Scottish Patient Safety Programme – Reducing Pressure Ulcers in Care Homes Improvement Programme (SPSP-RPUCH)

Induction Event
27-28 June 2016
you said,

we did
MODEL FOR IMPROVEMENT

Aim

Measures

Interventions

Testing and Implementation

Test
THE MODEL FOR IMPROVEMENT
Ground rules

- Be present
- Participate
- Listen openly
- Ask if you don’t understand
- Challenge if you disagree
- Respect the learning
- Vegas rule
- Hawaii
Teach, Learn, Inspire
## Agenda – Day 2

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<tr>
<th>Timings</th>
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<tr>
<td>09.00</td>
<td>Reflections on Day 1</td>
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<td>09.30</td>
<td>What pressure ulcers matter and why they occur</td>
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<td>10.15</td>
<td>What is a care bundle?</td>
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<td>11.00</td>
<td>Refreshments</td>
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<td>11.15</td>
<td>Evaluation and data collection</td>
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<td>Other improvement work in care homes</td>
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<td>13.00</td>
<td>Lunch</td>
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<td>Brainstorming of ideas</td>
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<td>Next steps planning</td>
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Why pressure ulcers matter and they occur
Q: How many people over 65 will develop a pressure ulcer?

A: 1 in 23
B: 1 in 150
C: 1 in 15
D: 1 in 230

£1,000,000
Q: How many people developed a pressure ulcer in a care home setting in Scotland in 2014?

A: 896

B: 1,124

C: 1,533

D: 1,863

£1,000,000
Impact on residents

Pain

Infection ➔ death

Distress

Odour / drainage
Financial impact

The expected cost of healing a pressure ulcer in the UK from £1,064 (grade 1) to £10,551 (grade 4).
Pressure Ulcers in Care Homes

What is the scale of the problem in care homes?

Why do pressure ulcers happen in care homes?

Root cause analysis?
Summary of draft standards

Standard 1: The organisation demonstrates leadership and a commitment to the prevention and management of pressure ulcers.

Standard 2: Education and training on the prevention and management of pressure ulcers are mandatory for all healthcare and social care staff involved in pressure ulcer care.

Information and support is accessible to people at risk of, or identified with, a pressure ulcer, and/or their representatives.

Standard 3: An assessment of risk is undertaken as part of initial admission or referral, and informs care planning.

Standard 4: Regular reassessment of risk for pressure ulcer development, or further damage to an existing pressure ulcer, is undertaken to ensure safe, effective and person-centred care.

Standard 5: A care plan is initiated and implemented to reduce the risk of pressure ulcer development and to manage an existing pressure ulcer.

Standard 6: People with an identified pressure ulcer will receive a person-centred assessment, grading of the pressure ulcer and care plan.
Why do pressure ulcers happen in care homes?

Joyce O’Hare
Fatal Accident enquiries

• Care Commission/Inspectorate has given evidence at 3 FAIs where care home residents have died following an infected pressure ulcer

• Findings:
  Serious failings in standards of care and support
  Poor record keeping
  Staff not competent or had sufficient training to provide good care and support
  Poor staffing levels/inadequate staff supervision
Pressure for change (2007)

- A review of Care Commission inspection, complaints and enforcement activity in care homes for older people 2002-2006

- Findings from:
  - 29 Inspections
  - 31 Complaints
  - 11 Enforcement notices
Why we did the review

“Our role is to inspect care homes for older people, investigate complaints and enforce standards of care.

From these activities we found some aspects of poor practice in preventing, caring for and treating pressure ulcers.

We wanted to share this information so that we can make recommendations for change to improve care.”
6 Key themes of review

1. Allocation/maintenance of pressure reducing equipment (Beds, mattresses, seat cushions)
2. Policies and procedures relating to pressure ulcer prevention, care and treatment
3. Care planning and recording of pressure ulcer prevention care and treatment
4. Training/education for all grades of staff
5. Pressure ulcer assessment, care and treatment
6. Pain assessment/management in pressure ulcer care and treatment
Allocation/maintenance of pressure reducing equipment

FINDINGS

Insufficient amounts/how many/who’s using?
Not being allocated on based clinical need
Sheepskins/fibre filled overlays in place
Minimal staff training on how to select/use equipment
Maintenance contracts/cleaning procedures
Sourced from? Confusion about homes responsibilities
Policies and Procedures

FINDINGS

None in place or out of date

Not based on current best practice

Evidenced but not implemented - Staff hadn’t read them

No pre-admission/transfer process for pressure ulcer prevention, care and treatment
Care planning

FINDINGS

Some areas had a risk assessment tool in place – usually Waterlow

Evaluated monthly – routine task

Identify resident at risk – no care plan!

Care plans in place – did not always reflect the resident’s individual needs

No resident/family involvement in process
Training/Education

FINDINGS

No regular updates
Difficulties in accessing appropriate training/support for staff
Lack of advice/support from Tissue Viability Nurse/Community Nurse in most areas
Pressure ulcer assessment, care and treatment

FINDINGS

No formal wound assessment process
Lack of knowledge re appropriate dressings
Prescribing, storage, administration and disposal of dressings
Pain assessment/management in pressure ulcer care/treatment

FINDINGS
Pain was a big feature in complaints
No formal assessment process in place
Inadequate knowledge re pain, assessment and management
Current position – what our inspection and complaints inspectors say 2016

• “Unreliability of assessment – Waterlow scoring”
• “Person identified at risk – no care plan in place, no real focus on prevention”
• “Residential care – don’t know how to risk assess – encouraging to use PPUA”
• “Pressure ulcer safety cross – not all using this – some homes don’t understand how to use”
• “Some homes use SSKIN bundle – not sure what they are meant to do”
• “Wound assessment process – patchy use of assessment tools and pressure ulcers not always graded or accurately graded”
• “Matching assessment to treatment choice”
• “Wound photography – no policy/consent/data protection issues”
Addressing the right issues
Fishbone diagram

5 Whys

People
- Rude
- Wrong fee
- No training
- Computer not updated

Procedures
- Too much water
- Too much coffee
- Amounts not specified
- No training
- Wrong size filter

Material
- Bad cream
- Outdated
- Bad sugar
- Lids don’t fit cup
- Different suppliers

Equipment
- Dirty cups
- Coffee not hot enough
- Warmer not working
- Dishwasher not working properly
- Wrong settings
- Numbers faded

Based on work by KellyLawless
1. Create your own fishbone diagram to illustrate what causes pressure ulcers in care homes.

2. You have 5 dots each. Stick them next to the issues you think cause pressure ulcers more commonly. More than one dot can be allocated to one cause.
Not hot enough
Too much water
Rude staff
Lids do not fit cup
Too expensive

Pareto Diagram
80%-20% rule
“Without data you're just another person with an opinion.”

W. Edwards Deming
Baseline data

- Safety Cross
- Pressure Ulcers investigation tool?
- Best practice self-assessment vs detailed self-assessment?
Discuss potential challenges and barriers in using data in care homes
Care bundles
Requires examination and redesign of existing care processes through measurement and testing
What is a Care Bundle?

A care bundle is a set of evidence-based interventions that when used together significantly improve outcomes.

- A small set of evidence-based interventions
- Defined patient segment/population
- Origins – Intensive Care bundles
- When implemented together will result in better patient outcomes
Why use Care Bundles?

• Reliable implementation of care bundles for processes ➔ improved outcomes
• Drives teamwork, communication and local ownership
• Defines a shared baseline
• Reduces unwanted variation
• Clear who has to do what and when, within a specific time frame*.

*With thanks to Carol Haraden, PHD, ‘What Is a Bundle?’ www.ihi.org
Essential elements of a Bundle

• 3–5 interventions (elements) which have been agreed by clinical team
• Bundle elements are relatively independent
• Bundle is used for specific patient group, usually in one location
• Bundle should allow for local adaption (not too prescriptive)
• For measurement, all components need to be completed ‘all-or-none’ measurement

A care bundle is not.....

THINGS I HATE
1. VANDALISM
2. IRONY
3. LISTS
A simple 5 item checklist protocol to reduce pressure ulcers:

**Surface:** make sure your patients have are on the right surface

**Skin inspection:** early inspection means early detection. Show patients & carers what to look for

**Keep your patients moving**

**Incontinence/moisture:** your patients need to be clean and dry

**Nutrition/hydration:** help patients have the right diet and plenty of fluids
# SSkin Care Bundle

**Name**

**Frequency of care delivery (circle as appropriate)**

- 1hrly
- 2hrly
- 3hrly
- 4hrly

**Date**

**Time** - record using 24 hour clock

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## Prevention of Pressure Ulcer Interventional Plan

**Aim:** To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

**Outcome:** To prevent pressure ulcer development through establishment of effective work practices in line with 5Skins bundle.

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<tr>
<td>- Cushion:</td>
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<tr>
<td>- Detail additional pressure redistributing equipment:</td>
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<tr>
<td>Reposition _____ hourly in bed and chair.</td>
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<tr>
<td>- Overnight patient / carer has agreed to repositioning _____ hourly</td>
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<tr>
<td>- Specify any manual handling equipment used:</td>
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<tr>
<td>Skin care to be carried out _____ hourly.</td>
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<tr>
<td>- Specify products required for increased moisture / continence management:</td>
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<tr>
<td>Optimise nutrition and hydration.</td>
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<tr>
<td>- Refer to MUST</td>
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<tr>
<td>- Discuss and agree changes to plan with patient / family / carer</td>
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<tr>
<td>- &quot;Prevent Pressure Ulcers”’ leaflet given to patient / family / carer?</td>
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</tr>
</tbody>
</table>
**NHS Greater Glasgow and Clyde**
**Active Care Checklist**

**DATE**

I have evaluated and deemed that the frequency of care delivery over the next 24 hours, based on the patient’s most critical need should be every: (Please circle)

1 hr 2hr 3hr 4hr 6hr

1. Signed: Name: Designation:
2. Signed: Name: Designation:
3. Signed: Name: Designation:

**USE FOLLOWING CODE**

- O = Off the ward
- D = Declined
- V = Variant
- R = Refused
- S = Sleeping
- I = Independent

**Attach Addressograph label**

**Ward:**

<table>
<thead>
<tr>
<th>USE FOLLOWING CODE</th>
<th>Individual patient needs –</th>
</tr>
</thead>
<tbody>
<tr>
<td>O = Off the ward</td>
<td>Red mat required Y / N</td>
</tr>
<tr>
<td>D = Declined</td>
<td>Bed rails Y / N</td>
</tr>
<tr>
<td>V = Variant</td>
<td>‘Must do’s’ for me. Ask the patient if there is anything they want specifically done today…</td>
</tr>
<tr>
<td>R = Refused</td>
<td></td>
</tr>
<tr>
<td>S = Sleeping</td>
<td></td>
</tr>
<tr>
<td>I = Independent</td>
<td></td>
</tr>
</tbody>
</table>

**Times**

1. Pain: Assess and address.
   If in pain inform nurse in charge Y or N/A

2. (S)SKIN INSPECTION
   A. Pressure areas checked:
   B. Redness (R)/ discoloration (D)
   Pressure Ulcer (PU) *

3. (K) Keep moving:
   A. Have you moved or walked* Y / N / I (independent)
   B. Bed Right side (30° tilt) – R
   Left Side (30° tilt) – L
   Back –
   C. Chair – assist to walk, stand or tilt (W/S/T)

4. (I) Elimination:* Do you need the toilet? I = independent A = assistance given IC = patient incontinent of urine or faeces

5. (N) Food, Fluids and Nutrition *:
   Is the patient nil by mouth? Y / N (Consider mouth care)
   Encourage the patient to drink. Y / N / N/A
   Food, snack or supplement taken Y / N / N/A

6. ENVIRONMENT: Is the patient’s call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach?
   Is the bed in lowest position? Is the room at a comfortable temperature?

7. INFORMATION:
   Ask
   Is there anything else I can help you with?
   Inform patient of the time of return.

8. ESCALATION: Escalate any issues to the Registered Nurse. Y / N/A

**Nurse Initials**
How reliable is your bundle? How will you know?
Care Bundle Data – a process measure

- All or nothing
- Small frequent samples
Some examples

Diabetes data from 59 practices

<table>
<thead>
<tr>
<th>Measure</th>
<th>% of patients achieving</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHB done</td>
<td>95.4</td>
</tr>
<tr>
<td>BP done</td>
<td>95.0</td>
</tr>
<tr>
<td>Cholesterol done</td>
<td>93.6</td>
</tr>
<tr>
<td>Smoking recorded</td>
<td>96.2</td>
</tr>
<tr>
<td>GHB≤7.4%</td>
<td>55.3</td>
</tr>
<tr>
<td>BP&lt;140/80</td>
<td>38.7</td>
</tr>
<tr>
<td>Cholesterol≤5</td>
<td>75.0</td>
</tr>
<tr>
<td>Non smoker</td>
<td>82.9</td>
</tr>
</tbody>
</table>

Some examples

<table>
<thead>
<tr>
<th>Measure</th>
<th>% of patients achieving</th>
<th>% of patients with all care done</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHB done</td>
<td>95.4</td>
<td></td>
</tr>
<tr>
<td>BP done</td>
<td>95.0</td>
<td>88.3</td>
</tr>
<tr>
<td>Cholesterol done</td>
<td>93.6</td>
<td></td>
</tr>
<tr>
<td>Smoking recorded</td>
<td>96.2</td>
<td></td>
</tr>
<tr>
<td>GHB≤7.4%</td>
<td>55.3</td>
<td></td>
</tr>
<tr>
<td>BP&lt;140/80</td>
<td>38.7</td>
<td>16.2</td>
</tr>
<tr>
<td>Cholesterol≤5</td>
<td>75.0</td>
<td></td>
</tr>
<tr>
<td>Non smoker</td>
<td>82.9</td>
<td></td>
</tr>
</tbody>
</table>
## Understanding variation

<table>
<thead>
<tr>
<th>S</th>
<th>S</th>
<th>K</th>
<th>I</th>
<th>N</th>
<th>Bundle</th>
</tr>
</thead>
<tbody>
<tr>
<td>client 1</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>client 2</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>client 3</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>client 4</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>client 5</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>client 6</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>client 7</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>client 8</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>client 9</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>client 10</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S</th>
<th>S</th>
<th>K</th>
<th>I</th>
<th>N</th>
<th>Bundle</th>
</tr>
</thead>
<tbody>
<tr>
<td>reliability</td>
<td>80%</td>
<td>100%</td>
<td>60%</td>
<td>60%</td>
<td>100%</td>
</tr>
</tbody>
</table>
SSKIN reliability - 10 clients - 1 week
SSKIN Bundle in Acute Care – lessons learned

- Frequency of each element is decided – ‘prescribed’ - by risk assessment
- Documentation is built in to existing care processes
- Data is used to understand reliability of each element AND whole bundle
- Any bundle exists to support professional judgement
- The SSKIN bundle – or any other bundle – does not cover everything
Successful teams have paid attention to ...

<table>
<thead>
<tr>
<th>Aim</th>
<th>Primary Driver</th>
<th>Secondary Driver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building a culture of Improvement</td>
<td>Using data for improvement</td>
<td>Process reliability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Connecting process &amp; outcome</td>
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<tr>
<td></td>
<td></td>
<td>Visibility</td>
</tr>
<tr>
<td></td>
<td>Learning form events</td>
<td>Informing improvement plans</td>
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<tr>
<td></td>
<td></td>
<td>New ideas</td>
</tr>
<tr>
<td></td>
<td>Team working</td>
<td>Using all available resources</td>
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<tr>
<td></td>
<td></td>
<td>Sharing successes &amp; challenges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Celebrating success</td>
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<tr>
<td></td>
<td></td>
<td>New ideas</td>
</tr>
</tbody>
</table>
What are we trying to accomplish – the outcome?

Pressure Ulcer (Grade 2-4) Rate

No Assessment can be made as Board believe data is not robust

New data source from January 2015
Discussion

• How would this bundle be applied in care homes?
• What would be the operational definition for each question? (eg. Frequency)
It’s about what you do with the data...
Like what?

• Test a change (PDSA)
• Share at team meeting
• Notice board
• Ask patients
“Without data you’re just another person with an opinion.”

- W. Edwards Deming, Data Scientist
Evaluation

Sarah Harley
Health Services Researcher
Why evaluation is needed

• **Improves programme design and implementation**
  - by assessing and adapting the programme activities

• **Demonstrates programme impact and how this was achieved**
  - by enabling success or progress to be accounted for
## Aligning evaluation to the programme

<table>
<thead>
<tr>
<th>STAGE</th>
<th>Before programme begins</th>
<th>New programme</th>
<th>Established programme</th>
<th>Mature programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROACH</td>
<td>Formative</td>
<td>Formative</td>
<td>Summative</td>
<td>Summative</td>
</tr>
<tr>
<td>QUESTIONS</td>
<td>To what extent is the need being met? What can be done to address the need for improvement?</td>
<td>Is the programme working or operating as planned?</td>
<td>Is the programme achieving its objectives?</td>
<td>What predicted and unpredicted impacts has the programme had?</td>
</tr>
<tr>
<td>EVALUATION TYPES</td>
<td>Needs assessment</td>
<td>Process evaluation</td>
<td>Outcome evaluation</td>
<td>Impact evaluation</td>
</tr>
</tbody>
</table>
Assumptions
- There is capacity for care home staff to engage in learning

External factors
- Lack of protected learning time

Activities
- Test site needs identification activities (e.g. assessment of current processes)
- Learning and coaching sessions
- Evidence-based tailored support
- Steering group meetings
- Promotion of multi-disciplinary team working
- Campaign activities

Outputs
- Areas of need identified
- Staff participated in learning and coaching
- Staff supported to work with evidence based resources
- Feedback identified
- Progress data shared

Reach
- Care home staff
- Patients and relatives

Short term outcomes
- Increased knowledge and skills
- Increased QI capability
- Increased aspiration for improving practice

Medium term outcomes
- Practice in line with best practice in the prevention and management of pressure ulcers

Long term outcomes
- Improved care experience
- Improved health and wellbeing

Assumptions
- There is capacity for care home staff to engage in learning

External factors
- Lack of protected learning time
Brainstorming the logic model

• Brainstorm your ideas for the logic model under each category:

  1. the activities required to influence change (are there any gaps?)

  2. the short term outcomes you expect of these activities (change in knowledge, confidence?)

  3. the medium term outcomes you expect in terms of improvement in practice

  4. any assumptions and external factors that you can identify
Data collection
For discussion

- Care home profile sheet
- Self-assessment spreadsheet for PU prevention
- Monthly progress report
- Data collection spreadsheet vs/ & CI notification system
- Pressure Ulcer Investigation tool

Qualitative data and Quantitative data
Improvement in Care Homes
ASSKINE-THE COLLABORATIVE APPROACH TO REDUCING PRESSURE ULCERS IN CARE HOMES

Lorraine Jones
Tissue viability Lead Nurse
lorraine.jones12@nhs.net
01902 695361
Brainstorming of change ideas
Primary Drivers for Improvement

- **Will**: Having the *Will* (desire) to change the current state for a better one.
- **Ideas**: Developing *ideas* that will contribute to achieve a better state.
- **Execution**: Being able to *execute* the ideas, applying quality improvement theories, tools and techniques.

**QI**: Primary Drivers for Improvement
Innovation, Improvement and Generating Ideas

The greatest discovery comes not from seeing new landscapes but in seeing the familiar with new eyes

*Marcel Proust*

We don't grow when things are easy, we grow when we face challenges.
What could be done to improve pressure ulcers in care homes?
Matrix of Change Ideas

Place concepts in matrix. Strive for easy, low-cost solutions. Translate high-cost solutions into low-cost alternatives.
Planning next steps
Next steps – for us

• Finalise the revised draft agreement
• Send details of the programme’s secure webpage
• Ensure presentations from past 2 days are uploaded
• Ensure dates for Steering Group meetings available on the site
• Draft scale up strategy
• Continue visiting local teams
• Send baseline data collection forms asap
• Produce an overarching fishbone diagram, driver diagram, ideas matrix
Next steps – for you

• Sign off agreement
• Finalise recruitment of care homes
• Gather baseline data and know your system
• Gather intelligence on where there are opportunities for improvement
• Start preparing for Learning Sessions 1
• Give feedback on baseline data collection forms
Steering Group Membership

2 people from each participating H&SCPs:
– Clinical Lead
– Facilitator
Dates for your diary

Steering Group Meetings

Thursday 18 August
Tuesday 24 October
Tuesday 13 December
Tbc February

Glasgow or Edinburgh, venue tbc

Learning sessions

Wednesday 14 September – D&G
Wednesday 22 September – A&B
Wednesday 28 September - ED
Thursday 29 September – P&K

Locally – Please select a date
Planning time

• Reflect on all the discussions over the last two days

Agree your action plan (what, who, by when)
Feedback from H&SCP teams
We are almost there!
RPUCH Scaling up discussion with IHI
Feedback on today’s sessions

• What has gone well?

• What has gone not so well?

• What could we do differently?

• Any other comments?