Improving Older People's Acute Care

Learning from a Blended Local Collaborative Approach 2015-2016
Acknowledgements

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Executive summary

This report highlights the learning from an alternative model of improvement support for older people’s acute care (OPAC) that was tested with three NHS boards between June 2015 and August 2016.

The work sought to explore whether a different model of improvement support that took account of local context would help the alignment of improvement initiatives and facilitate a joined-up approach to improving care for older people. OPAC improvement advisors worked within each NHS board to co-ordinate improvement activity and facilitate a collaborative approach to improvement activity locally.

The challenges of testing and implementing the local collaborative programme in the three participating NHS boards included a wide range of contextual and system factors, specifically managing expectations, balancing demand with capacity and the need to undertake a baseline assessment of readiness for change. Balancing the emergent and responsive nature of improvement programmes with the need for focus and clarity was also highlighted.

In all areas, staff reported improvements in their knowledge skills and confidence, and a number of improvements initiatives and approaches will continue and be expanded in some of the sites.

OPAC improvement advisors reported a number of advantages to the model. These included the benefits of protected time to work with staff to enable them to drive improvements locally, the opportunities for sharing, learning and networking, and the value of understanding the local context in order to build relationships and influence strategically.

Within Healthcare Improvement Scotland, learning from this work will be shared widely and used to improve the planning, design and execution of similar approaches. Recommendations for how this learning should be used to inform future improvement work are included.
Introduction

Healthcare Improvement Scotland has led on a national programme of work to improve acute care for older people across NHSScotland since April 2012. The Improving Older People’s Acute Care programme is responsible for leading this initiative.

In its initial phase (2012-2015), the programme focused on supporting local teams to improve the quality of care around frailty and delirium. This initial work had a positive impact on raising awareness of areas for improvement, enabling shared learning and influencing improvements in practice. This was highlighted in an impact report "Improving Older People’s Acute Care" (June 2015). Healthcare Improvement Scotland secured an additional year of Scottish Government funding from the Chief Nursing Officer’s Directorate to build on that progress and to test a new model of improvement support.

In this second phase (June 2015-August 2016), the aim was to test the theory of whether dedicated improvement support focused on bringing together different areas of improvement activity based in an NHS board could lead to more rapid improvements in older people’s acute care. Three NHS boards, NHS Dumfries & Galloway, NHS Grampian, and NHS Greater Glasgow and Clyde were involved in testing this approach working with Healthcare Improvement Scotland. A local older people's acute care (OPAC) improvement advisor was recruited from within each NHS board with a remit to co-ordinate improvement efforts and to blend inter-related domains of older people’s care at board level. This formed the foundation of the “blended” model (Figure 1).

Figure 1: Blended approach to best care for older people
The aim of this innovative approach was two-fold:

1. to test and learn from this model of improvement support using these domains of care as a framework for improvement activity, and

2. to support the alignment of improvement initiatives to facilitate a collaborative approach to improving care for older people.

The three NHS boards represent different complex and dynamic environments that provide an excellent opportunity to better understand how the wider context affects the intervention and how Healthcare Improvement Scotland and NHS boards work together to support national and local priorities.

The focus of this report is on what has been learned so far in relation to the planning, testing and implementation of the blended model of improvement support across the three participating NHS boards. Recommendations for how this learning should be used to inform future improvement work are included.
Background

Following an older people in acute hospitals inspection in February 2014, an opportunity for improvement was identified within the Langlands Unit, NHS Greater Glasgow and Clyde. The OPAC national clinical lead undertook a short piece of work with the team at the Langlands Unit to help them identify their priorities and to streamline improvement activity in order to improve care for older people. The work was carried out in collaboration with the unit’s lead nurse and a colleague from the Person-Centred Health and Care national programme. The challenges staff face in balancing local and national improvement priorities were highlighted and the team was supported to make connections between these strands of work. There was a focus on transitions of care and significant improvements were seen in areas such as assessing risk of delirium and reduction in falls.

An improvement day was organised to bring together relevant workstreams and to highlight the links between individual programmes in order to deliver best care for older people.

In addition to the work in the Langlands Unit in NHS Greater Glasgow and Clyde, an older people's collaborative was established between NHS Grampian and NHS Tayside in 2012 to improve standards of care for older people in acute hospitals. The NHS Grampian and Tayside Older People in Acute Care Collaborative ran for 18 months until the end of 2013. The Institute for Healthcare Improvement’s Breakthrough Series approach was adopted to support teams from both NHS boards with their improvement activity. NHS Dumfries & Galloway was also keen to explore opportunities for improvement support following a challenging older people in acute hospitals inspection in May 2015 and it was agreed they should also take part in testing the blended approach.

The results of the work with the Langlands Unit and learning from the NHS Tayside and Grampian collaborative provided a foundation for the blended approach that Healthcare Improvement Scotland has been testing with the three NHS boards over the past year (2015-2016). Healthcare Improvement Scotland wanted to explore whether a different model of improvement support that took account of local context would help the alignment of improvement initiatives and facilitate a joined-up approach to improving care for older people.
Blended local collaborative approach

Theory of change

Creating conditions for improvement requires recognition of the importance of local context, visible leadership and building improvement capacity into the workforce. Learning from the work outlined earlier suggests that integrating improvement support into the local system will facilitate this because of greater understanding of local systems and processes and the ability to use and develop existing networks and relationships. Early indications are that this approach has the potential to accelerate change by:

- providing a greater sense of ownership by clinical staff
- having an enhanced understanding of local context
- building on and strengthening existing relationships
- increasing opportunities for engagement with clinical staff
- enhancing cohesion across improvement programmes and generating opportunities to apply improvement knowledge in practice, and
- engaging leaders and managers in local and national improvement priorities.

In order to build sustainable improvement and contribute to the building of local improvement, it was agreed to test the impact of having a locally-based OPAC improvement advisor.

Theory of execution

A blended local collaborative approach was developed in collaboration with the three NHS boards in order to test this theory. A logic model (Appendix 1) was developed to describe the differences the blended collaborative approach sought to make and the main interventions to deliver those outcomes. The logic model was reviewed at monthly meetings in order to help understand what was working well, what challenges were encountered, what had been learnt, and how that learning was used to adapt activity. In addition to facilitating and co-ordinating improvements, part of the OPAC improvement advisor's role was to support national work and contribute to sharing learning across NHSScotland. The posts would be based within NHS boards and would work with an agreed number of teams to support OPAC improvement work locally. A Memorandum of Agreement (Appendix 2) was established with each of the three NHS boards.
Planning

Discussions were held with the Chief Nursing Officer’s Directorate and executive nurse directors of each of the NHS boards to support the design and planning of the intervention. Specific risks associated with this approach were identified and discussed. These included:

1. expectations of NHS board OPAC improvement advisor posts exceeding individual capacity because of competing agendas
2. different understanding and interpretation of the role between NHS boards
3. other priorities or areas of service improvement emerging (for example through older people in acute hospitals inspections) that could impact on the improvement activity that OPAC improvement advisors were co-ordinating, leading to difficulties in capturing and measuring outcomes.

Controls were put in place to reduce the likelihood of the risks occurring. These included the Memorandum of Agreement between Healthcare Improvement Scotland and each of the collaborating NHS boards and regular progress updates and planning meetings. The Memorandum of Agreement, signed by Healthcare Improvement Scotland and the respective NHS boards outlined shared expectations between Healthcare Improvement Scotland and the NHS board.

The three OPAC improvement advisors took up their posts in their respective NHS boards in June 2015 (NHS Greater Glasgow and Clyde and NHS Grampian) and August 2015 (NHS Dumfries & Galloway). Recruitment took longer than planned as it was necessary to re-advertise and interview a second time in two of the NHS boards. The OPAC improvement advisor role comprised three days a week dedicated to supporting improvement activity in the NHS board and two days to supporting the national OPAC agenda. Project plans were developed with OPAC improvement advisors to agree the number of sites that were to be involved locally and also the aims and measures within each site. The programme timeline (Appendix 3) with key milestones included dates for meetings with OPAC improvement advisors and their NHS board line managers to review progress. Reporting mechanisms were agreed to monitor progress and identify any challenges and opportunities. Reflective learning diaries were introduced to be completed fortnightly by each OPAC improvement advisor in order to capture:

- their experiences of what was working well
- changes they were testing
- challenges they were facing, and
- what they were observing as a result.

A core team comprising project staff, the OPAC improvement advisors, national clinical leads for improvement of older people’s acute care and dementia, a data and measurement advisor and a health information scientist met monthly to monitor progress, share learning and plan ahead. Data and measurement support was a regular feature of the monthly planning meetings and opportunities to discuss key issues or learning points identified by the OPAC improvement advisors were scheduled into the meetings.
Implementation

OPAC improvement advisors used their local knowledge and understanding to share and spread learning at board level and worked with local teams to support staff, to co-ordinate improvements in the quality of care for older people in acute care and capture learning. Specific measures reflecting local and national priorities were identified and agreed with each NHS board and local measures relating to the domains of care were agreed in discussion with the executive nurse director. These were laid out in the Memorandum of Agreement and included:

- reduction in falls with harm
- an increased recognition of delirium
- increased capability and confidence of staff
- a reduction in complaints, and
- a reduction in pressure ulcers.

A range of local collaborative improvement events were held to raise awareness of the work and enable the blending of these different domains of care, including education and learning sessions that brought teams together to learn from each other, to share expertise and to co-produce local solutions. These aimed to build local ownership and sustainability of improvements. Feedback from learning events and from individual staff reinforce the fact that thinking about how these domains interrelate can contribute to best care for older people by influencing staff attitudes.

Local events were effective in engaging teams and demonstrating and enabling staff to think more holistically. Staff were asked to rate their knowledge and understanding in relation to specific topics, such as quality improvement, person-centred care and delirium, before and after learning events. They were also given the opportunity to provide free text feedback to inform the planning of future events.
‘Learning and sharing work/seeing frontline staff empowered to make change’
(Allied health professional, NHS Greater Glasgow and Clyde)

‘Getting to share experiences & thoughts with colleagues to get reassurance that we are all experiencing similar things’
(Staff nurse, NHS Dumfries & Galloway)

‘Sharing experiences with other areas – many of us are in the same boat and progressing with the same changes and ideas’
(Nurse specialist, NHS Grampian)

Testing the approach

Each of the participating NHS boards took a slightly different approach to testing the blended local collaborative reflecting their individual context and priorities.

The following case studies present a summary of activity, impact and feedback from each of the three NHS boards.
Case studies

NHS Dumfries & Galloway

Introduction

NHS Dumfries & Galloway serves a population of 148,190 within a large geographical area of about 2,400 square miles. Dumfries and Galloway Royal Infirmary is based in Dumfries and is the main hospital for the region providing a wide range of inpatient and outpatient health services. The Galloway Community Hospital serves Stranraer and the west of the region and is an intermediate unit providing maternity services, and medical and surgical beds. There are eight cottage hospitals which provide care services such as minor injuries units.

Who was involved - reach of the programme

The OPAC improvement advisor took up post in August 2015 and began to work with one orthopaedic/gynaecological ward (ward 16) within Dumfries and Galloway Royal Infirmary. This ward, identified by NHS Dumfries & Galloway as a priority area for improvement support, has a high proportion of older patients and the OPAC improvement advisor had worked with the ward previously. Ward staff included a senior charge nurse, nurse manager, band 5 and band 2 representation and individuals leading work on specific clinical topics.

Additional wards were included from November 2015 (starting with wards 14 and 18, followed by ward 6). The aim was to improve care for older people in three acute wards based around the Care of Older People in Hospital Standards, published in June 2015. Wider sharing of the programme occurred through six weekly updates to all senior charge nurses at their regular meeting. Influence at a more strategic level was facilitated by meetings between the OPAC improvement advisor and the associate nurse director. The OPAC improvement advisor was also invited to update the NHS board’s strategy group for older people.
Education and awareness raising

In order to understand their learning needs and plan support accordingly, staff were asked to complete questionnaires developed by the OPAC improvement advisor. Questionnaires were designed to capture baseline knowledge relating to specific topics, including falls, pressure ulcers, delirium and dementia.

Staff found the initial questionnaires took too long to complete and questionnaires were subsequently amended. This data was augmented with additional information gathered through the process of caring observations on the pilot ward 16. An information database was created to indicate the level of knowledge among staff around specific aspects of care, and education support was tailored to support staff to increase their knowledge and skills.

A series of 30-minute education sessions were planned specifically for the staff on ward 16 to enhance and/or address gaps in knowledge identified by them. Specific aspects of care included falls, pressure ulcers, nutrition, continence, patient involvement and delirium. The initial goal of 50% of ward staff to attend the sessions within the three-month period November 2015-January 2016 was achieved.

As a result of staff changes on ward 16 and requests from other areas, the sessions were opened up to all staff in Dumfries and Galloway Royal Infirmary from April 2016. Recognising the impact of staff changes on ward 16 and reviewing how the model was working, the OPAC improvement advisor adjusted the approach to reflect the uncertainties of ward conditions. The format was changed to ‘topic of the month’ training (Figure 2) and topics included falls, nutrition and delirium. The OPAC improvement advisor engaged with the clinical education team in supporting and delivering these sessions and provided support and guidance for staff undertaking tests of change on the ward.

**Figure 2: Topic of the month**
Staff appeared to find the short targeted education sessions helpful.

“Staff value the short education sessions, [they] sometimes struggle to get to other sessions” (Nurse manager)

“I think it’s great we’re all working together” (Clinical educator)

A more consistent approach to delivering education across a range of settings has also resulted in the clinical education team using the questionnaires to support their sessions with cottage hospitals, prison services and other wards within acute services for delirium, pressure ulcers and falls.

Networking

In addition to the tailored educational support, two board-wide learning events were organised by the OPAC improvement advisor.

Fifty-nine staff attended an ‘Enhancing Care of Older People in Hospitals’ event in December 2015 and 57 staff attended a second event in June 2016.

Facilitators in specialist fields discussed their respective specialties in the context of co-ordinated care for older people (falls, pressure ulcer prevention, nutrition, continence, forward care planning, medication levels, delirium/dementia, vital signs/sepsis, adults with incapacity and documentation). The format of these sessions supported the blended focus of the programme of work bringing different workstreams together with a focus on best care for older people. These events helped to generate ideas for tests of change in specific areas and also facilitated sharing of good practice. Building relationships and establishing connections across the NHS board was also cited as a benefit of these events.

“Great chance to network and ‘pinch ideas’ from other areas” (Staff nurse)

"Excellent event, loved the different stations. Good quality information, learned loads” (Senior charge nurse)

“Lots of information, bringing things together is a good idea with the 15 minutes sessions” (Staff nurse)

“Much better having less stations but more time at each one, all very relevant topics” (Allied health professional)
Since the events, some of the facilitators have reported an increase in requests for training from other specialties:

“I’m getting more requests to come and provide training on adults with incapacity within other areas/specialities” (Event facilitator)

There is also evidence of spread of learning to other settings, with care home education facilitators planning to review ‘This is me’ tool documentation within care homes.

Testing change ideas - improvements in practice

Education and networking activity has resulted in identifying local improvement priorities and progress being made in two particular areas of care – nutrition and delirium. Bringing ward staff and allied health professionals together enabled everyone to have a voice and generated a range of improvement ideas that were tested.

Nutritional care

Data suggests that the targeted sessions on nutritional care contributed to an overall reduction in inappropriate referrals to the dietitian (Figure 3) and an increase in compliance with Malnutrition Universal Screening Tool (MUST) reassessments (Figure 4).

Figure 3: An overall reduction in inappropriate referrals to the dietitian
A collaborative approach was adopted when developing a local contrasting crockery protocol. Evidence suggests that using contrasting crockery helps to make it easier for people to see what’s on their plate leading to an increase in food intake. Other activity relating to nutritional care specifically included:

- the introduction of adaptive cutlery
- a trial of coasters indicating how much fluid is in a cup to assist accurate monitoring of fluid intake, and
- safe sip covers to minimise the risk of spilling drinks and promote independence.

As of August 2016, the safe sip cover has been introduced throughout Dumfries and Galloway Royal Infirmary for all patients who would benefit from them. This has arisen from close collaboration with the catering department. Staff and family members have reported that patients are drinking more as a result of the safe sip covers.

“I feel more confident and much safer”
(Patient using the safe sip cup)
**Delirium care**

A single combined assessment booklet that includes both the Abbreviated Mental Test (AMT4) and the 4AT tool for assessing delirium was developed and tested as a collaborative effort between the OPAC improvement advisor and clinical colleagues. This, combined with the educations sessions, has helped to raise awareness and assessment for delirium.

“I now feel I am able to ‘think delirium” if I have a patient in my care with new confusion and now know how to escalate my concerns” (Staff nurse)

There has been an increased awareness of delirium and a corresponding rise in Abbreviated Mental Test compliance (Figure 5).

**Figure 5: An increased awareness of delirium with a rise in Abbreviated Mental Test compliance**

![Graph showing increased compliance from June 2015 to June 2016 with key events such as the combined assessment booklet trial in November 2015, staff education on delirium in April 2016, and current median of 70% compliance.](image-url)
Person-centred care

The introduction of ‘What matters to me’ charts displayed above patients' beds in some wards has also had positive benefits for staff and family members.

Increased staff confidence was reported:

“I feel better able to start a conversation with the patient now”
(Healthcare support worker)

“One relative took the ‘Hello my name is’ and ‘What matters to me’ chart to the community hospital as they thought it was such a great idea”
(Senior charge nurse, ward 18)

What went well - what could be done differently

When reflecting on what had worked well, the OPAC improvement advisor felt that the whole team approach had been particularly beneficial in helping her think more widely. Regular meetings with the Healthcare Improvement Scotland team provided a time for practical support, sharing and learning. She recognised that while her own personal expectations of the programme were not fully met, they were probably unrealistic. The challenge of trying to “do it all in a year” was highlighted. Tests of change have started in the areas described above but evidence of impact is limited at this stage. There are early signs of spread to other areas, with colleagues in other wards adopting some of the change ideas into their areas. Staff have generally reported feeling more supported and empowered to suggest ideas and to address areas for improvement. A number of factors within the NHS board have been highlighted as affecting progress, including delays to the development of a database to support data capture and monitoring. Delays obtaining equipment required for some of the tests of change, for example two-handled cups, were also a factor.

The OPAC improvement advisor also reflected that the closure of ward 16 for a week due to norovirus and staff vacancies impeded progress.

Reflecting on what might be done differently, the OPAC improvement advisor felt that NHS boards may have been at different starting points and she was starting from scratch. Having a clearer focus from the outset, with a few specific measures would have helped her adopt a more bite-sized approach. While she said she felt uneasy at the beginning of the programme, she valued the learning that she gained during the programme and is applying her broader knowledge and new ways of thinking in her new role.
NHS Grampian

Introduction

NHS Grampian provides NHS services for a population of half a million people who live in the Grampian region. NHS Grampian consists of acute services, corporate services and three Integrated Joint Boards and works closely with the local authorities. Aberdeen Royal Infirmary is the largest hospital within the region to provide acute care services. Emergency and urgent care services are provided there. Woodend Hospital, also in Aberdeen, provides acute orthopaedic services and elderly rehabilitation services. Dr Gray’s Hospital is the district general hospital based in Elgin, Moray. Teams from Aberdeen Royal Infirmary, Woodend and Dr Gray’s hospitals were all involved in the OPAC improvement work in NHS Grampian.

Who was involved - reach of the programme

The OPAC Improvement Advisor took up post in June 2015, working with an existing part-time improvement advisor and consultant geriatrician who were leading the newly established acute sector’s older people in acute hospitals collaborative. A total of 20 clinical teams were recruited to participate in the collaborative. Each clinical team identified key individuals from nursing, medical and allied health professional staff to take forward the improvement work and represent the area at teaching/learning events.

Due to local service pressures, the three days a week that the OPAC improvement advisor dedicated to supporting improvement activity in NHS Grampian stopped in April 2016 as the post holder had to return to her substantive role as clinical nurse manager. Balancing the demands of this role with two days a week for the blended collaborative work at a national level was a significant challenge for the OPAC improvement advisor.
**Education and awareness raising**

Four learning sessions were delivered between June 2015 and March 2016 which were attended by representatives from the 20 participating clinical teams across a variety of specialties. The number of attendees at learning sessions ranged from 100-130.

Other key stakeholders were invited to attend learning sessions, for example operational managers and lead nurses from Community Health Partnerships.

Feedback from teams who attended the learning sessions suggests the collaborative approach encouraged networking and was instrumental in the sharing of learning and ideas, which enabled staff to test and implement changes which would lead to improvement. In order to improve both the identification of risk of falls and care planning, teams adopted the idea of using ‘falls clocks’ and ‘measles charts’. These are visual aids that identify the time that a fall occurs and the precise place of the fall respectively and can help care planning by identifying factors contributing to falls.

“Being able to share good work and learning from others just makes sense” (Allied health professional)

“Being involved in the bigger picture is often only an opportunity given to senior members of staff” (Staff nurse)

“Sharing experiences with other areas – many of us are in the same boat and progressing with the same changes and ideas” (Senior charge nurse)

In addition to the learning sessions, the OPAC improvement advisor collaborated with the Alzheimer Scotland dementia nurse consultant, mental health and practice educator colleagues to deliver education sessions on specific topics. Topics included delirium, with a focus on the use of the 4AT and adults with incapacity. These sessions supported a consistent approach to the change from the AMT10 assessment tool to the 4AT. The 4AT for assessing risk of delirium is now the cognitive screening tool used on admission to the acute sector for all patients aged 65 years and above.

Improvement study days were arranged for community senior charge nurses by the lead nurse for Community Health Partnerships after attending one of the learning sessions. The aim of each study day was to focus on cognitive assessment, falls reduction and person-centred feedback.
Networking

In addition to the networking across and between teams that the collaborative facilitated, the OPAC improvement advisor was able to use existing relationships to strengthen networks with the local leads for national programmes of work (Scottish Patient Safety Programme, dementia, continence, tissue viability, and nutrition and hydration). This helped to co-ordinate approaches to improvement work locally and to support the delivery of the learning sessions. Further support for the clinical teams was secured from the practice education support forum. Practice education facilitators and practice/clinical educators from the forum supported staff to use PDSA (plan, do, study, act) cycles to implement changes for improvements.

The strong links between the OPAC improvement advisor and the local leads helped increase awareness of the opportunities to align improvement work, for example falls and cognition workstreams. Close working between the OPAC improvement advisor and the Alzheimer Scotland dementia nurse consultant and other colleagues ensured a more consistent and connected approach to education sessions for nursing, medical and allied health professional staff and also enhanced networking opportunities.

The OPAC improvement advisor worked with the nurse consultant for nutritional care to ensure the OPAC improvement work with ward teams was in line with local strategic action plans such as the older people in acute hospitals improvement action plan and food, fluid and nutrition work plan. Links with the tissue viability clinical nurse specialist helped identify how best to support and direct the teams in relation to pressure ulcer risk assessment and prevention. The OPAC improvement advisor also collaborated with the bowel and bladder specialist service manager to support two teams to test a new tool to improve bladder and bowel assessment documentation on the wards.

Testing change ideas - improvements in practice

The learning sessions facilitated the spread of ideas for improvements in relation to specific areas of care among the ward teams taking part in the collaborative.

Nutritional care

The benefits of a mealtime co-ordinator role were shared by clinical teams at the learning sessions. First introduced by the nurse consultant for nutrition and hydration as part of board-wide work, two wards tested the introduction of a mealtime co-ordinator alongside the introduction of new breakfast menus to ensure a more structured meal service. The result was a reduction in the amount of time staff had to spend on completing forms with patients, a saving of up to 20 minutes each day for three staff when serving breakfast (total of 60 minutes nursing time each day). Nursing staff used this time to assist patients who required help with eating and drinking.
Delirium care

The 51-bedded trauma orthopaedic unit (ward 212/213) introduced a number of changes to improve delirium care. These included:

- 4AT tool for all patients aged 65 years and above
- Single Question to identify Delirium - initially for patients aged 65 years and above; compliance continued to improve when spread to all patients, and
- review of analgesia given to hip fracture patients in order to reduce incidence of delirium - no data collected as yet.

Co-ordinating care

Ward 209 is a urology ward which tested and implemented a range of change ideas to improve care in relation to cognition, falls and nutrition:

- using information from 4AT assessment and/or Single Question to identify Delirium, patients are positioned where they can be closely monitored to reduce the risk of falling as a result of cognitive impairment
- use of ‘measles chart’ to identify environmental factors associated with falls: identified a particular bathroom area where many falls occurred due to bins being too large and patients not having sufficient room to move with their walking aids, causing them to fall (the bins were replaced with smaller ones)
- introduction of non-slip slipper socks
- high falls-risk patients were included on the safety brief
- afternoon tea, coffee and drinks with cakes was introduced to encourage patients to eat and drink while enjoying the company of other patients or families and carers, and
- referrals to the older people’s assessment and liaison team soon after admission to ensure patients are assessed by occupational therapists and physiotherapists in a timely manner.

Since the collaborative work and the support of the OPAC improvement advisor started alongside the introduction of robotic surgery (technological developments that use robotic systems to aid in surgical procedures), this ward has seen a reduction in average length of stay of 18% between June 2015 and May 2016. Falls have also reduced by 56% during the same time period (Figure 6).
Figure 6: Reduction in falls - ward 209

Building improvement capacity

In addition to the learning sessions, weekly ‘improvement clinics’ lasting one hour were provided as a drop-in service for teams to attend for support with their improvement projects and change ideas. Support at these improvement clinics was provided on a rota basis by the improvement team, Scottish Patient Safety Programme manager, quality improvement facilitator, head of service improvement, lead physiotherapist, nurse consultant for nutrition and hydration, and Alzheimer Scotland dementia nurse consultant. Although attendance at the clinics fluctuated, feedback indicates that they helped in terms of building teams’ and individuals’ knowledge of quality improvement approaches and also for using data for improvement. Some teams, for example respiratory medicine, have now established their own regular quality improvement meetings.

As well as advising on clinical matters, the OPAC improvement advisor provided one-to-one support for clinical teams and individuals, including practical help with developing PDSAs, run charts, implementing change ideas and measurement. Input was also provided to the newly-established quality improvement meetings for respiratory medicine and the orthopaedics quality meetings.
What went well - what could be done differently

The OPAC improvement advisor reflected that the collaborative approach worked well locally, although it was not possible to provide all 20 clinical teams with the same level of improvement support from the available resource. Focused support was directed to teams who consistently demonstrated will, motivation and enthusiasm for the collaborative and for taking improvement work forward.

The OPAC improvement advisor highlighted the additional benefit that the national collaboration with Healthcare Improvement Scotland brought:

“There is a richness to joint working that allows the OPAC improvement advisor in the local context to be outward looking as well as having a local focus” (OPAC improvement advisor)

She also valued the learning she got from meeting monthly with the other OPAC improvement advisors and the core team at Healthcare Improvement Scotland.

The drop-in improvement clinics were well attended initially. Attendance fell towards the end of the collaborative, with staff citing reasons of being too busy in their wards to leave and others said they had no concerns with their improvement work. When changes were made to the format of the improvement clinics to include formal teaching sessions, attendance did improve.

With hindsight, the OPAC improvement advisor felt that greater understanding of the work that had been undertaken before the blended local collaborative with the Langlands team would have helped her understanding of what had been achieved:

“This in turn might have helped make things clearer with the development of a measurement plan”

The OPAC improvement advisor also reflected that a meeting between the collaborative improvement team (OPAC improvement advisor, existing improvement advisor and clinical lead) and other key stakeholders before the collaborative started would have been beneficial in:

- clarifying the OPAC improvement advisor role, and
- enabling a review of the Care of Older People in Hospitals Standards and how these could be achieved through local collaborative improvement work.
Difficulties securing medical staff engagement delayed progress for some of the clinical teams and again more communication before the collaborative started may have improved this.

Data collection and analysis was a challenge for many areas. Substantial effort was needed to ensure that systems and OPAC improvement advisor support were in place to enable ward staff to collect and interpret data associated with any improvement project.

“Many teams struggled to get time to collect and analyse data as well as write PDSAs” (OPAC improvement advisor)

It was recognised that having dedicated data and measurement advisor support from Healthcare Improvement Scotland enabled the core team to develop a data collection tool which is now making data collection easier for teams on the wards.
NHS Greater Glasgow and Clyde

Introduction

NHS Greater Glasgow and Clyde is the largest NHS board in Scotland and one of the largest in the UK, providing healthcare to over 1.2 million people. There are 35 different types of hospital within NHS Greater Glasgow and Clyde and the population is served by around 240 GP surgeries (790 GPs). The NHS board has recently undergone a massive re-organisation, including the amalgamation of three acute hospitals and the opening of the Queen Elizabeth University Hospital in Glasgow, the largest acute hospital in Europe. Each of the three sectors (North, South and Clyde) has an older people’s improvement group.

Since 2014, NHS Greater Glasgow and Clyde has aligned all improvement programmes with the Care Assurance Scheme Standards. The Care Assurance Scheme is designed to support teams to understand how well they deliver care, identify what works well and where further improvements are needed. While the overall responsibility and accountability for achieving and maintaining the required standards lie with the senior charge nurse, the emphasis is on a multidisciplinary team working with the Care Assurance Scheme. Any improvements made as a result of the OPAC blended local collaborative will assist teams in gathering the evidence required for the scheme, the Care of Older People in Hospitals Standards and other applicable measures, including Scottish Patient Safety Indicators. There are 13 Care Assurance Scheme standards, with one relating specifically to older people in acute care and adult protection. At the time that the local collaborative was being tested in NHS Greater Glasgow and Clyde, the Care Assurance Scheme measurement framework was not fully implemented. The aim of the OPAC improvement advisor was to test the blended local collaborative approach in that context.
Who was involved - reach of the programme

The OPAC improvement advisor took up post in June 2015 and in consultation with the five chief nurses for the acute division, identified 22 wards from across the three sectors to take part in the local collaborative work in NHS Greater Glasgow and Clyde. The initial aim was to test a local collaborative approach to blend a number of national improvement initiatives (falls, pressure ulcers, nutrition, person-centred care and delirium) in order to facilitate a joined-up approach to improving care for older people mapped to the 16 Care Of Older People in Hospitals standards and 13 Care Assurance Scheme standards. Within NHS Greater Glasgow and Clyde, it was proposed that an Older People’s Collaborative was established to develop tests of change and to share best practice across the acute division. In September 2015, an unannounced older people in acute hospitals inspection presented the NHS board with specific challenges that resulted in the OPAC improvement advisor being asked to re-focus and concentrate on providing specific support to the seven wards within the Langlands Unit (Medicine for the Elderly) on the Queen Elizabeth University Hospital site and two wards in Lightburn Hospital, Glasgow.

Activity summary

Linking in to the Care Assurance Scheme, the OPAC improvement activity was focused on delivering best care for older people. Progress has been made in relation to falls reduction, delirium, ‘What matters to me’ and staff engagement.

The OPAC improvement advisor sought to build on initial progress made as a result of previous improvement work undertaken within the Langlands Unit.

Education and awareness raising

Activity included collaborating with the Alzheimer Scotland dementia nurse consultant to deliver delirium awareness sessions incorporating ‘What matters to me’. Over 1,000 colleagues received delirium training during the time the OPAC improvement advisor was in post. Recognising that delirium awareness training is an ongoing process and requires to be widespread, medical illustration filmed the OPAC improvement advisor delivering an awareness-raising session. This ‘virtual training' provided opportunities for wider reach and support for colleagues unable to attend sessions. It also reduced the amount of time spent on training.
Delegates were provided with ‘before and after’ training evaluation forms to assess their level of knowledge and understanding. Questionnaires demonstrated increased knowledge and awareness of delirium after training. The OPAC improvement advisor was also involved in planning the roll-out of NHS Greater Glasgow and Clyde’s delirium guidelines, including the testing of new paperwork.

The development of a quality improvement hub (Figure 7) provided another opportunity for sharing and learning together. Teams are encouraged to use the white board to share their work and are supported to focus on key areas of care. The OPAC improvement advisor provided guidance and support with PDSAs and interpretation of results. Increased staff understanding of quality improvement methodology has empowered staff to make changes and analyse data from tests of change.

Figure 7: Development of a quality improvement hub
A board-wide local collaborative learning event was held in September 2015. Attended by 124 staff, including nurses, allied health professionals, consultants, managers and nurse specialists, feedback again reinforces the value attached by staff to this sort of local education:

“Very enjoyable event, learned a lot and there are definitely things that I will take back to own area...” (Staff nurse)

“Always best to hear from folk on the shop floor... practical examples useful” (Allied health professional)

“...I'm more aware of the need to individualise care for older patients. I like the idea of using 'What matters to me' in delirium care” (Staff nurse)

“Great hearing ideas about what has worked in other places in my own board” (Senior charge nurse)

“I think many of the staff working on the wards directly with the patients and relatives could relate to and understand many of the talks today...” (Nurse manager)

In March 2016, following discussion with the senior charge nurses and lead nurse, a learning event was planned specifically targeting staff from Lightburn and Stobhill hospitals. This session focused on delivering best care for older people in acute care and used a real case study of an older person with complex care needs as the basis for an interactive session where groups planned what best care should look like for the individual in the case study. Discussions were facilitated by nurse specialists. Consistent themes from the group work included:

- using professional judgement
- actively engaging and working in partnership with families
- putting the individual at the centre, and
- rapid identification of delirium.
Staff were asked to identify what learning they would take back to their clinical area and anything they were going to do differently as a result of the session. Their responses reflected the themes identified above:

“...look at patient as an individual and fit care around their needs” (Staff nurse)

“Using own clinical judgement” (Staff nurse)

“Involve patient/relative more in their care plan” (Allied health professional)

“Treat patient as a person. Involve relatives as soon as possible following patient admission...treat patients as I would like my own family treated” (Staff nurse)

They were also asked what had worked well about the day and what could improve things for them:

“Not often I say this but the study day could be longer to facilitate more discussion at group work” (Facilitator)

“Dissected all aspects of person centred care in single case study case conference approach made it more realistic” (Staff nurse)

“Very interactive... Encouraged thinking outside the box” (Allied health professional)
Networking

Monthly meetings were held with the chief nurse for the South Sector and corporate practice development nurse to plan improvement priorities. In order to help streamline improvement activity locally, the OPAC improvement advisor collaborated closely with a range of colleagues, including practice development staff, the Alzheimer Scotland dementia nurse consultant, lead nurses, senior charge nurses with their nursing teams and medical colleagues.

Local knowledge and strengthening of these relationships created opportunities to discuss priorities, progress and agree resources required to enhance improvement activity.

The OPAC improvement advisor had the opportunity to influence strategically as a member of the older people’s quality improvement group for the North and South sectors.

Testing change ideas – improvements in practice

Earlier improvement work within the Langlands Unit had resulted in a reduction in falls. This improvement has continued since the beginning of 2013 with less variation since the OPAC improvement advisor came into post in June 2015 (Figure 8).

Figure 8: Reduction in falls since 2013 showing less variation since OPAC improvement advisor came into post.

Ward 55

Langlands Unit

![Graph showing reduction in falls and improvements in practice]
Collaborative working between the OPAC improvement advisor, local leads and specific teams and education sessions have resulted in a number of change ideas being tested and implemented in different settings.

Since the learning event in September 2015, there has been a reduction in the number of falls in some of the participating wards (Figure 9).

**Figure 9: Reduction of falls in Lightburn Hospital - ward 2**

Evidence suggests that having meals out of bed promotes mobility, decreases the risk of pressure ulcers, increases social interactions and reduces the risk of falls. Two wards tested the idea of actively encouraging patients to use the day rooms at mealtimes (wards 55 and 56 in the Queen Elizabeth University Hospital, Figure 10).
Working with the surgery and orthopaedics lead nurse has facilitated the roll-out of ‘What matters to me’ in this area and has helped to support the delivery of person-centred care with positive feedback from families and carers.

Collaboration with the orthopaedic medical staff in The Queen Elizabeth University Hospital has resulted in implementation of the delirium care TIME bundle.

The OPAC improvement advisor also worked with junior medical staff in the development of an aide memoire for Adults with Incapacity (AWI), Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and medicines reconciliation.

A ward information booklet that provides patients and carers with information on all aspects of their care, including falls and delirium, has been developed in collaboration with the practice development lead nurse for the South Sector.
What went well - what could be done differently

As mentioned previously, NHS Greater Glasgow and Clyde was undergoing a period of significant re-organisation at the time of the local collaborative work. One of the main reflections from the OPAC improvement advisor relates to the impact of the NHS board restructuring and the challenge that presented in terms of accessing local infrastructure to support the work and managing demand.

“Being the only OPAC improvement advisor in a large board dedicated to improvement in the care of older people - how do we ensure support for others who want to get involved?” (OPAC improvement advisor)

As the restructuring settled and the post evolved, the OPAC improvement advisor reflected that relationships with senior colleagues matured and she felt that colleagues had a greater understanding of what the role could offer locally: “I am being called on to describe national work and how it fitted with GGC context.

“I feel I am beginning to influence the direction of travel for older people’s care within the acute division” (OPAC improvement advisor)

Reflecting on what worked well, the OPAC improvement advisor thought that having a board-wide perspective was very valuable in terms of enhancing understanding of the range of activity that was taking place. At the same time, however, having this overview served to emphasise the complexity that exists and the challenge of co-ordinating improvement activity across such a large NHS board.

Undoubtedly, the older people in acute hospitals inspection had an impact on the focus of the local collaborative within NHS Greater Glasgow and Clyde in terms of the NHS board’s response, with a shift in focus of the OPAC improvement advisor to concentrate efforts on a far smaller number of teams than initially planned.

Reflecting on what could be done differently another time, the OPAC improvement advisor highlighted the importance of taking time to ensure all those involved understood the aim of the approach and had a shared vision. She observed that: “The lesson to be learnt is that change takes time and successes in small areas such as Lightburn have enhanced the reputation of the programme, this has assisted with spread.”
Learning from a blended local collaborative approach

The three case studies outline some of the progress made in each of the respective NHS boards. While a number of challenges have emerged associated with the testing and implementing of the blended local collaborative approach, opportunities also exist to develop the strengths of the work and improve future planned and responsive improvement activity. As part of Healthcare Improvement Scotland’s commitment to continuous improvement, learning has been captured on an ongoing basis through monthly core team meetings, discussions with NHS board colleagues and OPAC improvement advisors’ reflective diaries. In order to gain further insight into the opportunities and challenges that emerged during the course of this work, an after action review was conducted with the core team and a short survey was sent to a few key stakeholders in each NHS board. This included frontline teams and NHS board leads.

Analysis of the core team’s reflections, the after action review and the survey generated some key themes. These are presented below as opportunities, challenges and recommendations.

Opportunities and strengths to be sustained

Understanding of local context - making connections - influencing strategically

Feedback from the NHS boards and the local OPAC improvement advisors all confirmed that the approach taken to test a blended collaborative approach was beneficial. Staff reported a number of benefits and can evidence a range of improvements in knowledge and clinical care that have been achieved as a result of the programme. The benefit of having an individual locally who was able to make connections and enable staff to try out improvements in their own areas, through sharing knowledge and learning was highlighted. OPAC improvement advisors were able to build links across and between teams and specialists, to facilitate multidisciplinary working and strengthen relationships. The value of this was reflected in feedback:

“Having an OPAC improvement advisor locally was a real strength of the programme ... ensured strong links with the national programme, as well as access to support/learning from other areas” (Executive nurse director)
OPAC improvement advisors used their knowledge of local human factors, team dynamics and culture to understand teams’ readiness for change and work with teams to create conditions for change and opportunities for sharing.

“OPAC improvement advisor was aware of the team dynamics within each department and worked through the strengths and weaknesses of that team” (Nurse manager)

The OPAC improvement advisors were increasingly seen as a source of information and expertise in their respective NHS boards. They contributed to and influenced discussions locally.

“It took some time but senior colleagues within the board now utilise the OPAC improvement advisor as a source of expertise in older people’s care” (OPAC improvement advisor)

**Multidisciplinary working within Healthcare Improvement Scotland**

Support required to test, measure and evidence the impact of improvement work requires a range of skills. As a result of its multiple functions across evidence, improvement and assurance, Healthcare Improvement Scotland is uniquely positioned to provide a comprehensive range of improvement support. In testing the blended local collaborative approach, knowledge and skills were sought from across the organisation, specifically the evidence and evaluation team and the data management and business intelligence team. The contribution from different areas of knowledge and expertise in Healthcare Improvement Scotland was recognised as a key strength of the work. Efforts to draw proactively on the skills and knowledge within the evidence directorate meant that peer working and learning had extended beyond just the OPAC improvement advisors in the team. It was felt that data and measurement advisors working more closely with the NHS boards resulted in a more coproductive approach to using data to monitor improvement.

Due to the emergent nature of the programme, it was difficult to provide specific guidance about expectations of colleagues, for example the fact that priorities for each NHS board were shaped by the teams involved. It was recommended that future conversations should start as early as possible in order to develop greater clarity of the expected contribution of different disciplines based on available expertise and capacity.
Sharing learning and evidence

Given the emergent nature of the programme, opportunities for peer learning and support were seen as very helpful in making sense of how best to implement the approach across the three boards with monthly core team meetings being invaluable for making sense of things as the programme evolved.

“Coming together monthly really helped my learning and it was good to share progress and challenges with the others” (OPAC improvement advisor)

The use of reflective diaries to capture information about the experience of the OPAC improvement advisors in each NHS board was seen as important for capturing experiential learning. While these had been challenging to complete, it was identified that there is a need to consider how this formative evidence should be best captured in future and whether this is through the use of reflective diaries or other suitable methods. It was recommended that this form of learning and evidence capture should have an intrinsic role as part of testing what is or is not working as part of improvement approaches. The need for innovation in methods and tools to support this evidence capture was identified such as the use of audio recording and podcasts.

The impact the blended local collaborative approach had in terms of learning from others at national and local level, was identified by stakeholders in the NHS boards as one of its biggest benefits:

“...there were strong links with the national programme, as well as access to support/learning from other areas” (Executive nurse director)

“It has encouraged staff to learn from each other and share learning and experiences - much more local ownership, many more improvement actions nearer to the patient coming from the staff - it has 'empowered' staff on the front line to take ownership and given them the support and time to make changes that they believe will make a difference to the care of older people” (Executive nurse director)

“OPAC improvement advisor working with other boards' OPAC improvement advisors to share learning - testing different ways of working across the 3 [NHS] boards” (OPAC improvement advisor)
Challenges – what we would do differently

There are numerous challenges in planning and implementing complex change initiatives, such as the Improving Older People’s Acute Care programme, that aim to bring together a range of improvement activity (falls, pressure ulcers, person-centred care, delirium, and nutritional care) to deliver best care for older people. Recognising the emergent and responsive nature of improvement programmes can be in direct tension with having adequate focus and clarity. These need to be taken into consideration when planning future models of improvement support.

Readiness for change

A number of tools exist to help assess readiness for change and workforce capability. These include the Public Service Improvement Framework (PSIF), the Model for Understanding Success in Quality (MUSIQ) and the NHS Education for Scotland workforce capacity and capability tool. Knowledge and understanding relating both to readiness for change and creating conditions for change are growing. Readiness for change is recognised as being difficult to assess when there is an emphasis on increasing scale and pace of improvement work. Due in part to pressures of short-term funding, pressure to get started, delays in recruitment and the number of wards involved in testing, readiness for change tools were not used with the three NHS boards. In future, available tools would be considered as part of the process to help Healthcare Improvement Scotland and NHS boards understand their readiness and to ensure improvement programmes are sufficiently targeted to address the local needs of NHS boards.

The scale of the programme was regarded as having been challenging due to the complexity of the contextual conditions in NHS boards. At the same time, it was recognised that it can be difficult to plan and foresee what can be achieved because of how conditions shift. One example of this was with each of the NHS boards experiencing changes in executive nurse leadership during the programme. There were also other competing priorities in each NHS board that may have affected the level of support and engagement that could be secured. However, it was recognised that managing expectation about the scale of change possible and providing a focused and realistic message to each NHS board about what can be achieved are vital. The growing requirement for transformational change is also seen as a challenge in terms of ensuring there is sufficient focus of programmes of work to be able to effect change at an appropriate scale. A recommendation from these points is the need to agree realistic and explicit aims and objectives that take into consideration the complexity and scale of change that can be reasonably expected to happen within a given timescale, particularly when efforts are being made to scale up smaller tests of change.
Creating the conditions for improvement

Securing NHS board engagement – managing expectations – competing priorities – maintaining focus

One of the biggest challenges the improvement advisors and the programme faced was balancing demand with capacity. Lack of clarity in terms of the level of support available within the NHS boards for both improvement and data gathering and analysis was particularly significant in this regard. It was highlighted that one improvement advisor working in an NHS board cannot achieve the level of change expected without the necessary support and infrastructure to enable their contribution. It was agreed that explicit detailed agreement about the support structures available to the OPAC improvement advisor within the NHS board was critical to maximise the impact of blended local collaborative efforts. In future, specific information about the support structures available to the improvement advisor should be identified and agreed in advance with the NHS board as this will affect the scope and scale of the programme.

While a peer learning approach was identified as a key strength of the programme in being able to navigate the complexity of change in this context, it was also perceived that this, at times, may have been at the expense of having a clear enough focus on the developing aims and objectives. It was recognised that measurement efforts were found to have been pulled in different directions at times because of this. Planning for data collection and measurement should start as early as possible to be able to move towards clearer goals as the programme develops. This was reflected in feedback from NHS board leads about what could have improved the programme:

“...thinking of the evaluation right from the start” (Lead nurse)

“Concentrate on some of the more qualitative type of information” (Nurse director)

“More focus on key areas of the measurement plan developed at the outset which was agreed to be mandatory for all areas would have been helpful” (Nurse consultant)
It was also recognised that obtaining access to data was challenging because of lack of explicit agreement about who would be responsible for providing this. It was recognised that the Memorandum of Agreement did not function as well as anticipated as a contract with the NHS boards to ensure that there was adequate commitment in terms of their support. It is recommended that a contract, such as the Memorandum of Agreement, should be enacted differently in future, along with efforts to clearly establish as part of planning conversations what support will be required for NHS boards to maximise the contribution of improvement advisors. Considering the systems and structures that are in place to support people during change is a key part of understanding organisational readiness for change.

**Changing service priorities**

The importance of mobilising a range of evidence and intelligence as part of identifying where improvement activity should focus is recognised. Changing service priorities are a reality of the complex systems in which we work. The outcomes of an older people in acute hospitals inspection led to a change in focus for one of the NHS boards, making it difficult to maintain momentum and evidence the impact of improvement work.

“We have to think about the capacity and capability of teams to work on changes that will deliver improvements – not keep changing direction” (Lead nurse)

**Conclusions**

A number of lessons have been identified in relation to the challenges of testing and implementing the local collaborative programme in the three participating NHS boards. These include a wide range of contextual and system factors. In all areas, staff have reported improvements in their knowledge skills and confidence, and a number of improvement initiatives and approaches will continue and be expanded in some of the sites. Within Healthcare Improvement Scotland, learning from the tests will be shared widely and used to improve the planning, design and execution of similar approaches. Finally, a number of recommendations were agreed that should be considered in further work to identify a suitable action plan for their implementation.
Recommendations and next steps

- Continue to develop and test the use of appropriate media, methods and tools for capturing formative and experiential learning and evidence, so that they become an explicit part of testing and evaluating improvement efforts within Healthcare Improvement Scotland.

- Utilise opportunities for wider and more explicit testing and use of tools for assessing readiness for change in NHS boards.

- Ensure realistic aims and objectives are developed from efforts to understand the scale and complexity of change that can be reasonably expected in a given timescale, particularly when efforts are being made to scale up smaller tests of change.

- Ensure conversations start early about what support and engagement will be required in the boards to support the work of improvement advisors, as part of a contract that can be enacted throughout the programme.

- Utilise opportunities to better align the range of evidence, expertise and intelligence within Healthcare Improvement Scotland that can inform the focus of planned improvement programmes.

- Provide opportunities to formally share the learning and outcomes from the programme with the NHS boards.

- Create opportunities to test the participation of staff from the evidence directorate in board visits to facilitate broader knowledge exchange.

- NHS boards should consider how they will use learning to address future sustainability and inform the best care for older people and care assurance workstreams.

- Sustain and develop the benefits of multidisciplinary working within Healthcare Improvement Scotland by ensuring steps are taken early in the design of improvement programmes to establish how each role can be expected to contribute and when, based on disciplinary expertise and available capacity.

Healthcare Improvement Scotland remains committed to:

- ensuring that the learning from this work informs future approaches to improvement support
- continuing to provide support to NHS staff to share learning and good practice to improve care for older people
- agreeing priorities for future improvement support identified through a range of discussions and consultation, AND
- learning from a review of the work of both the Improving Older People’s Acute Care programme and the Older People in Acute Hospitals inspection programme (in progress) in order to agree how Healthcare Improvement Scotland most effectively continues to provide assurance of and support improvements in older people’s care.
## Appendix 1: Logic model

### Inputs
- Scottish Patient Safety programmes
- Implementation & Improvement programmes
- OPAH Inspections
- Excellence in Care Improvement

### Assumptions
- HIS core team supports boards & boards support test site teams to carry out improvement activities throughout the testing period
- IAs facilitate recognition of importance of local context, visible leadership & build local improvement capability; creating conditions for improvement
- Test site teams are released to participate in training & learning events
- The resource and capacity to support spread of successful improvements within Boards

### Activities
- Networking & sharing data to drive improvement
- Teams apply QI approaches in tests of change and use data for improvement
- Teams recognise opportunities for improvement
- Local specialists: FFN & tissue viability nurse specialists, Dementia champions, Alzheimer nurse consultants
- Boards prepared to provide the support required
- Local specialists willing to cooperate

### Outcomes
- Increased awareness of the need to improve care for older people
- Boards support processes for delivering improvement
- Teams increase their knowledge of QI approaches & using data for improvement
- Teams feel supported & empowered to address areas for improvement
- Increased sharing & learning from local data
- Teams increase their understanding of how components of care interrelate & impact on patient outcomes
- Teams challenge unsafe practices and processes
- Increased local spread & sustainability of improvement

### Reach
- So that all older people in hospital receive safe, coordinated, person-centred care
- Increased local QI capacity & capability
- Boards share data & take part in events

### Reactions
- Regional learning events
- Education on the interrelatedness of frailty, falls, delirium, FFN, PCC, dementia
- Education in QI
- Local teams want to be involved
- Teams feel they have permission to stop doing what's not helping
- More opportunities to share & learn from local data & to spread & sustain improvement locally

### Reach
- Informs shared learning across NHS Scotland
- Teams implement change in day to day practice
Appendix 2: Memorandum of Agreement

Older People’s Acute Care Improvement Advisor
Memorandum of Agreement
between
Healthcare Improvement Scotland and NHS X

Introduction

Scottish Government is funding a further year (2015/16) of the Healthcare Improvement Scotland Older People’s Acute Care Programme. The next phase of work will build on progress to date and design and test a blended local collaborative approach which aims specifically to support the alignment or integration of a number of national improvement initiatives (frailty, delirium, person-centred care, SPSI) at local level to facilitate a joined up approach to care.

Funding is available for NHS Board for one year to appoint an Improvement Advisor (Band 8A) to work in collaboration with Healthcare Improvement Scotland and CNOD. In addition to facilitating and driving improvements locally this individual will play a significant role in supporting national work and contributing to sharing learning across NHS Scotland. This post will be based in NHS Board and work within an agreed number of wards to support the improvement programme.

Healthcare Improvement Scotland will fund an Improvement Advisor during Financial Year 2015/16 up to a maximum of £xx (this funding to be ring fenced by the NHS Board) in order to meet the key aims below, to help build improvement capacity and capability locally and support local teams to deliver measurable improvements in care for older people.
Agreement in Relation to Role

In return for this contribution, NHS Board commits to the following:

National / Local Aims

The Improvement Advisor will:

• Lead the design, development and testing of improvement activity and raise the knowledge and skills for multidisciplinary teams in acute hospitals each year, extending knowledge particularly of what constitutes ‘best practice’ and what is available and possible in relation to community based supports

• Undertake a baseline assessment of current quality improvement capacity and capability to identify learning and development needs of ward based teams and managers

• Undertake a baseline assessment of existing measures for improvement within older people’s care and develop a measurement framework and process for sharing data to drive improvements in care

• Work in collaboration with the national team to agree approaches to knowledge transfer and rapid sharing of learning within NHS Grampian and across NHS Scotland

• Work in collaboration with local and national teams to agree an approach to evaluation of the role and impact and benefits of this model of working

• Provide support to both national and local improvement activity that contributes to the delivery of Older People’s Acute Care improvement aims and outcomes

• Provide regular updates on improvements outcomes to inform local and national learning

• Work collaboratively with Healthcare Improvement Scotland with a commitment of 2 days per week to support the national programme of work alongside the Older People’s Acute Care team, Alzheimer Scotland Dementia Consultants and other stakeholders to support integration of programmes

• Support dementia 10 care actions - promoting the understanding of dementia and opportunities to streamline improvement activity

• Establish partnerships and strong working relationships with key stakeholders in Local Authorities, Primary and Community Care, Voluntary and Independent sectors
Key individual attributes

- Demonstrate contemporary attitudes to, and up to date knowledge of older people's acute care and dementia clinical practice including frailty and delirium
- Demonstrate strategic thinking and integrated approaches to initiating and facilitating change
- Play an active part in the Older People's Acute Care programme and contribute to local, regional and national action planning to align and extend best practice
- Actively contribute to organisational strategic discussion re older people's acute care
- Act as a source of advice and expertise to staff supporting and caring for older people in acute hospital settings. This contact should be as proactive and flexible as possible and should not require lengthy waiting times or complex referral procedures

Specific Local Aims (agreed with NHS Board) eg

- 90% of patients asked report a positive experience of care
- No patients from participating wards are boarded elsewhere in the hospital

The Improvement Advisor will be supported by Healthcare Improvement Scotland Older People's Acute Care Team and there will be regular liaison to ensure that the individual is provided with up to date information, support and direct access to the ongoing work of Healthcare Improvement Scotland and the national policy agenda.

Measures of success -

Progress will be measured quarterly against the aims outlined above.

Measurable improvement in care and outcomes for patients in agreed improvement and measurement framework, namely:

- 25% reduction in number of falls (with harm)
- 100% compliance with 4AT, increase in number of patients assessed for delirium
- 100% of patients with 4AT score of 4 or more started on TIME bundle
- Evidence of reliable application of 5 must do with me measures
- Increase in competency, capability and confidence of staff in using a range of improvement tools and techniques
- Improved staff experience
Monitoring

- Improvement advisor will produce quarterly written reports on progress towards the outcomes and targets identified above to their line manager, the Older People’s Acute Care programme board and Healthcare Improvement Scotland.
- The Older People’s Acute Care programme lead will speak with improvement advisor to review progress at least monthly intervals.
- Improvement advisor will present report to Older People’s Acute Care programme board and Healthcare Improvement Scotland.

Payment

Healthcare Improvement Scotland will pay two instalments totalling a maximum of £54081 (includes on costs). Payment to be made half yearly in arrears upon settlement of invoices from NHS Board for the first 6 months of Improvement Advisors employment and the final months of the employment contract up to xx 2016.

Duration & Termination

Healthcare Improvement Scotland funding will cover a one year period from xx to xx with the proviso that the objectives outlined above are delivered and that there is no substantial deviation in the post holder’s role away from a focus on improving older people’s acute care intervention and activity.

This agreement will remain in place until xx 2016 or earlier if either Healthcare Improvement Scotland or NHS Board mutually agree to terminate it or until either gives notice to terminate the agreement.

Should either party wish to terminate the agreement early, the following undertakings will apply:

- Six months’ notice will be given.
- Healthcare Improvement Scotland will cease providing the contribution from the next due payment or be reimbursed for funding already provided.

Name: ___________________________  Name: ___________________________

Position: Head of Implementation and Improvement  Position: ___________________________

Date: ___________________________  Date: ___________________________

Healthcare Improvement Scotland  NHS Board
## Appendix 3: Project timeline

<table>
<thead>
<tr>
<th>Period</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>January–March 2015</td>
<td>Discussions with CNOD, Executive Nurse Directors</td>
</tr>
<tr>
<td>March–June 2015</td>
<td>Improvement advisor recruitment and interview process</td>
</tr>
<tr>
<td>NHS Grampian, NHS Greater Glasgow and Clyde (NHS GGC), June 2015</td>
<td>Improvement advisor took up post</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway (NHS D&amp;G), August 2015</td>
<td>Improvement advisor took up post</td>
</tr>
<tr>
<td>April–August 2015</td>
<td>Memorandums of Agreement drafted and agreed between NHS boards and Healthcare Improvement Scotland (HIS)</td>
</tr>
<tr>
<td>June 2015–August 2016</td>
<td>Monthly HIS/improvement advisor planning and progress meetings</td>
</tr>
<tr>
<td>NHS Grampian, June 2015–March 2016</td>
<td>Weekly improvement clinics</td>
</tr>
<tr>
<td>NHS GGC, 1–5 June 2015</td>
<td>NHS GGC Delirium Week training days</td>
</tr>
<tr>
<td>NHS Grampian, June 2015</td>
<td>Collaborative Learning Event 1</td>
</tr>
<tr>
<td>NHS D&amp;G, September 2015–June 2016</td>
<td>Weekly 30-minute education sessions</td>
</tr>
<tr>
<td>NHS D&amp;G, April 2016–August 2016</td>
<td>'Topic of the month' education sessions</td>
</tr>
<tr>
<td>NHS GGC, 10 September 2015</td>
<td>Unannounced older people in acute hospitals inspection - Queen Elizabeth University Hospital</td>
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<tr>
<td>NHS GGC, 17 September 2015</td>
<td>&quot;Best Care for Older People&quot; learning event</td>
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<tr>
<td>NHS Grampian, 22 September 2015</td>
<td>Collaborative Learning Event 2</td>
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<tr>
<td>NHS Grampian, 1 December 2015</td>
<td>Collaborative Learning Event 3</td>
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<tr>
<td>NHS D&amp;G, December 2015</td>
<td>&quot;Enhancing Care of Older People in Hospitals&quot; learning event</td>
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<tr>
<td>NHS Grampian, March, 2016</td>
<td>Collaborative Learning Event 4</td>
</tr>
<tr>
<td>NHS GGC, March 2016</td>
<td>&quot;Best Care for Older People&quot; collaborative learning event (Lightburn)</td>
</tr>
<tr>
<td>NHS D&amp;G, June 2016</td>
<td>&quot;Enhancing Care of Older People on Admission to Hospitals/Caseload&quot; learning event</td>
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