

Remobilising elective care

Sharing innovations from across Scotland
webinar 3



Thomas Monaghan
National Programme Director for Access QI
Healthcare Improvement Scotland

Access QI



We support NHS boards to use their quality improvement expertise to improve waiting times.

Access learning system



Maximising service capacity and capability



Managing the physical environment



Enabling digital access



Maintaining staff safety and wellbeing

Agenda

Topic	Speaker(s)
Welcome and Introduction	Thomas Monaghan, National Programme Director Access QI, Healthcare Improvement Scotland
Measuring and understanding capacity	Toby Stead, Data & Measurement Advisor Data, Measurement & Business Intelligence, Healthcare Improvement Scotland
Maximising service capacity and capability, innovations from NHS boards	Working with health and social care partnerships to reduce waiting lists, Alison Molyneux, Care Home Dietician, NHS Greater Glasgow and Clyde Designing a patient initiated follow-up pathway to improve quality of care, Dr Robin Munro, Clinical Lead for Rheumatology, NHS Lanarkshire Using infographics to increase staff confidence, Dr Stefanie Lip, ST5 in Clinical Pharmacology & Therapeutics and GIM, NHS Greater Glasgow and Clyde
Close	Colette Dryden, Improvement Advisor Access QI, Healthcare Improvement Scotland

Measuring and understanding capacity

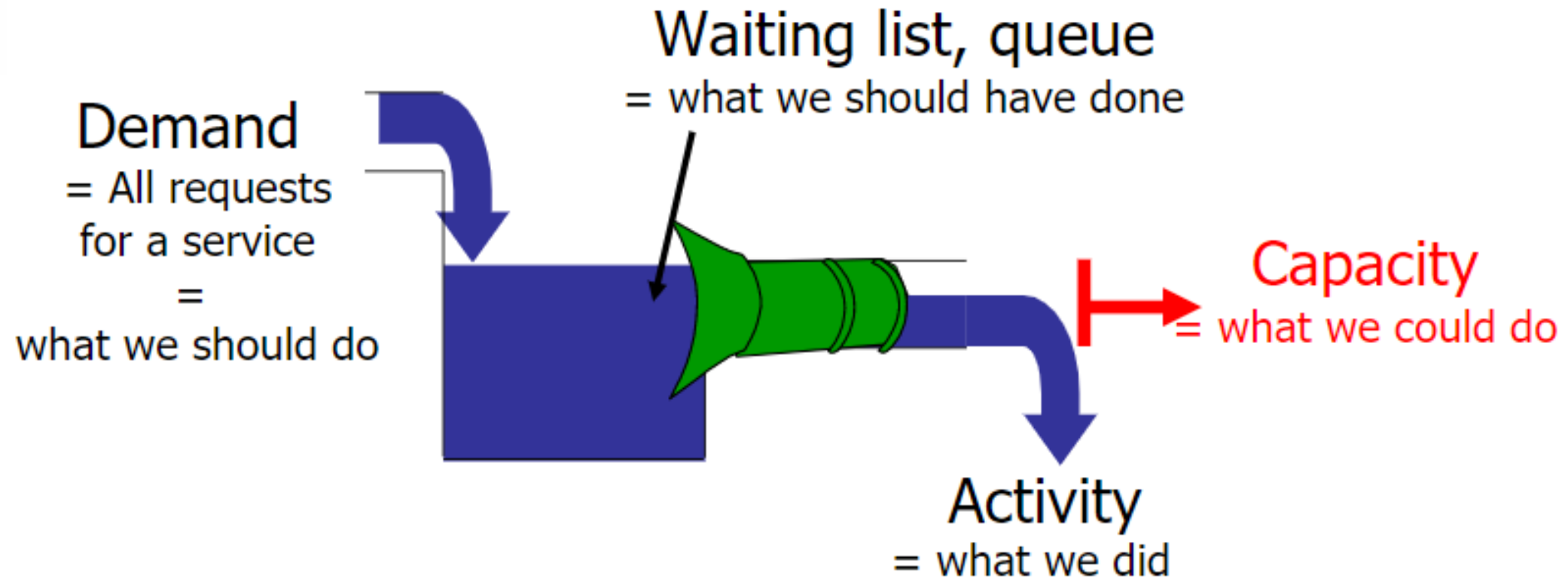


Toby Stead

Data & Measurement Advisor

Data, Measurement & Business Intelligence,
Healthcare Improvement Scotland

Concepts

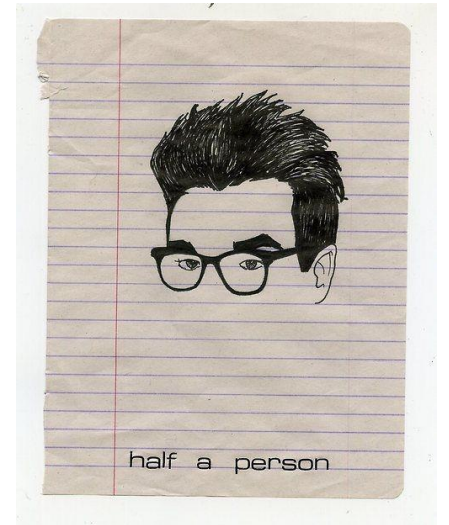


Any ideas?

- Number of sessions
- Number of new patients
- Clinical contact time

Constraints

- Hours of service
- Room availability/physical environment (CV19)
- Equipment & shared resources
- Non-clinical work



*If you have 5 seconds to spare,
I'll tell you the story of my life...*

Pessimistic

- Number of available sessions
- Weak from an improvement perspective – good as an outcome measure for improving “capacity” but doesn’t actually tell you anything, or tell you what you need to improve

Optimistic

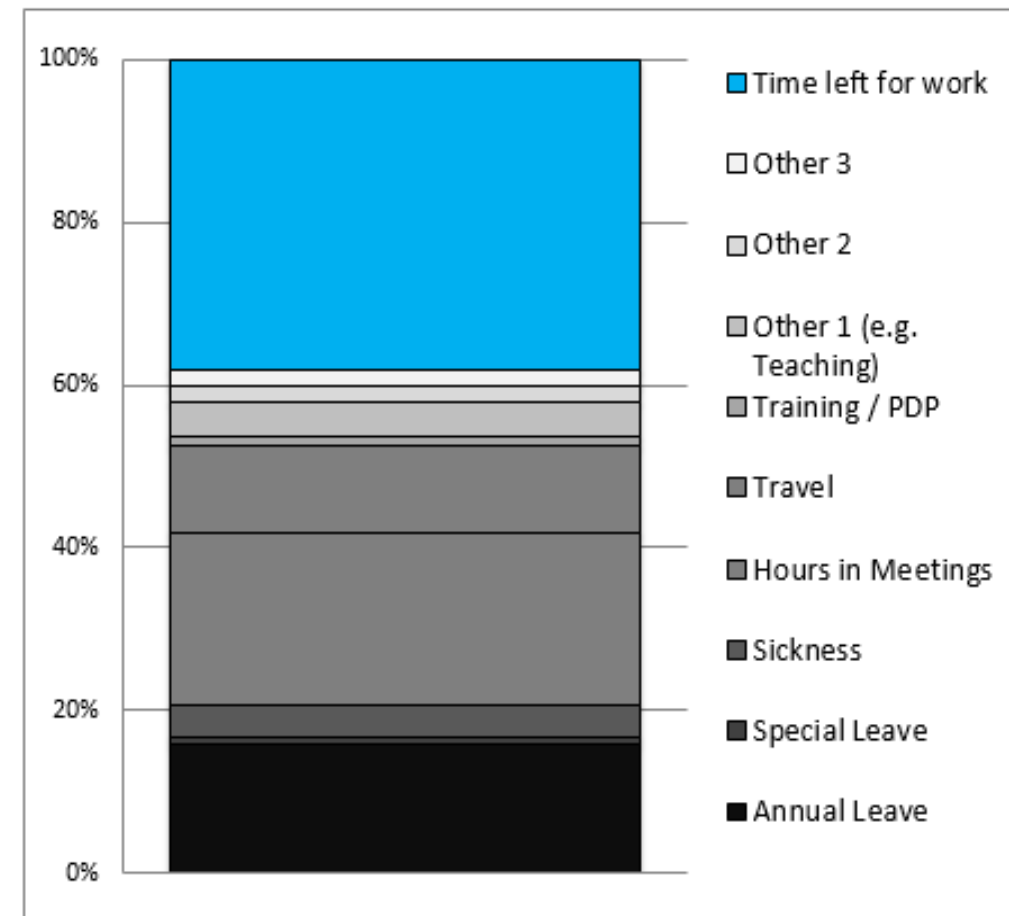
- Job planning
- Team Service Planning
- Says how much availability there would be if job plan is perfectly adhered to

Realistic

- [Capacity calculator](#)
- Shows how much time is available for clinical work after everything else is taken care of
- BMA offer an activity tracking tool to members (most/all consultants)

Capacity Calculator (example)

	Activity	Frequency		Days per Year	%	Days per week
	Contracted Hours	per week	37.5	260	100%	5
Non-work time	Annual Leave	days per year	41	41	16%	0.8
	Special Leave	%	1%	3	1%	0.1
	Sickness	%	4%	10	4%	0.2
In work activities	Hours in Meetings	hrs per week	10	55	21%	1.1
	Travel	hrs per week	5	27	11%	0.5
	Training / PDP	days per year	3	3	1%	0.1
	Other 1 (e.g. Teaching)	hrs per week	2	11	4%	0.2
	Other 2	hrs per month	4	5.1	2%	0.1
	Other 3	hrs per week	1	5.5	2%	0.1
	Time left for work	hrs per week	14	99	38%	1.9



Top tips

- Scale with volume of demand
- DCAQ is all of them together, interrelated, not in isolation
- Units – needs to be same across DCAQ
(patients/time/sessions)

Maximising service capacity and capability



Colette Dryden
Improvement Advisor for Access QI
Healthcare Improvement Scotland

Working with health and social care partnerships to reduce waiting lists



Alison Molyneux: Care Home Dietitian
NHS Greater Glasgow and Clyde
Alison.Molyneux@ggc.scot.nhs.uk

Challenge

The number of residents in care homes with a diagnosis of COVID, potentially leading to unplanned weight loss and malnutrition would increase need for Dietetic Assessment and intervention.

Provide access to information to support care homes to respond quickly to support the nutrition and hydration needs of residents in care homes during COVID and on their journey to recovery and rehabilitation.

Innovation

- **Key information from international nutrition webinars were summarised on A3 Posters with QR reader codes and A4 infographic This provides easy access to consistent messages and best practice.**
- The importance of maintaining good nutrition and hydration in vulnerable groups during and post COVID was emphasised.
- **Posters and infographic were disseminated electronically and by post/hand to every care home in NHS GG&C**
- Care providers are displaying this information in their clinical areas to provide quick access to nutrition and hydration messages to support assessment and management of residents' nutritional wellbeing to maintain their quality of life.

COVID-19: Good Nutrition & Hydration Helps Recovery

Top tips for Care & Residential Homes

During critical stages of C19:

- significant weight loss
- muscle loss
- poor appetite
- altered taste
- reduced mobility
- dysphagia related to being intubated



Good nutrition and hydration can:



prevent further infection
prevent skin breakdown
improve quality of life
minimise weight loss
Improve muscle mass

Complete **MUST** Step 5

Nutritional
Management Plan

» liaise with specialist nurse / HCP

Review food &
fluid likes and
dislikes



monitor
intake

Maximum energy &
protein options

Food fortification



» liaise with Catering Team



weigh
weekly

or mid-upper arm
circumference monthly

Assist
if required



High protein
snacks &
nourishing drinks

encourage

mobility



DYSPHAGIA

occurs in **30%**
post being intubated

SLT Assessment ?
Correct consistency ?

TASTE CHANGES

Use **strong flavours**

offer
condiments



DIABETES

During infection
monitor **BLOOD GLUCOSE**

Target **7 - 12 mmol/l**



scan for more info

Produced by the Care Home Dietitians, NHS Greater Glasgow & Clyde (May 2020)

Outcome

As most of the care homes were on lock down to the local community to limit COVID spread, the feedback comments have been received have been from the care providers and professionals staff.

- ✓ Providers very much valued the accessible, easy read format
- ✓ The specialist nurses supporting the care homes who were continuing to provide face to face support appreciated the clear direction and key messages provided
- ✓ This guidance is providing ongoing support in maintaining resident health and well-being in the management of any potential Dietetic referrals.

For further information please refer to : <https://www.nhsggc.org.uk/your-health/health-services/allied-health-professionals-ahps/dietetics/care-homes-overview/covid-nutrition-care-homes/>

Designing a patient initiated follow-up pathway to improve quality of care



Dr Robin Munro
NHS Lanarkshire
Clinical lead for Rheumatology

Challenge

Challenges

- Medical staff return capacity running at 100% and new capacity 108%
- Discharge rate 49% for new patients but 4% for returns
- Difficulty find space for urgent returns with the appropriate member of staff
- Introducing new ways of working, staff resistance and training needs
- Rheumatology historically is a very 'hands on' specialty

Opportunities

- Disease activity has improved substantially in the last 20 years
- An audit of returns showed 82% of patients were classified as stable
- Experience building to suggest that more remote follow up was safe
- Already a good skill mix within the Department

Innovation

Stepwise changes

- Consulted colleagues and patients what ideal follow up would look like
- Longer review periods with the opportunity for rapid review when necessary
- Modelling of changes with team from Strathclyde University looking at how any alteration of clinic profiles would affect patient flow
- Utilisation of ePROMS to gauge disease activity between clinic appointments
- Use of nurse led telephone review clinics to review patient and ePROMS at 1 year with more formal face to face assessment at 2 years
- Freeing up of clinic space to allow urgent reviews when patients need seen

Outcome

Was due to launch at a single site in June 2020 however Covid intervened

Recovery planning has required all clinic profiles to change so it is an opportunity to expand the original scope

Current situation

- Strathclyde University team are updating their demand/capacity analysis to allow new clinic profiles to be developed
- Update patient group with current plans and get their feedback
- Launch date provisionally March 2021 involving all 3 acute sites in NHSL

Using infographics to increase staff confidence

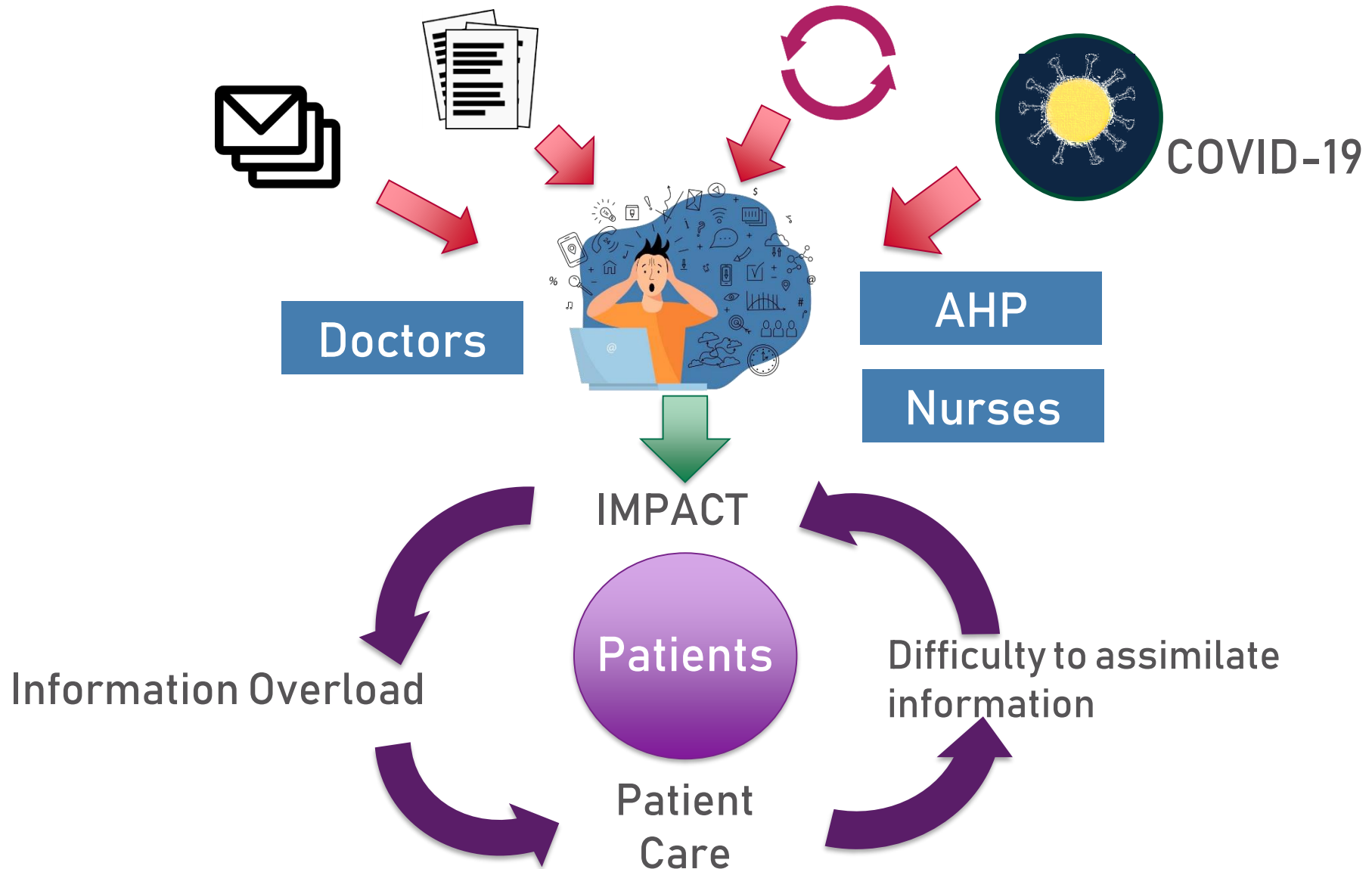
"A picture is worth a thousand words"



Dr Stefanie Lip
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Challenge



Innovation

What was implemented to address the challenge?



COVID Related Clinical Guidance

Guide to Clinical Evaluation of Suspected COVID patients

Clinical

- Clinical Symptoms: Dry cough (occasional sputum), Fever, Dyspnoea, Fatigue / Myalgia, Confusion
- Other symptoms: High fever and/or prolonged fever, High oxygen saturation, High respiratory rate

Oxygen

- Suspected COVID pneumonia: Target SpO2 94-96%
- If COPD or risk of hypercapnia: Target SpO2 92-94%
- Consider providing ward patients with an oxygen requirement

Bloods

- CRP may be raised or normal and does not reflect presence of bacterial co-infection
- Lymphopenia is common
- Thrombocytopenia may occur
- NT Pro BNP, Troponin and D-Dimer may be elevated and need to be interpreted with caution

Imaging

- CXR: Typical initial presentation is bilateral peripheral ground glass opacities
- Chest CT only if will change management

Differential Diagnosis

- Patients are likely to have comorbidities
- Always consider other diagnoses or dual pathology including bacterial pneumonia

Treatment Escalation Plan (TEP) required for all suspected COVID patients

Drugs to think about in suspected COVID patients

- VTE Prophylaxis**
 - The risk of VTE is increased
 - Ensure VTE prophylaxis prescribed unless contraindicated
 - Refer to Thromboprophylaxis in COVID-19 Patients (NHS/GCC Guidelines)
- Dexamethasone/Steroids***
 - Dexamethasone 6mg daily is indicated if 1. COVID suspected or confirmed And 2. Supplemental O2 required And 3. Adult (in pregnancy use 40mg prednisolone or IV hydrocortisone 400mg bd)
 - Duration 10 days (stop if alternative diagnosis or discharged before this)
 - Check blood glucose 4x daily
 - * Refer to NHS/GCC Therapeutics Handbook
- Remdesivir***
 - Antiviral treatment for severe cases only (SpO2 ≤ 94% on room air or requiring supplemental oxygen or ventilatory support)
 - Discuss with senior colleague/pharmacy
 - * Refer to NHS/GCC Therapeutics Handbook
- Antibiotics**
 - Most patients do not require antibiotics
 - Infective Exacerbation COPD with purulent sputum:
 - Doxycycline 200mg oral twice daily or Amoxicillin 500mg thrice daily (5 days total)
 - Suspected Bacterial Pneumonia:
 - Follow NHS, GCC, CAP, guidelines, however NOT ASSESS
 - Micro/ID/Resp advice
 - Oral Doxycycline may be used for typical cases
 - Suspected Hospital acquired pneumonia:
 - Respiratory: Doxycycline 200mg 12 hourly or Co-trimoxazole 960mg 12 hourly (5 days)
 - Severe (to amoxicillin 1g 6 hourly)
 - Levofloxacin (if penicillin allergy) and usually 5 days
 - Remember:
 - GI: (levofloxacin), Drug interactions (doxycycline-levofloxacin)
 - IVOST when improving

HOW TO TAKE BLOOD SAMPLES

Requires 2 members of staff

Pre-label blood sample tubes before entering room
With the exception of Group and Save samples which must be handwritten at the bedside.
In this circumstance please leave pen in patient room once labelling complete or ensure it is cleaned with 70% isopropyl alcohol after use.

HCW 1 puts on PPE and goes into patient room and takes samples as normal

HCW 2 wears gloves and waits outside of room- no need for full PPE

Once samples obtained, HCW 1 informs colleague outside of room who can open door

HCW 1 drops samples into clear specimen bags held by HCW 2 at the door to the room, without touching the bag or colleague

HCW 2 holds out sharps box and sharps are dropped into this by HCW 1

HCW 1 then goes back into room non-sharps waste can be put in clinical waste stream

HCW 1 doff PPE in room, perform hand hygiene

How to clean your reusable eye protection (visor/goggles)

Do not touch the front of the mask/eye protection as it is contaminated

Remember to write your name in indelible ink on your eye protection

- Removal of PPE**
 - Remove gloves and apron
 - Perform hand hygiene after each patient contact
 - Once clinical session complete
 - Remove eye protection and place on trolley
 - Remove mask from behind
- Inspection of eye protection**
 - Perform hand hygiene
 - Put on clean apron and gloves
 - Inspect eye protection - Discard if not intact or there is visible contamination with blood/body fluids
- Cleaning of eye protection**
 - Clean eye protection with detergent wipe then an alcohol wipe. Repeat this cleaning process for the elastic/strap
 - Clean trolley with an alcohol wipe
 - Remove gloves and apron
 - Perform hand hygiene
 - Clean visor to be kept in clear plastic bag

COVID-19 Scottish Primary Care Hub Triage Guide

Clinical Course

At risk of deterioration

- Increasing age over 50
- Male sex
- BAME populations
- Chronic cardiac disease
- Chronic non-asthmatic respiratory disease
- Chronic kidney/liver disease
- Chronic neurological disease
- Malignancy
- Cerebro

1. Connect

Get prepared

VC possible?

Confirm Patient ID

Location

Contact Number

2. Clinical triage

If they sound or look very sick - such as shortness of breath - go direct to red

Establish what the patient wants out of the consultation

General assessment

Respiratory function (especially inability to talk in full sentences)

Over video

General assessment?

Skin colour?

Respiratory rate?

3. COVID most likely diagnosis?

Yes? No? CFS? 7? ACYD/ACPR?

4. Clinical Frailty Score

Frailty

Do they need help with walking or driving?

Assessment at home

Do they need help with walking or driving?

Do they need help with walking or driving?

Patient information leaflets

1. WE WILL HAVE TO TAKE ABOUT DYING: COVID-19

ALL CHANGING, SOME MORE IN A SUDDEN AREA

HOW CAN WE DO THIS WITH CONFIDENCE AND EMPATHY?

OPENNESS COMMISSION DIGNITY

2. WHY IS THIS SO HARD?

BEFORE TIME

DEATH

HOPE

EXPECTATIONS OF TREATMENT

EMOTIONS

3. SUPPORT + PREPARATION

YOU ARE NOT ALONE

WE DON'T GET IT RIGHT EVERY TIME

IT'S OK TO FEEL ANNOYED + FEARFUL

LISTENING

POWER OF SILENCE

LEAVE SPACE FOR QUESTIONS

4. THINGS YOU MIGHT SAY...

WHAT I'M SAYING IS HARD TO HEAR

IT'S IMPORTANT TO BE HONEST WITH YOU

WE ARE IN A DIFFERENT PLACE NOW

THIS IS YOUR FINAL JOURNEY

5. REDMAP FRAMEWORK

R - READY

E - EMBELLISH

M - MATTERS

A - ACTION

P - PLAN

CHAMPA TALK ABOUT YOUR CARE?

WHAT DO YOU KNOW/ WANT TO KNOW?

WE KNOW/DON'T KNOW

WHAT MATTERS TO YOU?

THIS CAN HELP/ THIS WILL NOT HELP/ LET'S PLAN AND CARE FOR YOU + YOUR FAMILY

What is Orthostatic Hypotension (OH)?

When we sit or lie down, blood pools in the legs.

If you have OH, the body is slower to push the blood back up to the brain when you stand.

This may cause dizziness or light headedness. It can cause falls and/or blackouts in some people.

It is therefore important to take care when you stand up.

Symptoms are often worse in the morning or overnight so take care at these times.

Lots of medications can cause OH, your doctor will review this.

What is Vasovagal Syncope (VVS)?

Fainting occurs when your blood pressure drops and the blood is slower to reach the brain.

Your heart may also slow down for a short time.

You may look pale and feel dizzy, sweaty, or sick.

Sounds may become distant and your vision may be blurred.

It can cause blackouts in some people.

Certain triggers can cause this and recognising your own triggers is key.

Examples would include:

- Standing or sitting still for a prolonged period
- Dehydration or extreme heat
- Stressful or emotional situations
- Seeing blood or having an injection

Vasovagal syncope is not life threatening and with the following measures most people will be able to control their symptoms.

Outcome



Confidence

In the management of COVID-19

Feedback Survey

130 responses, 4 NHS GGC sites

Impact

Improving patient care and giving confidence to all healthcare professionals

Digital age (posters are still preferred)



Confidence



Accessibility

Acknowledgements



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@ericamcmillin



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@Openchangeuk



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@laramitchdr

Next Steps

- The next webinar will be on 3 December 2020, [register now](#)
- Do you have an innovation that you would like to share?
Then please [get in touch](#) 😊

Keep in touch



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