Final report

February 2017

Innovating for Improvement

Designing and testing ‘always events’ as a person-centred quality improvement approach in multiple care settings

NHS Education for Scotland

The Health Foundation

About the project

Project title: Designing and testing ‘always events’ as a person-centred quality improvement approach in multiple care settings

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Part 1: Abstract

Background

- Run by NHS Education for Scotland.
- A multi-setting project – acute, primary and community care.
- 'Always events' (AEs) are actions and behaviours that create a satisfactory patient experience.
- Will introduce health care teams to the linked concepts of AEs, person-centredness and Quality Improvement; facilitate AE development and testing with patient groups; and assess whether the AE approach can drive improvements in patient experience.

Taking a person-centred approach to care involves health care professionals working in partnership with patients. It helps support patients to make important decisions about their own health and care in a way that is specifically designed around their needs and wants, and treats them compassionately and with respect.

Delivering on this consistently is difficult given the complexities, constraints and pressures of frontline care, and the challenges of managing large-scale organisational changes with limited resources. Many patient experience/satisfaction surveys are available to frontline staff, but routinely capturing meaningful patient feedback to actually drive quality improvement is problematic.

The 'always event' (AE) concept and process (Figure 1) offers an innovative person-centred approach to quality improvement that can optimise care experiences in any setting. AEs are those actions and behaviours of care teams that create a satisfactory experience for patients at a local level. The method is strongly rooted in identifying care quality issues that are important to patients, families and carers.

This project will recruit health care teams from acute, primary and community care and introduce them to the concepts of AE, quality improvement and person-centredness. It will involve testing AE in priority patient groups to determine if collecting patient feedback can generate localised AEs, which can then be linked to existing or new care systems/processes; and determining if application of the AE method by care teams can drive measurable improvements in local patient experiences.

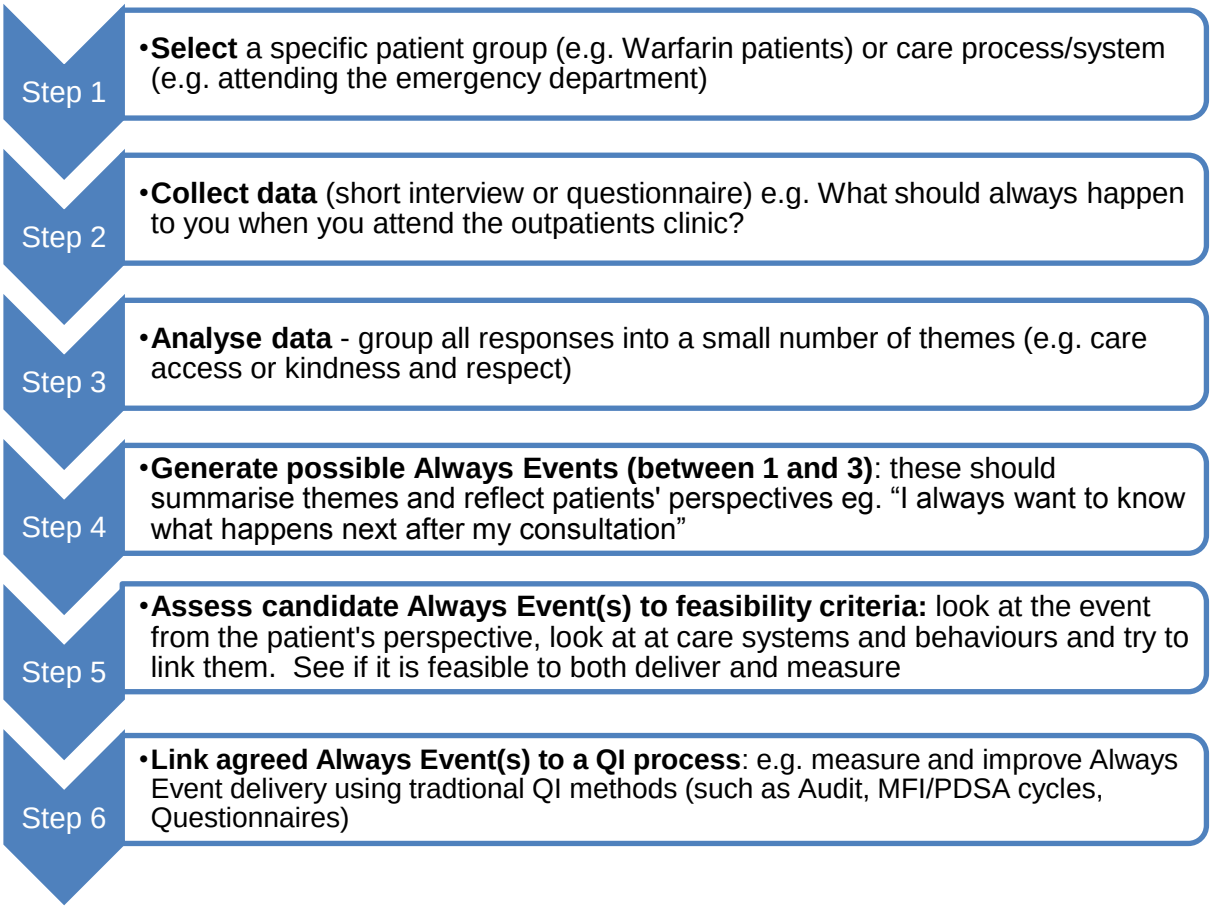


Figure 1: Generating 'Always Events' and Linking to QI

Testing our intervention - what did we do?

- A total of 36 care teams from across NHS Scotland expressed an interest in participating in the study. Of these, we purposively sampled and recruited a diverse group of teams (n=18) that were reflective of different care sectors, settings and professions (Box 1).
- Building on our previous pre-pilot work, and informed by a QI Collaborative method (IHI Breakthrough Series – Figure 2), we provided initial training on Always Events and QI, held two further *Learning Sessions* and offered ongoing educational support throughout the project (e.g. access to BMJ Quality online resources and fortnightly phone-in clinics with project leads)
- During *Action Periods*, care teams engaged with their patients, gathered feedback, generated and implemented Always Events (using criteria previously adapted and redefined by NHS Education for Scotland – Box 2), and attempted to measure and improve delivery of these AEs using a chosen QI process.
- We collected and analysed quantitative and qualitative evaluation data (e.g. using documentary analysis, stakeholder workshops and survey questionnaires) on team progress and self-reported learning and improvements and to assess generic validity, acceptability and feasibility of the AE concept and approach

Box 1: Initial recruitment of a diverse mix of Care Teams (n=18)

Patient Group or Care Service	Setting	Care Sector
1. Schizophrenia patients prescribed Clozapine	Pharmacy	Mental Health
2. New mothers	Breastfeeding Support	Community
3. Minor Injuries Unit	Emergency Department	Acute Hospital
4. Immediate Assessment Unit	Emergency Department	Acute Hospital
5. Dental Emergencies	Dental	Primary Care
6. Repeat Prescribing Service	General Practice	Primary Care
7. Patients with addictions	Addictions Team	Community
8. Patients attending treatment centres	Out-of-hours	Primary Care
9. Patients attending for consultation	General Practice	Primary Care
10. Women in pregnancy	Antenatal clinic	Acute Hospital
11. Haemo and peritoneal dialysis patients	Renal Dialysis	Acute Hospital
12. Diabetic patients	Pre-Op Assessment	Acute Hospital
13. Patients aged 65 and over	Emergency Department	Acute Hospital
14. Relatives and carers of dementia patients	Orthopaedic Trauma	Acute Hospital
15. Patients attending for consultation	General Practice	Primary Care
16. Diabetic patients	Diabetes Clinic	Acute Hospital
17. Patients attending for consultation	Dental	Primary Care
18. Emergency	Scottish Ambulance Service	Ambulance

Box 2: Criteria for Generating Always Events

An Always Event...

1. Is **any** healthcare interaction, process or outcome that is **judged** by patients, carers or relatives to be a highly **important determinant of care quality** and experience; AND
2. Is **unambiguous and specific** to **enable reliable measurement**; AND
3. Is **consistently deliverable** to applicable patient groups **by all relevant** health care organisations, teams and individuals; AND
4. Is **feasible** as part of **routine** health care delivery

What has gone well?

- The great majority of teams across all settings were clearly positive about the concept of Always Events and the need to take a more person-centred approach to Quality Improvement, which was evident in the areas of local care practice/patient groups chosen by them to focus on enhancing the patient experience
- Most teams were able to grasp the concept sufficiently enough and demonstrate application of related knowledge to collect and theme feedback from their patients/clients, generate AEs and link delivery of these to a quality improvement method and action (or had the potential to do so).
- The subsequent self-reported data demonstrates that most teams acted on their QI data and made a variety of changes and improvements to their practices, much of which was around reacting to patients' needs to, for example, improve knowledge of clinical conditions/drugs, improve the provision of necessary

information, and improve flexibility of access to services.

- Two teams have provided evidence to us of their intention to publish their own project findings, while 2-3 other teams have also expressed a strong interest in this and are confident that their data and change/improvement interventions are worthy of potential publication. This was not a particular goal of our project but is very pleasing nonetheless.
- The view of the project leadership is that the combination of a Collaborative learning model to bring teams together periodically to share progress and learning, and the NES project team offering ongoing formal and informal support worked well.

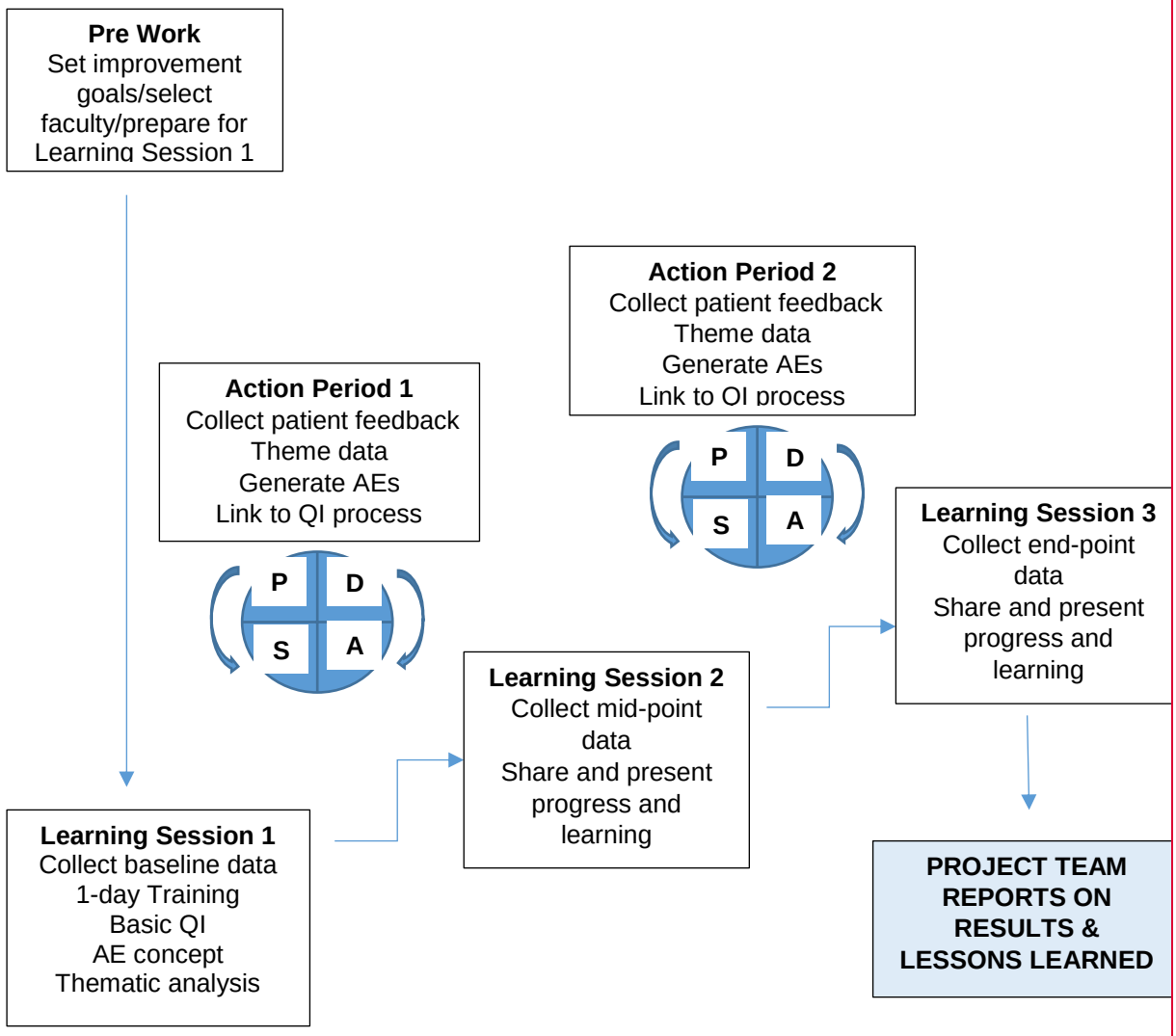


Figure 2: Model and content of Always Event intervention ('mini-model' adaptation of IHI Breakthrough Series Collaborative)

Challenges and how they were addressed?

- *Early withdrawal of one participating team* - A key lesson for the future is that we must ensure that there is full frontline 'buy-in' and capacity before agreeing to test a new concept (suggested by a senior manager).
- *Decreasing attendance at Learning Sessions* - It is easy to predict and understand that attendance will decrease over the course of a project, but difficult for the project leadership to manage and influence this. Our response to non-attenders was to immediately contact them by email and telephone and use questionnaires to get feedback on their progress, successes and challenges – by-and-large the project team felt that this approach, while not ideal, worked to a significant extent.
- *Misunderstanding the AE approach and the generation of explicit AE statements* – A minority of teams may have been misinterpreting the core principle underpinning the AE approach and failing to explicitly generate AE statements with which to assess and measure improvement. The project team picked up on the aforementioned-issues at the various learning sessions and spent time with all teams drawing attention to this specific challenge and re-visiting some of the training provided at the launch event as well as pointing them to the practical guidance they had also been provided with on this area. This had some impact on improving AE statement generation at the end, but not for all teams, so we have identified this as a clear learning need to be addressed when it comes to further spread and dissemination
- Significant challenges are still apparent for most teams around engaging in QI activity in a sustainable way – a well-recognised NHS issue regardless of the QI approach adopted, which needs to be accommodated/addressed under future spread and dissemination plans
- Interestingly, most teams did not access the education support provided (e.g. BMJ Quality online resources or phone-in clinics held by the project team citing timing and pressures of work, although some accessed other local resources (e.g. their local organisational QI advisers or different online information sources). The limited appeal of the BMJ Quality resources was of significant interest because we had invested heavily in providing free access for the teams; the provision of what we assumed to be a good supporting and reference resource on all aspects of QI. We would not use this approach as part of any future intervention in this way.

Outcomes and Impacts

- The Always Events concept translated well and was positively supported by all participating care teams across different settings
- Most teams engaged well with the project and gathered feedback from patients, generated AEs and linked these to a QI process that led to reported improvements in care systems/behaviours, or had the potential to do so.
- As stated, some teams did not follow the orthodox AE approach as expected (i.e. it was more clinician-centred than patient-centred), but paradoxically still managed to engage with their patients, act on feedback and enhance experiences of care.

Part 2: Progress and outcomes

Key project 'high level' measures:

- Participation rates (project completion and learning session attendance; use of educational support resources)
- Generation of AEs and linking to a QI process
- Self-reported learning, improvement and innovation (individual, team and organisational, where appropriate)
- Team perceptions and experiences of AE concept, approach, barriers and facilitators around acceptability, feasibility and impact (on learning/improvement related to practice systems/behaviours and patient experiences)

Project Outcomes

Care Team Recruitment, Project Participation and Attendance at Learning Sessions

- A total of 36 care teams from across NHS Scotland expressed an interest in participating in the study. Of these, we selected and recruited a diverse group of teams (n=18) that were reflective of different care sectors, settings and professions to test the AE concept as widely as possible.
- Of the 18 teams recruited, 17 attended the 1-day opening project launch event. One team failed to attend (Scottish Ambulance Service). Follow-up with this team led to the project visiting with two representatives to the SAS team to provide similar training that other teams received at the launch event. However, a few weeks later SAS formally withdrew from the project – a key lesson here is that initial interest in participation was from a senior SAS leader; participation was then delegated to staff further down the hierarchy who although keen were unprepared in terms of knowledge of the project and having the capacity to both participate and lead their own team(s) in this endeavor, which arguably explains the withdrawal of this organisation at an early stage.
- After the launch event a further two ½ day learning sessions were held. At the project mid-point a total of 14 teams attended a session to update progress and share learning; while at the final learning session, a total of 7 teams were represented and shared their project outcomes and learning points.
- In total, 10 teams accessed the BMJ Quality online resources, although most only used this on a single occasion (the resource evaluated as: slightly useful n=6; moderately useful n=3; very useful n=1).
- In terms of accessing local organisational support with the project (e.g. improvement advisers, clinical governance team), four teams indicated that they used these services
- The motivation for participation by teams was on undertaking QI to enhance patient care experiences (75%), and to increase understanding around a new idea (58%)
- Shift work arrangements and busy clinical practice meant that team attendance at Learning Sessions reduced as the project progressed: 1st session (n=18); mid-point session (n=13); final session (n=7)
- However, the project team were still in touch via email and telephone to monitor progress, offer support and collect evaluation data.

Generation of Always Events

- To help generate AEs, care teams used either short face-to-face or telephone interviews or survey questionnaires to gather patient feedback
- Most teams generated more than one AE to link to a QI process: single AE (33%), two AEs (27%), three AEs (27%) and 4 or greater (13%). Examples of the areas of focus for generated AEs are outlined in Table 1.
- All teams required the support of immediate work colleagues with 60% reporting team members had 'some' or 'moderate' project involvement, and 40% having 'significant' involvement or were 'involved at all stages'.

QI Methods Applied

- Care teams used a range of QI methods, including: questionnaire surveys (87%); Model for Improvement/PDSA cycles (80%); clinical audit/care bundles (67%); Run charts/SPC (27%) and process mapping (13%)

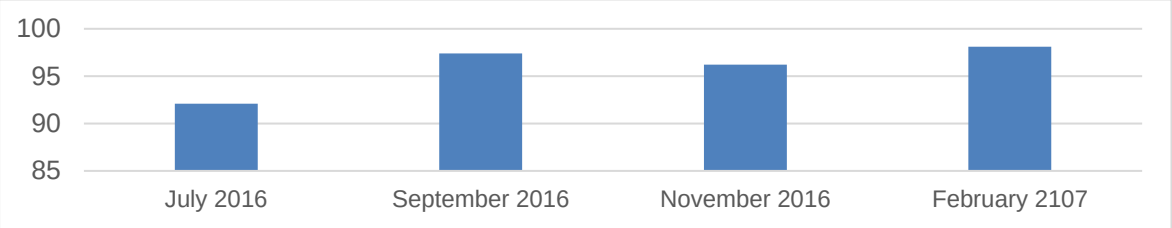
Reported Care Improvements and Innovations

A range of changes/improvements were reported to facilitate delivery of AEs in response to patients' wishes and needs (Figure 3) e.g.

- Alterations to electronic case lists and working practices – greater freedom of visiting
- New systems to ensure patients seen by most appropriate staff in GP led to Rota changes to ensure more staff on frontline at peak times
- New system at an Initial Assessment Unit of an Emergency Department led to reduction in mean triage waiting times (down 30 minutes to 17 minutes), while complaints regarding front door activity reduced 40% over 12-months
- New information and contact sheets for clients introduced
- Named medical staff for patients 65 years and over
- GPs now moving from 10 to 15 minute consultations and swapping days of work to improve continuity of care for patients
- New care booklet introduced for guidance on managing diabetes and HbA1c
- New morning and afternoon slots introduced for patients with dental emergencies
- Introduced informational posters and a staff video explaining the care process and staff roles for those attending a Minor Injuries Unit – patients now more knowledgeable of the care process when entering the department
- Patients' knowledge of a hazardous drug and implications increased (vulnerable group largely without internet access)
- Flowcharts triage introduced with staff training, leaflets produced, websites updated.

GP Health Centre, Glasgow

- Patient determined AE highlighted an inefficiency in the repeat prescribing process
- In July 2016, 292 patients attended to collect repeat prescriptions and 269 (92.1%) were ready
- Practice team used this information to create a more efficient system for all involved in the process → reduced workload, reduced frustration
- Reception area runs more smoothly, which re-enforces the gain of the change increasing the likelihood of sustainability.



- Measurement of AE delivery was conducted 3 times and the results show that the changes that were implemented detailed above were working:
- In February 2017, our percentage had increased to 97% from 92.1% in July 2016

Figure 3: Case study in general medical practice

Table 1: Examples of areas of focus for generated Always Events

'Reader Friendly' patient information with prescriptions for Clozapine
Provision of timely information when needed for those accessing Breastfeeding support
Keeping patients informed of care process when attending a Minor Injuries Unit
Pain management advice for emergency dental patients
Timely access to 'repeat' prescriptions
Asking prescribers to discuss upcoming life events and how this may impact those with addictions
Providing analgesic appropriate to pain levels experienced by haemodialysis patients
Patients with diabetes knowing their HbA1C level after consultation

Evaluation Outcomes

Common Challenges

- Staffing issues: *staff levels, sickness, annual leave, limited administrative support*
- Time and workload issues: *'time to do it'; 'day gallops along'; 'swamped with paperwork'; 'engagement at staff level'; 'data surprised us – patients' expectations are changing'*
- Knowledge and understanding: *explaining concept to colleagues; capturing appropriate information; understanding the concept, difficult for staff and patients; literacy skills of patients; developing concise information*
- Patient feedback: *negative comments – polarised feedback; confusion regarding terminology ('minor ailments'); questionnaires needing interpreting for patients;*

patients as passive recipients

- Data gathering: *lack of IT support*; *undertaking thematic analysis – breaking down descriptions; actually measuring a polite welcome – how to do it?*
- Change and improvement*: staff groups struggling with change; polarising of opinions on how to act on feedback and what to do next; ongoing relocation and re-organisation of the service*

"*Patients and staff initially found the concept difficult*…" (Dentist)

Reported Enablers

- Working and communicating with the care team: *collaborative working with colleagues; providing feedback to staff; weekly staff meetings; disseminating learning and sharing improvements; set goals with patients and have active discussions; the sharing of learning at the sessions – beneficial and inspiring*
- Understanding and applying Model for Improvement/PDSA cycles: *focus on one or two issues only*
- People are interested in the topic; allocating dedicated time for meetings and to oversee project; good team dynamics and working; patients appreciated being asked; staff received more positive feedback from patients than other methods;
- Implementation of change leading to: positive reception by staff; changing mind-sets; being better for patients; less stress for staff

Experience and understanding gained

- Data are presented on pre-project, mid-point and end of project reported experiences and understanding (Table 2); overall experiences were positive and understanding increased for in some areas but was mixed in others which is indicative of the challenges of undertaking and sustaining interest in QI as part of everyday healthcare work

Table 2: Always Events – Team leaders on Always Events: levels of agreement with selected attitudinal statements rated 4 or more on a 5-point Likert Scale (where 1=strongly disagree, 5=strongly agree)

	Pre-project (n=33)		Mid-point (n=15)		End of project survey (n=17)	
Statement	**>4**	**%**	**>4**	**%**	**>4**	**%**
I have a good understanding of what 'Quality Improvement' means in the context of my healthcare role.	31	93	15	100	16	94
I have a good understanding of what is meant by an 'Always Event' in the context of my healthcare role.	23	69	15	100	16	94
I have a good understanding of what 'Person Centred care' means in the context of my healthcare role.	32	96	15	100	16	94
I fully understand how to lead and implement a Quality Improvement project.	20	60	14	93	14	87
We are on track to deliver (or have delivered) improvements in patient care related to the Always Events project.	-	-	10	66	12	70
I fully understand how to solicit, capture and act upon patient feedback and opinions.	26	78	13	86	15	88
My care team is enthusiastic about the Always Events concept.	-	-	12	80	11	64
Before this project our care team was experienced in undertaking quality improvement projects.	-	-	9	60	6	35
Before this project, our care team routinely collected feedback from patients / clients on how they would like to see care improved.	-	-	8	53	6	35
My impression is that patients have been pleased to be asked what they would always want to happen when they interact with our care team/setting.	-	-	11	73	16	94
As a team we have already made improvements in the delivery of our health care because of the Always Event project.	-	-	10	66	12	70
I feel that care team knowledge around the Always Events concept has increased.	-	-	12	80	15	88
I feel that I am actively using my skills to improve health care delivery.	-	-	14	93	15	88
The development of the Always Events for our project was a relatively simple process.	-	-	9	60	13	76
I feel that my patients are benefitting from my involvement in this type of quality improvement programme.	-	-	13	86	15	88
It has been difficult to engage other team members in the Always Event project.	-	-	5	33	7	41
I would recommend the Always Events concept to other health care teams.	-	-	13	86	14	87

Individual and Team Learning

- Undertaking thematic analysis of qualitative feedback
- Inspired one participant to undertake a QI course
- Team looking to build departmental QI capacity and capability
- Overcoming challenges around staff engagement

- Increased patient-centred focus on other work areas – new conversations more person-centred than service-centred
- Project been a contributor to a new team working well together
- Wider team learning – transferable to other areas, '…*has sparked debate'*

Selected Quotes from Participating Teams

"We found the Always Event model to be a quick and effective intervention. We particularly found that it was successful in achieving patient-centred care as the entire topic of the event was generated by patients" **[Consultant Physician]**

"*It's been brilliant for the staff as well as the patients…because as well as improving care for the patients it also made life easier for the staff over dealing with repeat prescriptions*" **[GP Practice]**

"Seeing the changes to patients – makes you want to continue, better reaction gives us confidence to use and implement" **[Hospital Nurse[**

"*This has directly involved a vulnerable group of patients who don't normally get to express their thoughts on their care*" **(Pharmacist]**

"*The approach is good and it certainly has a role but may be limited because we're struggling to expand it with other areas of clinical practice beyond emergency dental care and access*…**" [Dental Practitioner]**

"*The potential for spread throughout our department and emergency departments everywhere is clear*….". **[Consultant in Emergency Medicine]**

Part 3: Cost impact

- The costs, direct and indirect, associated with the project and future support and implementation of the AE concept were not an explicit consideration of our whole approach at this early testing phase
- The underlying assumption for our take on the cost impact element of the project is based on the fact that all healthcare professionals are expected (e.g. professionally, regulatory and under service obligations) to routinely participate in QI activity and provide supporting evidence. At face value, the addition of the AE approach to this large QI toolbox should not cost any more or less than other QI methods that are currently applied by care practitioners – the key difference with the AE method is the focus on linking patient feedback much more explicitly with QI activity.
- It is possible that as the method is promoted and implemented more widely that we and others become aware of the possible additional cost implications associated with gathering and acting of feedback from local patients about their wishes and needs when they interact with NHS services. So, for example, there may be additional costs of providing information related to print and design and the time taken to coordinate and distribute this. We would need to carefully monitor this in future. However, the counter-argument to this might be that the NHS has thus far been failing to provide fundamental information to these patient groups, which can cause stress, anxiety, inefficiency etc for patients and staff (as witnessed in our project) and so there may be a greater cost-benefit to applying the AE approach

Part 4: Learning from your project

Milestones and enablers

- We are confident that we met our project objectives and fulfilled the goals of Innovating for Improvement Programme (IIP). In this sense we have successfully planned and organised the testing of the 'always events' concept amongst a large group of diverse care teams from different NHS Scotland care settings and professions. A major enabler for us was that our host organisation has a national remit and from a QI perspective has a reach into and influence over specialty training, CPD and medical appraisal, and national improvement programmes/stakeholders
- The vast majority of project-related milestones have now been reached, such as delivering the learning sessions for participating teams, facilitating the action periods for developing 'always events' and linking delivery of them to QI 9or having the potential to do so), collecting and analysing project and evaluation data, raising awareness of the project amongst key national stakeholders, and gathering support to explore potential implementation of this method within key training programmes and service initiatives. A key milestone still to be reached will be to submit our learning and findings for journal publication, and an early draft of an academic paper is now in progress.

Challenges

- Arguably, the biggest challenges to the project currently and for future spread and dissemination of the concept are related to the everyday implementation issues faced by the application of most QI methods by frontline care teams - which are now reasonably well understood: understanding and application of the method in robust way; making time to build QI efforts into daily routines; winning over hearts and minds of colleagues around the importance of both QI and taking a person-centred approach to improvement.
- As previously stated, it was clear both at the launch event and later at the mid-point event that a minority of teams may have been misinterpreting the core principle underpinning the AE approach – that is that AE generation is directly and explicitly linked to feedback which is based on the expressed wishes and needs of patients (rather than what clinicians thought or assumed were areas of necessary improvement for patients, regardless if it at face value that these assumptions were sensible and a priority). Similarly, for many teams the actual generation of explicit Always Events statements based on patient feedback proved to be a challenge, and it was difficult for us to gather concrete evidence of these statements – rather, these teams adapted by focusing in on a high level, even broad/vague, statement – for example, 'increase knowledge and information around this important drug'.
- The project team picked up on the aforementioned-issues at the various learning sessions and spent time with all teams drawing attention to this specific challenge and re-visiting some of the training provided at the launch event as well as pointing them to the practical guidance they had also been provided with on this area. This had some impact on improving AE statement generation at the end, but not for all teams, so we have identified this as a clear learning need to be addressed when it comes to further spread and dissemination
- Not all teams were able to demonstrate tangible improvements within timescale

but the majority appeared well placed to do in the near future – a range of common issues such as staffing, workload, re-organisation and lack of project support from colleagues were cited as contributory factors

Advice for others

- In general terms, our project assumption that the AE concept can translate to any care setting (with patients who interact with care practitioners) holds true based on the evidence and feedback from participating care teams. To this extent, following what we did in terms of educating care teams on the AE concept and in basic QI techniques should mean that this approach is replicable for others in the NHS
- With hindsight, given the low levels of interest and access we would not have funded free access to the BMJ Quality online materials for participants as a supplementary educational resource - but perhaps have encouraged those who wished to publish in the related journal or who had a strong interest in using the resource to seek us out as the project progressed
- Adapting the Breakthrough Series collaborative models of learning and action at scale for multiple participating teams is a productive way of getting people together for training, gaining a shared understanding of project goals, monitoring progress and sharing learning and successes etc
- With hindsight, it would have been good to have focused much more than we did on the facilitators and inhibitors associated with effective Quality Improvement – if we could go back we would have perhaps offered a further ½ day education on this topic

Summary of Our Learning

- The Always Events concept translated well and was positively supported by all participating care teams across different settings; the whole idea of taking a person-centred approach to the AE project and also other areas of practice came through strongly from participating teams – this was pleasing rhetoric from a project leadership perspective, but we are well aware that frontline reality related to implementation of ideas/improvement can skew the best of intentions
- Overall, most teams engaged well with the project and gathered feedback from patients, generated AEs and linked these to a QI process that led to reported improvements in care systems/behaviours, or had the potential to do so.
- Interestingly, some did not follow the orthodox AE approach as expected (i.e. it was more clinician-centred than patient-centred), but still managed to engage with their patients, act on feedback and enhance experiences of care
- Significant challenges are still apparent for most teams around engaging in QI activity in a sustainable way – a well-recognised NHS issue regardless of the QI approach adopted
- Most teams did not fully access the education support provided (e.g. BMJ Quality online resources or phone-in clinics held by the project team), citing timing and pressures of work, although some accessed other local resources or online information sources.

Part 5: Sustainability and spread

- We have begun to invest in the development of educational resources (e.g. entry level e-learning) and materials (e.g. flyers and short guides) to support the benefits of the 'always events' approach for NHS Scotland frontline clinical leaders, care practitioners, educators, managers and policy makers. The topic is now also a permanent agenda item on a small number of relevant NES multi-disciplinary working groups in order for us to monitor both current progress and organise and plan future development, testing and implementation within, for example, training curricula, medical appraisal and application by frontline care service providers (e.g. local enhanced services by NHS Boards or GP Quality Clusters).
- As a first step, we plan to spread this innovation via implementation and testing of the concept within primary and secondary care clinical training environments in NHS Scotland. We believe that there is enough empirical evidence to suggest that the concept is generic enough to be replicated (where appropriate socio-cultural and resources conditions to support QI exist) in any health and care context or setting. While we can currently absorb some of the costs for further educational development and promotion on a national basis (e.g. we have dedicated project management, education and research support that we can tap into), we will need to make the case for acquiring additional funding support from different sources (e.g. our own organisation, Scottish Government or apply to the Health Foundation for spread and dissemination funding).
- We have already engaged with NES leaders and educators for a range of clinical training programmes (e.g. GP, dental, pharmacy, practice manager and nurse training) as well as external service providers (e.g. newly formed GP Quality Clusters and clinical leads; Out-of-Hours services), and care policy bodies (e.g. Healthcare Improvement Scotland). The purpose has been to explore the potential for supporting the implementation of the 'always events' concept and methods within these programmes and initiatives.
- We will also make contact with Scottish Government colleagues with responsibility for national person-centred approaches to care improvement (e.g. What matters to me) to explore similarities and differences and how the 'always events' concept can 'fit' with these initiatives and be better supported on a national basis.
  http://www.healthcareimprovementscotland.org/our_work/person-centred_care/person-centred_programme.aspx
- We also intend to make contact with colleagues in NHS England who are now leading the testing of the 'always events' with a number of frontline care providers. The purpose would be to share learning and explore how we have both approached the development and testing of this person-centred QI method.
  https://www.england.nhs.uk/ourwork/pe/always-events/
- Given the national influence, networks and support of the lead organisation, the potential risks associated with further spread and dissemination are greatly reduced. NES works closely with Scottish Government, Healthcare Improvement Scotland and territorial NHS Boards, all of whom have clear policy and implementation goals to link person-centredness with QI activity. Indeed given the Scottish Chief Medical Officer's report on '*Realising Realistic Medicine'*, the AE concept is an ideal mechanism for linking these agenda and

closing the gap in how this is actually done meaningfully for patients at the local level. Strong early indications from these NHS Scotland stakeholders are positive in terms of promoting and supporting the use of the AE concept.

- In terms of some immediate milestones we would like to achieve: 1. To introduce the AE concept into the clinical training environments of which NES has influence; 2. To introduce and promote the AE approach as evidence of Quality Improvement Activity in support of medical appraisal and revalidation for hospital doctors and GPs in Scotland (an area over which NES has influence and decision-making authority); 3. Introduce the concept in general practice either as part of a local enhanced service by an NHS Board(s) or nationally as part of the GP Quality Clusters which are currently in formation; and 4. To publish our findings in an international peer reviewed academic journal (article draft is underway) and present (oral and poster presentations) at national and international healthcare quality conferences

In terms of related conference presentations, the AE concept has been promoted at:

- Improving Patient Experience Conference, London – June 2016
- EQUiP, Dublin, March 2017
- Scottish Patient Safety Programme in Primary Care Conferences/Workshops, Glasgow and Edinburgh (2016-2017)
- NES Annual Medical Education Conference, Edinburgh – May 2017

Conclusions

- Overall project success could be rated as modest for most participating care teams, with small numbers either struggling or excelling with the idea which would be reasonably typical of any QI related intervention in its embryonic stage.
- The AE approach potentially provides a different perspective on healthcare QI by enabling a diverse range of care teams across settings to actively engage patients at a local level to ascertain and deliver on their wishes and needs when they interact with our services.
- We will now look to further test, spread and disseminate the concept more broadly through a range of education and service programmes across NHS Scotland.

Appendix 1: Resources and Appendices

Examples of AE related changes, improvements and innovations in practice

<u>NHS Greater Glasgow & Clyde Mental Health Pharmacy</u>

Clozapine Patient Information

Once the AE themes were agreed six themed cards were produced and a different card would be in their repeat prescription when coming to collect.

<u>Accident and Emergency Services, Queen Elizabeth Hospital, Glasgow.</u>

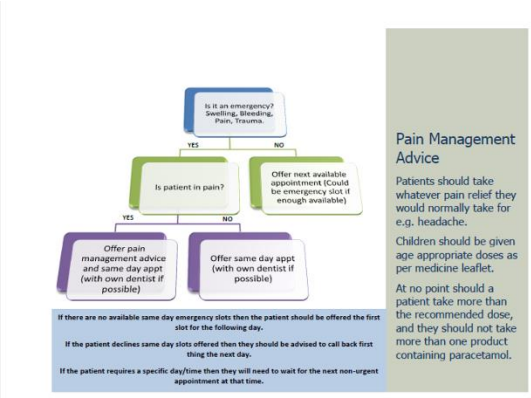
A poster has been produced which explains the process to the patient so they understand what will happen to them, these posters are now located throughout the hospital department.

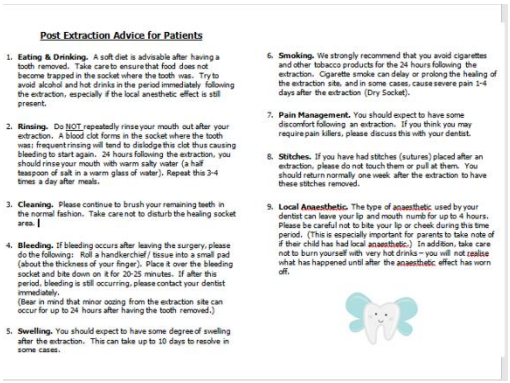
A video has also been produced https://vimeo.com/191127108

Riverbank Dental Practice, Glasgow

Changes implemented:

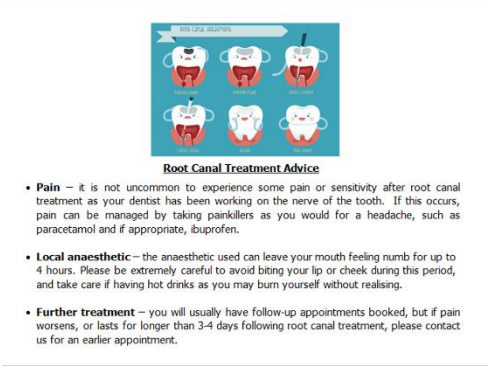
- Flowchart for dealing with calls from patients requiring emergency appointments, this included triaging to make sure patients were offered an appointment on an appropriate timescale, and pain advice
- Leaflets produced to explain what to expect after certain procedures
- Staff training in use of flowchart and distribution of leaflets
- Website updated to include generic pain management advice and copies of the leaflets





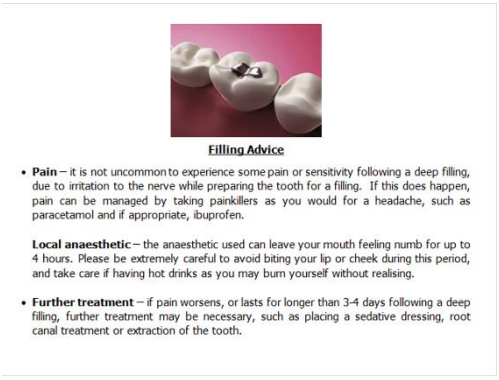
Post Extraction Advice for Patients

1. **Eating & Drinking.** A soft diet is advisable after having a tooth removed. Take care to ensure that food does not become trapped in the socket where the tooth was. Try to avoid alcohol and hot drinks in the period immediately following the extraction, especially if the local anesthetic effect is still present.
2. **Rinsing.** Do NOT repeatedly rinse your mouth out after your extraction. A blood clot forms in the socket where the tooth was; frequent rinsing will tend to dislodge this clot thus causing bleeding to start again. 24 hours following the extraction, you should rinse your mouth with warm salty water (a half teaspoon of salt in a warm glass of water). Repeat this 3-4 times a day after meals.
3. **Cleaning.** Please continue to brush your remaining teeth in the normal fashion. Take care not to disturb the healing socket area.
4. **Bleeding.** If bleeding occurs after leaving the surgery, please do the following: Roll a handkerchief / tissue into a small pad (about the thickness of your finger). Place it over the bleeding socket and bite down on it for 20-25 minutes. If after this period, bleeding is still occurring, please contact your dentist immediately.
(Bear in mind that minor oozing from the extraction site can occur for up to 24 hours after having the tooth removed.)
5. **Swelling.** You should expect to have some degree of swelling after the extraction. This can take up to 10 days to resolve in some cases.
6. **Smoking.** We strongly recommend that you avoid cigarettes and other tobacco products for the 24 hours following the extraction. Cigarette smoke can delay or prolong the healing of the extraction site, and in some cases, cause severe pain 1-4 days after the extraction (Dry Socket).
7. **Pain Management.** You should expect to have some discomfort following an extraction. If you think you may require pain killers, please discuss this with your dentist.
8. **Stitches.** If you have had stitches (sutures) placed after an extraction, please do not touch them or pull at them. You should return normally one week after the extraction to have these stitches removed.
9. **Local Anaesthetic.** The type of anaesthetic used by your dentist can leave your lip and mouth numb for up to 4 hours. Please be careful not to bite your lip or cheek during this time period. (This is especially important for parents to take note of if their child has had local anaesthetic.) In addition, take care not to burn yourself with very hot drinks – you will not realise what has happened until after the anaesthetic effect has worn off.



Root Canal Treatment Advice

- **Pain** – it is not uncommon to experience some pain or sensitivity after root canal treatment as your dentist has been working on the nerve of the tooth. If this occurs, pain can be managed by taking painkillers as you would for a headache, such as paracetamol and if appropriate, ibuprofen.
- **Local anaesthetic** – the anaesthetic used can leave your mouth feeling numb for up to 4 hours. Please be extremely careful to avoid biting your lip or cheek during this period, and take care if having hot drinks as you may burn yourself without realising.
- **Further treatment** – you will usually have follow-up appointments booked, but if pain worsens, or lasts for longer than 3-4 days following root canal treatment, please contact us for an earlier appointment.



Filling Advice

- **Pain** – it is not uncommon to experience some pain or sensitivity following a deep filling, due to irritation to the nerve while preparing the tooth for a filling. If this does happen, pain can be managed by taking painkillers as you would for a headache, such as paracetamol and if appropriate, ibuprofen.

  Local anaesthetic – the anaesthetic used can leave your mouth feeling numb for up to 4 hours. Please be extremely careful to avoid biting your lip or cheek during this period, and take care if having hot drinks as you may burn yourself without realising.
- **Further treatment** – if pain worsens, or lasts for longer than 3-4 days following a deep filling, further treatment may be necessary, such as placing a sedative dressing, root canal treatment or extraction of the tooth.

The Cairns Practice, Shettleston Health Centre, Glasgow

From the project we have drafted up a report and are hopeful that this will be published within the BMJQIR.

BMJ Quality Improvement Reports

BMJ Quality Improvement Reports 2017; u214656.w5771 doi: 10.1136/bmjquality.u214656.w5771

Patient centred improvement to repeat prescribing using Always event concept

Katherine Grosset, Elaine Deary, Nancy El-Farargy UK

Abstract

Repeat prescriptions are prescriptions issued to a patient for a second or subsequent time without requiring a consultation with a doctor. Repeat prescribing is common and an efficient system is necessary to deliver a high quality service. Always Events can be used to drive patient centred improvements in health care delivery. Our aim was to use the Always Event concept to improve our repeat prescribing system.

This quality improvement project was carried out in a deprived, inner city general practice setting in Glasgow, UK. 51 patients taking repeat medications completed short questionnaires, and the Always Event "Repeat prescriptions should be ready and available to collect" was generated. We used Plan-Do-Study-Act cycles to elucidate how our system could be improved and check if our intervention was effective.

Over a 3 day period in July 2016, 269 out of 292 prescriptions (92.1%) were ready. We mapped out the repeat prescribing process and discovered that sometimes reception staff graded a request as inappropriate, e.g. requested too early, and these requests were therefore not processed. Patients would then attend to collect a prescription that was not there, and it was time consuming for the reception staff to investigate the reason and inconvenient for the patient. Our system was changed so that any request that was not being processed was recorded and the patient informed. In September 260 out of 267 (97.4%) prescriptions were ready and in November 350 out of 364 (96.2%) were ready.

In conclusion, the Always Event approach allowed us to elicit important feedback from patients to identify a weakness in our repeat prescribing system which was simple to rectify and led to an improved, more efficient service.

Easterhouse GP Practice

ALWAYS EVENTS RELATED TO:

- Waiting times for patients when they are waiting to see a GP.
- Continuity of care for patients.

ALWAYS EVENTS PARTICIPANTS

- We randomly asked patients to complete questionnaires over a one week period. We carried this out twice at the beginning of the project and at the end.

CHALLENGES/BARRIERS

- Time is the main barrier, it can be difficult for the admin staff to hand out questionnaires, the practice manager has to analyse results and we have to meet to discuss outcome and way forward.
- PDSAs are a lovely little tool and we have used this approach for several years now. This helps us break change into small pieces of work.

CHANGES IMPLEMENTED

- Our GPs now consult at 15 minutes (it was 10 minutes in the past). This has been well received by GPs and patients and we will continue to work with this.
- Our GP partners have swapped the days they work to help with continuity. Again, patients have responded positively to this. I don't know if we will continue to swap GP sessions in the future.

RESULTS

- In our most recent patient survey, the patients have given positive feedback on waiting times. They also like having more time with their doctor.
- Patients are reassured when they can book an appointment with 'someone who knows my history' – this seems to be the main comment we get.

NEXT STEPS

We will continue to ask patients what they feel should always happen when they interact with our GP practice

Emergency Medicine, NHS Dumfries and Galloway

ALWAYS EVENTS RELATED TO:

- That all the ‘over 65s’ should be seen promptly
- be given a named nurse
- be kept informed about the investigations/diagnostic plans
- early information about plan whether discharge or admission

ALWAYS EVENTS PARTICIPANTS

The over 65s presenting with any medical or surgical condition to the Emergency Department. (the families and carers were also involved where necessary to either given an opinion or take dictation from the patient) Patients in Stream s 2 and 3 were included. Patients in Stream 1 were excluded as they were usually too unwell to be consulted.

CHALLENGES/BARRIERS

- Staff changes
- Busy department with staff involved in seriously ill patients
- Not all staff ‘buy-in’ to the concept

CHANGES IMPLEMENTED

- Named nurse & doctor
- Information around PLAN
- Timescales given

RESULTS / NEXT STEPS

- Still gathering results. Once a follow-up questionnaire has been completed then the results can be analysed.
- BMJ Report

Proposed BMJ Quality Blog

http://blogs.bmj.com/quality/

Through the lens of patients: Using 'Always Events' to drive healthcare improvements. Nancy El-Farargy, NHS Education for Scotland

What is Important to Patients?

Healthcare providers usually have a myriad of patient feedback data, but usefully listening and acting upon comments may be problematic in health and social care. This may be due to the quality of data obtained or even due to low response rates. Additionally, actual patient and family involvement in improving the quality and safety of care may prove problematic.

In bridging this gap, the "Always Event" concept aims to provide care teams with a localised method of gauging what is important to patients, and using that information to drive consistent and measurable improvements in the healthcare environment.

Always Events

Originally developed by the Picker Institute, Always Events are based on the principles of patient- and family-centred care, such as: respect for values, preferences and needs; the coordination and integration of care; emotional support; and continuity and transition [1]. At a policy level, there are calls for improving patient experiences of care, with active patient participation in treatment, and collective involvement in service design, delivery and improvement [2]. Indeed, within the Scottish context, there is a clear commitment to person-centred care provision [3,4], and there are ongoing commitments to enhancing patient safety and clinical effectiveness at all levels of healthcare [5,6]. This vision has emerged across all countries of the UK in recent years [2].

Additionally, practical improvements to person-centredness have been suggested via the five "must do with me" areas [4]:

1. What matters to you?
2. Who matters to you?
3. What information do you need?
4. Nothing about me without me

5. Personalised contact

Defining Always Events

Always Events refer to a clear set of behaviours and actions that offer [7]:

- "A foundation for partnering with patients and their families;
- Actions that will ensure optimal patient experience and improved outcomes; and
- A unifying force for all that demonstrates an ongoing commitment to person- and family-centered care."

Always Events should meet four criteria: important; evidence-based; measurable; and affordable and sustainable [7].

1. Important: Patients and families highlight the identified experience as being fundamental to care.
2. Evidence-based: The experience is known to be related to optimal care and respect for the patient.
3. Measurable: The experience can be measured and accurately determined when it has occurred.
4. Affordable and sustainable: The experience is feasible by the organisation, and does not require any substantial investment (financial or otherwise).

Based on patient feedback, a redesigned Always Event selection criteria was developed by NHS Education for Scotland (NES) [8]:

1. "Is any healthcare interaction, process or outcome that is judged by patients, carers or relatives to be a highly important determinant of care quality and experience; AND
2. Is unambiguous and specific to enable reliable measurement; AND
3. Is consistently deliverable to applicable patient groups by all relevant healthcare organisations, teams and individuals; AND
4. Is feasible as part of routine healthcare delivery."

Generating Always Events

The Always Events method engages specific groups of patients, at a local practice level, to determine their views on what they would *always* like to happen when they interact with care teams [9]. Of specific note, the concept is based on the needs and preferences of patients, as opposed to what care teams believe what patients want. Patient feedback can be obtained via patient questionnaires, interviews or focus groups, and the usual thematic analysis takes place. Should any feedback meet the 'Always Events' criteria, then it is usually helpful to use these as verbatim quotes. These Always Events can then be linked into quality improvement methods for eventual implementation into the healthcare environment.

Examples of Always Events

In the Scottish primary care context, the following four Always Event themes emerged [8]:

1. Emotional support, respect and kindness
2. Clinical care management
3. Communication and information
4. Access to, and continuity of, healthcare

Examples of candidate Always Events include [8]:

- "I want to see the doctor or nurse who best knows me"
- "I want all practice team members to show genuine concern for me at all times"
- "I want the correct treatment for my problem"
- "I want the clinician who sees me to know my medical history"

Quality Improvement Projects

Once Always Events have been gathered and noted, it is important to practically think about how this could 'look' to patients and link them to care processes. Thought also needs to be given to ongoing measurement and a potential target [8].

- Always Event: "I want all practice team members to show genuine concern for me at all times"
- Link to care process: Staff have good communication and listening skills and are able to empathise with patients, as appropriate.

- How to measure: Observation of staff and patient satisfaction feedback data (specifically relating to staff interaction with patients).

These links to care and measurement processes should be discussed with all team members, and data can be gathered at specific timeframes. Incremental changes can thereafter be implemented in discussion with the care team.

Working with Care Teams

Through a highly competitive process, NES has been successfully awarded funding by The Health Foundation [10,11], to test and explore the Always Events concept with diverse care teams. The project is part of 21 teams taking part in Round 2 of the 'Innovating for Improvement' programme, which aims to improve health care delivery or the way people manage their own health care through the redesign of processes, practices and services. The project has recruited teams from acute, primary and mental health care and so far, has introduced them to the concepts of Always Events, quality improvement and person-centredness. Care teams will be working with priority patient groups to collect feedback and generate a list of Always Events.

Summary

In conclusion, the Always Event method allows practitioners to really focus on what matters to patients and to link quality improvement with person-centred care. Attention is shifted from patient experience surveys to the long terms needs and preferences of patients and families. These Always Events are captured directly from patients (and their families) and form the basis of spreading improvements in health and care processes, at individual, care team, organisational and system-wide levels. The potential of such work simply cannot be underestimated.

References

[1] Picker Institute, Always Events ® for Communication and Care Transitions: An Idea Guide, Camden, Maine, 04843, 2011. http://alwaysevents.pickerinstitute.org/wp-content/uploads/2011/10/2-FINAL-Always-Events-for-Communication-and-Care-Transitions1.pdf.

[2] N. Ahmad, J. Ellins, H. Krelle, M. Lawrie, Person-centred care: from ideas to action, The Health Foundation, London, 2014. http://www.health.org.uk/publication/person-centred-care-ideas-action.

[3] Scottish Parliament, Parliamentary Business: 05 November 2013, (2013). http://www.parliament.scot/parliamentarybusiness/BusinessBulletin/69495.aspx (accessed July 1, 2016).

[4] Healthcare Improvement Scotland, Person-Centred Health and Care Programme, (2016). http://www.healthcareimprovementscotland.org/our_work/person-centred_care/person-centred_programme.aspx (accessed July 1, 2016).

[5] Scottish Government, The Healthcare Quality Strategy for NHSScotland - putting people at the heart of our NHS, (2010). http://www.gov.scot/Publications/2010/05/10102307/0 (accessed August 16, 2015).
[6] Scottish Government, A National Clinical Strategy for Scotland, (2016). http://www.gov.scot/Resource/0049/00494144.pdf.
[7] Institute for Healthcare Improvement, Always Events Getting Started Kit, Cambridge, MA, 2014. http://www.ihi.org/resources/Pages/Tools/AlwaysEventsGettingStartedKit.aspx (accessed January 26, 2016).
[8] P. Bowie, D. McNab, J. Ferguson, C. de Wet, G. Smith, M. MacLeod, et al., Quality improvement and person-centredness: a participatory mixed methods study to develop the “always event” concept for primary care, BMJ Open. 5 (2015) e006667. doi:10.1136/bmjopen-2014-006667.
[9] P. Bowie, J. McKay, D. McNab, C. de Wet, The past, present and future of patient safety education and research in primary care, Educ. Prim. Care. (2016). http://www.tandfonline.com/eprint/eEzzbG3qI76tIK3DGKZ6/full (accessed February 12, 2016).
[10] The Health Foundation, Twenty-one innovative projects are selected to improve the quality of health care, (2015). http://www.health.org.uk/news/twenty-one-innovative-projects-are-selected-improve-quality-health-care (accessed January 19, 2016).
[11] NHS Education for Scotland, “Always Events” to put patients and service users at the heart of care, NHS Educ. Scotl. Website - Media Release. (2016). http://www.nes.scot.nhs.uk/newsroom/media-releases/always-events-to-put-patients-and-service-users-at-the-heart-of-care.aspx (accessed June 23, 2016).

NHS Education for Scotland Resources on Always Events

Online information and resources

http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/patient-safety-and-clinical-skills/always-events.aspx

BMJ Open Link to original NES Academic Paper on Always Events

http://bmjopen.bmj.com/content/5/4/e006667?sid=2236cfe0-f9a8-46c7-9ff4-2325d4a5db96

Project timeline: intended versus actual progress

Original Project Timeline	Actual Progress
Set-up phase (February-March 2016) - Form steering group and finalise project planning, preparation and goals - Form evaluation sub-group and finalise project theory; short, interim and long term project aims/goals, and linked learning and improvement measures/date collection methods (to be illustrated in a Logic Model) - Design of dedicated webpage/online community of practice for project team and short e-learning intervention outlining problem and proposed solution and with downloadable information (10 minutes) - Start care team recruitment process	**All completed, basic and accessible e-learning module is in development to be completed by April 2017**
1st Phase (May-September2016): - 2nd steering group meeting/meeting of evaluation sub-group - Recruitment completed and participants are aware of community of practice online resource - 1st Learning Set (March 2016) - Baseline qualitative & quantitative measures captured (participants and steering group) - Co-design of AE method and selection criteria	**Steering group met, successful recruitment of 18 teams, 1st learning set was held, baseline evaluation and project data captured and analysed** **Co-design of AEs began during action period**
2nd Phase (October-February2017) - 3rd Steering group meeting/meeting of evaluation sub-group (mid-project corrections) - Action Period (testing, data collection, improvement) - Interim qualitative & quantitative measures captured (participants, steering group)	**Steering group meeting held, action period for participating teams, 2nd learning session was actually held at this stage (treated as mid-point)**
3rd Phase (March-April 2017 - 4th Steering group meeting/meeting of evaluation subgroup - 2nd Learning Set - Further qualitative & quantitative measures captured (participants, patients and steering group) - Triangulation and verification of final project and evaluation data measures - 6th Steering group meeting - Project and evaluation report drafts - Finalise dissemination of findings/communication plan - Finalise spread plan - Prepare results for journal publication/conference presentations	**3rd phase involved a steering group meeting, final learning set was held here, final evaluation and project data was collected. Initial project delay after a change of organisational leadership led to some re-alignment of timescales and priorities, meaning we finished only slightly later than anticipated** **Data analysis complete, report drafted, finalising plans for spread and dissemination and preparing an academic publication**