on [page 75](#).

As shown, the data has been improving since 2010 and this will be focused on later in this case study.

Aim

To achieve sustained improvements to access CAMHS for children and young people consistently across NHS GG&C, whilst achieving Referral to Treatment Heat Targets.

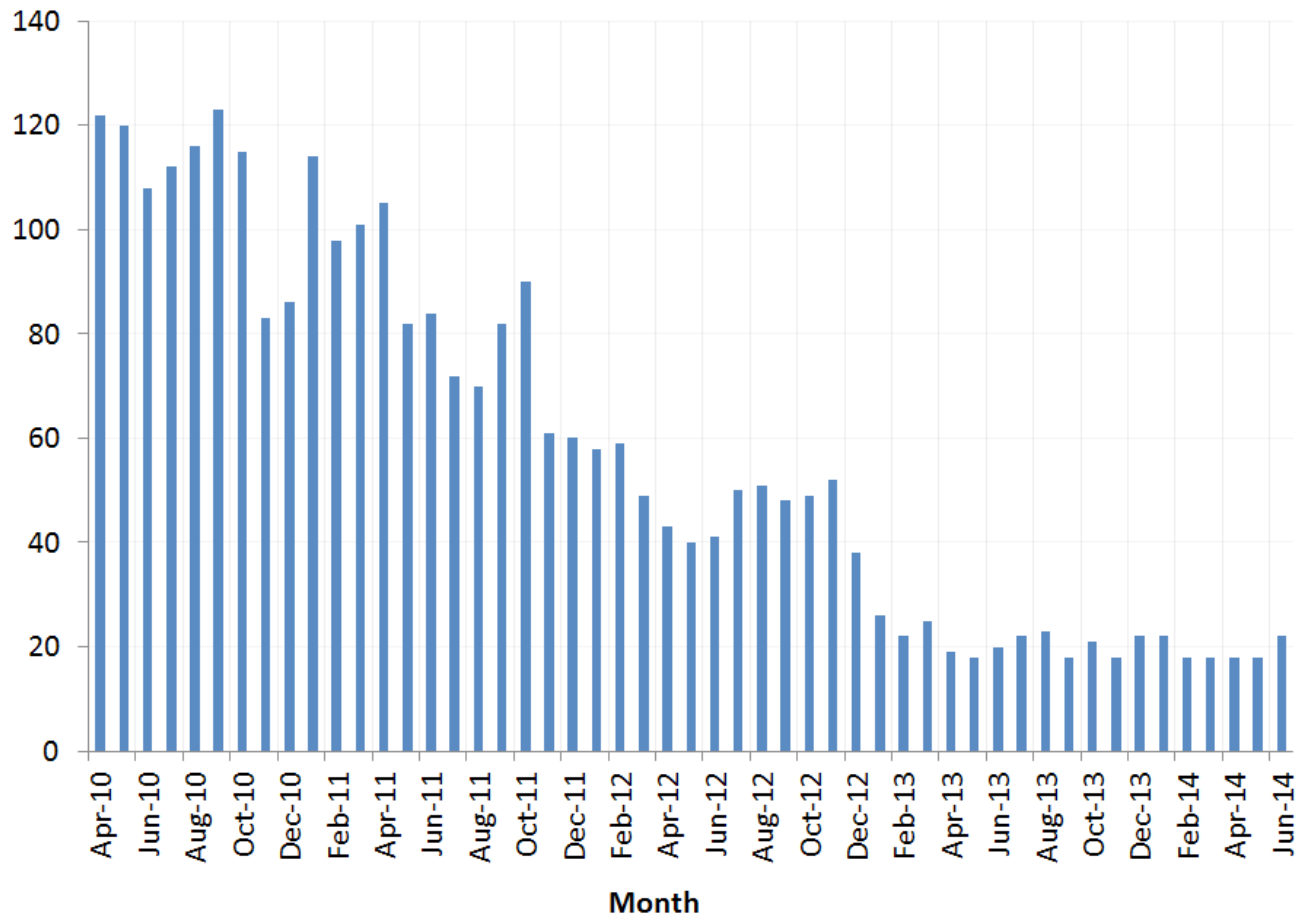
Action taken

Within the programme of work and redesign of the NHS GG&C CAMHS Service Framework, key overarching workstreams have been identified as being central to the achievement of the RTT targets and the development of the areas indicated as problems:

- Implementation of CAPA (Choice and Partnership Approach) as our Lean Methodology for managing demand and capacity in all NHS GG&C CAMHS teams.
- Established robust information and data collection systems within teams and performance reporting and monitoring purposes consistent across NHS GG&C.
- Establishing CORC (CAMHS Outcomes Research Consortium) as our Clinical Outcomes Measurement Tool.
- Reviewed our business processes and administration support.
- Development of the above processes as part of a single patient management system (EMIS Web project requirements).

Longest Wait RTT (2012 - 2014)

Longest Wait (Weeks)



Results

Over the past three years, we have seen dramatic improvements as a result of the above work. For instance, in January 2011, the longest RTT wait was 113 weeks. This figure has been reduced to below 26 weeks by March 2013 target and continues to decrease toward the 18 weeks target in December 2014. The graph on [page 78](#) demonstrates this.

In the graph, there is a noticeable decrease in waiting times and numbers waiting over 26 and 18 weeks. However, the increased accepted referral trend stands out.

It is clear that the data produced from this work demonstrates excellent results, allowing CAMHS to accept a larger demand, whilst drastically improving access to service.

Efficiency savings and productive gains

Throughout the time period shown in the data, there has been no increase in resource to NHS GG&C CAMHS. Efficiencies have been realised through the use of CAPA and the informatics which accompany this model.

Looking at the accepted referral statistics, there has been a 223 per cent increase in accepted referrals since January 2011 to its peak in March 2014. Analysis shows that this increase is not necessarily due to re-referrals as our re-referral rate is currently at 21 per cent which is standard to NHS England CAMHS and CAMHS in Ireland and Australia.

It is likely that this increase is due to various reasons. For instance, it is clear from analysis that there has been an increase in referrals sources as professionals become more aware of the service. Coupled with the third party organisations decrease in activity and funding, CAMHS have seen an unprecedented increase in demand.

The graph on [page 78](#) demonstrates the trend against the average monthly accepted referrals. There is a clear positive trend overall and we can see some prolonged bias in the most recent 17 months of data.

The data highlights that the workforce is now operating much more efficiently than it has done before with no extra resource. This data will continue to be monitored, and further efficiencies will be sought with assistance from the current data and future analysis.

Sustainability

The programmes of work are intrinsically linked and the benefits of achieving these will ensure the following:

- Ensure we continue to meet the 18 week CAMHS RTT target
- Support full implementation of CORC across NHS GG&C CAMHS
- Ensure the quality of data for performance and reporting for HEAT targets and internal performance and monitoring purposes
- Continuous service improvement through robust performance and monitoring, and improved access to services and quality of care for children and young people and their families
- Streamlined business process for CAMHS
- On-going implementation/training of EMIS Web Patient Management System across CAMHS

Lessons learned

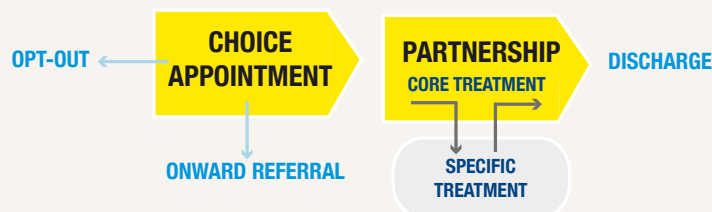
One of the main lessons learned is to increase the awareness of the success in CAMHS. In June, we submitted a poster presentation to the NHSScotland Event with details of the methodology and data analysis used to improve CAMHS waiting times. This poster won 1st place in the Effective category and an award was presented to CAMHS and SCS Management by the Cabinet Secretary for Health and Wellbeing.

A copy of the poster is shown on [page 77](#).

IMPROVING ACCESS AND INCREASING EFFICIENCY OF SERVICE DELIVERY

A CHOICE AND PARTNERSHIP APPROACH

In order to reduce waiting times and improve access to Child and Adolescent Mental Health Services, a lean referral methodology (Choice and Partnership Approach) was implemented across NHSGCG Specialist Children's Services. This tool would improve the patient journey, whilst also ensuring capacity would meet demand for service.



WHAT IS THE CHOICE AND PARTNERSHIP APPROACH?

CAPA brings together:

- The active involvement of young people and their families
- Demand and capacity ideas
- A new approach to clinical skills and job planning

Services can then:

- Do the right things (have a clear working goal with the family and the young person)
- With the right people (use clinicians with the appropriate clinical skills)
- At the right time (without any external or internal waits)

It is:

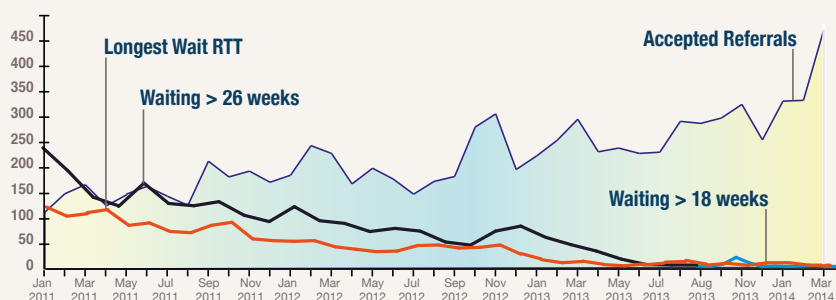
- Flexible
- Can be tailored to fit individual services

CAPA improves services to users by:

1. Focusing on engagement, therapeutic alliance, choice, strengths, goals and care planning
2. Improving access by ensuring timely appointments that are fully booked i.e. no vacant appointments
3. Ensuring users are seen by a clinician with the right skills
4. Use of Outcome Measures
5. Facilitating commissioning and provision of CAMHS by transparency of capacity and services

STRUCTURE:

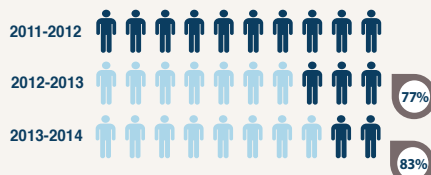
As in the CAPA diagram (above), 'Choice' is an assessment appointment. 'Partnership' is the first appointment in a series for treatment.



METHODOLOGY

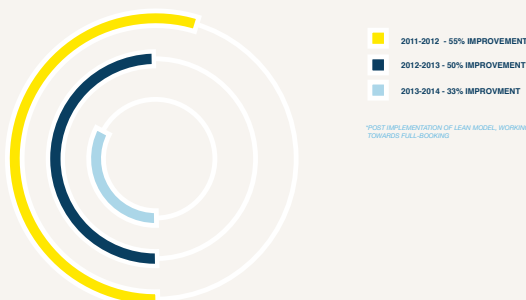
In 2009, the Choice and Partnership Approach (CAPA) was identified for implementation across Child and Adolescent Mental Health Service (CAMHS) in NHSGCG. The 'Choice and Partnership Approach' is seen as a more effective way of working which also lowers waiting times. The diagram demonstrates the flow. CAPA provides the structure and resource to provide safe services by reducing the risk involved with lengthy waits for treatment. The approach also encourages effectiveness in the service as improved referral process and patient journey. Further, the choice framework provides a culture within the service to ensure young people and their families have individualised care, making the service person-centred. This approach has been implemented across CAMHS teams and is currently operating effectively.

WORKFORCE



Throughout the previous 3 years, there has been no additional workforce resource. However, dramatic improvements have been achieved including assessing and treating children and young people much more quickly. This has been realised by increasing the efficiency of CAMHS teams by better use of clinical capacity and an improved internal process to remove duplicated steps in the patient journey. The diagram demonstrates the increase in workforce efficiency, by 77% in the second year to 83% in the third.

REFERRAL TO TREATMENT TIMES - IMPROVEMENTS



CONCLUSION

Accepted referrals have increased by over 200% in 3 years, which demonstrates improved access for young people with longest waits reducing from 113 weeks wait for treatment to less than 18 weeks. Alongside this, the CAPA lean methodology has increased the clinical and administrative efficiency of our teams leading to the service working towards the NHS Scotland Quality Ambitions. The service is person-centred through the choice element of CAPA, safe through the significant reduction in waiting times and effective in the improved and efficient patient journey, benefiting young people, families/carers and staff.

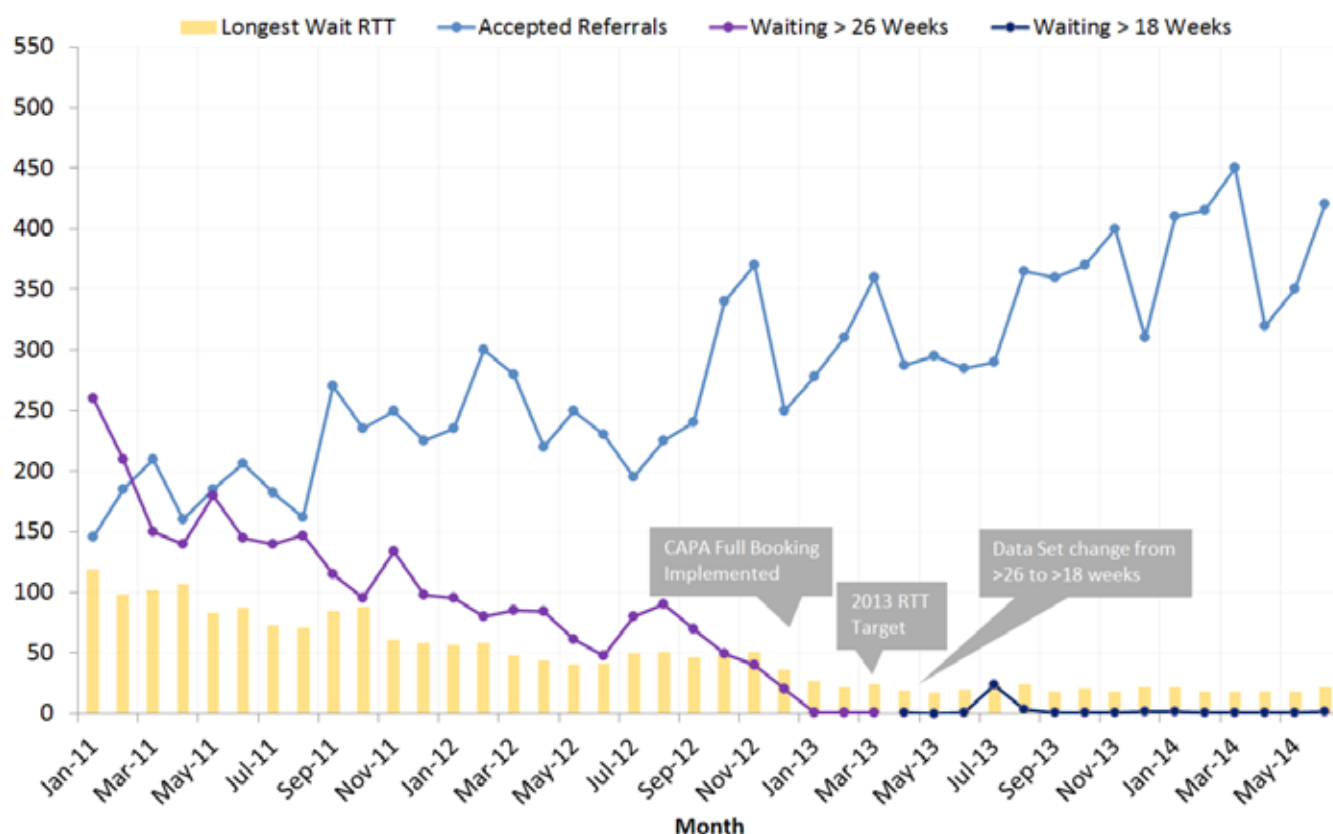
References:
York A, Kinsbury S. The Choice and Partnership Approach - A Guide to CAPA. UK: Caric Press Ltd, Bournemouth; 2009.

Julie Metcalfe, Clinical Director Specialist Children's Services
Scott Wilson, Senior Information Analyst
Louise Maxwell, Development Officer
Jacqui Wray, Development Officer
Neil Sugden, Development Officer
Lee MacPherson, Development Officer

NHS
Greater Glasgow
and Clyde

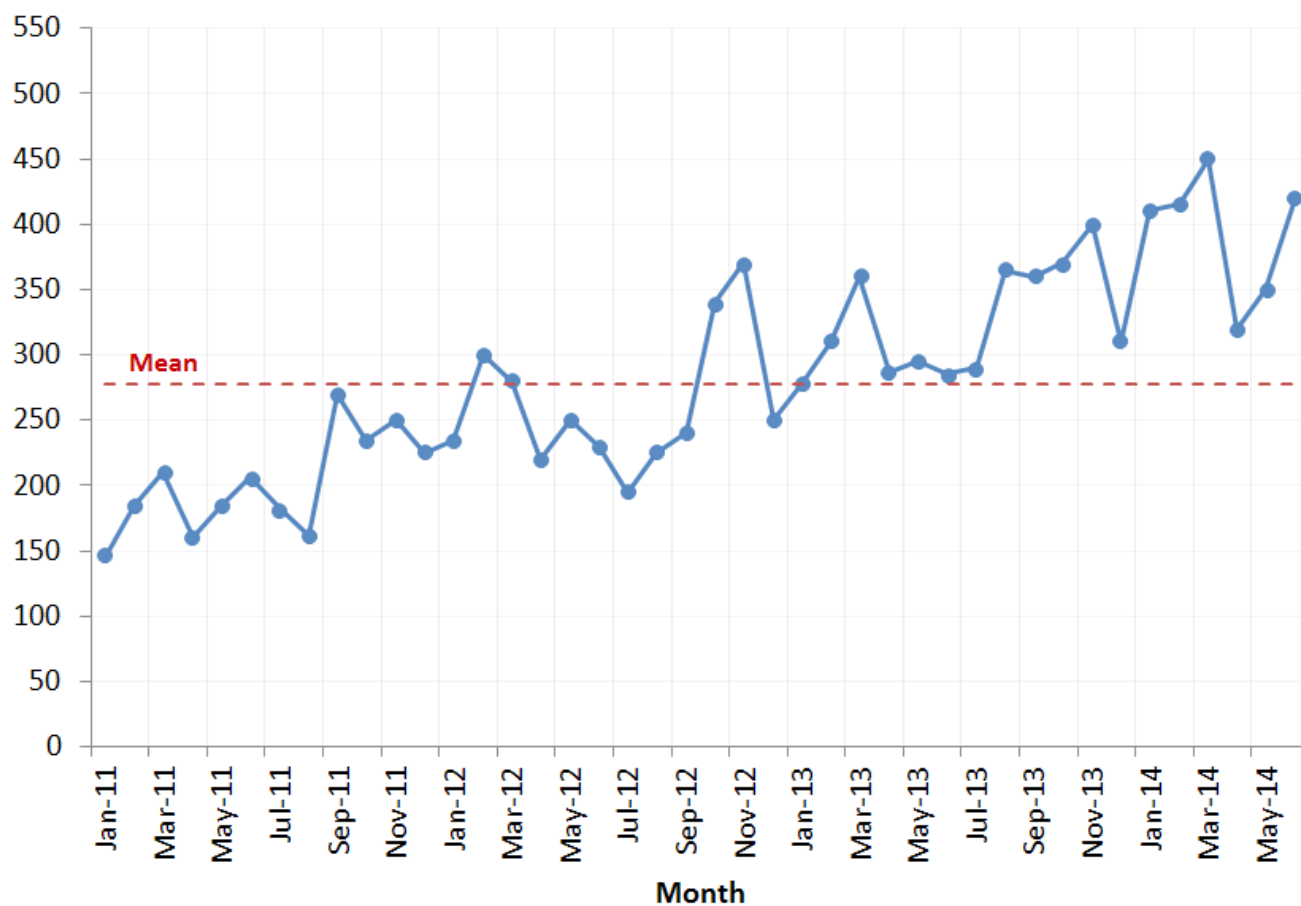
Specialist Children's Services

RTT Progress - CAMHS Greater Glasgow and Clyde



Trend for the Average Monthly Accepted Referrals

Number of Accepted Referrals



Improved Access to the Community Mental Health Team in Mid- Argyll

Background and context

The Community Mental Health Team (CMHT) in Mid-Argyll had a total of 109 clients being seen within the service in 2013. There were a further 23 clients waiting for their first appointment with the service – with the average wait being 34 weeks – and the longest wait being 58 weeks.

Problem

The CMHT is a small team comprising a core of five members supported by other specialists looking after clients from the geographic area of Mid-Argyll. There was variation in referrals into the service, and variation in the methods used to process referrals once received.

Case load triage on referral was via a single point, with 1st and 2nd stage triage being a completely manual process.

Clients were allocated in accordance with need, priority, specialty and available capacity (gender preference also a consideration).

There was variation in capacity of specialist team members to accommodate Mid Argyll referrals, due to their commitments in Kintyre and Islay.

Clients placed onto the waiting list were not offered an appointment until an existing client

was discharged from a team member's case load (if at capacity). There was variation in waiting time for first appointment.

Aim

To decrease the lead time from a client being referred into the service to the date of first appointment.

Action taken

We used a Lean Rapid Process Improvement Workshop (RPIW). This had a twelve week preparation phase, in which the scope of the work was agreed, and observations were conducted. Staff identified waste and completed ideas forms. A value stream map was produced and percentage load charts developed. In the RPIW week, staff from the service reviewed the service flows, and their ideas forms. They developed new ways of working including streamlining the current referral and triage process, and also undertaking 5S on equipment and rooms. Standard work was developed by the team and incorporated into an RPIW newspaper (action plan) which was supported by a series of standard process descriptions and a skills matrix (to support training and development requirements).

A visual display board was used to monitor progress of clients through the service, and the use of WebEx conferencing allowed team review sessions (weekly) to be joined by team members working from the Kintyre and Islay areas.

The referral and single stage triage process are now completely electronic.

Results

The average wait in the service was 34 weeks at the baseline measurement. Following the RPIW, the average wait slowly decreased to an average figure of 20 weeks at 90D.

However, at 365D the longest wait for first appointment is:

- Tier 1 – 2 weeks
- Tier 2 – 11 weeks
- Tier 3 / 4 – 7 weeks

Patient experience

.....

Clients are experiencing improvements in access to the service, which is benefiting from a team approach to their well-being.

Staff experience

.....

Some team members were apprehensive about the RPIW at the outset. The team excelled in the process, and have ‘shared and spread’ their work to other parts of Mid-Argyll.

Efficiency savings and productive gains

.....

No additional staff were required, although at the outset there was a belief that a further CPN would be needed to manage the caseload.

Waiting times have decreased from an average of 34 weeks to figures quoted in the Results section.

Sustainability

.....

- A sweep system was introduced for 5S.
- A visual control board was developed to allow staff to see their service status quickly.
- All staff now use electronic diaries, and all referrals are made into the service via SCI gateway.
- Staff are following Standard Work and effectively ‘Sharing and Spreading’ their success to other areas within Mid-Argyll.

Lessons learned

.....

The RPIW process, using Lean principles, was effective. There were implementation challenges related to staff concerns, and our main lesson was that service staff are the key agents of change, and need to be supported as much as possible. This demonstrated that understanding the boundaries of a process is important, and that changes outside the scope of the original work can take longer.



CANCER

ABOUT THE PROGRAMME

David Linden
t: 0131 244 3288
e: david.linden@scotland.gsi.gov.uk

drivers

Every year, about 30,000 people in Scotland are diagnosed with cancer and trends predict that the number is likely to rise to almost 35,000 in 2016-2020. The reason for this increase is that there are more elderly people in the population and life expectancy is increasing further.

Over the last 20 years, almost all cancers have shown improvements in survival five years after diagnosis and survival rates from cancer in Scotland are broadly similar to those in England and Wales.

The Cancer Programme focuses on three key areas:

- Sustaining cancer waiting times standards performance
- Cancer Modernisation: further improvements in the effectiveness, efficiency and patient centredness of service delivery
- Detect Cancer Early: contributing to and improving five year survival from cancer for the population of Scotland, through earlier diagnosis and treatment

aims

Over the last few years, cancer services have developed and improved significantly with more doctors, nurses and other healthcare professionals and state of the art equipment in all five cancer centres. The Scottish Cancer Taskforce Cancer Modernisation Programme aims to build upon the progress already made in effective and efficient cancer service delivery, further improving patient experience and patient outcomes, whilst managing the anticipated increase in cancer incidence.

The Detect Cancer Early Programme aims to increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25 per cent by 2015.

workstreams

- Cancer waiting times performance support
- Detect Cancer Early Programme
- Acute oncology service delivery, including development of national chemotherapy helpline
- Surgical oncology, including enhanced recovery after surgical treatment
- Radiotherapy, including the capacity and capability for radiotherapy treatment
- Transforming Care After Treatment Programme

achievements 2014

Cancer Waiting Times Standards Performance

- NHSScotland achieved and sustained performance above 95 per cent in all Cancer Performance Support quarters against the 31-day cancer access target throughout 2013.
- During the final quarter, October to December 2013, 94.6 per cent of patients started treatment within 62 days of urgent referral with a suspicion of cancer. Within the same period, 97.9 per cent of patients started treatment within 31 days of decision to treat, irrespective of the route of referral.
- The team continue to maintain scrutiny of cancer waiting times performance and are providing support to those NHS Boards where there are challenges to sustained above standard performance.

Cancer Modernisation

- The development and piloting of the 24-hour cancer treatment helpline.
- The Radiotherapy Programme Board (RTPB) was established in June 2012 to drive forward improvement work across Scotland. The RTPB reports to the Scottish Cancer Taskforce. A cohesive work-plan has been developed and implementation of the RTPB's objectives is supported by the wider Radiotherapy community. RTPB priority areas of work include:
 - Development of national pathways to ensure equity of access to new innovative techniques and technologies
 - Continued development of workforce capacity and capability
 - Development of evidence based consensus treatment protocols and pathways
 - Robust patient engagement to better understand and improve the experience of radiotherapy
 - Development of future models of working that meet the rising incidence of cancer and radiotherapy demand
 - Promotion of clinical trials and research, and the unique opportunities that exist within Scotland
 - Proactive commitment to exploring new technologies and techniques to ensure Scotland's radiotherapy programme is up-to-date and well prepared

- Collaboration with our NHS colleagues across all UK countries, and Europe, to better understand the cost-benefits of radiotherapy

Transforming Care After Treatment Programme

- The Transforming Care After Treatment (TCAT) Programme was launched in May 2013 and aims to ensure that people diagnosed with cancer are prepared for and supported to live with the consequences of the diagnosis and its treatment.
- To achieve this aim, Macmillan Cancer Support is working in partnership with the Scottish Cancer Taskforce and providing up to £5 million in funding over the next five years, supporting clinical teams and other partners to review, redesign and test new approaches and models of cancer care after treatment.
- The Programme focuses on redesign of current models of cancer follow-up, managing the transition between acute care and home, and enablement and support for effective self-management.
- It builds upon what has already been achieved in Scotland and other parts of the UK and also contributes to the delivery of the Healthcare Quality Strategy. The timing of this development coincides with a growing appetite for greater collaboration and mutuality across the public sector.
- The Scottish Cancer Taskforce will monitor progress of the programme to ensure that there is delivery against focused, evidenced outcomes that will inform ongoing commissioning of services.

Detect Cancer Early Programme

- Development and launch of priming, breast, bowel and lung cancer social marketing campaigns.
- Development of systems and processes for data collection to support the Detect Cancer Early HEAT target.
- Development and implementation of nGMS contract element to support the primary care contribution to increasing bowel screening programme participation and improvement.
- An e-health refresh of the GP referral guidelines for suspected cancer and progression of education sessions for primary care professionals.
- Funding to support diagnostic and treatment capacity building.

priorities 2015

- Sustain cancer waiting times standards performance
- Cancer Modernisation
 - Further rollout of cancer treatment helpline
 - Continue to support safe, efficient and patient-centred radiotherapy treatment delivery and Radiotherapy
- Programme Board work-plan
 - Support Transforming Care After Treatment project development and Implementation

- Detect Cancer Early
 - Develop breast screening social marketing campaigns
 - Support further lung, breast and colorectal campaign activity bursts
 - Support NHS Boards to build capacity in diagnostics and work towards HEAT target achievement
 - Continue to support development and implementation of cancer referral guidelines
 - Continue to support national nGMS bowel screening initiative
 - Programme evaluation
 - Explore potential for inclusion of further tumour types to programme



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/cancer.aspx>

Detect Cancer Early – Bowel Cancer

Background and context

The Detect Cancer Early (DCE) programme forms part of the work of QuEST's Cancer Performance Support Team.

The DCE programme was formally launched in February 2012 and aims to improve the overall five year survival rates for people in Scotland diagnosed with cancer.

The incidence of cancer in Scotland has increased over the last 10 years from 26,169 cases (2000) to 29,449 cases (2010) largely due to an ageing population. Individuals living in deprived communities have an increased incidence of cancer and a higher mortality rate.

The DCE programme has an associated HEAT target to increase the proportion of people diagnosed at stage 1 (as a proxy indicator of survival outcome) for the three most common cancers in Scotland – lung, breast and colorectal cancer. If successful, this initiative could save an additional 300 lives a year.

Problem

Bowel cancer is the third most common cancer in Scotland – every year, almost 4,000 people are diagnosed with the disease.

Although bowel cancer is common, it is also highly treatable if detected early – 9 out of 10 people beat bowel cancer when it is found early.

However, one issue that people face is the fact that the early signs of bowel cancer are often hidden – symptoms regularly cannot be seen or felt. The most effective way to detect bowel cancer in its earliest stage is through screening. This helps determine whether there is any presence of blood in stools, which can

indicate the presence of cancer cells, long before an individual or their doctor notices them. Figures show that 28.3 per cent of all cancers detected by screening are at the earliest stage, when it is easier to treat and the chance of survival is higher.

All men and women between the ages of 50 and 74 are invited to participate in the national bowel screening programme every year. Those aged over 74 can request a screening kit via the Scottish Bowel Screening Helpline.

Currently, just over half of the approximate 750,000 people who are eligible to participate in screening each year, actually do (54.5 per cent) with 57 per cent of that figure being women and 51 per cent men. Data shows that this figure falls into the thirties for men living in the most deprived areas of Scotland, who are more at risk of bowel cancer.

Aim

The overall objective of the Detect Bowel Cancer Early campaign was to increase uptake in participation in the National Bowel Screening Programme. To do so, social marketing had a key role to play in shifting behaviours by:

- Educating people that the best way to survive bowel cancer is to detect it early, by taking the bowel screening test
- Empowering those eligible for bowel screening to do so

Action taken

Approach

Evidence suggests that the main barrier to completing and returning a kit is the fact that people do not believe they are at risk of bowel cancer. This can be explained by a lack of understanding about the disease i.e. not knowing that your risk increases with age. Embarrassment around the subject matter and nature of the test also creates obstacles for people completing and returning kits.

In order to overcome these barriers and shift behaviours and beliefs surrounding one of Scotland's most common cancers, the social marketing approach had to be carefully considered.

Scale: In order to normalise bowel screening and generate conversations about the subject, in turn releasing the social stigma attached to it, a wide-spread, multi-channelled media campaign was needed.

Empowerment: While positioning bowel screening as the best way to detect the disease early, a person's decision to take part is a personal one. This had to be mirrored across all materials in order for the target audience to feel more engaged and informed about the issue.

Messaging: The campaign's core key messages had to be crafted to educate and empower the target audience about bowel cancer and the test i.e. 'bowel cancer is the third most common cancer in Scotland', 'bowel screening is the best way to detect bowel cancer early'.

Male skew: To overcome the embarrassment surrounding the subject matter, and appeal to the male-skewed audience, a touch of humour was carefully peppered in the creative brief.

Campaign

The Scottish Government's first bowel cancer campaign launched in February 2013 for six weeks. This was followed by an additional two phases of activity in September 2013 and March 2014 that both ran for one month.

Central to the campaign was a bold TV advert, featuring the voice of Scottish actor, Ford Kiernan. The advert used some humour and was based on the concept that Ford Kiernan was an invisible man, informing a regular guy on the toilet about the facts he didn't know about bowel cancer i.e. 'the early signs are often hidden'.

This was not the only time humour was used throughout the campaign to appeal to the male-skewed target audience. A 'poo song' was specially penned and orchestrated to increase talkability around the subject and encourage the campaign's key messages to be shared amongst the target audience and their influencers.

For the print creative, multiple executions were developed all carrying one of the core campaign messages:

- The early signs of bowel cancer are often hidden
- Nine out of 10 people survive bowel cancer when it is detected early
- The best way to find bowel cancer early is to do your home screening test

The channel being used determined the execution adopted. However, regardless of the execution, the call to action was clear and consistent – 'Bowel Cancer. Don't Take a Chance. Take the Test.' This was accompanied by the Scottish Bowel Screening Centre Helpline number and the campaign URL – www.bowelscreeningtest.org – that directed people to the screening zone on NHS Inform if they wanted/needed any more information about bowel cancer or the national screening programme.

A partnership engagement programme was also put in place, in order to reach more men with our campaign messages. Football clubs across Scotland were engaged and asked to publicly support the campaign and encourage their followers and fans to do the test when invited.

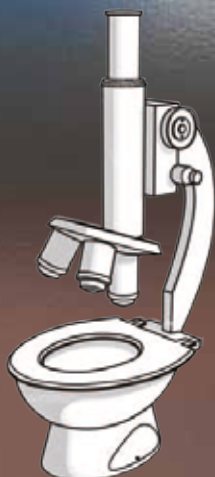
See example of press ad on [page 88](#).

Channels

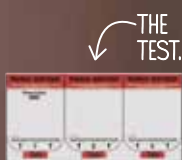
Our target audience are big consumers of commercial TV and trust the channel to deliver health messages. So, we used this medium to generate widespread awareness and create maximum impact, while landing more detailed campaign information. A 40-second-advert was broadcast alongside a 20-second version that featured a more detailed call to action, including details on who is eligible for the test and the phone number of the bowel screening helpline.

Press advertising was the main support to TV – a crucial channel in reaching the core DE male audience, while supporting a good spread of key messages to women. As well as

THE EARLY SIGNS OF BOWEL CANCER ARE OFTEN HIDDEN.



Bowel cancer is the third most common cancer in Scotland. But even your doctor can't see it in its early stages. So the best way to find it is to do a home screening test. Everyone 50 to 74 is sent one every two years. If you haven't done one in the last two years, you can ask about getting one by calling 0800 0121 833 or visit bowelscreeningtest.org



**BOWEL CANCER.
DON'T TAKE A CHANCE.
TAKE THE TEST.**



ads running across key national titles, helping maintain momentum and mass awareness, opportunities to further target men were explored where possible for example, placing an insert in the Racing Post or a campaign advert in the Scottish Cup Final programme.

Three different radio executions were developed – two carrying generic campaign messages from the TV advert while the third promoted a stronger, in-depth call to action. The same voice-over artists were however used to ensure the link between the two were made. These were aired across Scotland's key stations, weighted to peak listening times such as morning and drive-time shows when our target audience are more likely to be listening.

A targeted approach was taken to outdoor – small formats were used to upweight areas of high deprivation and low screening uptake, including:

- Lenticular posters (a message is hidden then revealed): Over 800 appeared in washrooms

in bars and clubs as well as in Rangers and Celtic football club stadiums.

- Toilet cubicles: 500 panels appeared in target areas.
- Bus headliners: Over 2,000 were placed in buses covering routes in Glasgow, Edinburgh, Forth Valley and Lanarkshire where screening is lowest.

Following the initial launch in February, we knew that in order to shift attitudes and foster social norming, regular bursts were needed. Two lower weight phases therefore followed – the first included TV while the second saw TV, radio, outdoor, press and digital rolled out.

Underpinning all campaign spikes was PPC activity, directing anyone searching for more information on bowel cancer to www.bowelscreeningtest.org.

All this activity was supported by field and PR. One-to-one engagement through field events took place in 60 locations across Scotland, with an emphasis on the East and West regions, where a high percentage of the population live in deprived areas, and are at higher risk of bowel cancer. Event staff also visited high attendance football matches where we were able to directly target and engage with large numbers of men.

Meanwhile, the PR team worked closely with key stakeholder, Bowel Cancer UK, to ensure that there was a drumbeat of bowel cancer media coverage landing throughout the campaign spikes and beyond. This included piggybacking on any reactive opportunities possible, for example organising a photocall with the Birds of a Feather cast when they were in town, to appeal to older women.

Results

.....

Overall, independent quantitative research shows positive shifts in behaviour amongst our target audience (45+ C1C2DE), for example:

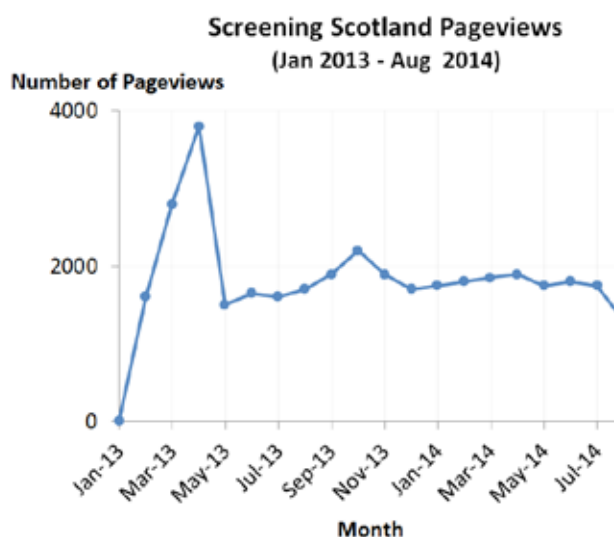
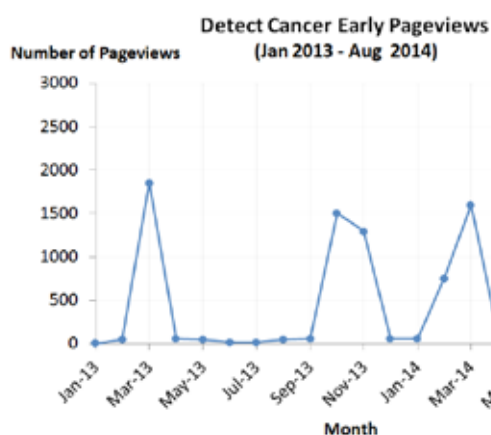
- Almost half (48 per cent) strongly agree that 'the best way to detect bowel cancer early is to use the home screening kit'. This is compared to just 31 per cent prior to the campaign going live.

- Almost three quarters (72 per cent) say they are very likely to do the test the next time they receive it, compared to 63 per cent before the campaign.

Alongside this:

- The number of helpline calls per 1,000 invitations saw a huge increase, compared to previous years, immediately following the first campaign spike (Feb 2013), with highs of a rate of 89 per 1,000.
- Data shows noticeable increases in replacement kit requests across 2013, with October seeing the biggest increase, compared with previous years, as a result of the second phase of activity (Sep 2013).
- Latest validated statistics from ISD show an increase in bowel screening uptake of 1.2 percentage points (56.1 per cent from 54.9 per cent) for the period November 2011 to October 2013.
- Uptake for females was 58.8 per cent and for males was 53.3 per cent.
- Uptake has increased across all deprivation quintiles with the highest increase in men in the most deprived communities (2.1 per cent increase)
- Uptake for females in the two least deprived quintiles exceeded the 60 per cent standard at 68.0 per cent and 64.8 per cent, respectively. Uptake for males living in the least deprived quintile was at 61.5 per cent. For males living in the most deprived quintile the uptake was 41.7 per cent.
- More than half of screen detected cancers (57.8 per cent) were diagnosed at Dukes' stage A and B. The earlier a cancer is detected, the greater the chances are of successful treatment.
- The 'poo song' received 74,316 views on YouTube.
- The 'how to do the bowel cancer test' film received 3,629 views.

- PR activity generated 274 pieces of coverage with a value of £952,924 and over 30 million opportunities to see or hear about the campaign.
- An array of famous faces backed the campaign – ten Scottish football clubs, Dorothy Paul, Janey Godley and the cast of Birds of a Feather.
- During the face-to-face engagement events, around 20,500 in-depth engagements took place.
- The Detect Cancer Early page on NHS Inform (under 'Cancer Zone') received 5,379 visits during the three campaign periods while the bowel screening page (under 'Screening Scotland') had 8,385. The graphs below demonstrate the increase in traffic around campaign times – the red circles mark the start of each campaign while the dots on the graph represent the 1st of each month.



Sustainability

.....

To support earlier detection of bowel cancers a new two year GMS contract initiative was introduced in 2013 focusing on bowel screening uptake through shared decision making in primary care. The DCE programme has enabled new IT solutions between the national bowel screening centre and GP practices enabling information on individual patient's uptake of screening and subsequent results to be loaded direct into GP systems, this will support primary care to raise the issue of bowel screening with their eligible practice population.

Next steps

.....

While independent tracking research shows positive shifts in attitudes towards the value of bowel screening and the hidden nature of its symptoms, more work needs to be done to make taking the test the 'social norm'.

The same creative has been running since February 2013 and while campaign recognition has maintained across this time, there is a real risk that it could become wallpaper, resulting in people switching off from its messaging.

Also, another point to note is the fact that while the Scottish National Bowel Screening Centre, has noticed a remarkably sharp rise in the number of people requesting a replacement kit, similar numbers aren't being noticed in the volume of returned tests. We therefore need to review how/if social marketing can support in filling this gap and encourage those who request a kit to do the test and return it. This could well mean tweaking our messaging or up-weighting the role of influencers.

As with all tumour types, fear is a barrier that prevents people from engaging with national screening programmes or presenting to their GP with potential symptoms. This behaviour will be addressed as part of a new strand of activity that falls under the DCE umbrella. The 'wee c' aims to reduce the fear surrounding cancer (regardless of the tumour type), helping shrink the 'big c' to the 'wee c'. This is a long-term task so a more consistent strand of communication, focused on increasing early detection rates in Scotland, will be introduced early next year.



PRESCRIBING

ABOUT THE PROGRAMME

Simon Hurding
t: 0131 244 2397
e: simon.hurding@scotland.gsi.gov.uk

drivers

NHSScotland spends £1.3 billion a year on medicines. Of this expenditure, around £1 billion is spent on medicines dispensed in primary care.

There has been considerable work to improve the quality and efficiency of primary care prescribing over the last 10 years. Further improvements are possible and require partnership working between the NHS Boards and all clinicians involved in prescribing.

The Prescribing Programme is now in its third year, with the aim to take a national approach to improving the use of evidence-based and cost-effective prescribing.

aims

- Identifying the improvement opportunities in Scottish prescribing
- Developing national prescribing strategies
- Monitoring progress and sharing learning and expertise between NHS Boards

workstreams

- National Therapeutic Indicators
- Polypharmacy
- National prescribing strategies (respiratory and diabetes)
- Waste and repeat prescribing
- Development and support of the Scottish Prescribing Advisers Association

achievements 2014

- There have been three sets of National Therapeutic Indicators (NTI) from 2012-13 to 2014-15. They provide comparative prescribing data between the NHS Boards and between Scottish General Practices. They are based around agreed areas of prescribing that are suitable for the use of comparative data. The key aim is to challenge inappropriate variation whilst recognising the different case mix of patients treated. Analysis of the distribution curve of achievement allows the setting of practice-based individualised targets for practices to work to. The NTI 2013-14 demonstrated £8.1 million of improved efficiency whilst also improving the quality of prescribing.
- The first National Polypharmacy prescribing guideline was published in 2012-13. The strategy provides a framework for the review of patients with multiple conditions, who are subsequently prescribed multiple medicines. The guideline has been used by the NHS Boards to implement polypharmacy reviews. The requirement for polypharmacy has been included as part of the Scottish GP contract (2013-14 and 2014-15) and most NHS Boards have an enhanced service polypharmacy contract for General Practices to use. The guideline recognises that many patients on multiple medications are deriving benefit. The challenge is to identify those patients who are at increasing risk of an adverse drug event. The polypharmacy guideline is currently undergoing an in depth review.
- National prescribing strategies in both diabetes and respiratory were published in May 2014. These have been developed through partnership working between the relevant managed clinical networks, the NHS Boards and the QuEST National Prescribing Programme. The aim for the strategies is to help standardise care between the NHS Boards to improve the quality and efficiency of patient care.

priorities 2015

- The work of the QuEST National Prescribing Programme has been transferred to the Pharmacy and Medicines division as the nascent Therapeutics branch.
- NTIs will be refreshed for 2015 and work will be undertaken to continue to embed these in prescribing practice. Work is on-going to ascertain the success of this approach.
- Work will be undertaken to support the implementation of polypharmacy reviews and to measure the impact of the reviews on patient safety.
- The Scottish Therapeutics Utility (STU) is being developed as an IT tool to help General Practices review their use of repeat medicines with the ultimate aim of reducing medicines waste.
- Publication and follow-up for the diabetes and respiratory prescribing strategies.
- Review of the medicines management domain of the Scottish GP contract.



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/prescribing.aspx>

Programme Case Study

Prescribing – National Therapeutic Indicators

Background and context

The annual drugs budget for primary care is approximately £1 billion per year – this equates to around 10 per cent of the total NHSScotland spend. It is important that this resource is used as effectively as possible.

National Therapeutic Indicators (NTIs) were first established in April 2012 to provide benchmarking across primary care prescribing in Scotland.

NTIs are a way of providing an evidence-based prescribing standard. They identify major areas where there is variation in prescribing quality; the intention is to reduce inappropriate variation in prescribing. The ideal indicator promotes effective, safe and efficient prescribing.

Within the last 10 years, medicine use has consistently risen between 3 and 5 per cent annually. During 2013-14 the increase rate was reduced to 1.7 per cent in Scotland – further work is required to identify the NTIs role in the reduced rate of medicines volume increase.

Problem

- Variation occurs in prescribing practice, between NHS Boards and between General Practices. This can have implications for health outcomes for patients as well as the overall efficiency and cost of the service.
- An aging population is one factor leading to an increase in morbidity rates as well as a growth in the volume of medicines use. The resulting increase in prescriptions

and implications for drug expenditure is considered potentially unsustainable.

There are a number of national medicines use priority areas, where variation between General Practices may have an effect on clinical outcomes and patient safety. One important area is around the inappropriate use of antibiotics.

Aim

The aim for NTIs is to improve the quality (effectiveness, safety, equitability and efficiency) of primary care prescribing. Specific focus is on:

- identifying the improvement opportunities in Scottish prescribing
- informing the development of local and national prescribing strategies
- monitoring programmes and sharing learning and expertise between NHS Boards
- informing NHS Board prescribing plans
- facilitating NHS Boards to challenge inappropriate variation whilst recognising the different case mix of patients treated
- achieving improved health outcomes for patients through appropriate use of medicines

Action taken

The Prescribing Information System for Scotland (PRISMS) is recognised as a source of highly robust primary care prescribing data, and provides the data used for the NTIs. PRISMS is maintained by Information Services Division (ISD) and allows access to the data collected by Practitioner Services Division (PSD) when processing each prescription dispensed. The resulting payment verification data is then accessed via PRISMS.

QuEST coordinated the compilation of data and led the analysis and interpretation – the resulting report was the first instance of a consistent national approach to benchmarking of prescribing in primary care.

The report presents the rationale as to why NTIs will improve prescribing and advocates

a consistent approach to data collection. Achievement against each indicator is analysed from the normal distribution curve. 'Best in class' practices are identified from the lower quartile for indicators promoting a reduction in medicines use, and the upper quartile for indicators promoting increased medicines use.

QuEST has also worked towards the creation of wider structures to support NTIs. One NTI focuses on the prescription of antibiotics; and this is aligned to the HEAT target focusing on reducing antibiotic prescribing.

NTIs allow prescribers, general practices, Community Health Partnerships (CHPs) and NHS Boards to compare current practice against the national position. Moving towards the agreed standard can lead to change in prescribing behaviour and ultimately improve patient care. The belief is that a national approach with shared focus on key areas will deliver the improvements in quality and efficiency required to maintain the excellent standard of healthcare in Scotland.

The report is refreshed annually with the 2014-15 version being the third edition to be published. This enables general practices to have access to the most up-to-date data available on a continuous basis.

NHS Boards are empowered to use their own approaches for local adoption of NTIs to suit local needs. NHS Boards have used a combination of methods, including incentives and action through the GP contract to drive change.

The backbone of improvement through NTIs has been QuEST's collaboration with the Scottish Prescribing Advisors Association (SPAA). The Association's improvement advisors aim to visit all Scottish General Practices at least once a year. NTIs provide a national framework based on clinical evidence which enables prescribing advisors to provide better and more consistent improvement advice.

Results

.....

The results of the National Therapeutic Indicators project can be described as:

- Variation in prescribing has been reduced, as shown by the decreasing gaps between the lines representing NHS Boards on the graph below.
- Comparative cost per patient for the suite of NTI medicines reduced during 2012-13. Fewer unnecessary prescriptions are being processed; contributing to a reduced rate of prescription volume increase in Scotland.
- An increase in the number of patients moved from branded drugs, which are more expensive, to generic drugs, which are just as effective but better value for money.
- A reduction in the use of broad spectrum antibiotics has occurred. There is an associated reduction in the rate of *Clostridium difficile* infections.

See graph on [page 97](#).

Patient experience

.....

The following patient benefits are anticipated as a result of the NTI project:

- Improved clinical outcomes
- Reduced variation between NHS Boards
- A reduction in the risk of adverse drug reactions on account of (where clinically appropriate):
 - reducing dosage
 - reducing the use of unsafe medicines
 - discontinuing the use of inappropriate medicines

Staff experience

.....

The following staff benefits are anticipated as a result of the NTI project:

- Staff feel more supported due to the availability of evidence-based national guidance for improving the care of patients.

- Less variation in prescribing practice enables staff to feel more confident in their day-to-day work.
- NTIs provide prescribing advisors with a consistent approach across NHSScotland.
- Prescribing advisors are not working in isolation due to improved national guidance.
- Collaboration with partners and a focus on local implementation were very successful methods. Local control has facilitated ownership, which in turn led to excellent results. The NTIs project is not viewed as Scottish Government enforced but is aligned to national strategy.
- Engagement of stakeholders is key – involving prescribing advisers from all NHS Boards in the development of NTIs facilitated a feeling of ownership and helped to lend credibility to the report.

Efficiency savings and productive gains

Improvements in prescribing has led to around £8 million in efficiency savings for 2013-14.

See graph on [page 97](#).

Sustainability

The following key activities will ensure that the benefits of the NTIs project are sustainable:

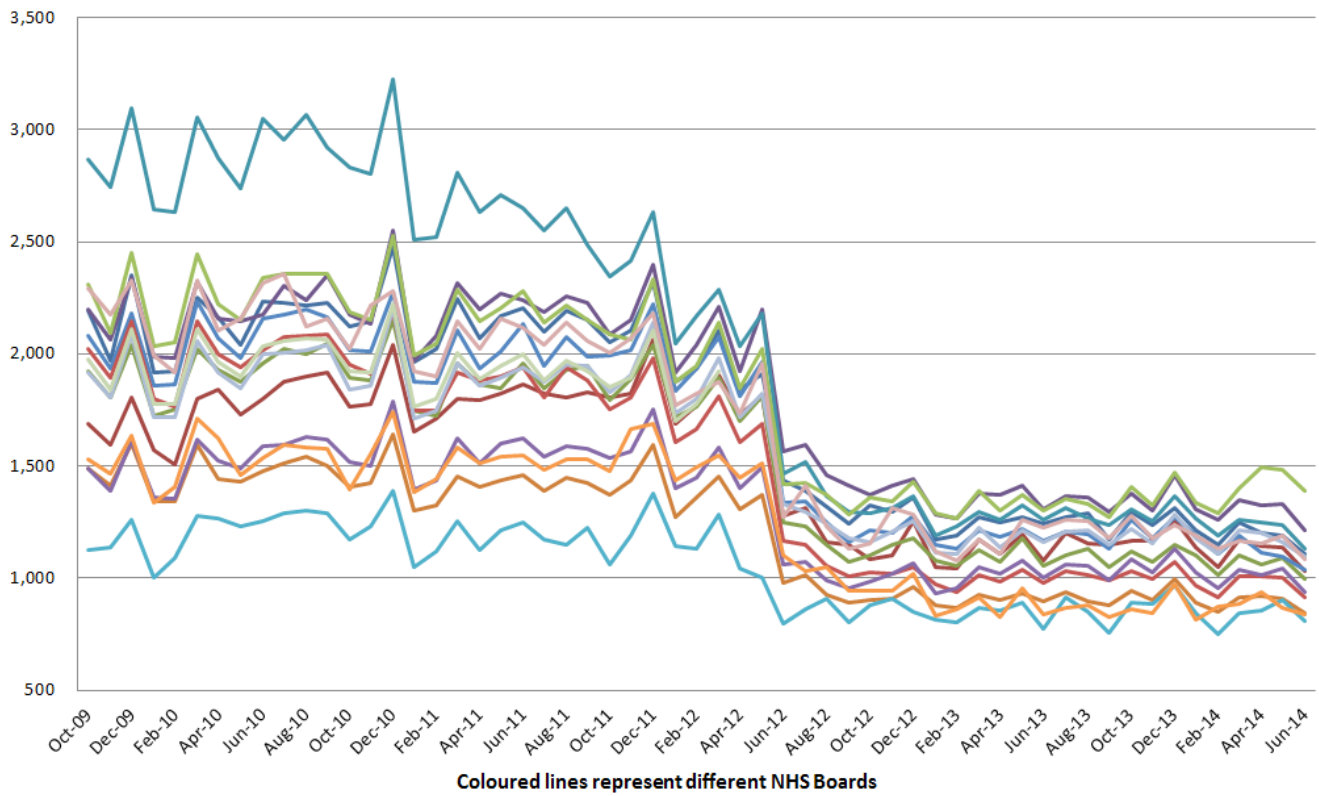
- NTIs are refreshed and reissued annually; this ensures that guidance is based on recent evidence and data at all times.
- The QuEST Prescribing Programme has now successfully transitioned to the Therapeutics Branch of Pharmacy and Medicines Division of the Scottish Government; this means that funding for the NTIs workstream is agreed until at least March 2016.
- Continued monitoring of PRISMS data – ensuring that NTIs are flexible and adjusted if required.

Lessons learned

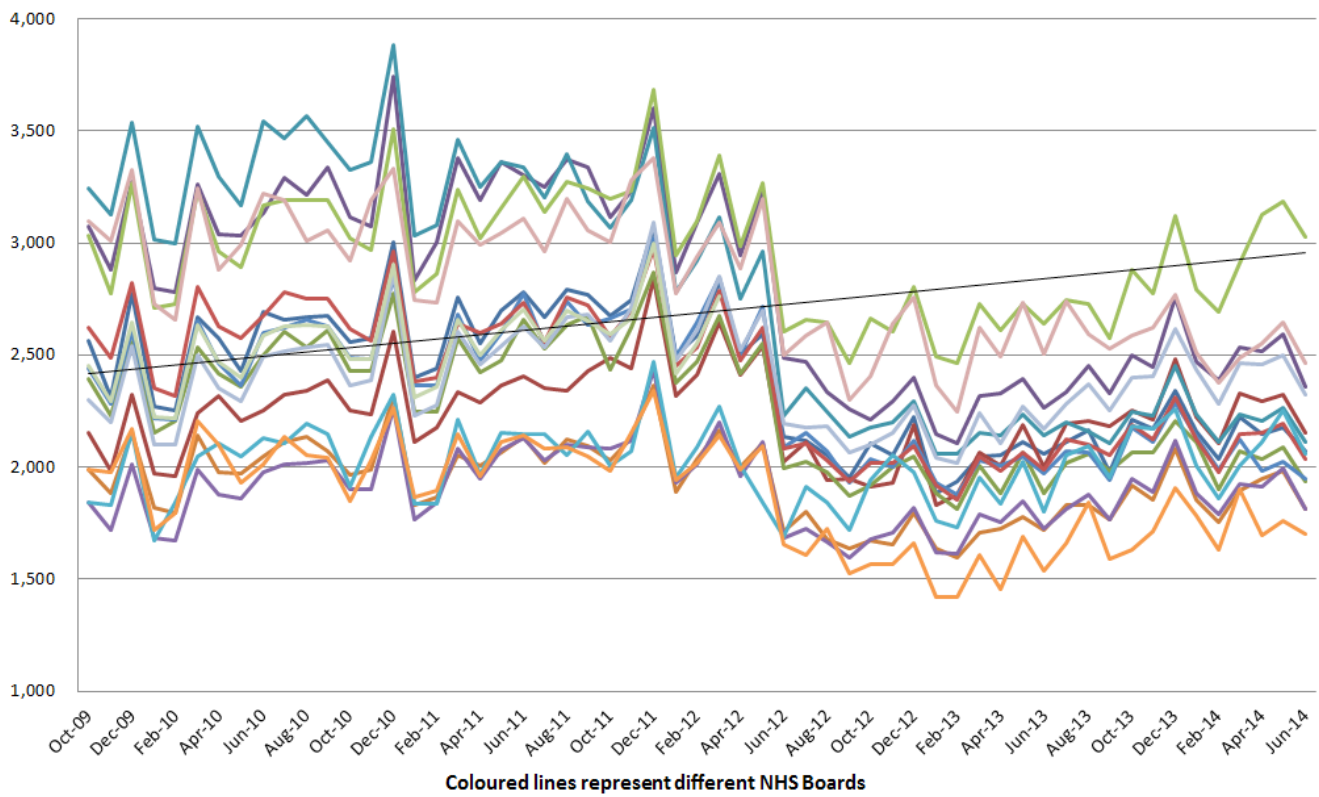
The following lessons have been learned:

- Well-validated indicators need to be used to ensure quality is maintained; at the same time new indicators should be introduced to realise further opportunities for improvement.
- Providing NHS Boards with comparative data is a powerful tool in changing prescribing behaviour.

Cost (GIC/1,000pts) National Therapeutic Indicators 2012-13



Cost (GIC/1,000pts) National Therapeutic Indicators 2013-14



Polypharmacy for Patients identified at Risk using the SPARRA Tool

Background and context

In 2012 the Scottish Government released CEL 36 Appropriate Prescribing for Patients and Polypharmacy Guidance for Review of Quality, Safe and Effective Use of Long-Term Medication. NHS Lothian worked with the Scottish Government to develop a data collection spreadsheet to capture data regarding patient risk assessment scores, quantity of high-risk medication prescribed before and after medication review, numbers of medicines stopped and reduced.

In a successful pilot in Lothian (2012) medication use was reviewed in 2,616 patients living in care homes or identified as high risk by GPs and this resulted in an overall reduction in the use and dose of medicines. On average 1.0 medicines per patient were stopped.

In April 2013 NHS Lothian Efficiency and Productivity – Invest to Save funding was made available to support a further 12 month Polypharmacy project to review medication in patients identified at risk using the Scottish Patients at Risk of Readmission and Admission (SPARRA) tool.

Problem

The increase in the prevalence of chronic illnesses and an ageing population have seen a significant rise in the number of people on four or more (and often 10 or more) repeat medicines. Research has demonstrated that

patients on multiple medications are more likely to suffer drug side effects which can consequently lead to hospital admission.

Aim

This project aimed to improve patient safety, provide high quality pharmaceutical care, increase awareness amongst prescribers as to the potential harm from polypharmacy prescribing and report on the financial efficiencies which had been delivered as a consequence of this quality work.

Action taken

Using the SPARRA tool 3,076 eligible patients were identified in 87 participating GP Practices across Lothian during 2013-14.

A team of clinical pharmacists undertook joint polypharmacy medication reviews with GPs who signed an SLA with NHS Lothian Primary Care Contract Organisation.

2,969 patients were reviewed between April 2013 and March 2014 and detailed analysis of a subgroup of 602 patients was completed in April 2014.

Results

A total of 6,870 medicines were reviewed in the subgroup of 602 patients from 24 GP practices and the following 1,111 interventions took place:

- 659 medicines stopped (this includes 150 high-risk medicines stopped)
- 169 medicines doses reduced
- 26 medicines doses increased
- 91 new medicines started
- 166 medicines switched e.g. to formulary choices and/or safer and more cost effective alternatives

The average number of medicines per patient before review was 11.4 and after review 10.5, a reduction of 0.9 across Lothian.

Patient experience

Patients have benefited from this approach as the average number of medicines per patient

was reduced. For a number of patients the dose of medicines was reduced and a number of patients did no longer require high-risk medicines as a direct result of this work.

Staff experience

The joint review between pharmacist and prescriber raised awareness amongst prescribers as to the potential harm from polypharmacy prescribing. The feedback from GPs has been positive with many of them seeing the benefits to their patients from reducing risk of harm to reducing their “pill burden”.

Efficiency savings and productive gains

The 1,111 interventions in the subgroup of 602 patients resulted in a saving of £39,049 and a cost avoidance of £16,139, representing an average saving of £64.87 and a cost avoidance of £26.81 per patient per year.

The financial efficiency and productivity gain from reduced adverse events and hospital admissions have not yet been quantified and Lothian are in discussions with the Information Services Division about further analysis which may be undertaken to evaluate impact.

The cost savings and cost avoidance achieved in this project were lower than in the pilot involving care home patients, although the number of medicines stopped were on average broadly the same.

Data analysis of the full cohort of 2,969 patients is on-going and has not been completed, however based on the initial findings of the subgroup of 602 patients it is anticipated savings of around £193,000 and a cost avoidance of around £80,000 have been achieved in 2013-2014.

Sustainability

The success of the polypharmacy medicines review and the impact on patient safety, quality of prescribing and efficiency savings has been recognised by the Efficiency and Productivity Group and GP prescribers. The

CHP General Managers have agreed to a top slicing of the primary care prescribing budget for 2014-15 to continue the on-going work and a sustainable future for this work is currently being discussed.

Lessons learned

- Quality improvements and recurrent savings were achieved using the polypharmacy medicines review approach, further improvements can be achieved with continued funding for additional pharmacist hours and GP engagement.
- Strong engagement between Pharmacy and Primary care was essential to ensure the success of this work.
- Consistent data collection and analysis was necessary to evaluate and measure the impact of the project.
- Further analysis is required to understand the variance in efficiency savings gained from reviews conducted in care home patients versus those living in the community.

Next steps

The next steps for the NTI project will be:

- Gathering more qualitative data on benefits using a QuEST template; this will draw on knowledge and expertise of SPAA.
- One challenge will be to evidence directly improved health outcomes. The project team will improve the use of available data, for example, patient-identifiable prescribing data is now available which can then be linked to clinical outcomes.

Promoting Quality and Cost- Effectiveness in the use of Wound Dressings

Background and context

The expenditure on wound management products has been increasing over the past years, an increase of 4.7 per cent was observed between 2011-12 and 2012-13 with silver dressings being widely used across primary and secondary care. Silver dressings are antimicrobial dressings used in the prevention of wound infection, which are more expensive than non-medicated wound dressings. The Healthcare Improvement Scotland technologies scoping report (Jan 2013) stated that there is a lack of clinical efficacy and cost-effectiveness evidence to support or refute the use of silver dressings to either prevent wound infections or completely heal wounds. The National Therapeutics Indicators (2012-13 and 2013-14) have allowed NHS Boards to benchmark their comparative use of antimicrobial dressings. Based on these findings NHS Lothian removed silver dressings from the formulary and aimed to ensure any non-formulary use of silver dressings was appropriate on the advice of a specialist in tissue viability.

Problem

Silver dressings are being used widely for many indications without adequate evidence for effectiveness. Other wound dressings that are potentially more cost-effective but provide the same quality of wound management are available.

Aim

The aim was to promote adherence with the wound dressings specified in the Lothian Joint Formulary and to reduce the use of silver dressings with the aid of a step by step guide (i.e. Ropper Lothian Ladder).

Action taken

The work taken forward in Primary Care focused on providing prescribing data to individual prescribers as well as providing education on how to effectively use the new products contained in the formulary. The aim was to promote adherence with the first and second choice dressings as specified in the Lothian Joint Formulary to ensure appropriate and cost-effective prescribing. Invest to save funding for a part-time band 6 nurse was used to support change management and maintain onward education and awareness.

The work taken forward in Secondary Care focused on engaging clinicians and service managers in a range of specialties, discussing the need for silver dressings and introducing the requirement for approval by specialist prescribers.

In addition, pharmacy staff promoted the change in the dressings on formulary. Silver dressings were withdrawn from all clinical areas as stock items and request for supplies from pharmacy should have been accompanied by a non-formulary dressing requests form.

Results

Adherence to the Lothian Joint Formulary for antimicrobial dressings has improved as a result of this work (i.e. adherence is defined as the use of formulary drugs as a percentage of all drugs in the relevant section).

The Medicines Utilisation Review Group adherence monitoring showed that between January-March 2013 adherence for antimicrobial dressings was 18 per cent in primary care; 30 per cent in secondary care; and 33 per cent in the Royal Edinburgh and associated hospitals. The reports for January-March 2013 showed an increase to 48 per cent in primary care; 72 per cent in secondary care;

and 70 per cent in the Royal Edinburgh and associated hospitals.

The work in primary care and secondary care resulted in a reduction in the use of silver dressings. The exception to this was within the burns service where specialist clinicians were allowed to continue the use of silver dressings for the entire pathway journey from inpatient care to outpatient care and in the homecare setting. The decision was made after consultation with this clinical area. Preliminary discussions have been held with medical and nursing academics with a view to undertaking a study in burns around the efficacy and cost-effectiveness of silver dressings compared to alternatives.

Efficiency savings and productive gains

In primary care in 2012-13 total dressing expenditure was £3.686 million, of which £494,000 was for silver dressings. In 2013-14 around £3.72 million was spent on all dressings of which £216,000 on silver dressings. The work done in primary care has resulted in a reduction of silver dressing spend of £278,000. The overall expenditure on dressings increased.

In secondary care, the following table shows the change in expenditure on dressings between 2012-13 and 2013-14:

	2012-13 (£k)	2013-14 (£k)	Change (£k)	Change (%)
Total dressings	1,092	1,078	-14	-1%
Medicated	790	679	-111	-14%
Non-medicated	302	393	91	30%
Silver	105	67	-38	-36%
Honey	14	21	7	50%
Iodine	12	13	1	8%

There was a 14 per cent decrease in the expenditure on medicated dressings and a 36 per cent decrease in the expenditure on silver dressings. However, there was a 30 per cent increase in the expenditure on non-medicated dressings and honey

dressings, and iodine dressings expenditure increased by 50 per cent and 8 per cent respectively. Therefore the work may have resulted in a shift in practice from the use of silver dressings to the use of other non-medicated dressings or honey or iodine dressings. Overall the decrease in expenditure on dressings was £14,000.

In previous years an increase of around 4.7 per cent on dressings expenditure was observed, therefore the decrease of 1 per cent in 2013-14 represents a cash releasing saving of 1 per cent and a cost avoidance of around 4.7 per cent.

Sustainability

Adherence to the Lothian Joint Formulary is essential to ensure appropriate and cost-effective prescribing. Pharmacy will continue to promote adherence to the formulary. Education in relation to wound management and the use of appropriate dressings has resulted in a change in practice. There are ongoing discussions to extend the band 6 nurse post to maintain education and awareness of effective prescribing in dressings.

Lessons learned

Lessons learned include:

- Engagement and clear communication with all relevant staff about upcoming changes in prescribing and the reasons for the changes is required in advance of any changes.
- The work achieved a reduction in silver dressings expenditure of £278,000 in primary care and £38,000 in secondary care. However the reduction in overall expenditure on dressings was small as expenditure on alternative dressings increased.
- Education and training with the aid of a treatment guide is an effective way of increasing the adherence to the Lothian Joint Formulary.



PROCUREMENT

ABOUT THE PROGRAMME

Linda Semple
t: 0131 244 2297
e: linda.semple@scotland.gsi.gov.uk

drivers

Virtually all NHS Board activity involves the requirement to procure some form of product or service meaning spend with suppliers is approximately 20 per cent of NHSScotland's total budget.

NHSScotland spends £2.1 billion per annum on goods and services from around 10,000 suppliers. Currently about £1.5 billion of this spend is influenced nationally, regionally or locally by the procurement community. As such, efficient and effective procurement is imperative.

aims

Our Procurement Programme aims to drive increased value from NHSScotland spending as well as supporting economic growth. This will be achieved through improving processes and tools, obtaining reductions in price, influencing demand, working closely with suppliers, encouraging Scottish businesses to bid for opportunities and creating new and improved structures.

areas of focus

- Ensuring a higher percentage of total spend is covered by an appropriate procurement process and increasing the level of national contracting activity.
- Improving current contract conformance and compliance levels.
- Driving further savings from existing national and local contracts while improving quality through initiatives such as Intensive Improvement Activity (IIA).

- Developing regional procurement consortia (the East of Scotland Procurement Consortium and West of Scotland Regional Procurement Project) to drive economies of scale, accelerate delivery of savings, share expertise, reduce costs and improve capability and capacity.
- Continued roll-out of eProcurement systems and the SpendAnalyser spend dashboard to support management decision-making, nationally, regionally and locally.
- Conducting an independently-led national review of procurement structures and functions to ensure continued procurement capability development, resilience, continuity and accelerate delivery of efficiencies and improved quality in our procurement system.

achievements 2014

- The East of Scotland Procurement Consortium has delivered over £7.5 million through implementing national, regional and local contracts in 2013-14. Additional efficiency gains of £100,000 in resource savings per annum have also been achieved by sharing management and operational resources between NHS Lothian and NHS Tayside.
- The West of Scotland Regional Procurement Project targeted 74 projects during 2013-14. Contracts with potential savings of £6.1 million were awarded during 2013-14 and by end March 2014, £3.5 million of these savings had already been fully implemented and realised. To deliver this, 74 expert 'Peer Groups' were established, bringing together staff experienced in the product's use to select best value for money products which fully meet their needs. The West of Scotland approach is to make decisions once for all five regional NHS Boards. Since project commencement in 2012, £8 million of savings have been delivered to the West of Scotland Boards.
- Development and roll-out of a national spend dashboard, the SpendAnalyser, with real time information available to managers to support faster and better decision-making. The SpendAnalyser has now 600 registered users across all regional NHS Boards.
- Fourteen Intensive Improvement Activity events have been undertaken to improve procurement capability and to identify savings opportunities. Five commercial review engagements have been undertaken and have identified over £7 million of savings opportunities so far with a sixth underway with a target of over £1.5 million, and four more in the pipeline.

priorities 2015

- Implementation of NHSScotland Procurement Framework which will give strategic direction and a performance framework for the function.
- A review of Procurement structures across NHSScotland to identify the optimum structures that could drive increased savings and effectiveness will be concluded.
- Regional consortia will continue to create consistent operational practice and systems, build procurement capability by sharing best practice, exploit economies of scale to deliver savings and share workload to improve capacity.
- NHS Boards in the East of Scotland Procurement Consortium will scope out the advantages of restructuring PECOS to a single instance and benefits of sharing catalogue content management.

- The West of Scotland Regional Procurement Project's 2014-15 workplan identifies a further 47 projects with potential savings over £4 million for delivery this year.
- National Procurement will continue to deliver IIA to support NHS Boards to identify additional savings opportunities, increase procurement capability, and improve performance.
- The SpendAnalyser roll-out will continue and will be supplemented by benchmarking and invoice enhanced functionality development. Testing project team access to consortia-wide spend dashboard information to improve collaboration has been approved by all East of Scotland Procurement Consortium NHS Boards.



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/procurement.aspx>

NHSScotland Procurement Review

Background and context

Annual spend with suppliers to NHSScotland is around £2.1 billion per annum with a further £500 million approximately spent between NHS Boards, local authorities, third sector and some Private Finance Initiatives (PFIs). This is currently controlled through National Procurement and 22 local NHS Board procurement processes. In addition over the last two years a regional approach has been developing for the main territorial NHS Boards in the east and west of Scotland.

National Procurement, along with Health Facilities Scotland for some construction activity and the National Information Service Group for IT, has approximately £1.3 billion of the £2.1 billion under some form of national contract. The contracts are let by these organisations and are implemented in NHS Boards with support from the regional consortia and National Procurement.

The 22 NHS Boards (14 territorial and eight specials) all have separate procurement departments which vary significantly in size with a range of NHS Board spend from £4 million to £580 million. The regional approach is beginning to have an impact but essentially each NHS Board department is responsible for the implementation of national contracts and for tendering products which are sensibly procured locally. Although the picture is variable, procurement activity in NHS Boards can also be carried out in construction, facilities, IT and pharmacy separate from the core procurement function.

There are a number of national issues which will also influence the procurement landscape:

- The Scottish Government continues to drive towards a ‘Once for Scotland’ approach across a range of functions to reduce duplication, waste and variation.
- The implementation of health and social care integration will require consistent input from procurement to ensure the link between NHSScotland and local authorities is managed effectively and the interrelationship between commissioning and procurement remains strong.
- The Procurement Reform (Scotland) Act 2014 is intended to support public procurement as an engine for economic growth and ensure community benefits are an integral part of major procurement projects as well as supporting small and medium-sized enterprises (SMEs) and the third sector.

A Strategic Procurement Framework for NHSScotland which reflects the aims of the Quality Strategy and the 2020 Vision has been developed under the auspices of the Procurement Steering Group and delivering the outcomes will be heavily dependent on an effective and efficient procurement and supply chain service.

Problem

The procurement function in NHSScotland has achieved much since McClelland’s report ‘Review of Public Procurement in Scotland’. For example, there has been significant investment in common systems e.g. PECOS (for procurement management) and PCS-T (for the tendering of public contracts). It is now time to see how the procurement profession can be best organised to maximise the opportunities presented by this investment.

At present there is no single, consistent model of procurement service delivery across individual NHS Boards (although progress has been made on a regional basis). This means that there is a risk of duplication of effort and, more likely, a risk that the right skills and experience are not consistently available across all NHS Boards. It is also

necessary to clarify and optimise allocation of work between the centre of excellence and customer NHS Boards.

Professional procurement resources are scarce and, as demand in the economy grows, there is a risk that the service is not sustainable in terms of the number of people with the requisite knowledge, skills, and experience.

As outlined above there are also a number of strategic challenges (health and social care integration and the Procurement Reform (Scotland) Act 2014) for the future which will require a robust procurement organisation to be in place.

In order to ensure continual accelerated delivery of improvements in quality and financial benefits, it is necessary to undertake a review of procurement throughout NHSScotland.

Aim

.....

The primary objectives of the NHSScotland Procurement Review are to:

- Identify options for a professional procurement and supply chain service, with a wide scope of influence across buying organisations, which meets the increasing needs of NHSScotland and reflects changes in wider Scottish public sector.
- Identify alternative options that will provide substantive benefit, and will drive improvements in quality and increased savings and effectiveness, when compared to existing operations/ current structure.
- Ensure the procurement function is recognised as a strategic priority and is represented at a senior level within NHSScotland.

Action taken

.....

In order to deliver the strategic review the following actions have been undertaken to date:

- **Data Gathering** – leveraging the experience of the Facilities Shared Services Programme, the data gathering template

was designed in a simple to use way, specifically designed to provide sufficient high-level data on the procurement activity undertaken throughout the organisation in a timely manner.

- **Data Analysis** – the data analysis has provided detailed information about the number of whole time equivalents (WTEs) split across, for example, different organisation types (e.g. National Procurement, NHS Board procurement or devolved procurement), work area (pre-tender, tender, implementation, contract management) or qualification type.
- **Stakeholder Engagement** – three workshops focused on people, processes, and systems and logistics have been delivered. These workshops have been targeted at practitioner level in order to gain a range of perspectives from all areas, including procurement, construction, facilities, IT, pharmacy, partnership, and organisational development. This positive engagement has helped to create a shared understanding of the challenges and a sense of community in preparing for change.

Results

.....

The Review is on-going, however, the following results have been achieved to date:

- The data gathering and analysis exercise has, for the first time, provided visibility of procurement activity as a whole, including construction, facilities, IT and pharmacy. This data has enabled a recognition of the level of professional procurement activity that is undertaken outwith procurement departments.
- The stakeholder engagement events have enabled a rejuvenation of the procurement community and have provided an opportunity for procurement professional across different functions (procurement, construction, facilities, IT and pharmacy) to come together and establish, or build upon, relationships.

- There has been a reestablishment of the link between government procurement policy and NHS Board procurement delivery.

Patient experience

.....

The following patient benefits are anticipated as a result of the Review:

- Goods and supplies, of the right quality, for use in the delivery of patient care are consistently available across all NHS Boards supporting equity of treatment and ensuring value for money.
- Significant savings will be realised by NHS Boards which can be reinvested in patient care.

Staff experience

.....

Whilst it is too early to have evidence of staff benefits it is anticipated that the following benefits will be realised:

- Improved capacity and capability amongst the procurement workforce through a focus on the recognition, development and utilisation of their expertise.
- Increased procurement capability through sharing good practice, skills and expertise.

Efficiency savings and productive gains

.....

Whilst it is too early to have evidence of improved efficiency, a new operating model for the procurement function within NHSScotland would be expected to deliver, as a minimum, the following benefits:

- Improved quality and reduced product variation
- Enabling NHSScotland to implement contracts more quickly
- Increased procurement savings and cost avoidance
- Increased focus on demand reduction and overall supply chain cost
- A more efficient and cost effective procurement organisation

- Wider scope of influence for procurement supporting increased compliance to contracts, standing financial instructions, etc.
- Improved management information due to implementation of common systems

Sustainability

.....

A primary aim of the review is to identify options for a professional procurement and supply chain service, which meets the increasing needs of NHSScotland and reflects changes in the wider Scottish public sector. Sustainability of the service is at the heart of this aim – ensuring a sustainable workforce, with the requisite capacity and capability, to meet the challenges of the future.

Lessons learned

.....

Key lessons learned include:

- Engagement with individuals at practitioner level is key to build and harness enthusiasm for the potential benefits that may be realised and to help create momentum for change.
- Robust and sufficient project management support is essential, as is ensuring that the right skill mix and capacity is available within the project team.
- Ensuring a project governance board, representing all aspects of the community affected, is in place is critical to ensure that the project maintains momentum and has buy-in from key stakeholders.

Next steps

.....

Next steps for the NHSScotland Procurement Review include:

- Engaging with senior stakeholders (NHS Board Chairs, Chief Executives and Executive Directors with responsibility for procurement) to understand their key priorities for procurement today and in the future.

- Benchmarking with external organisations to explore the benefits and challenges of alternative approaches to procurement operations.
- Delivery of a Recommendations Workshop during February 2015 to develop recommendations for the future procurement organisation based on the outputs from the data analysis and stakeholder engagement events.
- Delivery of the final report in March/April 2015. The report will identify options and recommendations for a professional procurement and supply chain service which will meet the future procurement requirements of NHSScotland.

Orthopaedic Loan Kits – Theatres

Background and context

The Theatre Department at Raigmore Hospital orders and processes an average of 56 orthopaedic loan kits per annum (2013-14).

Problem

There was variation in the types of loan kit ordered through the Theatre Stores and Orthopaedic Theatre teams in 2013-14. The majority of requests for the ordering of loan kits were made late in the patient pathway, which had an impact on Central Decontamination Unit (CDU) processing time, availability of loan kits and in some instances resulted in patient procedures being cancelled at short notice. All orthopaedic loan kits were categorized as 'urgent' and the communication between all involved parties in the process was poor. The service was being charged additional delivery costs for short notice requests of orthopaedic loan kits. The ordering process left the organisation at risk in that there were several 'open orders' within the system, which took on average 144 days to close. When loan kits were delivered to theatres they were left in an unsecured area – at times this was in excess of five days.

Aim

To review and improve the current processes related to the selection, ordering, assessment, delivery and return of orthopaedic loan kit items.

Action taken

We used a Lean Rapid Process Improvement Workshop (RPIW). This had a twelve week preparation phase, in which the scope of the work was agreed, and observations were conducted. Staff identified waste and

completed ideas forms. A value stream map was produced and percentage load charts developed. In the RPIW week, staff from the service reviewed the current processes and flow of information. The team developed new ways of working including streamlining the current ordering process – which included involvement of main stores, Orthopaedic Consultants, Orthopaedic Theatre team, Theatre Stores, Procurement and Accounts Payable. The team also undertook 5S on storage rooms within the Theatre Department. Standard work was developed by the team and incorporated into an RPIW newspaper (action plan) which was supported by a series of standard process descriptions and a skills matrix (to support training and development requirements).

A visual display board was used to monitor the progress of orthopaedic loan kits through the service.

A secure loan kit storage area was created, along with standard process descriptions for the delivery and collection of the instrumentation and consumables from the Theatre department.

Results

- No loan kits delivered to the Theatre Department are left in an unsecured environment. The new secure location also offers improved lighting for the checking of kits prior to CDU processing.
- Prior to the RPIW there were an average of 11 people involved in the ordering process – this figure has now been reduced to two.
- The lead time for the process has not been reduced but the time available to process the request for loan kits has increased from 9 per cent to 90 per cent – which will have the impact of reducing short notice cancellations due to kit availability to zero.
- The number of 'open orders' will ultimately reduce from 56 to a target of zero.
- The number of possible TP numbers used in ordering loan kits has reduced from five to one.

- There is an expectation that additional delivery charges will reduce from £2,900 per annum (2013-14) by 90 per cent.
- All invoices are paid within 10 days of receipt.

Patient experience

.....

Patients will benefit from the reduction of short notice cancellations due to kit availability to zero.

Staff experience

.....

Some team members were apprehensive about the RPIW at the outset. The team excelled in the process, and are beginning to 'share and spread' their work to other parts of the Theatre Department. Feedback from the team via Survey Monkey has been very positive.

Efficiency savings and productive gains

.....

There is an expectation that additional delivery charges will reduce from £2,900 per annum (2013-14) by 90 per cent.

The lead time for the process has not been reduced but the time available to process the request for loan kits has increased from 9 per cent to 90 per cent – which will have the impact of reducing short notice cancellations due to kit availability to zero. The average orthopaedic joint procedure is 156 mins at an estimated cost of £20 per min in terms of theatre time. Therefore the average cost per cancellation = £3,120 without calculating the cost of rescheduling this procedure.

There is an opportunity to ensure that all orthopaedic loan kits are on National Contract using the new process, which will ensure that we will obtain the best price (rather than list price) for any implants used.

Sustainability

.....

- A sweep system was introduced for 5S.
- A visual control board was developed to allow staff to see the order status quickly.
- All staff now use an eForm for requesting orthopaedic loan kits.
- Staff are following standard work and effectively 'sharing and spreading' their success to other areas within the Theatre team.

Lessons learned

.....

The RPIW process, using Lean principles, was effective. There were implementation challenges related to staff concerns, and our main lesson was that service staff are the key agents of change, and need to be supported as much as possible. This demonstrated that understanding the boundaries of a process is important, and that changes outside the scope of the original work can take longer.

Programme Case Study

East of Scotland Procurement Consortium Regional Supplier Management

Background and context

The East of Scotland Procurement Consortium (ESPC) is a regional consortium supported by QuEST consisting of eight NHS Boards, each one historically managing suppliers separately. The consortium team is hosted in NHS Tayside.

Best practice supplier management was recognised as opportunity to increase leverage, reduce variation and share best practice and the Consortium agreed to develop a joint regional supplier management (RSM) toolkit and test joint management of suppliers.

Regional performance measures are a necessity for collaboration and capability measurements showed that lower performing NHS Boards could learn and improve by joining up with higher performers.

Problem

Variance in pricing and conditions was evident and did not prove best value. Varying pricing also led to duplication of local catalogues and the effort to maintain those catalogues is potentially undertaken eight times.

Aim

Do things once rather than eight times, reducing prices and effort and make it sustainable.

Action taken

A standardised RSM toolkit was developed and supplier meetings are arranged to use video conferencing allowing all stakeholders including the supplier to attend virtually.

The toolkit allows the nominated regional lead to:

- categorise for level of management and review frequency
- implement agreed objectives on behalf of all
- negotiate better terms
- view key performance indicators (KPIs)
- apply improvement measures

A database of suppliers identified for review was created and SWOT assessments were undertaken to identify the best opportunities. This is updated by the project team and available to all ESPC Boards using a joint intranet hub. Automatic emails update NHS Boards and in effect create a shared regional supplier calendar.

Results

- Additional savings have been negotiated.
- Suppliers no longer negotiate varying individual terms.
- Suppliers divert fewer costs to marketing and sales.
- NHS Boards have shared common challenges and solutions.
- All negotiations are transparent and recorded.

Staff experience

- Local teams were initially sceptical of success and there was a risk of loss of ownership.
- Careful communication, phasing and inclusion have seen that staff realise the joined up benefits and release in time

Efficiency savings and productive gains

.....

- £263,000 price saving opportunities have been identified.
- Other measures of success are in development and will include:
 - reduction in hours invested by each NHS Board
 - increased capability score
 - reduced deliveries and costs
 - carbon reduction
 - KPIs

Sustainability

.....

This work has been approved by the consortium Project Board and a roll-out plan will continue for as long as ESPC exists. This is a key enabler for any future shared services models.

Lessons learned

.....

- Some NHS Boards were operating at a high level of capability and needed to trust to let go rather than lead everything.
- Video conferencing culture is still not universal.
- Selecting less contentious/complex suppliers proved the concept.
- Stick to the agreed objectives to ensure standard and comparable outputs.

NHS Education for Scotland

Procurement Transformation

Background and context

In September 2010 NES senior management implemented a review of procurement activities across NES. The findings from this review resulted in the introduction of the 'No Purchase Order (PO) No Payment' policy and approval from the Executive Team and Change Management Board to develop a centrally managed Procurement function.

Problem

Until recently, NES operated a devolved procurement model with advice and guidance provided, as required, by two procurement staff. Engagement with the procurement team was not mandatory and staff throughout NES were able to procure goods and services without the input of the procurement team.

A review of procurement activities identified that over 300 staff had some involvement in the procurement cycle. It also identified various risks, limitations and disadvantages:

- multiple suppliers engaged for similar/same commodities
- no aggregation of demand resulting in multiple small value POs raised against a single supplier (1,500 POs less than £50)
- full advantage not being taken of national contracts, losing potential cost savings
- little opportunity for strategic management of suppliers and contracts
- valuable specialist resource throughout the organisation engaged in procurement rather than their core activity
- inconsistent application of procurement legislation

- inexperience and a lack of understanding of the procurement process results in process inefficiencies

Aim

To transform the way procurement is carried out in NES by implementing a centrally managed procurement team.

Action taken

The Procurement Transformation Project was established to develop the procurement operating model and organisational structure. The project was split into three separate workstreams which consisted of:

- **People** - to focus on the organisation structure and job descriptions, identifying impact on individuals and Directorates, and carrying out the staff consultation
- **Process** - to conduct a capacity review exercise and carry out the modelling and mapping of the proposed procurement journeys
- **Communication** - to involve staff and ensure they were kept up to date

Results

The centrally managed procurement team was introduced in October 2013, which has led to many benefits and improvements, including:

- initial savings of £300,000 and on-going savings of £430,000
- staff promotion and career development opportunities
- 10 per cent increase in Procurement Capability Assessment and the Procurement Transformation Project described as best practice
- category A contract compliance has increased to over 99 per cent
- the majority of POs are processed within one hour

Efficiency savings and productive gains

.....

Initial savings of £300,000 and on-going savings of £430,000 have been realised.

There has been productive gain with staff time being released as a result of no longer having to carry out procurement activities.

Sustainability

.....

A full review and evaluation will take place once the team has been in place for 12 months. In the interim, a short satisfaction survey has been issued to all staff so that the team can endeavour to provide the best possible service.

Lessons learned

.....

- Ensure managers are engaged in the process by involving them early and as much as possible.
- Involve staff in the communication strategy to ensure consistent messages are provided at all times and the positive aspects of the change are clearly communicated.

Efficiency Savings made by the Marketing Team

Background and context

NHS Health Scotland has identified organisational excellence and innovation as one of the five core programmes required to deliver our strategy A Fairer Healthier Scotland (AFHS). This strand of activity, central to our business model of continuous improvement, is demonstrated through this case study which builds on efficiency savings reported in the 2012-2013 QuEST Annual Report.

The marketing team is a team of 30 professionals who are expert in the fields of defining and reaching target audiences; producing publications; web and digital content; and associated procurement.

The marketing team is responsible for designing, delivering and evaluating strategic marketing communications outcomes to support and equip NHS Health Scotland to achieve the ambitions outlined in A Fairer Healthier Scotland. The team works with colleagues from across the organisation to identify tailored communication channels and products for specific target audiences.

A key part of the function of the marketing team is to procure products and services efficiently and effectively, using their specialist expertise along with creativity to find cost effective, innovative, fit for purpose communication solutions that effectively meet the needs of the target audiences.

Problem

NHS Health Scotland is operating under the constraints of reduced budget and had a 5 per cent efficiency target.

Aim

Cost-effective product development and procurement are part of the marketing team's core function and are embedded into its procedures and processes. The team was empowered to develop innovations that would contribute towards NHS Health Scotland's 5 per cent efficiency target. They also had a target of matching the £123,151 efficiency savings made in 2012-13.

Action taken

Utilising staff's professional expertise and creativity to find ways to maximise efficiency savings through the following methods:

- operating within Scottish Government approved procurement frameworks and competitive tenders processes
- examining the specification/supplier for every project to ensure the most cost effective solution
- negotiating price discounts on bought-in products provided by specialist suppliers not on the Scottish Government framework.

Results

Overall financial savings of £158,984 achieved for 2013-14 (29 per cent increase on 2012-13 figures) against a total publishing budget of £1,179,000 (13.5 per cent savings).

These results demonstrate a real and continuous year-on-year improvement by the team since efficiencies started to be recorded in 2010-11.

Patient experience

NHS Health Scotland continues to develop and provide high quality communication products and services for our target audiences. Most of the above work remains unseen by the patients. In the case of the Play@Home series of publications, we radically changed the format and binding to realise £78,000 of efficiency savings. There is no evidence of any detrimental impact to service provision at the front line and we continue to experience high demand for the materials.

Staff experience

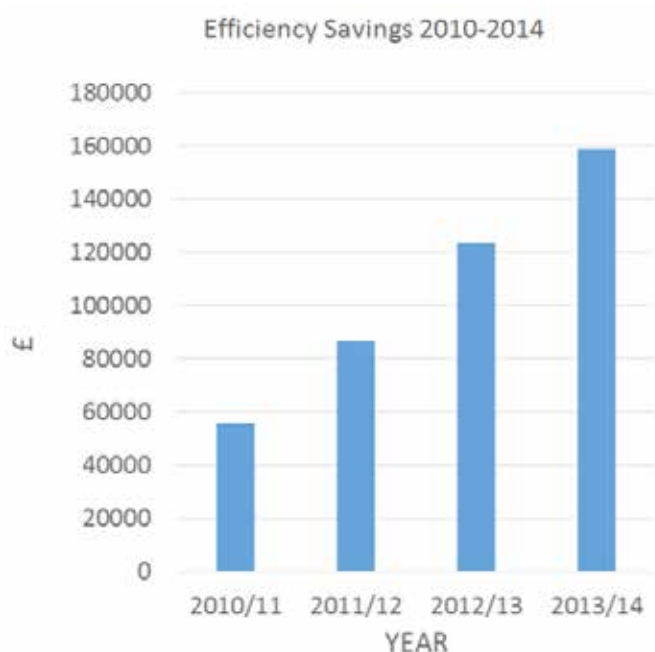
Marketing staff feel empowered that their specialist expertise is acknowledged and that the budget saved is being reinvested to tackle inequalities, improving feelings of job satisfaction. Staff report that their ability to positively influence colleagues has increased.

Efficiency savings and productive gains

Efficiency savings of £158,984 made through:

- changing existing supplier to achieve a competitive price: £9,445
- changing existing specification to reduce costs without negatively impacting overall quality: £115,175
- negotiating price discounts on bought-in products provided by specialist suppliers not on Scottish Government frameworks: £33,640

The chart below demonstrates the savings for the last four years:



Sustainability

These procurement and product development approaches have been embedded within marketing's standard procedures and are applied to every project. They are very much part of the day-to-day operation of the team.

In addition, the team has championed the use of carbon-balanced paper from sustainably-managed forests and has been awarded a certificate by the World Land Trust for

off-setting 123,000kg of carbon dioxide between April 2013 and March 2014. This represents a fivefold increase over the previous year.

Lessons learned

The Marketing team has increased its confidence to provide constructive challenge to colleagues to ensure that their professional expertise is fully utilised to deliver the most efficient and effective outputs. A good example of this was the £78,000 savings realised on one series of publications by changing to a more cost-effective format and binding, whilst maintaining the quality of the product. Sharing examples across the team helps to share the knowledge and motivates the team to continue to deliver efficiencies.



SHARED SERVICES: HARD FACILITIES MANAGEMENT

ABOUT THE PROGRAMME

Douglas Seago
t: 07805 862143
e: douglas.seago@nhs.net

drivers

The key drivers for change were identified by Directors and Heads of Facilities Services across NHSScotland.

These include:

- Skills shortages and a need to share scarce specialist resources
- A need to develop services, building on models of good practice already extant in NHSScotland
- A need to reduce variation and exploit the economies of scale offered by NHSScotland
- A need to share intelligence amongst NHS Boards regarding major contracts
- Changes in legislation and government policy in relation to improved environmental standards
- Health and social care integration which will require closer working between NHS Boards and Local Authorities

aims

- Improve the quality, efficiency and resilience of facilities services
- Support change in healthcare delivery and, where possible, accelerate change
- Ensure that facilities services are fit-for-purpose to support NHS Boards to deliver the 2020 Vision
- Build on the opportunities offered by wider collaboration with public and private sectors
- Ensure better use of specialist resources, ensuring specialist skills are shared across NHS Boards

These objectives are supported by a number of workstream specific objectives:

- Ensure the capital programme is delivered
- Ensure proper skills are available for delivering maintenance
- Ensure better investment of capital in relation to sterile services
- Improve procurement for transport
- Increase contract management capacity and capability

workstreams

- Capital and Hard FM
- Sterile Services
- Transport
- PPP (Public-Private Partnership)
- Waste

achievements 2014

- Completion of an options appraisal to assess options for service delivery to address skill and staffing shortages in relation to capital planning. Development of a regional model of capital planning to share resources and build on good practice already extant, for example, in NHS Grampian and NHS Highland.
- Establishment of a contingency plan and business continuity arrangement in relation to the provision of sterile services. Quantification of spare capacity through a review of decontamination of endoscopy and primary care equipment.
- A review of all logistics routes has been completed, the results of which will be used to rationalise routes and vehicles.
- Establishment of a national advisory group to share best practice in relation to operational management of PPPs to drive significant savings from PPP contracts to ensure best value and improved delivery of patient care. Up-skilling of staff to enable challenge of contracts, with the involvement of the Scottish Futures Trust (SFT).
- Development of common standards and training systems in relation to waste management to encourage recycling and reduce the level of waste sent to landfill to achieve compliance with the Waste (Scotland) Regulations 2012.
- Full engagement of NHSScotland in the programme (including NSS Project Management Service, National Procurement, Health Facilities Scotland (HFS), NHS Boards and staff side).

priorities 2015

- Transition of Hard Facilities Management to business as usual including identification of areas where NHS Boards are purchasing the same supplies and services which could be procured through a national contract by National Procurement.
- Development of a common barcoding and tracking system to enable tracking and traceability of instruments enabling NHS Boards to share more costly equipment and resources.
- Implementation and embedding of standardised principles for car leasing in all NHS Boards.
- Development of a PPP core team to advise on operational management of PPP contracts and transition of this workstream to business as usual through HFS.
- Transition of the waste workstream to business as usual through HFS.



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/shared-services/facilities-shared-services.aspx>

Public Private Partnership and Private Finance Initiative

Background and context

A Public Private Partnership (PPP) is a government service or private business venture which is funded and operated through a partnership of government and one or more private sector companies. Private Finance Initiative (PFI) is a specific type of PPP whereby capital investment is made by the private sector on the basis of a contract with government to provide agreed services and the cost of providing the service is borne wholly or in part by the government.

NHSScotland currently has 28 live PPP and PFI contracts. The first buildings were occupied in the early 1990s and had a total estimated capital value of £1 billion at the time of construction.

These PFI/ PPP contracts have a total unitary payment for the participating nine NHS Boards of £215 million per annum. The service element is £86 million per annum, giving a non-service or financing element of £129 million per year. This financing element is generally fixed unless refinancing is negotiated; in the current economic climate this could be considered feasible for a very small number of contracts.

Problem

Contract management skills throughout NHSScotland are variable. This means, in some instances, NHS Boards are not receiving the level of service they are paying for. In addition, there is variability between NHS Boards who have contracts with the same provider, meaning that some NHS Boards are paying a greater sum for the same service.

Contract management practices vary between and within NHS Boards. In some NHS Boards there may be a number of contracts, each one being run by a separate team leading to a lack of consistency. There is also a large amount of duplication throughout NHSScotland and within each NHS Board, which results in poor resource utilisation.

As each NHS Board operates in isolation there is a lack of sharing of good practice, knowledge and expertise between NHS Boards and no option to participate in critical mass opportunities.

A more powerful, consistent client-side, empowered with contract management skills and the knowledge of good practice, would help to ensure that NHS Boards receive what they pay for within their existing contracts.

Aim

The PPP/PFI project was established as part of QuEST's Facilities Shared Services Programme in 2012. The project objectives were established as:

- Improve contract management of the variable element within PFI/PPP contracts and to deliver a 2 per cent (£2.16 million) recurring reduction in the variable element costs with no diminution in service. The variable element would be defined as the service element of £86 million plus energy costs of £22 million, thus giving a total of £108 million.
- Produce a Recommendations Report to the Facilities Shared Services Programme Board on improving the effectiveness of contract management and monitoring within PFI/ PPP contracts by December 2013.
- Produce an Options Appraisal to the Facilities Shared Services Programme Board for the management of operational PFI/ PPP contracts across NHS Scotland based on three options: local (individual NHS Board), regional (geographically based) and national by December 2013.

Action taken

.....

In October 2012 NHS Lothian hosted a workshop to identify the common issues in the monitoring and management of operational PFI/PPP contracts across NHSScotland.

A range of issues were identified and one of the identified priorities was the establishment of an advisory group to share good practice, lessons learned, and to provide mutual support. A PFI/PPP Advisory Group was established to meet this need. The group has representation from all NHS Boards with PFI/PPP contracts and colleagues from Scottish Futures Trust (SFT).

Following establishment of the PPP/PFI project a data gathering exercise was undertaken across NHS Boards to identify the current PPP/PFI contacts. Data was gathered on the contract value, timeframe, provider, services provided and contract management arrangements. In addition this was also an opportunity to identify the issues and priorities for NHS Boards in relation to PPP/PFI contracts.

A gap analysis was undertaken based on the NHS Board priorities, comparing the as-is state to the desired to-be state. Following the gap analysis a Recommendations Report on improving the effectiveness of contract management and monitoring within PFI/PPP contracts was presented to the Facilities Shared Services Programme Board. This report was accepted and endorsed in December 2013.

An option appraisal process to identify options for the future delivery of operational PFI/PPP contracts in NHSScotland was undertaken by the Core Project Team and the Advisory Group. At a workshop event held in October 2013, the group scored the shortlisted options on the basis of non-financial benefits and identified a preferred way forward. All shortlisted options were costed and the non-financial and financial benefits then combined to give the recommended preferred option. This workshop played a crucial part in engaging stakeholders in co-creating the solution.

The preferred option was identified as a regional model with national support. NHS Boards will share/ re-deploy staff resources so that PFI/PPP contracts are managed by teams of contract management and contract monitoring staff arranged on a geographical or functional basis. The responsibilities of these regional / grouped teams will include day to day monitoring, managing cyclical tasks, including benchmarking, dispute resolution, compliance and variations, together with the development of the new HubCo, Non-Profit Distributing (NPD) and other revenue funded schemes.

Additionally there will be a central specialist support team established to provide expert advice on PFI/ PPP/ NPD / HubCo, and to act as a single point of contact for the regional teams. The responsibilities of this support team will include training and developing capability in client side expertise, providing central advice on legislation/ guidance, sharing and dissemination of best practice nationally, providing independent review and support, and maintaining strategic oversight of contracts in NHSScotland.

The report on Options Appraisal for the management of operational PFI/PPP contracts across NHS Scotland based on three options: local (individual NHS Board), regional (geographically based) and national was accepted and endorsed by the Facilities Shared Services Programme Board in December 2013.

The Business Case was approved in August 2014.

Results

.....

The following results have been achieved by the PPP/PFI project:

- A PFI/PPP Advisory Group has been established to share good practice, lessons learned, and to provide mutual support. The group has representation from all NHS Boards with PFI/PPP contracts and colleagues from SFT.
- As a result of the data gathering exercise, for the first time there was visibility at NHSScotland level of the PPP/PFI contacts in place and also of the level of variation

between contracts. This has enabled negotiations to be undertaken with providers to standardise some of these variations.

- A PPP/PFI Specialist Support Team has been established to provide expert advice and support to contract management staff within Boards. The team will provide a ‘knowledge centre’ for existing PFI/PPP contracts and future private revenue funded projects, for example NPD and HubCo.
- Savings of £670,000 were achieved in 2013-14. It is estimated that savings of £1.07 million will be achieved in 2014-15 and savings of £2.16 million will be achieved in 2015-16.
- Collaborative working with SFT has been established and SFT personnel are embedded within the Specialist Support Team to carry out in-depth contract reviews and provide focused commercial support to NHS Boards to negotiate changes to individual contracts.
- Facilitation of NHS Boards working together to share expertise and skills to drive maximum value from PPP/PFI contracts.

Patient experience

The following patient benefits are anticipated as a result of the PPP/PFI project:

- Significant savings will be realised by NHS Boards which can be reinvested in patient care.
- Patients will be in a better environment and will receive a better level of service including cleanliness, quality of catering, increased and more timely maintenance.

Staff experience

The following staff benefits have been realised as a result of the PPP/PFI project:

- Staff responsible for contract management feel empowered and able to do a better job.
- Staff responsible for contract management will have access to consistent, specialist central advice and will be able to share

good practice and skills.

- Staff based within PPP/PFI sites will know how to report defects.
- Staff will be in a better environment and will receive a better level of service including cleanliness, quality of catering, increased and more timely maintenance.

Efficiency savings and productive gains

In 2013-14 recurring efficiency savings of £670,000 were achieved as a result of negotiated savings as an alternative to Soft FM benchmarking – installation of energy efficient lighting and removal of theatre humidification.

In addition this model offers the potential for:

- Maximum resilience as a larger regional operation may have a wider range of expertise that can be shared
- Greater consistency across larger geographical areas to minimise variations
- Potential to benefit from economies of scale
- Potential to share training opportunities

Sustainability

The establishment of the Specialist Support team will ensure that savings and benefits continue to be realised. The provision of on-going support to NHS Boards will help to build capacity and capability in respect of contract management expertise. In addition, a training programme will be implemented to ensure that the requisite skills and expertise are available in-house.

Lessons learned

The following key lessons have been learned:

- It is crucial to use a project management approach to manage change. Using a structured approach with clear plans and milestones helps to maintain momentum and drive the change forward. Project and programme management is also important to ensure that benefits are captured and realised. As the project transitions

to business as usual, these tools and techniques will continue to be used.

- It is important to engage with stakeholders to ensure buy-in to the process. Engagement with stakeholders to identify their needs and issues, and to co-produce a solution ensures that the change is sustainable.
- This project was driven by a desire to improve the quality of service rather than realise savings. However, this is also a benefit of the work.

Next steps

.....

- The Project Team will undertake a process to establish benefits realisation processes and undertake lessons learned reviews.
- Although work has commenced it is necessary to recruit additional posts to the Specialist Support Team including a Senior Advisor and a Project Support Officer.
- A key area of focus will be the identification of priorities for the Specialist Support Team using a work plan approach (it is anticipated that the number of HubCo/ NPD contracts will increase). A number of requests for consultancy support and SFT in-depth review have already been received suggesting there will be a large demand for the service.
- The Business Case will be reviewed at the end of March 2016. At this point it will be decided whether the team will transition to business as usual and become a core function.

Patient Transport Project

Background and context

An Integrated Patient Transport Strategy was agreed to implement the following:

- development of alternatives to use of patient transport services
- development of voluntary sector transport services – ‘Getting You There’ single booking system for community transport established (Change Fund)
- Integrated Day Service Transport – dedicated service established in Peebles
- discharge transport – improved booking systems, dedicated daytime discharge vehicle, reduced use of private ambulances
- renal transport – establishment of dedicated service

Problem

- Overspend on patient transport budget
- Patient-centred service efficiency

Aim

To conclude cost-saving elements of the Patient Transport Strategy and deliver remodelled patient transport services to meet changing service delivery models.

Action taken

- establish dedicated renal transport service provided by Scottish Ambulance Service (SAS) and release funding currently allocated to renal transport
- commission single provider service for NHS and Scottish Borders Council (SBC) older peoples day services and release SAS resource from day hospitals

- release recurrent £50,000 funding for out-of-hours vehicle
- continue to reduce spend on private ambulances to a minimum (aim to ensure all transport is within £80,000 budget)
- establish effective performance monitoring and governance of transport, including mainstreaming operational management of patient transport

Results

- Establish dedicated renal transport:
 - Extensive negotiations to establish a solution continue with SAS as the concept of a dedicated renal service provided by SAS contravenes Patient Transport eligibility criteria. Other service providers are also under consideration.
- Commission single provider service (Haylodge)
- Release recurrent £50,000 funding for out-of-hours vehicle:
 - To achieve this goal required the release of the SAS vehicle/staff from the single provider – Haylodge Joint Working initiative with SBC, however, SAS have been, and continue to, experience resource challenges and a reluctance to accommodate shift patterns that reflect Borders General Hospital (BGH) peaks which has not enabled this to succeed. SAS are currently involved in a recruitment drive whereby shift patterns offered will reflect BGH peaks (predominantly between the hours of 2pm and 6pm) which should address and release the recurrent funding.
 - SAS TD15 funding - £30,000 savings realized as of April 2014.
- Reduce spend on private ambulances:
 - 2012-13 £81,300
 - 2013-14 £35,448

- Establish effective performance monitoring and governance:
 - Transport bookings (SBAR) are transposed into an excel spreadsheet which automatically creates data charts that allow us to study the results of our actions each day from service utilization, daily sitrep, cost, peak challenges, etc. and allow us to react effectively and efficiently based on supported evidence.
 - Daily calls to SAS to establish service provision for that day/week vs average discharge (SAS transport calculator/schedule)
 - Transport bookings only once med/letters are with patient
 - Attendance at Alpha Zone/Delta Zone
 - Attendance at 11am meeting
 - Quarterly finance tracking/invoice reconciliation
 - PTS DATIX – review/report/address
 - SAS/PTS manager meetings
 - Engagement with Winter Planning Group
 - SBC Sustainable Transport review
 - Operational Transport Group – BGH, SBC, public participation members, private ambulatory services, voluntary groups
 - Transport packs provided to wards, emergency department and community hospital with details of all available transport/support options, contacts and telephone numbers
 - Patient standard operating procedures/eligibility assessment

Patient experience

.....

Patient expectations are managed through clear, concise and consistent communication utilizing all available transport (SAS/voluntary/private) to ensure an improved, timely and appropriate discharge experience.

Staff experience

.....

Expectations are now successfully managed and working relationships between staff and providers have improved considerably, promoting flexibility and dual directional support further promoting a patient-centred experience.

Efficiency savings and productive gains

.....

Efficiency is consistently delivering more, lowering costs, whilst improving service quality:

- 2012-13 - £461,255
- 2013-14 - £359,001

Sustainability

.....

An exit strategy meeting has been held to establish if there is an appetite to engage a PTS manager/coordinator or divide the activities between current staffing complement.

This has yet to be decided.

Bespoke Care Facilities for two Learning Disability Patients with Complex Needs

Background and context

Patient A had a long standing history of unpredictable behaviour and required to be managed in a secure setting not available in Fife.

Patient B also had complex needs and was being cared for within an assessment and treatment facility within Fife.

Problem

Due to the complexity of their needs Patient A had been cared for in a facility in England for a number of years. Following a review of the placement it was found that it no longer adequately met the patient's clinical or social needs and was at the extreme high end in terms of cost.

Patient B's needs were not being adequately met within the assessment and treatment facility particularly as the facility had a high turnover of patients which did not readily allow for a quiet environment being maintained. This resulted in a high staff to patient ratio in order to safely care for the patient who has extremely challenging behaviours.

Aim

To provide a cost effective local facility to meet the complex needs of patients A and B. To

provide increased therapeutic involvement from a multidisciplinary care team with the aim to provide improved health outcomes. The ultimate aim is to integrate the patients into the service's mainstream provision.

Action taken

Following an assessment of the local NHS Fife estate an opportunity was identified to refurbish a unit within the existing Learning Disability campus. The unit was designed with the input of the patients, the patients' relatives and specialist staff to meet the patients' needs, provide a stable and homely environment for the patients and their families and to promote the multidisciplinary provision of therapeutic care.

Results

Patient A – although progress is slow, the clinical view is that therapeutically the patient is stabilising and there has been significant improvement in the patient's anxiety levels and their ability to engage with staff.

Patient B – the patient has a team of dedicated staff which ensures continuity of care, as a result the staff to patient ratio has been reviewed and with a change in the patient's behaviour has been gradually reduced. The relocation of the patient has also allowed for increased capacity in the assessment and treatment unit.

Patient experience

Having returned to Fife, Patient A has benefited from closer and more regular contact with their family. The environment is bespoke to the patient's individual requirements and their clinical care is tailored to meet their complex needs.

Patient B's parents are able to visit on a daily basis and have positive input in the treatment plan. The patient has benefited from the quieter environment and behaviour has improved to the extent that the patient has now been categorized fit for discharge (albeit to a highly supported package).

Staff experience

.....

There is a crossover of staff in managing the care of these patients within this small unit. Staff benefit from the co-location with other learning disability services in terms of communication, staff training, and line management.

Efficiency savings and productive gains

.....

In financial terms a recurring efficiency saving of £320,000 was identified by relocating Patients A and B to the bespoke facility. The quality of life of both patients and their families has been significantly improved and the quality of care has also been improved.

Sustainability

.....

The individuals care packages are funded on an on-going basis. The bespoke unit is part of the NHS Fife estate and as such will be maintained and serviced as part of that estate.

Lessons learned

.....

A review of the placements of patients with learning disability and complex needs revealed opportunities to improve patient care and reduce costs on an on-going basis. Investment in existing but underutilised estate allowed the development of a cost effective specialist facility which will meet these individuals medium to long term needs.

NHS Board Case Study

NHS National Services Scotland

NSS Office Consolidation and Rationalisation Programme

Background and context

In accordance with the Scottish Government Health and Social Care Directorate's Policy for Property and Asset Management in NHSScotland CEL 35(2010), NHS National Services Scotland (NSS) has a Property and Asset Management Strategy (PAMS) which is reviewed, updated and approved annually by the NSS Board.

Between 2003 and 2011 NSS successfully completed a significant number of property acquisitions and disposals across Scotland (primarily in Edinburgh, Glasgow and Aberdeen) aimed at consolidating and modernising its portfolio of office accommodation.

Problem

NSS identified that its office estate was oversized as a result of reducing numbers of staff requiring office space together with changing technologies and ways of working. This opened up the potential for reducing the size and cost of NSS's office estate going forward.

Aim

Since 2011, NSS has continued to progress a programme of further consolidation and

rationalisation of its office estate with a view to:

- improving space utilisation and driving out inefficiencies
- reducing recurring revenue costs
- providing well designed space that supports changing working practices and new technology and enables the introduction of agile working
- achieving synergies from sharing accommodation and support services with other NHSScotland NHS Boards

Action taken

NSS, supported by the Scottish Government, has been proactive in identifying opportunities to optimise the utilisation of office accommodation in Edinburgh and Glasgow by generating co-location opportunities with other Special Health Boards, thereby both reducing accommodation costs overall and also achieving best value in terms of shared facilities and services.

Results

NSS has delivered key results in terms of:

- its own office property portfolio consolidated into fewer sites and less space
- reducing costs, maintaining or improving services and providing modern and flexible working environment for staff
- sharing its estate and estate services with other NHSScotland NHS Boards, e.g. Scottish Ambulance Service, NHS Health Scotland and Healthcare Improvement Scotland all now work out of a Special Health Board 'Hub' at Gyle Square, Edinburgh
- tangibly contributing to the wider public sector 'smarter offices' agenda
- The financial benefit delivered between FY12 and FY14 has been £1.20 million per annum and as our activity plan continues through to 2016 we expect to see a further £1.44 million per annum of efficiencies delivered.

Staff experience

The replacement of NSS's stock of old, inflexible and dilapidated office accommodation with modern, fit for purpose facilities has resulted in a better working environment for our staff, making NSS a better place to work; one of our four strategic objectives.

Efficiency savings and productive gains

The following table illustrates the changes in the NSS's office estate from FY12 to the present date and through to FY16:

Please refer to table on [page 132](#).

Sustainability

The following chart illustrates the recurring revenue savings as a consequence of implementing the NSS programme of office consolidation and rationalisation since 2012 to the present date and then forward over the next ten years to 2024:

Please refer to chart on [page 132](#).

From a FY Baseline of £10.38 million per annum the total cumulative savings (baseline plus inflation v actual) over the 13 year period amount to £48.4 million which is broken down as follows:

- FY12 - FY14: £2.7 million
- FY15 - FY19: £18.8 million
- FY20 - FY24: £26.9 million

Lessons learned

NSS is also playing a leading role in developing and delivering the NHSScotland Smarter Offices Programme in conjunction with Scottish Futures Trust. The programme is focused on the corporate office portfolios territorial and special NHS Boards and its key objectives are to:

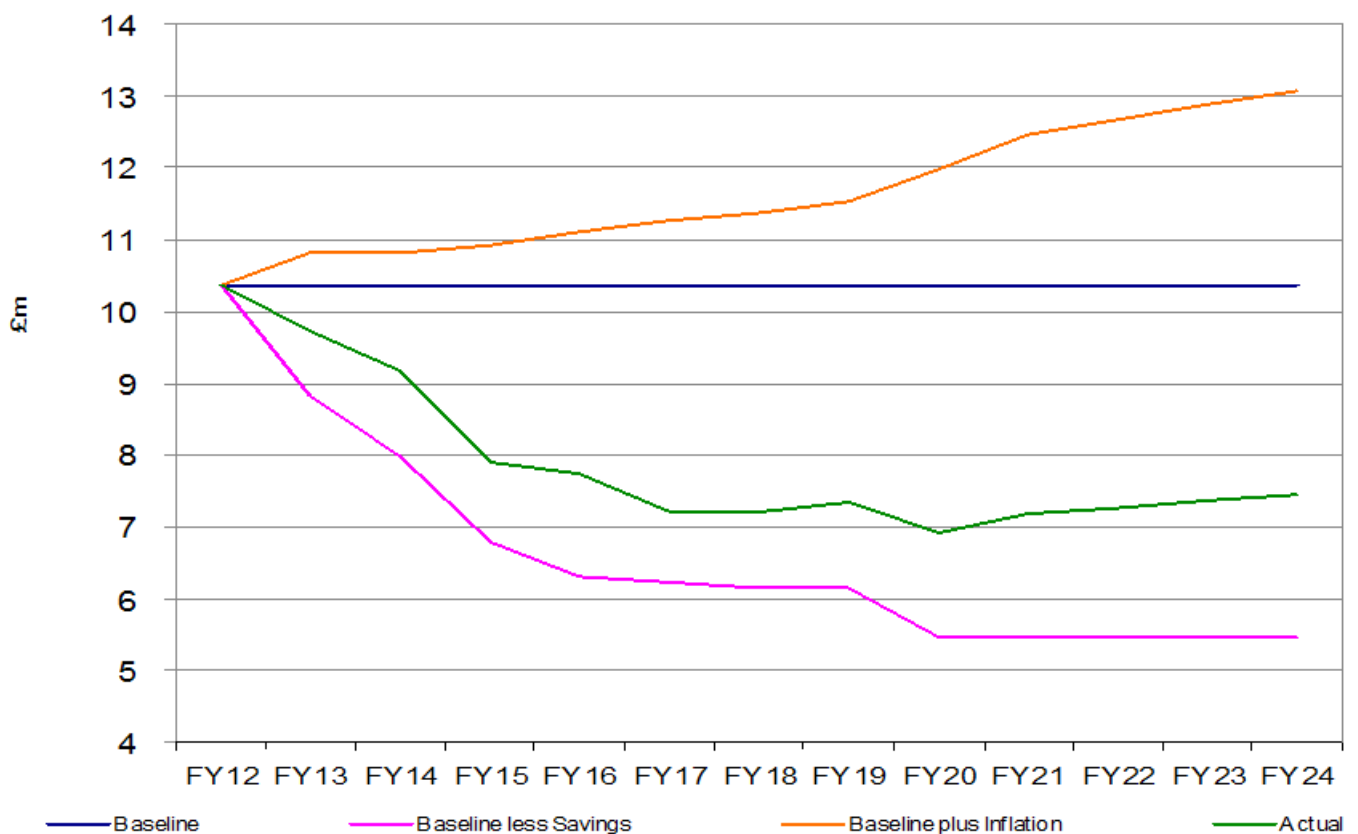
- improve the utilisation of office accommodation across NHS corporate office facilities by identifying opportunities for

consolidation and rationalisation, increased agile working and shared use of space with other public sector partners

- identify appropriate key performance indicators (KPIs) for monitoring and benchmarking of performance through the national performance framework
- use the national performance framework to improve the utilisation of NHS office accommodation through benchmarking and comparison with best practice and industry standards
- review of asset management strategies and provide challenge to improve performance
- agree target areas for improvement with each NHS Board
- identify areas of best practice within each NHS Board and develop plans for rollout
- develop investment and savings plans

NSS Office Accommodation		FY12	FY14	FY16	FY12 v FY16	
					+/-	% +/-
Space (m ² NIA)	Total	27,366	24,418	20,320	(7,046)	(25.7%)
	% of total estate	38.4%	35.8%	31.9%	(6.5%)	(16.9%)
	per person	11.95	10.84	9.19	(2.76)	(23.1%)
Cost of space (recurring Revenue)	Total	£10.38m	£9.18m	£7.74m	(£2.64m)	(25.4%)
	% of total estate	69.7%	65.4%	60.9%	(8.8%)	(12.6%)
	per person	£4,470	£4,074	£3,500	(£970)	(21.7%)

NHS National Services Scotland Office Estate Cost Analysis
(Financial Year 2012-2014)





SHARED SERVICES: SOFT FACILITIES MANAGEMENT

ABOUT THE PROGRAMME

Martin Henry
t: 0131 244 7795
e: martin.henry@nhs.net

drivers

The Shared Services Programme is part of NHSScotland’s long-standing commitment to the people of Scotland to ensure that our quality services are good value for money.

The purpose of the Strategic Review of Soft Facilities Management is to take stock of how facilities management (FM) is being delivered across NHSScotland in different NHS Board areas. It will also look to find out if there are better ways that the NHS can provide these services.

The State of the NHSScotland Estate (2012) identified the need for ‘a full and comprehensive NHSScotland wide strategic review of the basic systems and processes within Soft FM to ensure they remain effective and efficient. In particular there is a need to assess the potential for utilising relevant technological innovations to improve service effectiveness and efficiency’.

aims

Review all soft facilities management services across NHSScotland to see how the current service works and look at options to improve patient safety, efficiency and user satisfaction. The specific objectives are:

- The programme will complete a strategic review of soft FM services across NHSScotland, including an assessment and prioritisation of potential service improvement opportunities.
- The Strategic Review will be presented to the NHSScotland Efficiency Portfolio Board and the Chief Executives’ Group in order to consider, approve, and prioritise the potential service improvement opportunities for project initiation.

workstream

- Catering
- Linen and laundry
- Domestic
- Portering
- Retail

service improvement opportunities

Catering	Introduction of a range of standard meal delivery systems
	Introduction of standard patient menus
	Introduction of a standard meal ordering and stock control system
	Introduction of NHS-run bakeries and Aroma cafe
	Re-provision of catering production units
Laundry	Introduction of policies for the standardisations of linen, theatre drapes, blinds, curtains and bed screens
	Introduction of a national contract for purchase, repair and maintenance of laundry equipment
	Re-provision of laundry production units
Domestic	Introduction of standardised floor cleaning equipment and material
Portering	Recommendation of how the Portering role should adapt in order to support changing clinical services
	Introduction of a standardised tracking system
	Re-provision of mailroom services
Retail	Introduction of standardised private sector lease return rates
	Introduction of NHS-run retail outlets

achievements 2014

Catering reviews for each NHS Board are currently being completed by a catering expert, who has worked within the NHS environment in a number of locations. The reviews are identifying current service levels and costs for both patient catering and non-patient catering. These reviews are being conducted on a Board-by-Board rolling programme and will also identify cost savings and efficiencies.

Catering reviews have now been completed in all NHS Boards with the exception of NHS Greater Glasgow and Clyde, NHS Forth Valley, The State Hospital, National Waiting Times Centre Board and NHS National Services Scotland. Although there is significant variation in the cost of patient meals, food and labour, across NHSScotland, the initial findings have also shown a high standard in the quality of food and service.

After the first few catering reviews had taken place, it became clear that the services have been looking for a support tool to aid the efficient running of departments. Funding was approved for the initial two pilots of a Catering Information System – one in NHS Borders and one in NHS Fife. These pilots have now been running for several months and are already showing an impact in service improvements and efficiency gains, such as reduction in food waste and stock holding.

Features of the system include:

- An easy to use management tool that allows full analysis of all catering data
- Bespoke to each site
- Focuses on improving quality while reducing cost
- Mentoring and support for catering managers

priorities 2015

.....

- Prioritisation of the national service improvement opportunities across NHSScotland Catering, Domestic, Laundry, Portering and Retail services. Following approval, these prioritised opportunities will be progressed as part of the Programme during 2014-15.
- Further rollout of the Catering Information System and associated patient ordering system across NHSScotland



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/shared-services/facilities-shared-services/programme.aspx>

Programme Case Study

Catering Information System

Background and context

The Strategic Review of Soft Facilities Management (FM) Programme was initiated in November 2012 as part of the Facilities Shared Services Workstream within the Efficiency and Productivity Portfolio and encompasses the following services:

- Catering
- Domestic
- Linen and Laundry
- Portering
- Retail

As part of the first phase during 2013-14, the Programme set out to assess the current service provision across NHSScotland and evaluate potential service improvement opportunities which would identify the priority projects for the second phase of the Programme.

Problem

Board-specific catering reviews were conducted as part of the programme during 2013-14. Emerging findings from some of the early reviews indicated that a number of services were operating below their potential because of significant inefficiencies and wastage. This was partly driven by the lack of access Catering Managers have to timely and accurate service data which would allow them to make informed decisions and take appropriate management action in order to drive out waste and reduce costs whilst improving the quality and consistency of services.

Within NHS Fife there was a generic IT system with limited ability but no dedicated catering

IT system in place to capture all of the below items:

- Meal production numbers
- Production wastage and costs
- Purchases
- Stock control management
- Retail pricing, sales and margins

There was also a substantial non-patient subsidy.

Aim

To test the implementation of a Catering Information System (CIS) which would provide timely service data to the catering management in order to support cost and waste reduction decisions without negatively affecting the patient experience and quality of service.

Action taken

A bespoke Excel-based CIS was introduced to Queen Margaret Hospital (QMH) in Dunfermline. This enabled the local Catering Management Team to have instant access to review data including:

- Stock holding and consumption
- Meal production numbers for QMH
- Purchasing data
- Non-patient retail operations
- Production wastage

Results

The data produced by the CIS allowed the Catering Team to review all aspects of production/purchasing and stock holding, and also to review retail items that offered the best margin and produce a profit and loss account for non-patient catering.

Patient experience

A more efficient and productive catering service at QMH helps the service to be more consistent in meeting patient meal needs and requirements.

Staff experience

.....

"We introduced the Catering Information System at Queen Margaret Hospital, Dunfermline in September 2013. We use the system daily to track all our revenues, costs and wastage. With all information being linked and stored together it is very user friendly and gives you up to date information at the touch of a button. With our wastage being recorded we can show a significant drop in our overall waste which is easily monitored and recorded" Saffron Moir, Assistant Catering Manager, NHS Fife.

Within the production kitchen at QMH timely information for production has encouraged competition between cooks to aim for "spot-on" production.

The CIS has helped to decrease the management, storekeeper and clerical time and effort involved in stock management.

Efficiency savings and productive gains

.....

A total of £40,000 was saved within a year following an investment of £10,400 in the pilot system – a return on investment of 4:1. This specifically includes:

- A reduction in waste of £5,000
- Gross profit margin increase of £10,000
- Resource release saving of £20,000
- Service demand production accuracy – saving of £5,000

Sustainability

.....

Moving the system from Excel to a web-based format and linking it to an existing Health Facilities Scotland platform will support benchmarking and further embed the use of the system into NHSScotland catering management practices.

Lessons learned

.....

Sustaining the use of the system and ensuring the full range of the applications and reports are used by catering management requires training, mentoring and support in collecting and entering data, running reports and

analysing the results in order to take corrective action.

Next steps

.....

In the course of 2013-14 the pilot was also extended to NHS Borders, NHS Lanarkshire, NHS Tayside, NHS Shetland and NHS Orkney, with these NHS Boards now spreading the use of system and beginning to realise associated benefits.

The Catering Information System project, to be taken forward as part of the Programme and subject to tendering and funding, will encompass the move from Excel to a web-based platform and further development in Bedside Electronic Patient Meal Ordering.

Improving Efficiency and Reducing Cost in Laundry Services

Background and context

NHS Orkney has an ongoing requirement to make efficiency savings, with all departments contributing to achieving the NHS Board's savings target. Within the estates and facilities department there was an awareness of the national review of soft services and the need for all NHS Boards to explore opportunities for new ways of working, using partnership arrangements where appropriate to improve quality and reduce cost.

Problem

A review of NHS Orkney's performance against benchmarking data highlighted that laundry costs were much in excess of national averages (more than double at one stage at £1.46 per item). It was recognised that there were issues with the remoteness of Orkney and travel challenges which meant a partnership solution would not be ideal. However, there was a need to ensure learning and best practice from other NHS Board areas was used to support the roll out of improvements in the laundry operations which brought the cost per item in line with national averages.

Aim

To reduce laundry costs per item to in line with national averages by March 2014.

Action taken

The national benchmarking strategy was used as a means of understanding exactly how much we were spending to process each and every individual item of laundry. When labour, utilities, high cost of oil and steam generation etc were all considered the per item cost was in excess of £1 against an approximate cost of £0.50 per item nationally.

We then considered the soft services review, consulted with the national soft services lead and obtained advice from the assistant director at Health Facilities Scotland and concluded that biggest single expenditure in the laundry was the processing of staff uniforms, resulting in 33 per cent of the annual laundry throughput.

In line with national trends we created a business case outlining the expenditure and the efficiencies that could be made. The business case also highlighted the risks and mitigation that would be required to manage these risks as well as any remaining residual risk. Through the Corporate Management Team and Area Partnership Forum we were able to outline the existing pattern of expenditure and the case for reviewing the practice of laundering of staff uniforms.

Assurances were given to laundry staff that there would not be any redundancies as a result of the change however they may be offered the opportunity to evolve into other roles.

The process was supported by a significant piece of internal communications work which outlined the rationale for the change to staff and gave them the opportunity to contribute to discussions. The change in practice was perceived as the removal of staff benefit by some but was in general widely accepted as an appropriate way forward, particularly in light of the current financial climate and practice elsewhere.

In addition to ceasing to launder staff uniforms it was recommended within the business case that the use of sleep knit sheets be introduced within the Balfour Hospital. This was supported on the basis that the change would enable the achievement of

laundry efficiencies as well as lowering carbon emissions, water usage, transportation and movement by porters and wear and tear on machinery.

Results

The project has evidenced a number of successes – in the majority financial and linked to a reduction in carbon emissions, however it has also displayed fundamental success in introducing changes in line with national trends in a remote and rural location.

In relation to the introduction of sleep knit sheets, staff feedback has confirmed that the material is easier to handle and more efficient in terms of manual handling. Feedback from patients has also been very favourable.

With regards to the laundering of staff uniforms, this change has been implemented fully and is now contributing to a much reduced per item laundry cost as outlined below.

Efficiency savings and productive gains

Through the implementation of sleep knit we have seen a reduction in the amount of porter time associated with the moving and handling of bedding as well as a reduction in the capacity of work for the laundry staff and storage space at a ward level. We have also been able to remove inefficiencies associated with the folding of sheets, putting them into a trolley, moving the trolley, unloading the sheets, and using as needed. We have also been able to reduce the number of loads going through the laundry as more of the sleep knit sheets go in a machine than the older, bulkier bedding.

With regards to the laundering of staff uniforms we have been able to reduce the volume of activity in the laundry by 33 per cent per annum as a result of ceasing this practice. This coupled with our move to sleep knit sheets has reduced our price per item laundered to £0.37.

Sustainability

No issues foreseen – both practices are readily sustained within existing operations.

Lessons learned

From a NHS Orkney perspective, the importance of understanding existing practice and being able to benchmark appropriately with others to highlight areas for challenge has been recognised through this project. Having the soft service review and strategy to inform our thinking was extremely helpful in this regard.

Communication with all stakeholders, securing the support of relevant committees and ensuring there was robust evidence to support the rationale for change was central to the success of this improvement project. Additionally, having strong project leadership with a clear vision and aim was fundamental along with a willingness to challenge the status quo in order to achieve improvements.



HR SHARED SERVICES

ABOUT THE PROGRAMME

Linda Semple
t: 0131 244 2297
e: linda.semple@nhs.net

drivers

‘We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values. Together, we will create a great place to work and deliver a high quality healthcare service which is among the best in the world.’ (Everyone Matters: 2020 Workforce Vision).

NHSScotland is a people-focused organisation, employing more than 150,000 colleagues across Scotland who account for approximately 75 per cent of the overall NHSScotland budget. NHSScotland faces the challenges of public sector reform, integration of health and social care, financial sustainability, demography of the population and technological advances. Within the Route Map to the 2020 Vision for Health and Social Care the Scottish Government has identified 12 priority areas for action, one of which is workforce. Everyone Matters: 2020 Workforce Vision has emerged as the workforce strategy to address this.

The future of NHSScotland is dependent upon sustaining a highly skilled, multi-disciplinary, professional, caring workforce and Human Resources (HR) needs to transform to ensure it can continue to deliver and enhance the unique value-add it brings. The purpose of the HR Shared Services Programme is to demonstrate where the introduction of shared services can support this requirement, enhance the role of HR and deliver further benefits.

The underpinning ethos of the shared services agenda is:

- **Simplify:** processes and procedures are as ‘lean’ as possible, minimising inappropriate waste
- **Standardise:** variation between NHS Board areas and individual users is minimised or removed
- **Share:** where there are benefits in doing so, processes are delivered from fewer locations or once for the whole of Scotland

aims

The Programme has been established with the high-level objectives of ensuring that the appropriate development of HR Shared Services:

- Improves the quality and efficiency of HR services delivered to customers
- Improves the governance of HR and workforce-related services and activities
- Improves the resilience and sustainability of HR services
- Delivers redesigned HR service processes which are effective, efficient and productive
- Ensures the maximisation of business systems integration opportunities (e.g. eESS, e-payroll)

workstream

Phase one of the HR Shared Services Programme has focused on the following areas:

- Recruitment
- Employee Services
- Medical and Other Trainees

These three areas cover approximately 50 per cent of HR activity in NHSScotland.

achievements 2014

- Visible ownership of the programme by HR directors who have developed a paper Creating the Vision for Transforming the HR Operating Framework in NHSScotland, of which shared services is a part
- Completion of the option appraisal process for future operating models in February 2014 building on the activity scoping work previously undertaken
- Significant engagement with users and providers of HR services within the 11 NHS Boards represented on the Programme Board through completion of a customer insight exercise
- Augmenting the HR activity baselining exercise undertaken in 2013, further data capture of volumetric activity across all NHS Boards has been completed to enable reduction in variation and identification of areas of good practice
- Increased senior staff understanding of the potential of shared services gained through visits to other organisations which have implemented models of shared service and an HR Shared Services Showcase Event held in December 2013

priorities 2015

.....

- Completion of a Case for Change by January 2015 to enable consultation with stakeholders
- Engaging in a series of tests of change with NHS Boards which are developing innovative approaches to the development of HR services
- Continued close working with the eESS project team in relation to the roll out of the single national HR system.



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/shared-services/hr-shared-services.aspx>

Programme Case Study

HR Shared Services

Background and context

Shared Services is one of a number of workstreams that support the Efficiency and Productivity Framework across the NHS in Scotland. Considerable work has taken place within Financial Shared Services and there are further opportunities which will be progressed over the next few years. The Director General of the NHS in Scotland, along with the Chairs and Chief Executives, has committed to supporting a wider review of organisational “support” services, common to all Health Boards, where there is potential to adopt a shared services approach. A process mapping exercise in 2011 identified Human Resources (HR) as a second wave Shared Services work programme.

The underpinning ethos of the Shared Services agenda is:

- Simplify: processes and procedures are as “lean” as possible minimising inappropriate waste
- Standardise: variation between Health Board areas and individual users is removed
- Share: where there are benefits in doing so processes are delivered from a single (or limited number of) location(s).

Problem

A number of issues have been identified across HR services in Scotland (although not all of the issues are universal as some HR teams are already working towards solutions).

- There is a need for further standardisation and consistency in approach as well as a sharing of resources.
- HR issues are often complex and span across organisations.

- There is a great deal of duplication in a number of processes and workstreams.
- Some teams, particularly the smaller teams struggle with resilience and sustainability.
- Customer feedback with regard to the quality of service provision is not as good as it could be.

The drive therefore is to improve quality, while reducing costs and recycling savings back into the Boards.

Aim

The scoping and review of potential HR Shared Services delivery for NHSScotland, including:

- Establishing the need for investment,
- Appraising the main options for service delivery, and
- Providing management with a recommended or preferred way forward for further analysis.

– epitomized in the submission of a Compelling Case for Change document; to put in place the basis for delivery of the programme.

Action taken

A programme board was established to oversee the initiation and implementation of an approach to HR Shared Services. The programme has been established with the high level objectives of ensuring that the appropriate development of HR Shared Services:

- Improves the quality and efficiency of HR services delivered to customers
- Improves the governance of HR and workforce related services and activities
- Improves the resilience and sustainability of HR services
- Delivers redesigned HR service processes which are effective, efficient and productive, and
- Ensures the maximisation of business

systems integration opportunities (e.g. eESS, e-payroll etc)

The programme was split into three workstreams, namely:

- Recruitment
- Employee Services
- Medical and other Trainees

Each workstream is led by an HR Director, each with its own Steering group. A sub-group was set up by the HR Directors to ensure that outcomes from the programme are shared with HR Directors and that the HR Directors have a forum through which they can input to the programme.

Scoping and review of the workstreams was undertaken with a focus on stakeholder engagement. Several high profile scoping workshops were held in 2013.

Data gathering was undertaken, establishing a baseline for the programme.

The programme board agreed that it would be beneficial to understand what customers of HR felt about the current HR services they receive and where a move to shared services might add value or detriment existing quality.

The Customer Insights Exercise totaled 20 1-to-1 sessions (CEO and HR Directors in ten Boards), 84 people in focus groups (HR teams, a operational customers and staffside representatives) and 355 completed e-surveys (broad group of HR staff and operational customers). A further 110 staff in NHS Greater Glasgow & Clyde had contributed opinions to the review.

95% of those from the 1-to-1s and focus groups agreed that there was a need to change; with 81% of those in the e-survey also agreeing the need to change.

A series of options appraisals for each of the workstreams was undertaken between January and May 2014.

Information from the scoping and engagement workshops, workstream work, customer engagement exercise and options appraisals was then triangulated and presented in the CCfC document in December 2014.

Results

.....

The compiling of the Compelling Case for Change will enable the implementation and delivery of HR Shared Services across NHSS.

The report presents the findings of the scoping and review of potential HR Shared Services delivery. In the CCfC the following has been established:

- The scope for each of the workstreams
- Potential management and governance structure
- Benefits, risks, dependencies, constraints
- Critical success factors
- High-level benefits scorecard; measurement of benefits will take place in terms of the four quartiles: Quality, Cost, Service Delivery and People
- Strategy and programme investment aims
- Potential model(s) of service delivery for each of the workstreams
- Programme delivery milestones until 2016/17 and the basis for an implementation plan
- The programme costs
- Recommendations for each of the workstreams

Patient experience

.....

The following patient benefits are anticipated:

- Savings will be realised which can be reinvested in patient care.

Staff experience

.....

Whilst it is too early to have evidence of staff benefits, it is anticipated that the following benefits will be realised:

- The new model will ensure that specialist HR activity can be raised to ensure that HR specialists have a greater influence on the strategic and value added issues facing NHSScotland Boards.

- Greater job satisfaction of HR staff through:
 - Better communication and sharing of knowledge
 - Alignment and rationalising of processes and policies
 - HR staff knowledgeable about local and national issues
 - Capabilities/competencies set for HR professionals; staff will know better what is expected from them
 - HR professionals focused on added value tasks
 - The future model of HR will require more emphasis on understanding and optimising the unique value HR brings to the organisation, requiring HR to develop skill sets that will result in an improved approach to recognising and anticipating the factors which will have a strategic impact on Boards; be clearer on the potential impacts these will have; and play a greater part in shaping and implementing the resulting organisational changes (transformational activity).
- Improved experience for HR customers:
 - Consistent, accurate, timely delivery of HR service
 - Customer-focused service using simplified, standardised processes

The following dis-benefit was identified as part the CCfC:

- Staff may be remote from the cases they are likely to be dealing with

Efficiency savings and productive gains

.....

Whilst it is too early to have evidence of improved efficiency, HR Shared Services would be expected to deliver, as a minimum, the following benefits:

- The new model will ensure that administrative and support activities will be provided consistently, efficiently and effectively with a potential to achieve economies of scale.
- Investment in new models of delivery for the three workstream is estimated to result in significant savings after 5 years of delivery.

Sustainability

.....

The delivery of the HR Shared Services programme will ensure that the service is fit for the future.

Lessons learned

.....

- On a programme with a large scope, stakeholder engagement is more complex and time consuming than originally anticipated.
- To ensure support for a large and complex programme like this, sufficient programme resourcing is essential.

Next steps

.....

- The programme will move to the delivery phase of HR Shared Services.

Unscheduled Care: Changing the Frontline Delivery Model in NHS 24

Background and context

The development of the unscheduled care workforce plan within NHS 24 is a collaborative process, aligning HR, service and financial planning in partnership. This integrated approach aims to proactively define the workforce requirements for a 12 month period, ensuring that all parties involved are fully engaged in the planning process. Part of the service improvement methodology is to identify key workforce issues that support future models of service delivery so that NHS 24 will ensure the highest quality of service for the Scottish public and patients.

Problem

Some of the key challenges and problems that NHS 24 faces in relation to the unscheduled care workforce are:

- service change
- population demographics
- age demographics
- population diversity
- the impact of remote and rural living
- technology changes

In addition, internally, the following challenges have to be taken into account:

- predicting call volumes and demand for service in the short, medium and long-term

- building rotas which best meet the needs of the service
- resourcing special days such as public holidays and protected learning times (for GPs), exceptional periods such as festive and Easter
- predicting performance and identifying shortfalls – endeavouring to cover any gaps
- Against this backdrop, NHS 24 must identify efficiency savings of 3 per cent which is increasingly challenging to achieve and where cost pressures continue to grow as budgets level off. There is also limited flexibility to alter the overall staffing profile due to the current NHSScotland policy of no compulsory redundancies.

Aim

The first step was to identify a preferred workforce model to support the achievement of wider corporate goals and objectives.

The goals and benefits of change, the context of how services will be delivered in future, and the options for future service delivery and the drivers and constraints were considered.

These steps outlined the workforce required to meet the predicted service needs and all of the key issues, local and national, which impact on workforce design and deployment.

The workforce model was costed so that the level of cash releasing efficiency savings could be estimated and recognised against the previous model.

Action taken

The unscheduled care service remains NHS 24's key focus and priority, delivering a safe and effective service to the people of Scotland.

Based upon current modelling, the changes to the workforce for this service in recent years are detailed as follows:

- A reduction in whole time equivalent nursing numbers from 212 to 192 (-20) and a headcount reduction from 366 to 329 (-37).

- A reduction in team leader numbers from 90 to 69 (-21) and a headcount reduction from 89 to 77 (-12). This reduction is due to the change in the model of management in local and remote centres. In addition, team leaders no longer manage Health Information Advisors, Breathing Space and the Scottish Emergency Dental Service as these staffing groups have their own management structures. The introduction of the senior call handler role, has also reduced the demand on the team leader role.
- The other significant workforce group is call handlers where there has been a whole time equivalent increase from 252 to 353 (+101) and a headcount increase from 450 to 563 (+113).
- The ratio of nurses to call handlers was 1 : 1 and the current position is now 0.7 : 1.
- In recent years, the mitigating effect of the introduction of protocol based call handler advise and discharge processes need to be taken into account – these include exclusion of nurse interventions in, e.g. sore throat (over 5s), medication enquiries, bony injuries, death notification, minor ailments, suspected stroke, urinary tract infections, burns scalds and bites, earache and sunburn.
- The percentage of calls closed by call handlers has increased from 13.7 per cent to 26 per cent, an increase of 12.3 per cent.
- In recent years, there have been a number of ‘new’ roles introduced that would have reduced the need for trained nurses including the introduction of pharmacists, physiotherapists, dental nurses, breathing space advisors, mental health nurses and cognitive behavioural therapy (CBT) counsellors.
- Whilst the above have been introduced at varying stages, there is a clear justification in the reduced staffing ratios due to reduced nursing workload.

Results

.....

The move towards a higher proportion of the service being delivered by call handlers during the 2013-14 financial year was delivered. The move to this model of delivery was based on the experience gained over many years and consideration by management of the best, most efficient and appropriate way to deliver the service in future years.

Patient experience

.....

Patient service levels are aligned to key performance indicators (KPIs) in terms of the desired performance for time taken to answer calls and to deal with the needs of the patient within appropriate timeframes based on clinical priority. The performance targets are factored in to the workforce plan to deliver a highly responsive and effective service:

- Access Service Level – 90 per cent of all calls answered within 30 seconds
- Clinical Calls – 100 per cent of calls commenced consultation in three hours

Staff experience

.....

There has been a positive impact on staff experience with opportunities for staff to take on different roles and gain new experience as a result of the restructure of frontline services.

Efficiency savings and productive gains

.....

During the 2013-14 financial year, NHS 24 was able to recognise a recurring cash releasing efficiency saving of £1.955 million.

Sustainability

.....

NHS 24 continues to look at frontline delivery models to ensure that these support the clinical presentation of the calls received to the service on an on-going basis. The frontline workforce is modelled against changes in demand and takes account of the annual workforce and financial planning exercises. It is subject to scrutiny and review throughout the year.

Lessons learned

.....

The full impact of the presentation of calls has to be taken into account and the impact of this on the culture of the organisation. Whilst time was spent with staff when the new models were being put into place, there is always scope for further discussions to take place with staff which would have been better for staff engagement.

The last year has taught NHS 24 that the model introduced was quite well fitted to changing demand and NHS 24 has continued to meet its KPIs.

Much of the work used to introduce the new frontline delivery model was able to be utilised again during the planning for the introduction of the 111 free phone number.



PERFORMANCE SUPPORT

ABOUT THE PROGRAMME

Martin Hopkins
t: 0131 244 5178
e: martin.hopkins@scotland.gsi.gov.uk

Performance Support

The QuEST Performance Support Team supports NHS Boards to deliver HEAT targets and standards which contribute towards delivery of the Scottish Government's Purpose and National Outcomes and NHSScotland's Quality Ambitions.

drivers

- Maintain a flexible response to NHS Boards encountering challenges in delivery of HEAT targets and standards
- Bring together external expertise and facilitate a mechanism for collective support
- Provide a detailed analysis of local operational data
- 'Walk the patient pathway' to talk to the staff who deliver the service
- Support the exchange of ideas and sharing of good practice with staff providing the service
- Identify recommendations for NHS Boards to implement, and identify additional support as necessary

what is it?

The Performance Support Programme aims to help NHS Boards to achieve key Scottish Government objectives. The responsive nature of the Programme accommodates a range of skills. NHS Boards are able to access the skills and time of the Performance Support Team when needed.

aims

- Provide a mechanism of finding collective support and opportunities for NHS Boards to focus jointly on areas of concern such as the HEAT targets
- Assist in drawing together resources to support NHS Boards by making connections between experts and staff (in some areas the programme has assisted in creating professional networks of support and creating local champions to sustain change)
- Aid NHS Boards in the understanding and analysis of patient 'pathways', which may result in more rapid identification of inconsistencies and delays
- Collect and analyse data for the informed evaluation of improvement and performance measures
- Identify and offer further avenues of support for implementation such as timely assessment, appropriate interventions and use of specialist skills
- Stimulate the development of pathways to community support

The process of Performance Support is illustrated below:



achievements 2014

- The achievements of the Performance Support Programme 2013-2014 included sustained work in Scotland but also providing advice to health systems in England and Australia
- The Programme has delivered tailored support to several NHS Boards producing diagnostic reports containing operational data and observations, including expert advice following 'walking the patients pathway', this has provided NHS Boards with evidence to improve their performance and subsequently meet HEAT targets
- The Programme also spent time drawing together learning from its supportive work throughout the year and identified ways of moving towards deeper customised analysis of the data collected
- The Programme has become more accomplished in the analysis of large data sets and creating clean operational data that is more easily scrutinised by NHS Boards and other stakeholders
- The Programme has become more adept at exploring patterns and trends within data and sharing knowledge with NHS Boards and stakeholders to increase awareness and support informed change

priorities 2015

- Provide a responsive support mechanism that is informed and flexible for NHS Boards
- Support NHS Boards across Scotland to understand performance issues
- Improve the understanding of data to identify emerging priorities for NHS Boards and other stakeholders
- Diagnose the root causes and develop and implement strategies to improve the delivery of health services
- Work closely with the Scottish Government to improve the Quality of Care, including achieving HEAT targets
- Support broader plans and wider ambitions for improvement and performance objective



<http://www.qihub.scot.nhs.uk/quality-and-efficiency/performance-support.aspx>

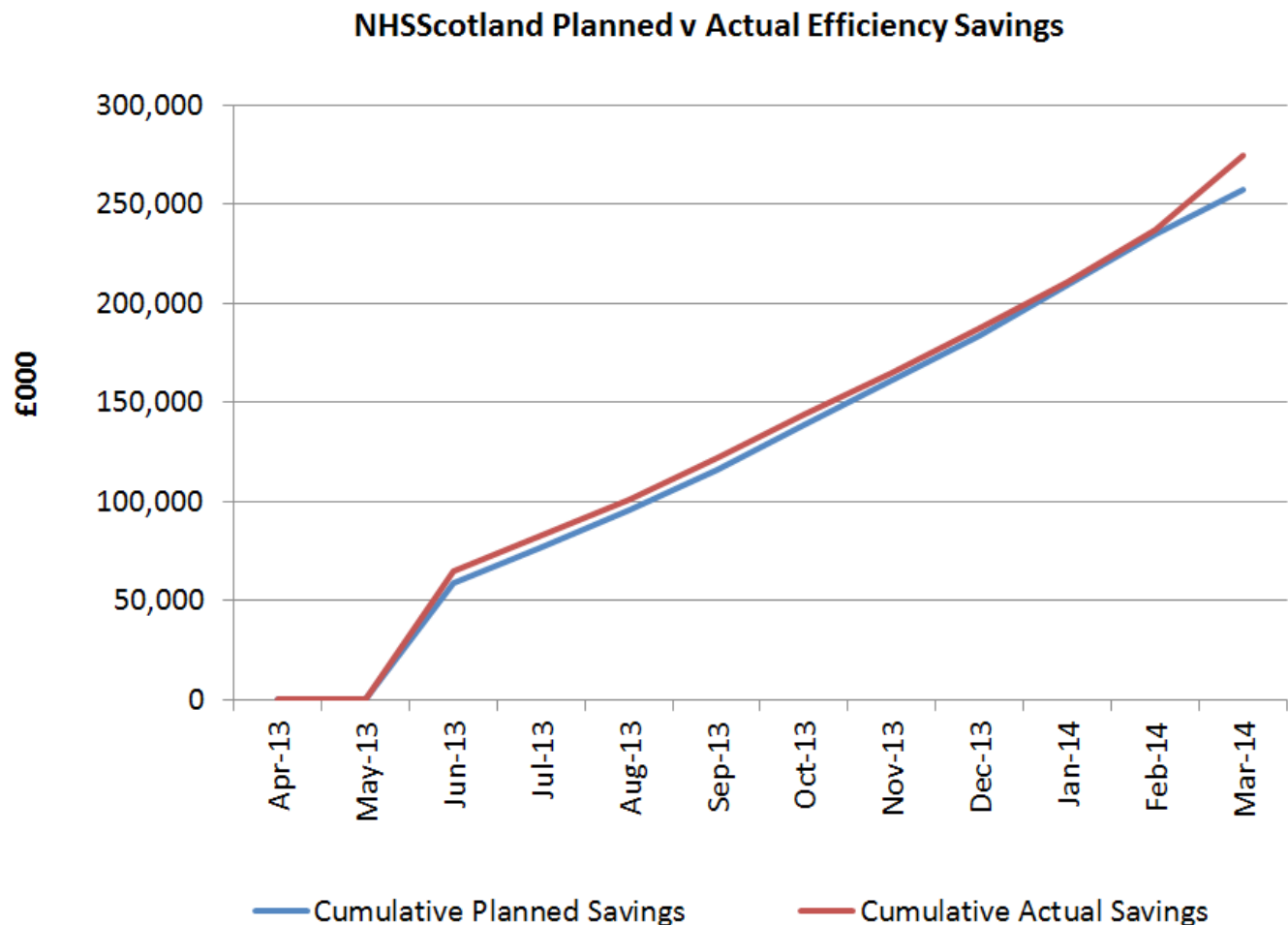


APPENDIX

Efficiency Savings 2013-14

Planned versus Actual Efficiency Savings

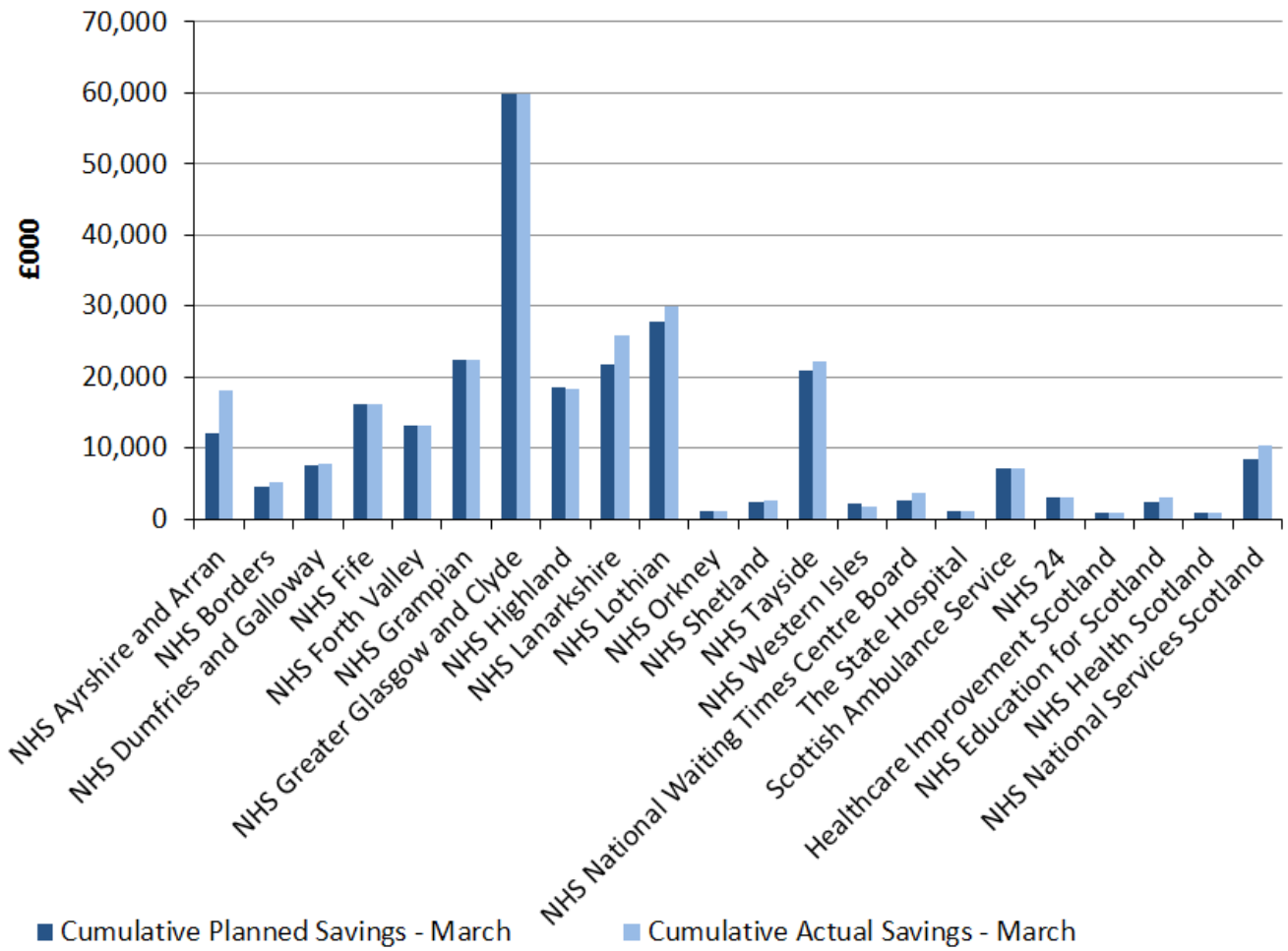
NHS Boards are required to identify planned efficiency savings as part of their Local Delivery Plan (LDP). The achievement of these savings is monitored on a monthly basis. Figure 1 below illustrates the planned and the reported actual efficiency savings achieved by NHSScotland during 2013-14.



Overall the achievement of actual savings has been slightly ahead of those planned throughout the year. As at March 2014 actual savings were 7 per cent over those planned at £275 million (£257 million target).

In the majority of cases the reported savings were in line with, or greater than, those planned per NHS Boards' LDPs.

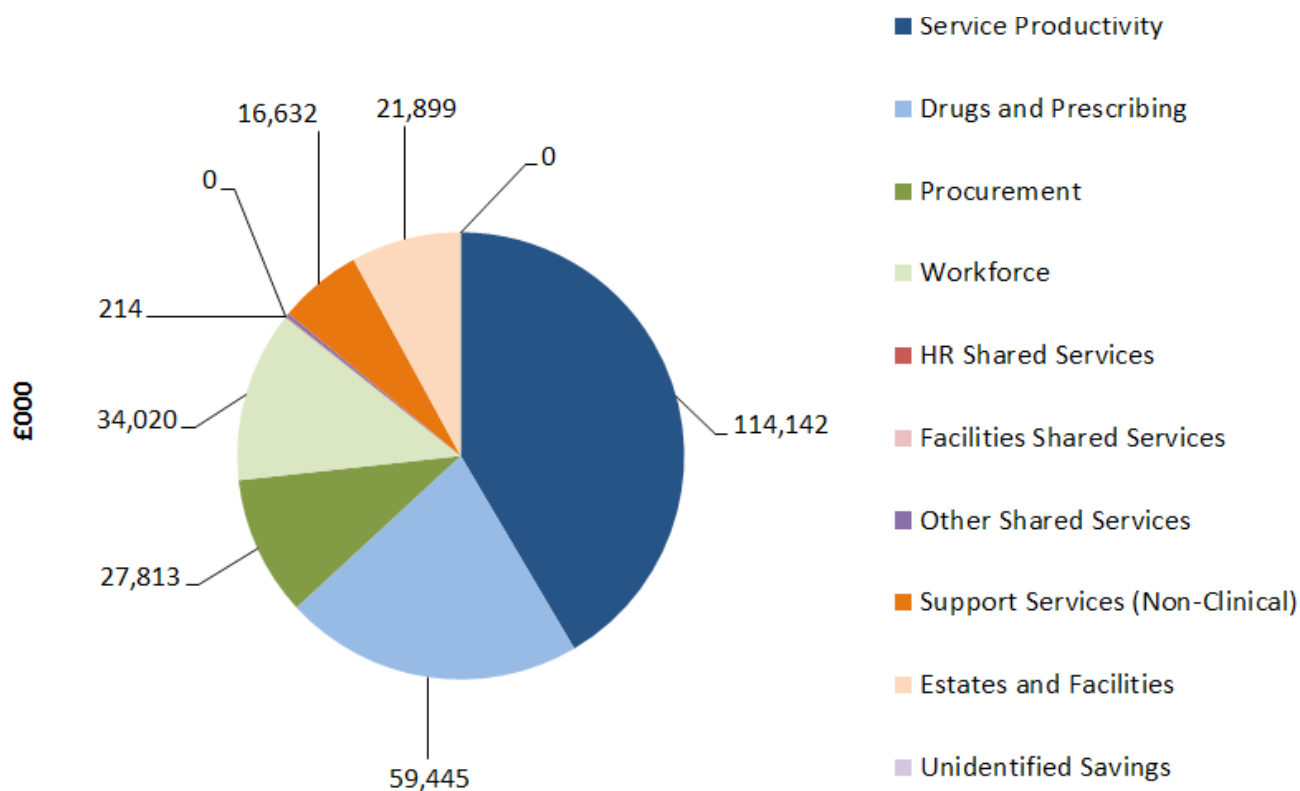
Planned v Actual Efficiency Savings per NHS Board (March 2014)



Savings per Efficiency and Productivity Workstream

The efficiency and productivity workstreams align to the savings categories in NHS Board LDPs and monthly monitoring returns.

Figure 3 below details the proportion of reported savings achieved through each of the workstreams.

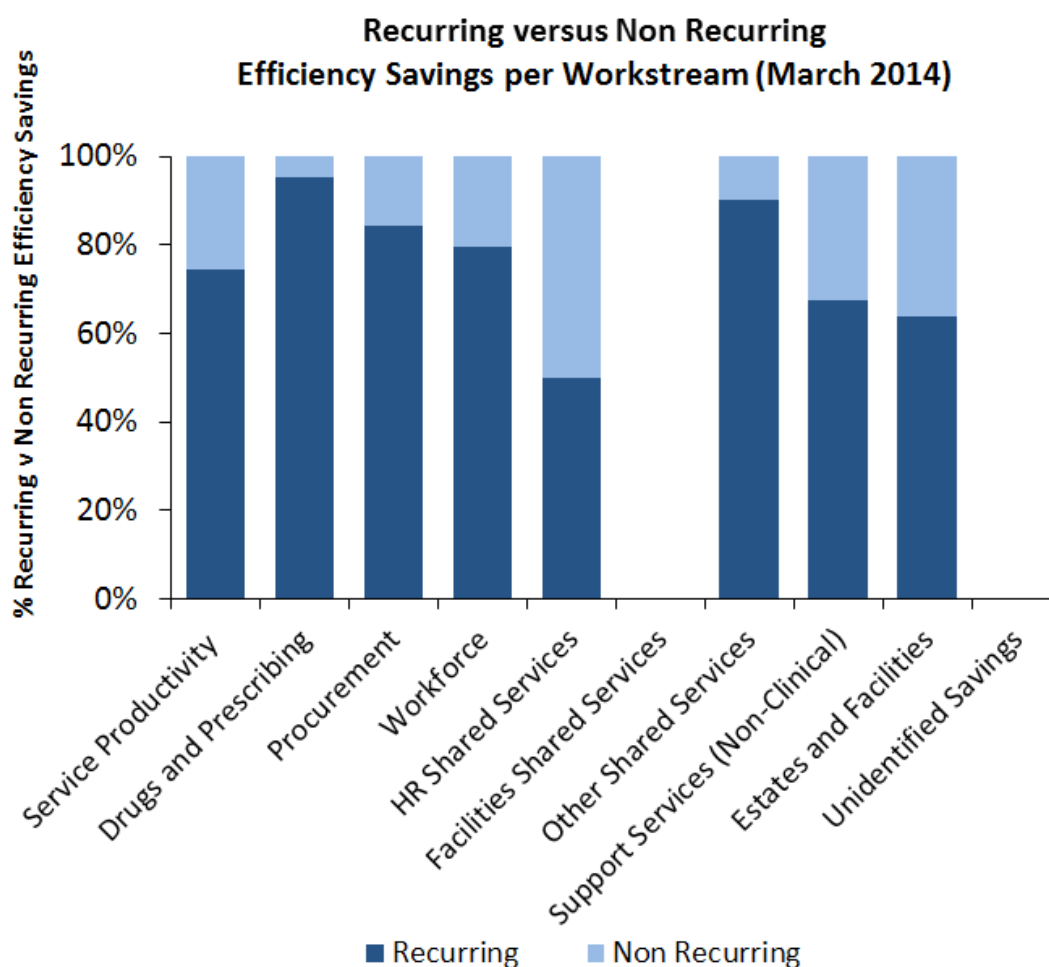


- Workstreams associated with service productivity delivered 42 per cent of the savings total amounting to £114 million. There is a significant increase in the proportion of savings delivered as a result of improvements in service productivity (2012-13, 20 per cent of total amounting to £55 million).
- Almost a quarter (22 per cent) of efficiency savings achieved in 2013-14 relate to prescribing, this amounts to £59 million. This is a slight decrease compared to 2012-13 (£66 million, 25 per cent of total savings).
- Workforce workstreams delivered 12 per cent of the savings total (2012-13, 19 per cent of total).
- Procurement, Support Services, and Estates and Facilities each delivered between 6 per cent and 10 per cent of the savings total. This is broadly in line with the previous year.
- <1% of savings were delivered by Shared Services. In 2014-15 there will be a focus on a 'Once for Scotland' approach.

Recurring versus Non-Recurring Savings per Efficiency and Productivity Workstream

Recurring savings are those which once achieved recur year on year from that date (e.g. savings on staff costs as a result of streamlining processes). Non-recurring savings are those which are one-offs (e.g. receipt from the sale of a fixed asset, such as a building). It is important that savings are recurring to ensure sustainability of the financial position and to reduce the risk of non-achievement of savings targets in future years.

Figure 4 below details the proportion of recurring and non-recurring savings achieved through each of the workstreams.



- £218 million (79 per cent) of savings across all workstreams are recurring; this is in line with 78 per cent recurring savings in 2012-13.
- 95 per cent of prescribing savings are recurring (2012-13, 96 per cent).
- Estates and facilities have the lowest proportion of recurring savings (64 per cent) (with the exception of HR Shared Services which has a small amount of savings in absolute terms).
- The remaining workstreams have achieved recurring savings of between 68 per cent and 90 per cent.

NHS Board and Efficiency and Productivity Leads

Every NHS Board within NHSScotland has an Efficiency and Productivity Executive Lead who is the primary contact within their Board in relation to efficiency and productivity. The current list is available on our website:

<http://www.qihub.scot.nhs.uk/quality-and-efficiency/quality-efficiency-and-value/efficiency-and-productivity-executive-leads-.aspx>



© Crown copyright 2015

ISBN: 978-1-78544-091-5

This document is also available on The Scottish Government website:
www.gov.scot

Contact details:
Quality and Efficiency Support Team
St Andrew's House
2 Regent Road
Edinburgh
EH1 2DG

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
DPPAS18983 (06/15)