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1 Introduction and context

This report presents a summary of the work undertaken by the Directorate of Safety and Improvement within Healthcare Improvement Scotland during 2015–2016.

In 2015–2016, the work of the Directorate of Safety and Improvement was structured into six major themes:

- Scottish Patient Safety Programme
- Implementation and improvement support
- Person-centred care
- Primary care out-of-hours
- Quality improvement for NHS Board members, and
- Tailored and Responsive Improvement Support Team.

Within each theme, a number of different programmes and portfolios of work were being undertaken and these are described in sections 3–8. A brief look forward to work planned for 2016–2017 is also included in each section. Highlights from work across the Directorate in 2015–2016 are presented in Section 2.

The year 2015–2016 marked a point of change in the work of the Safety and Improvement Directorate. In response to the integration of health and social care services in Scotland, the Scottish Government agreed that a review of the improvement support functions of Healthcare Improvement Scotland and the Scottish Government’s Joint Improvement Team (JIT) and Quality and Efficiency Support Team (QuEST) should be undertaken. The outcome of this work is the creation of the Improvement Hub (or ihub for short), a new improvement resource to support NHS boards and Health and Social Care Partnerships (HSCPs), which include health, social care, third sector, independent sector and housing organisations across Scotland. The ihub came into existence on 1 April 2016 and is part of Healthcare Improvement Scotland.

More information on the work of the ihub can be found in the ihub work programme 2016-2017 (Introducing the Improvement Hub – A new improvement resource for Health and Social Care Partnerships and NHS boards) or ihub.scot.

Despite these impending changes, the work of the directorate continued and developed throughout 2015–2016.
2 Highlights

- **SPSP Acute Adult** – there was an overall reduction of 18.6% in the rate of cardiac arrest (from 1.93 to 1.57 per 1000 discharges) among the 11 out of 25 hospitals that consistently reported data during the period February 2012 to December 2015 (see Section 3.2.1).
- **SPSP Maternity and Children** – the stillbirth rate in Scotland continued to decline, with provisional data from the National Records for Scotland showing a 19% fall (from 4.7 to 3.8 per 1000 live births) between 2012 and 2015 (see Section 3.3.1).
- **SPSP Maternity and Children** – NHS Greater Glasgow and Clyde recorded a 78% reduction in the rate of ventilator acquired pneumonia (from 11.4 to 2.5 per 1000 ventilator days) in their paediatric intensive care unit between January 2013 and June 2016 (see Section 3.3.3).
- **SPSP Mental Health** – 11 out of 59 wards reported an improvement (a reduction, in the use of restraint) and 13 out of 59 wards reported an improvement (a reduction in the rate of incidents of physical violence) in the period September 2012 to January 2016 (see Section 3.4).
- **SPSP Primary Care** – 83% (n=819) of GP practices across Scotland introduced the care bundles the programme developed and 80% (n=803) of GP practices were engaged in improving reliability in at least one high risk area. A Medicine Sick Day Rules card developed and tested by NHS Highland, with input from patients, carers, pharmacists and doctors, was launched nationally at the NHSScotland event in June 2015 (see Section 3.5).
- Publication in June 2015 of the *Improving Older People’s Acute Care - Impact Report* describing work undertaken from April 2012–March 2015 and highlighting improvements, including reductions in mean length of stay and number of falls and an increase in patients being assessed for delirium (see Section 4.2).
- Publication in March 2016 of the report on *Older People in Acute Care - Data Review and Cost Analysis, NHS Ayrshire & Arran – A pathway for frail older people in the emergency department* highlighting improvements resulting from a multidisciplinary ‘front door’ assessment at University Hospital Crosshouse of all over 65’s with frailty (see Section 4.2).
- Development and launch (May 2015) of a video gallery highlighting how the delirium and frailty assessment tools are working at Crosshouse Hospital, the Royal Infirmary of Edinburgh and the Southern General Hospital in Glasgow.
- Design and launch of the Living Well in Communities portfolio of improvement programmes (report published September 2015) which aims to prevent unnecessary hospital admission by supporting people to live well at home or in a homely setting (see Section 4.3).
- Development of the Tailored and Responsive Improvement Support Team, a new approach to providing flexible improvement support to help NHS boards and Health and Social Care Partnerships address improvement issues that are a priority in their local area (see Section 8).
- Working with partners and key stakeholders to co-design a new approach to supporting improvement in health and social care leading to the successful launch of the ihub on 1 April 2016.
3 Scottish Patient Safety Programme

3.1 Introduction

In 2015–2016, the Scottish Patient Safety Programme (SPSP) continued to develop its established programmes of work in:

- acute adult care
- maternity and children’s care
- mental health care, and
- primary care.

Two new programmes of work were also added:

- healthcare associated infections, and
- medicines.

Brief descriptions of each of these six areas of work are given in sections 3.2–3.7. Data reporting for the year 2015–2016 is not yet complete so it is not possible to report on national trends covering this period. Where national data are reported, they reflect the most up-to-date information available. In order to illustrate the range of improvements that are taking place across the programme, local data are reported, where available, within the specific sections. These data reflect the position at the current point in time. The reasons underlying change, whether positive or negative, are complex and improvement depends on reviewing outcomes, understanding the local context and applying the lessons learned.

Within each programme, development of the key elements of leadership, communication, safety culture and safer use of medicines continued alongside the topic-specific work described here.

The acute adult, maternity and children, and primary care programmes reached the end of a 3-year cycle of funding in 2015–2016 and individual final reports providing detailed information on the specific outcomes for each of these were published on 1 September 2016 and are available on the Healthcare Improvement Scotland website (www.healthcareimprovementscotland.org).

3.2 SPSP Acute adult

Since it was established in 2008, work on the SPSP acute adult programme has continued to develop and expand, building on previous successes in reducing infection rates for ventilator associated pneumonia and central line bloodstream infections.

The core aims of the programme are to reduce mortality and to reduce harm experienced by patients in acute hospitals in Scotland. In 2015–2016, the programme focused on five topic areas:

- improving the recognition and treatment of deteriorating patients
- recognition and management of sepsis
• reducing falls
• reducing catheter associated urinary tract infections, and
• reducing pressure ulcers.

3.2.1 Deteriorating patients
There was an improvement in the rate of cardiac arrest in seven out of 25 hospitals during the period January 2008 to January 2016. Among the 11 hospitals (out of 25) that consistently reported data during the period February 2012 to December 2015, there was an overall reduction of 18.6% in the rate of cardiac arrest (from 1.93 to 1.57 per 1000 discharges) (see Figure 1).

Figure 1 – Cardiac arrest rate

3.2.2 Sepsis
The 30-day mortality from sepsis fell by 21%, from 24.8% to 19.5%, between the launch of the collaborative in January 2012 and December 2015. This finding must, however, be interpreted with caution as it has occurred at a time when the number of patients recorded as having sepsis has increased rapidly (by over a third over the last 5 years) whilst the number of deaths from sepsis has remained more or less static. This suggests that at least part of the decline in mortality may be due to increased recording of less severe cases which would have the effect of reducing the mortality rate. The increased recording of sepsis may well, however, be linked to increased awareness of and coding of sepsis resulting from the work of the sepsis collaborative.

3.2.3 Reducing falls
Over the last 2 years (January 2014 to January 2016), there has been no consistent change overall in the rate of falls in hospitals or in the rate of falls which cause harm (approximately 7 and 0.4 per 1000 occupied bed days (OBDs), respectively), although two hospitals did report improvements.
The Western General Hospital in Edinburgh reported a reduction in the number of falls overall (down 15% from a baseline rate of 9.48 per 1000 OBDs in 2010 to 8.07 in 2015) (see Figure 2), and an improvement in the number of falls causing harm (down 41% from 0.34 to 0.20 per 1000 OBDs) (see Figure 3). In the Western Isles, medical ward 2 also reported a reduction in the number of falls causing harm, with a rate of zero attained by August 2015 and maintained until January 2016 (the most recent month for which data are available).

Figure 2 – All falls, NHS Lothian, Western General Hospital, January 2010 to February 2016

![All Falls rate per 1000 OBDs](image)

Figure 3 – Falls causing harm, NHS Lothian, Western General Hospital, January 2010 to February 2016

![Falls with Harm Rate](image)

A side-effect of the focus on falls may be better recording, causing rates to go up initially before falling as improvement activities take effect, and this may partly explain the reported increase in the overall rate of falls in three hospitals and the increase in the rate of falls.
causing harm reported in two hospitals. An absence of improvement may also reflect maintenance of a low baseline rate where the scope for further reductions is more limited.

### 3.2.4 Catheter associated urinary tract infection

This work has focused on testing approaches to measuring catheter associated urinary tract infection (CAUTI) and methods to reduce their incidence. Care bundles for catheter insertion and catheter maintenance have been developed, with the aim of reducing the use of catheterisation and reducing CAUTI rates where their use is unavoidable. Twelve NHS boards are reporting data on the reliability of the care bundles and counting incidence of CAUTI using an agreed measure. Pilot wards within six of these NHS boards are collecting data on catheter usage and four of these are showing a significant reduction in catheterisation. For example, in ward 14 at Wishaw General Hospital, catheter usage was reduced from 25% to almost zero between October 2014 and October 2015 (see Figure 4).

**Figure 4 – Catheter use, ward 14, Wishaw General Hospital, October 2014 to December 2015**

![Catheter usage graph](image)

### 3.2.5 Pressure ulcers

No consistent change in the rate of pressure ulcers was recorded in the nine hospitals that consistently reported data between May 2014 and January 2016 (baseline rate 0.29 per 1000 OBDs). In March 2016, only eight out of a possible 22 sites were regularly reporting data and none of these reported an improvement.

### 3.3 SPSP Maternity and Children

The Maternity and Children Quality Improvement Collaborative (MCQIC) was launched in March 2013 and comprises the SPSP’s maternity, neonatal and paediatric care programmes. The aim of the Collaborative is to improve outcomes and reduce inequalities by providing a safe, high quality care experience for all women, babies, children and families in healthcare settings in Scotland.
3.3.1 Maternity care
In 2015–2016, the focus of the maternity care programme was on:

- reducing stillbirth
- reducing severe post-partum haemorrhage, and
- offering all women carbon monoxide monitoring when booking their antenatal care appointment as a step towards improving the recognition, referral and management of pregnant women who smoke.

Stillbirth
The long-term fall in the rate of stillbirth in Scotland continued during the period 2012 to 2015, with provisional data showing a fall of 19% (from 4.7 to 3.8 per 1000 live births) in the rate of stillbirth (see Figure 5). In total, 211 stillbirths were recorded in 2015. The fall cannot be attributed to any individual factor or programme but the combined effect has been that the stillbirth rate has fallen to the lowest level since records began.

Figure 5: Stillbirth rate, Scotland 2000–2015

Severe post-partum haemorrhage
Between January 2013 and March 2016, there was no overall improvement in the rate of severe post-partum haemorrhage, although one maternity unit (out of 17) reported a reduction and three units reported an increase in rates.

Carbon monoxide monitoring
Between March 2013 and March 2016, there was a small increase in the percentage of women offered carbon monoxide monitoring at booking, with nine out of 17 units showing an improvement and no units showing a deterioration. Overall, over 95% of women were offered carbon monoxide monitoring at booking during this time period and this is now part of routine care in most maternity units. Future work will focus on ways of increasing smoking cessation rates.
Carbon monoxide monitoring is linked to two further measures:

- percentage of pregnant women with a carbon monoxide level of four parts per million or more or who say they are current or recent smokers, and
- percentage of pregnant women who continue to smoke who are provided with a tailored package of antenatal care.

During 2014 and the first half of 2015, around 90% of the former group were referred to smoking cessation services, and during 2015, in the third of NHS boards recording the latter measure, around half of women who continued to smoke were provided with a tailored package of improvement support.

3.3.2 Neonatal care

The overall aim of the neonatal care programme is to reduce adverse events that contribute to avoidable harm in neonatal care by seeking to reduce harm from:

- mechanical ventilation
- invasive lines
- high risk medicines
- transitions of care, and
- undetected deterioration.

The programme also aims to increase natural feeding and improve service user engagement.

The focus of work in individual units varies according to local priorities and, as such, it is not possible to assess impact at a national level. Improvements reported at local level include the following.

- Ninewells Hospital, Dundee – no instances of pressure sores or tissue damage in infants receiving respiratory support between December 2015 and April 2016; the longest period without a case since recording began in June 2014.
- NHS Fife – an increased time between instances of infiltration injuries in infants requiring invasive lines, with no instances between February and September 2015, a period of 223 days, compared with an average of 25 days between instances during 2014.

Vancomycin and gentamicin care bundles have been developed and uptake of the latter, in particular, by NHS boards has been good. In NHS Tayside, for example, by June 2015 there was 100% compliance with the gentamicin bundle (up from 25% at baseline in July 2014).

3.3.3 Paediatric care

Launched in June 2010, the paediatric care programme became part of MCQIC in 2013. The overall aim of the programme is to reduce avoidable harm in paediatric care by addressing:

- serious safety events
- ventilator associated pneumonia
- central venous catheter bloodstream infection
• unplanned admission to intensive care
• medicines harm, and
• child protection harm.

National data are currently not available as data relating to the core aims are incomplete. Local-level improvements have, however, been demonstrated. For example, NHS Greater Glasgow and Clyde, which has one of the two paediatric intensive care units in Scotland where ventilated babies are cared for, reported a 78% fall in ventilator associated pneumonia between January 2013 and June 2016 (from 11.4 to 2.5 instances per 1000 ventilation days); in four months (July and August 2015 and February and May 2016) no cases of ventilator associated pneumonia were reported (see Figure 6).

Figure 6 – Rate of ventilator associated pneumonia, Paediatric Intensive Care Unit, NHS Greater Glasgow and Clyde, January 2013 to June 2016

Among the five (out of 11) units that consistently reported data on unplanned admission to paediatric intensive care units between January 2014 and February 2015, the number of unplanned admissions fell during the first half of 2015 reaching their lowest level in July 2015 (n=4 compared with a median of 8 per month during 2014), although this fall was not sustained in the latter part of the year. Early results from 2016 suggest that numbers are falling again in 2016.

Scotland is now the first country in the world to have a nationally agreed approach to the use of the Paediatric Early Warning Score, an important tool to aid recognition of patients whose condition is deteriorating so that appropriate and timely action can be taken.

3.4 SPSP Mental Health

The SPSP Mental Health programme is a 4-year programme running from September 2012 to September 2016. The overall aim is to systematically reduce the harm experienced by people receiving care from mental health services in Scotland by supporting frontline staff to test and gather real-time data and to reliably implement interventions, before spreading successful approaches across their NHS board area.
Phase 2 of the programme began in September 2013 and marked the end of the pilot phase. The focus of this work is on:

- inpatient acute admission
- rehabilitation
- Intensive Psychiatric Care Units, and
- forensic units.

Within these settings, the main target areas for reporting are minimising the harm resulting from:

- restraint and seclusion practices
- incidents of self-harm by patients whilst in hospital, and
- incidents of physical violence.

Following completion of the pilot phase, the programme was rolled out to 59 eligible wards and, by January 2014, over 50 wards were reporting data on a monthly basis. During the period of stable reporting (January 2014 to November 2015), there was no clear national trend in the use of restraint or in incidents of self harm or physical violence. Over the full reporting period (September 2012 to January 2016), improvements were, however, reported at local level:

- 11 wards reported a reduction in the use of restraint
- three wards reported a reduction in the percentage of patients who experience self harm, and
- 13 wards reported a reduction in the rate of incidents of physical violence.

One site, the Lomond ward at Stratheden Hospital in Fife, reported improvements on all three measures, with sustained reductions reported in the use of restraint (see Figure 7) and in incidents of physical violence (see Figure 8). Stratheden hospital also reported a substantial fall in incidents of physical violence in its Intensive Psychiatric Care Unit (down from a baseline of 75 to 15 per 1000 OBDs), between 2013 and 2014; an improvement that has been sustained throughout 2015.
Figure 7 – Use of restraint, Stratheden hospital, Lomond ward, January 2013 to March 2016

Rate of incidents of restraint

Baseline Median 5.2
Reduction from Baseline = 62%

Current Median 2.0

In Argyle & Bute Hospital, the Succoth ward reported that no patients experienced self harm between July and December 2015; a fall from a baseline of approximately 12% (see Figure 9).

Figure 8 – Incidents of physical violence, Stratheden Hospital, Lomond ward, January 2013 to March 2016

Rate of incidents of physical violence

Baseline Median 12.4
Reduction from Baseline = 80%

Current Median 2.5

0
5
10
15
20
25
30
35
Jan 13
Mar 13
May 13
Jul 13
Sep 13
Nov 13
Jan 14
Mar 14
May 14
Jul 14
Sep 14
Nov 14
Jan 15
Mar 15
May 15
Jul 15
Sep 15
Nov 15
Jan 16
Mar 16
rate per 1000 bed days
Rate of incidents of restraint
Stratheden
Lomond

0
10
20
30
40
50
60
Jan 13
Mar 13
May 13
Jul 13
Sep 13
Nov 13
Jan 14
Mar 14
May 14
Jul 14
Sep 14
Nov 14
Jan 15
Mar 15
May 15
Jul 15
Sep 15
Nov 15
Jan 16
Mar 16
rate per 1000 bed days
Rate of incidents of physical violence
Stratheden
Lomond
Every 2 months, sharing of best practice took place by circulating leadership reports from NHS boards to all programme managers and clinical leads. Work was also undertaken in partnership with the Scottish Human Rights Commission to pilot a human rights-based approach to delivery.

The programme has successfully increased the number of service users, carers and third sector organisations who are involved in the work. For example, 14% of delegates at the third regional learning session in September 2015 were from these groups.

Changes in the prescribing of psychotropic medication, use of restraint and management of challenging behaviour suggest that a cultural and attitudinal change is beginning to take place within NHS boards.

### 3.5 SPSP Primary care

The SPSP Primary Care programme was established in 2013, with the overall aim of reducing the number of events which could cause harm. To support those working in primary care, tools and resources have been developed over the course of the programme for the three themes of:

- safety culture
- safer medicines, and
- safety across the interface.

The focus of this work in 2015–2016 was on:

- monitoring high risk medicines, and
- implementing reliable and safe systems for communication between services relating to patients.
Safety culture and leadership
The aim of this work is to create a culture of reflective learning and improvement by, for example, completing an annual safety climate survey and by carrying out structured case reviews. To date:

- 93% of all GP practices across Scotland have participated in the safety climate survey, and
- 74% of GP practices have carried out structured case note reviews, and NHS boards have reported that patient safety changes have been made at practice and at organisational level.

Safer medicines
The care bundles for warfarin, disease-modifying anti-rheumatic drugs (DMARDS), and medicines reconciliation developed as part of the programme were revised following participant feedback, and updated versions were distributed in June 2015 through the Safer Medicines network.

In 2015–2016, 83% (n=819) of GP practices across Scotland introduced the care bundles and 80% (n=803) of GP practices were engaged in improving reliability in at least one of these high risk areas. Improvement in use of the DMARDS bundle was recorded in four NHS boards, with sustained improvement in two (NHS Ayrshire & Arran and NHS Forth Valley). In NHS Forth Valley, for example, there was a 33% increase in use of the bundle between 2013 and 2014 (rising from 52% to 69%) (see Figure 10). Similarly, four NHS boards reported an improvement in use of the warfarin bundle, with sustained improvement in two NHS boards (NHS Ayrshire & Arran and NHS Highland – see Figure 11). In NHS Highland, for example, there was a 17% increase in attainment from 72% to 85% between mid-2014 and mid-2015; a level that has been maintained.

Figure 10: Use of the DMARDS care bundle in NHS Forth Valley, April 2013 to December 2015

![Graph showing improvement in use of DMARDS bundle in NHS Forth Valley]

- Baseline Median: 51.8
- Current Median: 68.9
- Improvement from Baseline = 33%
**Safety across the interface**

The purpose of this work is to develop safe and reliable systems for communication across the primary/secondary care interface, for example between hospital outpatient departments and general practice. The focus to date has been on developing reliable systems for results handling and written and electronic communication. In 2015, a care bundle for safer, more reliable results handling was introduced.

### 3.5.1 Dentistry in Primary Care Collaborative

The pilot Dentistry in Primary Care Collaborative was established in July 2015 and launched in March 2016 at the first Learning Session for the Collaborative. The Collaborative will initially work with sites in NHS Ayrshire & Arran, NHS Dumfries & Galloway and NHS Fife. These NHS boards have each recruited five dental practices to work with them on developing and testing their care bundles. The initial focus of the dental practice teams will be on:

- making the prescribing and monitoring of high risk medicines safer and more reliable, and
- developing their safety culture through the use of a dentistry safety climate survey.

Funding for the pilot collaborative is due to end in December 2016.

### 3.5.2 Pharmacy in Primary Care Collaborative

The Pharmacy in Primary Care Collaborative was established in July 2014, with the aim of improving communication between GPs and pharmacists working in primary care by fostering closer working between the two.

In 2015–2016, 29 pharmacy teams with representation from dispensing practices, independent pharmacies and multiple pharmacies in urban and rural locations in four NHS
boards (NHS Fife, NHS Grampian, NHS Greater Glasgow and Clyde, and NHS Highland) were taking part. Through their involvement pharmacy teams are:

- making the prescribing, monitoring and dispensing of high risk medicines safer and more reliable, with monthly collection of data for the high risk medicines care bundle in place
- developing their ‘safety culture’ through the use of a pharmacy safety climate survey, with 80% of pharmacy teams having completed their survey
- developing tools and resources for medicines reconciliation, and
- driving improvements in communication and promoting closer working with GP practices, with local learning sessions held in all four NHS board areas.

A Medicine Sick Day Rules card developed and tested by NHS Highland, with input from patients, carers, pharmacists and doctors was launched nationally at the NHSScotland event in June 2015. The card promotes better management of long-term conditions by promoting the safer, more effective and person-centred use of medicines. The card raises awareness of potential harms if patients continue to take certain widely prescribed medicines whilst suffering from a dehydrating illness.

Funding for the collaborative from the Health Foundation’s Closing the Gap in Patient Safety programme is due to end in June 2016.

### 3.6 SPSP Healthcare Associated Infections

Launched in April 2015, the aims of the Healthcare Associated Infections (HAI) programme are to:

- enable and support NHS boards to use quality improvement methods in their approach to managing and reducing the risk of HAIs occurring
- provide improvement advice and support to the Healthcare Environment Inspectorate to increase awareness and understanding of improvement activities at NHS board level, and
- support other Healthcare Improvement Scotland improvement programmes with HAI improvement activity and share learning across programmes.

The HAI Team is working with local NHS board infection prevention and control teams to build capacity and capability around improvement science, and develop and test systems and processes to enable the reliable collection and monitoring of data on HAI.
To date, the HAI Improvement Team has met with stakeholders from all 14 territorial and four special NHS boards, has received requests for support from 15 NHS boards and is currently working with 13 NHS boards on projects focusing on:

- achieving reliable processes to support compliance with standard infection control precautions
- implementing care bundles for peripheral venous cannulae insertion and maintenance
- implementing care bundles for prevention of catheter-related urinary tract infections, and
- building capacity and capability around improvement science.

A national learning event held in March 2016 was attended by 120 delegates from across Scotland. The focus of the event was on sharing the learning from the HAI improvement projects undertaken so far.

### 3.7 SPSP Medicines

Launched in spring 2015, this programme brings together relevant activity from the SPSP Acute Adult, MCQIC, Mental Health, and Primary Care programmes. The programme is supporting a ‘whole system’ approach to medicines, considering the patient as they move between care settings and home. The initial focus of this work was on:

- reducing medicines harm across transitions (medication reconciliation), and
- high risk medicines.

A medicines ‘infographic’ has been developed by Healthcare Improvement Scotland as a prompt for healthcare professionals when discussing the safer use of medicines in Scotland (available at: [www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/medicines](http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/medicines)).

The first national medicines event was hosted by SPSP in February 2016, with a focus on harm due to medicines and taking a ‘whole system’ approach. Specific topics covered included:

- reducing medicines harm across transitions
- innovative improvement projects happening in Scotland to reduce harm due to medicines
- leadership and culture
- improvement tools, and
- engaging patients in improvement activity.

A monthly WebEx series, focusing on reducing medicines harm at transitions, has been introduced for teams across Scotland. Key points from each WebEx are summarised and available on the SPSP website.
3.8 Looking forward

The next phase of the Maternity and Children programme has been designed to take account of the lessons learned to date and on the basis of extensive discussion during 2015–2016 with key stakeholders and policy leads.

- The future programme will take on a more phased approach, with a focus on fewer outcomes. Although national outcome aims will be specified, NHS boards will have the flexibility to work on their choice of processes that contribute to these outcomes.
- Topic-specific networking sessions will allow NHS boards to share targeted knowledge and experience.
- Measurement plans will be revised in an effort to reduce the data burden on NHS boards.

The next phase of the Mental Health programme will begin in September 2016 and extension of the programme to include Community, Child and Adolescent Mental Health Services, Older Adult Services and Perinatal Psychiatric Services is being considered.

New for 2016–2017 is the SPSP Improving Observation Practice programme which will initially focus on mental health services, specifically the observation of suicidal, violent or vulnerable patients to prevent them from harming themselves or others at times of high risk during their recovery.

SPSP Primary Care – a new piece of work on reducing pressure ulcers in care homes will start in mid-2016 with three locality care teams involved in the initial stages. The pilot phase will run until December 2017.

SPSP Dentistry in Primary Care – the results from the pilot work will be used to support an application to The Health Foundation and other external sources for funding for a broader collaborative from 2017 onwards.

SPSP Medicines – future work and events will build on early work relating to reducing medicines harm across transitions and high-risk medicines. The team will also explore the linking of medicines-related improvement activity to specific patient outcomes.
4 Implementation and improvement support

4.1 Introduction

The implementation and improvement support theme comprised three programmes of work in 2015–2016:

- Older People in Acute Care
- Living Well in Communities, and
- Focus on Dementia.

4.2 Older People in Acute Care

The Older People in Acute Care (OPAC) programme was established in 2012 and early work focusing on frailty and delirium led to reductions in the number of falls and to improvements in recognition and assessment of delirium. The results of this work were published in June 2015 in the Improving Older People’s Acute Care – Impact Report.

Work on frailty and delirium continued during 2015–2016, with the focus remaining on designing, testing and delivering improved outcomes. NHS boards shared learning at two national events focusing on frailty (in June and October 2015, co-hosted with JIT and QuEST) and at local NHS board events, actively supported and/or led by OPAC. Local events included:

- the launch of the NHS Fife Older People’s Collaborative in November 2015, covering person-centred care, quality improvement, dementia and delirium
- the NHS Forth Valley improvement event in May 2015, and
- the NHS Ayrshire & Arran delirium and dementia event in January 2016, attended by 110 delegates from multidisciplinary teams.

Opportunities for improvement and a more co-ordinated approach have also been identified through the Older People in Acute Hospitals (OPAH) inspection process, for example in terms of documentation of delirium assessment.

An economic evaluation carried out at University Hospital Crosshouse to assess the cost impact of the frail older people’s pathway, demonstrated a potential annual resource saving associated with the pathway of £4.6 million, taking into account patient length of stay, ward of admission, avoided admissions, re-attendance rates and readmission rates. Compared to the previous year, during the 6 months the frail older people’s pathway was in place in 2014:

- the overall admission rate for all over 65s fell from 68.1% to 66.4%
- 232 patients avoided admission
- the overall re-attendance rate for all over 65s fell from 26.1% to 17.9%, and
- the overall readmission rate for all over 65s fell from 16.3% to 11.6%.

The report of this work, based on a 6-month testing period with the multidisciplinary team assessing frailty in all patients over 65 years of age presenting to the emergency department, was published in March 2016 (Older People in Acute Care – Data Review and
Cost Analysis, NHS Ayrshire & Arran – A pathway for frail older people in the emergency department).

In 2015–2016, testing of a new collaborative approach began in three NHS boards with a locally employed Healthcare Improvement Scotland-funded improvement advisor based in NHS Dumfries & Galloway, NHS Greater Glasgow and Clyde, and NHS Grampian for a year (ending August 2016). This approach will support the alignment of a number of national improvement initiatives at local level and facilitate a co-ordinated approach to the care of older people in acute hospitals. Learning from this work will be shared through the ihub website, newsletters, events and in briefings to staff groups.

By March 2016, each of the three NHS boards had run events or learning sessions (four in NHS Grampian, one in NHS Dumfries & Galloway and one in NHS Greater Glasgow and Clyde) which were positively received. Feedback suggests that the combination of such events and having a locally-based improvement advisor who could share and spread learning and help to establish connections between streams of work, has led to a greater understanding of the inter-relationships between different elements of older people’s care.

Targeted improvement work undertaken within specific clinical areas has also led to improvements, for example a 50% reduction in falls in ward 2, Lightburn Hospital, in NHS Greater Glasgow and Clyde (see Figure 12). Feedback from events has also shown that, in all three NHS boards, staff knowledge has increased.

Figure 12 – ward 2, Lightburn Hospital, number of falls, January 2013 to April 2016
4.3 Living Well in Communities

The current focus of the Living Well in Communities (LWiC) programme was agreed following scoping and design work undertaken during April-September 2015 by a specially-convened development group comprising of practitioners, subject matter experts and representatives from the Scottish Government, NHS boards, local authorities, third and independent sectors, and a public representative. Details of the process and what was agreed are set out in the Living Well in Communities - Scoping and Design report published in September 2015.

The agreed focus of the LWiC programme, as set out in the report, is on:

- identifying how high resource individuals (2% of the population) use local health and social care services
- improving the identification of people living in the community who are at risk of frailty or falls and intervening to allow them to remain at home
- developing a nationwide approach to anticipatory care planning
- understanding and maximising the impact of intermediate care and reablement services (see Section 4.5.2).

All four strands of work will be supported by the LWiC Advisory Board which first met in March 2016 and will meet every 3 months during the life of the programme.

4.3.1 Pathways of care for high resource individuals

High resource individuals make up only 2% of the population, but account for 50% of NHS spend and 77% of bed days. Work is under way in three Health and Social Care Partnerships (Argyle and Bute, Glasgow City, and Midlothian) to identify opportunities to change the approach to caring for these individuals to improve outcomes and their experience of care. During 2015–2016, the focus was on combining available data with local knowledge to take a ‘deep-dive’ diagnostic approach to try to understand patterns of hospital usage in order to identify where improvements in care could be made. Tests of change were designed and will be implemented in 2016–2017.

4.3.2 Frailty and falls in the community

Work is under way in five Health and Social Care Partnerships (Argyle and Bute, Fife, Glasgow City, North Lanarkshire, and South Lanarkshire) to improve care pathways and reduce the number of falls. Learning events have been held in each partnership. Progress with this work has been slower than planned due to the level of development work required in the lead up to and immediately following the creation of HSCPs on 1 April 2016. A workshop on risk prevention for frailty was held in conjunction with the Information Services Division of NHS National Services Scotland, and a tool to assess people at risk of frailty in the community has been developed and will be tested in Fife early in 2016–2017.

4.3.3 Anticipatory care planning

Anticipatory care planning has been an area of interest and focus across health and social care for a number of years. Work began in January 2016 in four Health and Social Care Partnerships (Glasgow City, North Lanarkshire, South Lanarkshire and Orkney Islands) and in NHS Forth Valley (which is developing the content of the national Anticipatory Care Plan), and will run for 2 years. In order to develop a national approach, initial work focused on
understanding how anticipatory care plans are used locally. It is expected that all HSCPs will become involved over the next 2 years. This work is influencing the NHSScotland eHealth strategy, with work under way to ensure that the national Anticipatory Care Plan is accessible electronically across Health and Social Care Partnerships.

4.3.4 Delayed discharges

Work to tackle delayed discharges began in the Edinburgh Health and Social Care Partnership in October 2015, with the focus on preventing admissions by understanding how demand flows within the Health and Social Care Partnership thus identifying the priority areas for input. A whole system mapping approach is being developed that can then be used elsewhere. This work links to the anticipatory care planning, high resource individuals and reablement strands of the LWiC programme.

4.3.5 Sharing the learning

Two learning events, Living Well in Later Life and Living Well with Frailty, were held in October 2015 in conjunction with the Improvement Network for Integrated Care and Support and the Scottish Older People’s Assembly. Over 200 delegates from health, social care, third sector and the independent sector attended the event to “...share and learn about a range of topics including global examples of integrated care, active and healthy ageing, social isolation and enabling well being at home through intermediate care.” As well as presentations, videos and guidance materials, interviews were conducted with experts, colleagues and delegates during the event to get their views on the work currently being carried out and about the event itself. A range of digital platforms were used to spread the learning from the event to enable more people working in health and social care services to apply the learning locally. A blog page produced after the event has already been visited over 300 times.

A further event, Managing Frailty the Fife Way, took place in March 2016 attracting participants from across NHSScotland. The event explored good practice in managing frailty and highlighted innovative ways of working and successful examples of integration. Twitter was used successfully throughout the day for sharing and learning and a blog post was created.

4.3.6 Evaluation

The work of the LWiC programme will be evaluated using a contribution analysis outcome-based evaluation approach, agreed following consultation with other organisations delivering improvement activities in the community and based on advice from NHS Health Scotland. A logic model to underpin the evaluation has been developed and the collection of evidence to support the evaluation will be linked to the individual elements of the programme.

4.4 Focus on Dementia

A new 3-year project looking at dementia care in specialist (non-acute) units began in 2015–2016. This work is part of Commitment 11 of Scotland’s National Dementia Strategy and will become part of the Focus on Dementia portfolio of work within the ihub (see Section 1) from April 2016. The work arose in response to concerns raised in Dignity and respect, dementia continuing care visits, a report by the Mental Welfare Commission published in 2014, that reviewed the care provided in 52 long-stay dementia units across Scotland. The report
presented combined findings for all units so did not identify particular issues in particular units.

Based on initial scoping work, two core elements of the project were identified:

- initial work with four demonstrator units, with learning to be applied to other units over time
- development of a rapid learning network for all specialist dementia units to run in parallel with work in the demonstrator units to allow sharing of good practice and testing and implementation of good practice locally.

The demonstrator units, the topics to be addressed and the approaches to be taken in each unit have still to be identified, with each dependent on the other (that is the approaches taken will depend on the topics chosen which will depend on the units selected).

4.5 Looking forward

4.5.1 OPAC

A review of the OPAC and OPAH programmes will be undertaken in 2016–2017 to inform the future design and approach to improvement support for older people in hospital. Work to design the next phase will be carried out in conjunction with stakeholders (NHS boards, Royal Colleges, NHS Education for Scotland, clinicians, the Scottish Government, and the Care Inspectorate) taking into account the lessons learned from the work to date. Stakeholder interviews will inform the review and the results of these will be reported to the review group in November 2016. A period of discussion and reflection on the key themes emerging from the review will follow before final recommendations on the way forward are made.

4.5.2 LWiC

Within the LWiC work programme, work on intermediate care and reablement will begin in 2016–2017 once agreement is reached on the priority areas for improvement support.

Buurtzorg (neighbourhood care) – in March 2016 it was agreed that a new strand of work based on the Buurtzorg model would be added to the LWiC portfolio. A report (Buurtzorg Nederland (homecare provider) model – Observations for the United Kingdom), published by the Royal College of Nursing in August 2015, sets out how this approach, based on a district nursing system, could be adapted for use in the UK. The work is scheduled to start in September 2016 and work on scoping, engagement and site selection is under way.

Palliative care – in January 2016, it was agreed that this new strand of work should be added to the LWiC portfolio. Following discussions with the Scottish Government, it has been agreed that Healthcare Improvement Scotland will “provide Health and Social Care Partnerships with expertise on testing and implementing improvements in the identification and care co-ordination of those who can benefit from palliative and end of life care”, as outlined in the Strategic Framework for Action on Palliative and End of Life Care. This work is scheduled to start in October 2016.
Delayed Discharge – following a period for discussion and review this work has been incorporated into the Integrated Systems flow work which is currently led by the Tailored and Responsive Improvement Support Team.

A review of the LWiC programme will be undertaken in 2016–2017.
5 Person-centred care

During the early part of 2015–2016, the work of the existing Person-Centred Health and Care Collaborative continued to focus on:

- raising the profile of person-centred approaches to care across Scotland, including staff health and wellbeing
- developing and testing a range of evidence-based interventions and approaches designed to improve person-centred care
- identifying what can be done now to improve services
- providing reliable opportunities to personalise support for every person all of the time
- encouraging sharing of ideas and approaches between people who use services and people who provide them
- promoting the use of approaches for obtaining feedback from people who use services
- using feedback from people who use services to drive improvement
- providing a framework to measure improvement.

In February 2016, a national person-centred health and social care event, attended by 140 delegates from across NHSScotland, provided a showcase for work undertaken by the collaborative. Among the many examples of innovative and successful work presented were:

- ‘teach-back in musculoskeletal physiotherapy services’ - developed to check understanding of self management instructions; the approach resulted in improved patient experience and confidence in performing prescribed exercises, ultimately improving patients’ sense of control and confidence in self management (NHS Greater Glasgow and Clyde)
- ‘playlist for life’ – an approach that showed significant improvements in falls, length of stay and aggression incidents in a specialist dementia unit (NHS Borders), and
- ‘flipping the power of caring’ – this approach allowed patients to assist staff in monitoring and cleaning their dialysis line and resulted in zero infections and 100% use of chlorhexidine wipes (NHS Lanarkshire).

5.1 Person-Centred Health and Care Programme

From November 2015, the collaborative was redefined and extended to become the Person-Centred Health and Care Programme, with a focus on three areas of work:

- health and care experience
- person-centred health and care improvement programmes, and
- connecting people and good practice.

5.1.1 Health and care experience

This involves developing and testing new approaches to improvement that collect and act on information gathered from those who have accessed acute and primary care services. Recruitment of test sites began in summer 2015 and, by December 2015, four NHS board
areas were involved (NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Tayside, and NHS Western Isles). Testing of different approaches began in January 2016.

Work is also under way to test the Experience Based Co-design (EBCD) model of improvement. Unlike user-centred design and service redesign, the focus of EBCD is not only to improve, redesign or create a service, but also for people who will receive support and care from the service to work with staff to ‘co-design’ the experience of using and delivering the service. In a health or care setting, EBCD focuses on how people move (or are moved) through the service and how they experience and interact with its various parts, including frontline staff.

Recruitment of test teams began in November 2015 and three teams were recruited and received training on the EBCD model in March 2016. Each test is expected to take 6–18 months to complete. The test teams and their topics are:

- North Lanarkshire Integrated Joint Board - People who frequently attend accident and emergency in distress who do not require medical intervention
- NHS Ayrshire & Arran Maternity Services - Maternal education
- Healthcare Improvement Scotland - Specialist Dementia Units improvement programme

### 5.1.2 Person-centred health and care improvement programmes

This work focuses on providing support to staff working on national improvement programmes so they can develop person-centred methods and approaches to programme design.

Work during December 2015, gathering the views of public partners and of people currently receiving care, contributed to the key recommendations about the future improvement priorities of the SPSP Acute Adult and Primary Care programmes. The key themes arising were communication, trust, staffing levels and understanding the role of patients as partners in care and safety.

An involvement framework which links to the stages of improvement has been developed and is currently being tested by Healthcare Improvement Scotland improvement programme teams. This tool will be used to assess and plan how people who access care and support can be involved in all stages of national improvement programmes.

### 5.1.3 Connecting people and good practice

This work is the direct successor to the person-centred health and care collaborative. A new Person-Centred Health and Care Network was developed and launched at the national event in February 2016 (see above). The aim is to provide networking opportunities by connecting people working in health and social care who have an interest in developing and improving person-centred approaches to care and support to others who share these interests. In this way, examples of best person-centred care will be shared and spread.

### 5.2 Looking forward

During 2016–2017, support will be provided to the four NHS board carer-experience test sites to enable them to measure the improvement that has taken place, to evaluate their models and the learning that has occurred, and to share these across the Person-Centred
Health and Care Network. In 2017–2018, the focus will switch to implementation and spread.

Support will be provided to the three teams testing EBCD to help them develop skills in interviewing, person-centred observation and facilitation, with a view to building capacity within each of the teams so they can lead the process of co-design during 2016–2017.

Support to develop capability and capacity within Healthcare Improvement Scotland improvement programme teams will continue to be provided so that person-centred practice becomes an integral component of all national improvement programmes.

During 2016–2017, the Person-Centred Health and Care Programme team will work closely with the Personal Outcomes Partnership to build a health and social care system that focuses on personal outcomes and what really matters to people.
6 Primary care out-of-hours

During 2015, support was provided to primary care out-of-hours services in NHS Lothian and NHS Grampian to improve their ability to complete home visits within the recommended triaged timescales. Primary care out-of-hours services provide urgent care to people in their own homes quickly and outwith the usual opening hours of their GP practice. The support provided included exploring the factors that affect performance and the options for improving timely attendance.

NHS Lothian tested and implemented new approaches to managing home visits, focusing on weekends and holidays when demand is higher, and reported:

- improvement in the proportion of home visits at weekends/special holidays that were reached on time (see Figure 13), and had accurate start times recorded (up by 4%)
- increased awareness of home visits amongst staff, who previously did not know how well they were performing against this measure
- improved teamwork, and
- active involvement of staff in improving the service.

In NHS Grampian, the support provided helped to bring the team together and improve understanding of what affects the delivery of home visits within the triaged timescale. The focus of the work was on improving recording of when a clinician had reached a person’s home (see Figure 14).
The work completed with NHS Grampian and NHS Lothian has improved understanding of how improvement support can be provided and this will inform any future support Healthcare Improvement Scotland provides.

During the life of the existing programme, the Scottish Government launched a review of primary care out-of-hours services. The review group, chaired by Professor Sir Lewis Ritchie, was commissioned in early 2015 and reported in November 2015. Improvement support will be required to take forward the recommendations of the review and bring about the proposed changes to the ways in which these services are delivered.

6.1 Looking forward

The Healthcare Improvement Scotland primary care out-of-hours programme will work with stakeholders to design and develop a quality improvement approach to support the recommendations of the 2015 Primary Care Out-of-Hours Review.
7 Quality improvement for NHS Board members

Commissioned by the NHSScotland Board Chairs’ Quality Portfolio Group, the focus of this workstream is on developing the knowledge and skills needed for effective Board-level leadership and governance of quality improvement amongst Board members of NHS boards.

The key aim is to enhance knowledge and skills about quality improvement among the 356 executive and non-executive Board members of the 22 NHS boards in Scotland (14 territorial and eight special) to enable them to provide better leadership and governance around quality improvement within their NHS board.

Scoping work, including 30 individual conversations with various experts, group discussion and a review of data from previous work in this area, was undertaken between October 2015 and March 2016. This work was overseen by an Advisory Group that included NHS board members, NHS Education for Scotland and the Scottish Government. The key topic areas, learning outcomes and methodology were agreed at this stage. The proposed approach was very positively received and was endorsed by the NHS board Chairs in March 2016 without amendment.

7.1 Looking forward

In 2016–2017, two national masterclasses and at least four bespoke sessions within NHS boards will be held. The purpose of these is to create opportunities for NHS Board members to enhance their ability to lead organisations where a culture of quality improvement flourishes.

The key topic areas for these discussions include:

- quality improvement in Scotland
- developing effective organisational strategies for quality improvement
- using measurement to support NHS board members’ roles
- understanding human factors, and
- leading a learning organisation where improvement and assurance are positively related.

This work will continue, and evolve, to support NHS Board members now and in the future as Board membership changes.

Scoping work is also under way to understand the quality improvement knowledge and skills needs of members of Integration Joint Boards, with a view to extending support to these Board members.
8 Tailored and Responsive Improvement Support Team

Development work on the Tailored and Responsive Improvement Support Team (TRIST) began in summer 2015. TRIST is providing flexible improvement support to help NHS boards and Health and Social Care Partnerships address improvement issues that are a priority in their local area. It will also provide support to implement key findings from inspection reports produced by Healthcare Improvement Scotland. Support will be proactive or reactive and range from a one-off consultation session through to a longer term package of improvement input based on the scale, complexity and urgency of any request.

TRIST received 48 requests for support from health and social care partners between July 2015 and March 2016. At this early stage, the focus is on working with partners to quickly address their needs and to understand how TRIST, the ihub and wider improvement partners can best work together to make an impact.

8.1 Looking forward

8.1.1 Improvement Fund

Planning for the Improvement Fund started during 2015–2016. The Fund aims to provide grant awards to health and social care partners who put forward strong proposals to test a change idea locally or to spread improvement nationally. The aim is to invest in and expand innovative practices that have an impact on the national health and wellbeing outcomes. A secondment arrangement has been agreed with the Scottish Council for Voluntary Organisations to provide specialist advice on the design and delivery of the fund and funding. An Improvement Fund Manager and Improvement Fund Advisory Group will oversee the fund which will be managed through TRIST. Funding will be available from September 2016 and both competitive and direct grant awards will be made.
9 Assessing our impact

Assessing the impact of quality improvement initiatives is essential if future funding and resources are to be directed towards the most appropriate areas of care. Quality improvement initiatives usually start small and grow and spread on the basis of identified success in improving care. Capturing these successes and evaluating the contribution that Healthcare Improvement Scotland-led quality improvement initiatives have made to these successes will be of central importance to future work as will reporting of these successes at national level.

Equally important is the need to establish if initiatives don’t work or don’t deliver the desired outcomes. However good the idea and however robust the theory behind the approach, there will be times when initiatives are not successful. These failures provide invaluable learning opportunities and capturing them is as important as celebrating the successes.

Evaluating the effectiveness of quality improvement initiatives within the ihub will be an important aspect of future work. Where appropriate and whenever possible within the resources available, future programmes will be designed with evaluation in mind.

Training and support in appropriate evaluation techniques is already being provided internally to quality improvement staff within the ihub through the Evidence and Evaluation for Improvement Team (EEvIT) (see Section 9.1), with the aim of making evaluation of effectiveness central to all future quality improvement initiatives. To achieve this, evaluation must be built into initiatives at the design stage.

9.1 Evidence and Evaluation for Improvement Team

Recognition of the need to provide support to staff in the Directorate of Safety and Improvement to enable them to better use available evidence, harness health economic information and incorporate evaluation into future projects and programmes led to the establishment, in October 2015, of the Evidence and Evaluation for Improvement Team (EEvIT). The team comprises 3.8 whole-time equivalent staff (currently nine individuals) drawn from existing staff working in different disciplines across the Directorate of Evidence. EEvIT provides expertise in health economics, health services research, knowledge and information science, evaluation, data measurement and analysis, and report writing. Initial demand for support has been high, with 17 requests accepted onto the work programme and another 11 awaiting a decision.

One of the aims of EEvIT is to build capability across teams in the ihub, particularly in relation to evaluation, so that staff designing and developing new programmes of work can build evaluation into programmes from the outset and have the knowledge and skills necessary to evaluate their work on an ongoing basis.
10 Glossary

CAUTI    catheter associated urinary tract infections
DMARDS  disease-modifying anti-rheumatic drugs
EBCD    Experience Based Co-design
EEvIT    Evidence and Evaluation for Improvement Team
HAI      healthcare associated infection
ihub    Improvement Hub, part of Healthcare Improvement Scotland
JIT      Joint Improvement Team
LWiC     Living Well in Communities
MCQIC    Maternity and Children’s Quality Improvement Collaborative
OBDs    occupied bed days
OPAC    Older People in Acute Care
OPAH    Older People in Acute Hospitals
QuEST   Quality and Efficiency Support Team
SPSP    Scottish Patient Safety Programme
TRIST   Tailored and Responsive Improvement Support Team
11 Resources


- Buurtzorg Nederland (homecare provider) model – Observations for the United Kingdom (UK). Royal College of Nursing Policy and International Department, 2015.

- Primary Care Out-of-Hours Review. The Scottish Government, November 2015.
You can read and download this document from our website. We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net

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The Healthcare Environment Inspectorate, the Improvement Hub, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.