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Contents

QI Case Study 1
Introducing regular health checks for patients with learning disabilities 3

QI Case Study 2
Reorganising the administration for trainee reviews 5

QI Case Study 3a & 3b
Text messaging reminders 7

QI Case Study 4
Implementing a 3-week waiting time target for appointments 10

QI Case Study 5
Streamlining patient compliance aid provision 12

QI Case Study 6
Streamlining hospital admissions processes 14

QI Case Study 7
Reviewing the patient records held: culling and destroying 16

QI Case Study 8
Key administrator role in the multi-disciplinary team (MDT) 18

QI Case Study 9
Improving the PINNACLE database using process mapping 20

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Introducing regular health checks for patients with learning disabilities

Joanne Gibson is a practice manager in NHS Ayrshire & Arran. In this case study, she describes the work undertaken by her team to help improve services for patients with learning disabilities.

Tell us a bit about the problem or opportunity which prompted this piece of work: There is a range of measurable services that can be provided in general practices. Amongst these is the need to develop and maintain a register of patients (over 16 years) with learning disability. Practices agreeing to provide learning disabilities enhanced services are asked to offer three-yearly health checks for these patients, or to refer them to a specialist service for review.

Following review of our register, our practice identified benefits in providing these checks more often for this vulnerable group of patients.

Why was it important to make a change? Many of the patients have both physical and psychological problems that can be helped by regular review and referral where needed. This allows them to build up familiarity with the surgery, the clinical and admin staff and remove some of the fears patients in this group may have.

Many of these patients do not access the surgery readily. When they do attend, their learning disability means that, in a busy surgery session, it can be difficult for the clinical staff to deal appropriately and provide the level of care they would like to. A routine 10 minute appointment does not allow for the level of input required. As a practice team, we wanted to do something about this situation to assist this group of patients.

What did you decide to do? We decided to introduce annual reviews, with the practice administration staff carrying out the administration, the practice nurse seeing the patients and the GPs being brought in where needed. In addition, we enlisted the help of a Primary/Acute care liaison nurse from the South Ayrshire Learning Disability Service. This nurse was involved in setting the clinics up and now works with the practice nurse during the clinic sessions.

How did you go about making the changes needed? We already ran a variety of clinic sessions so we knew many of the issues we needed to beware of. Particular issues we needed to consider were communication, appointment length, information and resources needed, and the recall system.

As communication can be a key issue in providing the services that this group need, we needed to ensure that the appointment letter was appropriate and understandable. We knew that some people may need reminding about their appointment and that, for some, it can be beneficial to have carers with them and involved in the review.

Taking into account the need for time to
communicate appropriately and respond to individual needs, we set our appointment time at 60 minutes.

Bearing in mind communication issues and that we can all have difficulty in understanding and remembering all of the information from an appointment, we all worked together to find suitable leaflets and to ensure that information was provided in the best way possible. We telephoned the patient to arrange the appointment, and followed up with a letter. We also made a reminder call a day or two before the appointment. Where possible, we also updated our practice records to ensure that we had appropriate carer information. We all had different experiences and knowledge that fed into this process and this proved beneficial.

We had to ensure that we complied fully with legislation around assessing the person’s capacity to make decisions, to attend appointments, and to give consent to any treatments. All of this needed to be recorded. GPs were involved in the assessment. These capacity forms need to be updated every three years.

What results have you seen since making this change?
This group of patients are often unable to recognise the signs and symptoms of ill health and may have a number of undiagnosed conditions at any one time. Problems have been routinely picked up at their health checks and positive outcomes for the individuals have been achieved. Many services and opportunities are available through the learning disability service which primary care staff may not have been aware of prior to the collaborative approach which is now taken. The practice staff now have more insight into what is available for our client group.

The practice is now able to pick up physical and psychological problems earlier than we would have before, as many people in this group do not easily or readily access health services unless prompted. And we can take into account lifestyle and wellbeing factors in addition to other problems.

Has making this change resulted in any unexpected benefits for patients or for your team?
The patients have benefitted from the two-pronged approach as many of them have been referred to other services which can benefit their physical or mental health. For example, one particular lady was referred to occupational therapy when she attended her health check because she felt isolated in her own home. She now attends a cooking group where she is not only learning a new skill but is also benefitting from the social interaction this has brought to her. Working together with a colleague from another service has given us a greater appreciation of each others’ roles, and increased insight into what each of our services can offer. It has also resulted in better communication between the services, which can only lead to benefits for the patient, and has allowed us to gain an understanding of how to improve our communication with this group of patients.

A final benefit for us in the practice has been feedback from others on our project. A poster describing the project was awarded a prize at this year’s Practice Managers’ Conference. We felt that this showed how interested other colleagues in the service might be in this change we have made to practice.

Key Points
Joanne highlights the key points which helped make this project a success:

• Setting up and running this service has shown marked benefits for this patient group.

• The change has been achieved by the whole team working together - if we hadn’t worked in this way the results would have been very different.
Reorganising the administration for trainee reviews

Ashleigh Stewart is a postgraduate training support assistant working with NHS Education for Scotland (NES). In this case study, she describes how her improvement idea helped the support team work more efficiently.

Tell us a bit about the problem or opportunity which prompted this piece of work:
Doctors in training have their progress reviewed annually. I liaise with the different Training Programme Directors (TPDs) in order to organise the reviews.

Individual TPDs have different ways of going about this, and may require different information on the day to allow the review to go ahead. This means that a range of information is needed to set up the review appointments, and this is different for each TPD. Knowing what the right information is and collecting it is the responsibility of a group of administrators.

Why was it important to make a change?
Some administrators may know how their TPDs like their reviews to be run. However, if you are organising reviews for a number of specialties, it can be difficult to keep track of them all. The usual system for keeping track of the information requirements has been to print out e-mail correspondence and keep this in separate folders. If an administrator is on annual leave or is ill, it can take some time to look through numerous e-mails to find out how the TPD would like to run the reviews.

I recognised that if standard information was available to all of the administrators, then we would all be able to find out the information wanted by all of the TPDs and be able to set up reviews if the colleague usually dealing with this was not available.

What did you decide to do?
I suggested to my manager that we send a generic questionnaire to each of the TPDs to collect details of the information they wanted for reviews. The TPDs could also add details of any other requirements and this would help to streamline the service.

How did you go about making the changes needed?
This suggestion was discussed at a team meeting. I then created the generic template and this went out for discussion and comment straight away.

At the time of writing, we are piloting the questionnaire with the TPDs and I am awaiting feedback from them and from colleagues.

What results have you seen since making this change?
This is still work in progress but we are hoping that it will cut back considerably on work. The new system should only require one e-mail to the TPD attaching the questionnaire and one e-mail back from the TPD with the completed questionnaire.
Key Points

Ashleigh highlights what she has learned from undertaking this piece of work:

• Collecting information in a standardised way makes it much easier for any team member to arrange a review, making the processes more efficient.

• Having standard information can save everyone’s time, from the staff organising the review to the trainee and programme director. It is also clear what each TPD needs for their reviews.

• Other administrators can access the information easily and all in one place if an administrator is on annual leave or off sick.
Case Study 3a & 3b

Text messaging reminders

Susan Hogg is PA to the Director of Pharmacy in NHS Borders. In this case study, she describes how she helped to introduce text messaging reminders when she was team secretary with the Community Addictions Team1. Her successor as team secretary, Ashleigh Triebel, describes how the new service has developed since it was first introduced.

a) Introducing the system: Susan Hogg

Tell us a bit about the problem or opportunity which prompted this piece of work:
I was working as a Team Secretary with the local drug and alcohol services and a lot of our clients were missing appointments, for a number of reasons. These reasons included delays in the post, which often meant that their letters didn’t arrive in time. Also, clients may have been away from home or the appointment may have been sent at short notice – and many clients simply forgot. This meant that a lot of time was wasted and there was an impact on waiting lists.

I had read in the newspaper about another Health Board who had started to use text messaging and thought this might be useful for us. I thought it could be the easiest and most direct way for us to get in touch with clients.

What did you decide to do?
I decided that it would still be a good idea to send out an appointment letter. However, I also thought that sending a reminder by text on the day of the appointment would be important as most of our clients have mobile phones that they always have with them.

How did you go about making the changes needed?
I discussed my idea with my managers and the wider team. With their agreement, I got an old office mobile phone and started to collate mobile numbers, some of which were already included in the clients’ contact details. At first, we didn’t have many numbers, but we gradually managed to build up the information by asking clients themselves and by asking GPs to provide mobile numbers for new referrals.

We had to think carefully about what the message would say, bearing in mind the need to maintain confidentiality.

How long did it take for the change to be effective?
Introducing the text message reminders on the day of an appointment was effective from the start and the service has now been running for around seven years.

What results did you see after making this change?
The texting system had an important impact on the numbers of clients missing appointments. We had an increase in the size of the team, and therefore...
in the number of appointments – but no related increase in Did Not Attend (DNA) rates.

Although the system did mean that around half an hour of staff time was needed in the morning to send the text messages, this was more than made up for by the time saved for administrative and clinical staff in reducing other work related to the DNAs.

Reducing the DNA rate also allowed the service to be more efficient and has contributed to meeting targets e.g. around waiting lists and times.

Did making this change result in any unexpected benefits for patients or for your team?
Clients began to text us to cancel appointments rather than simply not turn up, knowing that they would not be questioned about why they were cancelling or being confronted with other questions which might be off-putting for them. Some of them also began to text to ask about their next appointment or saying that they had not received a letter when expected.

Using this system, we were also able to let them know about changes in their appointment times or location, and, if necessary, rearrange their appointment more easily at short notice and with the minimum disruption for everyone involved – both clients and staff. The use of texting meant that our communication with clients became more effective and efficient.

Knowing that clients had cancelled their appointments allowed clinical staff to use this time for other activities rather than spending it waiting for the client.

Key Points

Susan highlights the key benefits of introducing this change to the system:

- Text messaging has reduced the DNA rate for the service.
- The new approach contributed to the more effective use of staff time.
- This facility provided clients with a way to communicate with the service which is comfortable and convenient for them.
- The text service reduced the potential for problems for both clients and staff which can result from clients not receiving information about their appointments.

1 This Case Study was originally published in the 2008 edition of ACCESS – the newsletter of the NES ACS Project. Download at http://www.nes.scot.nhs.uk/search.aspx?maudiencestaff=Administrative+services&q=access
b) Refining the system: Ashleigh Triebel

We have read about the system of text messaging introduced as a result of Susan’s idea. Tell us a bit about why you wanted to update the system:

There has been further development over time of the reminder text initiative which started around seven years ago. As time has passed and the reminder texts have proved to be a valuable service, we have looked at how we could continue to improve the service.

As the service has grown, there have been increasing numbers of texts to be sent and we thought about how this could be done using a computer, rather than a mobile phone – especially as technology has moved on and the whole team have improved IT skills.

How did you go about making a change?
In collaboration with the IT department, we decided that using Microsoft Outlook and the Vodaphone network (used by the NHS) would meet our needs.

What results have you seen as a result of this change?
Over time, clients have started getting in touch if they have not received a text reminder and some use calendar functions on their phone to keep track of their appointments.

We have noticed that some clients lose letters which leads to them not attending their appointments, and some don’t want letters that other people may see and question. As a result, we are looking to send appointments by text too.

Have you identified any other benefits?
We have found that other services think that sending reminders by text is a good idea but think it will be time consuming. They don’t always see the benefits and how communicating by text can save time and make services more efficient. It saves administrative time overall, especially if you look at the work created by clients not attending. It also saves clinical time so there are wider benefits.

Key Points

Ashleigh highlights the key points to bear in mind:

• The use of computers to send texts builds on the success of the original work.

• Clients now rely on the service and it works for them. This is particularly important as they may have not have stable circumstances.

• Extending the service to include sending appointments is now being looked at as a range of benefits have been identified.

• Using this system may, on the face of it, take more time than the previous way of working - but you need to look at the overall impact on the service and not at one activity. Overall this system allows for more effective use of time.
Case Study 4

Implementing a 3-week waiting time target for appointments

Ashley Triebel is a team secretary with a Community Addiction Team in NHS Borders. In this case study, she describes the work undertaken by her team to help ensure that all appointments met the target of a maximum 3-week wait.

Tell us a bit about the problem or opportunity which prompted this piece of work:
The introduction of a three week waiting time target meant that clients had to receive an appointment within three weeks of being referred to the Community Addiction Team service. This meant that we needed to look at our systems for dealing with referrals and sending out appointments. Some clients had had a wait of up to four months and we needed to reduce this the time to the target of three weeks.

What did you decide to do?
We looked at the overall administrative processes and identified several areas where changes could be made to help us meet the target. These included:

• Allocating appointments on an opt-in system: This resulted in a system of sending clients a date for their appointment, rather than a time and date. We now phone to fix a time on the day before the appointment date. This allows greater flexibility for the clients.

• Looking further at how we deal with situations where clients do not attend for appointments when expected.

• (for clients who have ongoing appointments) Fixing the next appointment when the client is at the clinic: The nurse working with the client now fixes the next appointment there and then, rather than waiting for it to be sent out. The client is given an appointment card they can keep in a purse or wallet. This means there are no letters that can be lost, or issues about confidentiality when sending out information.

How long did it take for the changes to be effective?
We introduced the changes in September 2010 when we had a waiting time of approximately 8 weeks from referral to appointment. By October 2010 the waiting time had dropped to 6 weeks and since January 2011 we have continued to meet the 3 week referral to appointment deadline. We were therefore able to say it had been effective within 3 months.

What results have you seen since making this change?
These changes really have helped us work more efficiently whilst ensuring that clients have quicker access to services. The opt-in system means that we have reduced the time spent sending and resending appointments, and reduced stationery and postal costs. It also means that secretarial staff time has been freed up to complete other tasks.
Most importantly, however, we have managed to reach and stay at the three-week target, meaning that the wait for clients has been dramatically reduced.

Key Points

Ashley highlights that meeting the waiting time target was challenging. However, she highlights two key approaches which helped the team achieve this.

• It is important to examine the reasons why clients are not attending appointments so that these issues can be addressed.

• An opt-in system provides more flexibility for clients, enabling them to choose the time of their appointment. This means they are more likely to attend.
Case Study 5

Streamlining patient compliance aid provision

Phyllis Sproul is a systems manager in primary care in NHS Lothian. In this case study, she describes the work she undertook to help patients who need support to ensure they take their medication at appropriate times.

Tell us a bit about the problem or opportunity which prompted this piece of work:
Patient Compliance Aids (PCAs) are containers which can hold a patient’s medication for a week arranged by day and time. In our area, the medication is prescribed by the GP and dispensed into the PCA by the pharmacist, ready for patient use.

In 2007 we realised that the number of our patients who needed a Patient Compliance Aid (PCA) was increasing and that this increase in numbers led to risks and issues that we needed to address. Some of these risks and issues included:

- Patients not having changes in medications processed in time for weekly PCAs to be delivered. This meant there could be a delay of a week in them receiving the new medication.
- Patients continuing a medication inappropriately or even restarting one that had been discontinued. This might happen following in-patient care if changes were not actioned properly.
- The lack of allocated administrative support for this GP-led service, leading to communication between the practice, patient and pharmacists becoming fractured and person dependent.
- The lack of a comprehensive record of patients who were receiving PCAs.
- The amount of time spent by pharmacists contacting the practice to confirm a patient’s medication.

What did you decide to do?
The GPs, practice manager, systems manager and local pharmacies all agreed that a more robust system was required for these vulnerable patients and a team meeting was organised to discuss how we could improve this service to the patients and the pharmacists.

As the systems manager in the practice, I was already responsible for checking hospital discharges and ensuring that any changes in medication were processed. I was keen to develop my role and discussed with my practice manager, Theresa Cameron, how I could help lead the practice in establishing and implementing an improved service for the patients who required PCAs.

How did you go about making the changes?
I contacted all the pharmacists to establish which patients received this service and worked with the pharmacists to verify a list of the medication that each patient received. A list was then compiled detailing the pharmacists (including their phone numbers), the names of the patients they provided the service for and the patients’ prescribing intervals. This list was displayed in the administration area for GPs and staff. I also added information to each electronic patient record to indicate that the patient had a PCA and which
pharmacist dealt with this. Staff were kept up to date on all aspects of this development.

I contacted each of the patients involved, letting them know that the system was being enhanced and there would now be one contact person for them at the practice.

At each stage, I worked closely with Theresa, discussing changes and agreeing how they might be implemented appropriately.

**How long did it take for the changes to be effective?**

The system was trialled for a few months and we sought feedback from patients and pharmacists. We started working on this between February and April 2007 and started getting positive feedback from the pharmacists in October of the same year. This showed that they were more than happy with the system and that there had been very few teething problems. These included the need to help patients and family member accept that the pharmacy would order all medication when needed and deliver to the patient weekly. GPs also had to get used to remembering to inform the systems manager of any changes they made to the medication.

At the end of November, I gave a presentation to the practice team. I talked through the developments in the system and new processes for arranging a PCA for patients who were discharged from hospital. This ensured that the whole team were aware of all the changes and were up-to date on their progress.

I am now responsible for ensuring that everything is in place for each patient receiving their PCA from the pharmacist. I also ensure that the pharmacist has the correct prescribing information when changes to medications are made.

**What results have you seen since making this change?**

We have identified a range of benefits from changing the system. Some of these are listed below:

- Patients and their carers now have a named contact at the practice who they can speak to if they have any questions about their PCA.
- All staff members know who to direct queries to and are aware from the patient record that the individual has a PCA.
- The system now helps to reduce the risk of medication errors through the use of clear processes.

It is now five years since the system was launched and it is still working well. Some hospital clinics (e.g. the Memory clinic) are now aware of the system and know who to contact in the practice to request a PCA for a patient.

**Has making this change had any other (unexpected) benefits for patients or for yourself?**

Importantly, this has shown how a member of the administration team can work with the clinical team to devise and implement a robust change to the system. Since launching the new PCA system, we have shared the success of the model with colleagues at a Clinical Governance Conference and devised a poster to highlight what we did.

Patient safety is paramount and this system ensures it is not compromised.

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**Key Points**

Phyllis highlights some of the key points which she learned from making this change:

- There were potential safety issues with the old system that we have addressed in this development. We needed to ensure that changes in medication could be dealt with more quickly.
- Having one person responsible for administering the system has made communication much easier for everyone – patients, carers, the practice, pharmacists and hospital departments.
- Good communication, planning and keeping everyone involved and informed during the change was key to making it work.
Margaret Simpson is a health records manager working across two departments – Patient-Focussed Booking and Out-Patients – in NHS Dumfries & Galloway. In this case study, she describes how she and her team used quality improvement methods to help streamline the admissions processes across the two departments.

Tell us a bit about the problem or opportunity which prompted this piece of work:
We recognised with the use of Key Performance Indicators that there was duplication in the work being carried out in the main admissions unit and day case admissions unit. The health records lead at the Scottish Government Health Department suggested that this was an area where work might be streamlined. He came in to lead a process-mapping workshop to help us identify where improvements could be made. I had had some experience of process mapping prior to this, as a result of work which had been carried out by some consultants who came into my work area, and saw this as a good opportunity to improve our services.

What did you decide to do?
We held a staff focus group to help identify the duplication and brought staff from the two departments together for them to carry out process mapping of the work that they do. This allowed them to focus on improving the service, streamlining work, and reducing duplication. It gave staff some ownership of the changes from the start – they understood where the duplications sat, could see the bottlenecks and it ensured that all areas of work were taken into account. It also gave us all an inside view of how the work was done and helped staff to work together as a team, whereas before they were two separate departments. Staff understood why the changes were happening and had identified the areas for change themselves.

How did you go about making the changes?
Staff were fully involved in the changes and worked together to make them happen. At the same time, some of the staff were doing the Certificate of Technical Competence. This had the advantage of giving them insight into other departments and the work involved in other areas. However, in addition to the change in staff working, there were other issues to consider, including office space where everyone could be housed together. This all takes time and planning.

How long did it take for the changes to be effective?
Overall it took around seven to eight months from the initial walkthrough of the department, when specific changes were identified, to staff and the new system being in place.

What results have you seen since making this change?
Work is now more streamlined and admissions are done from one central place. This has allowed easier cover for staff breaks, holidays and absences. We have managed to cut the time before admission
that case notes need to be in the department from two weeks to three days. This means that the notes can stay in the filing room much longer and can be found easily by other departments who may need them.

Has making this change had any other (unexpected) benefits for patients or for your team?
During this process we picked up other aspects of administrative work that needed to be looked at. Also, having staff working together on this change is making moving over to electronic records easier.

From the patient perspective, the changes have meant that we can stagger the times that they arrive at the hospital to be admitted. This cuts down the stressful wait when they arrive.

How did knowing about process mapping influence the way you approached this work?
I see process mapping as a useful tool in my particular area. It has helped us to develop the system so that it is now more joined up and streamlined. One of the most important factors in process mapping is the involvement of the whole team in identifying and making the changes.

Any final thoughts?
Alongside this change that worked well, we tried to centralise the preparation of case notes for out patients, admissions and day case admissions with less success. Unfortunately, this did not work so well so we reassessed the situation and, when office space became available, we returned to the previous way of doing things. Sometimes you need to accept that changes won’t always work!

Key Points

Margaret highlights some of the key points which she learned from making this change:

• Involving everyone from the start helped us all to see the changes that were needed.

• Using process mapping helped everyone to understand all of the administrative work involved in admissions in the two original units.

• Change takes time and there are associated issues to think about, such as office space. The changes couldn’t have been put in place without this.

• Not all changes work and sometimes you need to accept this and rewind to the way things were done before – but there will be lessons in there that you can learn for the next change.
Lisa Welsh is a health records service improvement manager working in NHS Greater Glasgow & Clyde. In this case study, she describes how she worked with colleagues to develop systems for the safe and appropriate destruction of patient records.

Tell us a bit about the problem or opportunity which prompted this piece of work:
We faced a number of issues with the storage of patient records in our area. Patient records were being retained for longer than the minimum retention periods recommended in the Scottish Government Records Management Code of Practice and this led to a number of problems. The storage systems within one of the hospital libraries had become exhausted and the retrieval and filing of patient records was becoming inefficient due to lack of storage space.

Review of the records library identified that a programme of work to cull records would result in:
• improved records management, storage and retrieval
• service efficiency, with less need to send patient records to external offsite storage providers and more efficient retrieval and filing of records
• compliance with national guidance and the Data Protection Act

What did you decide to do?
I worked with a colleague to review working practice in the libraries in two hospital sites and identified where the system could be adapted to make it work more efficiently.

We spoke to the records staff and their supervisors and used the information that we gathered to prepare a paper for management, outlining the need for a cull to reduce the number and volume of records and to reorganise the systems to be more efficient.

How did you go about making the changes?
A new process was developed with stakeholder involvement. The change required staff to review the records in line with a locally-developed protocol, which was based on Scottish Government Records Management Code of Practice.

This involved checking to see when the patient last attended and the specialities and medical conditions they were treated for. The protocol specified the time periods and instances when patient records could be destroyed. Each day, 10% of the records selected for destruction were reviewed by a senior member of staff. This ensured that the work was quality controlled and maintained patient safety.

How long did it take for the changes to be effective?
Overall the project took around six months. We had to complete a number of processes in this time, including:
• reviewing the existing service
• planning the change
• discussion with management and engagement with other stakeholders training managers and supervisors, and briefing staff
• meeting site managers
• carrying out the cull

As a result of this project, 45,000 casenotes were destroyed in accordance with the NHS GGC Retention and Destruction Policy.

What results have you seen since making this change?
We now have a programme of work which reviews records held in the libraries and we are continuing to work towards two sites having a single, shared record. The review and destruction of records has now been incorporated in to business-as-usual activities, and the freed-up space means that individual patient records are now more accessible.

Has making this change had any other (unexpected) benefits for patients or for your team?
We have shared the lessons we have learned with other hospitals, and this has led to similar work within other hospital sites.

A number of temporary bank staff who carried out the work have progressed to work in the next phase or secured alternative employment, and temporary bank staff have shared their experience with permanent staff.

How much did you know about quality improvement methods before you started this project?
Although I did not have any formal experience of quality improvement learning, I am a PRINCE 2 Project Management Practitioner and Managing Successful Programmes Practitioner. This helped me understand the processes that were needed for the project to work well. I recognised how important it was to know the issues that needed to be considered, to work through them logically, and to involve stakeholders throughout the process. Overall, my previous learning gave me a structured approach to taking this work forward.

Key Points

Lisa highlights some of the key points which she learned from making this change:

• Communication with everyone who was involved in the work or who it impacted on was key to the project working well.

• Careful planning allowed us to put the work into action.

• Providing solid training, guidance and support helped the staff gain confidence in what they were doing. Destroying a patient record is an irreversible act, so staff need to understand the consequence of what they are being asked to do.

• Due to the nature of the work, it was essential for staff to have clear guidance for the work they were carrying out. For example, some medical conditions mean that notes need to be retained for longer than usual. Having clearly documented procedures made the process easier for everyone involved.
Barbara McCahery is an audit facilitator and multi-disciplinary team (MDT) co-ordinator in NHS Grampian. In this case study, Barbara explains how her role has developed to support a multi-disciplinary team of clinicians.

Tell us a bit about the problem or opportunity which prompted this piece of work:
Developments in the clinical governance of cancer care over the past ten years have seen a range of guidelines, protocols and targets being put into place. Roles such as mine have been developed to help ensure that services are delivered in line with these requirements. My role has two main parts - multidisciplinary team (MDT) co-ordinator and audit facilitator - and these two parts complement each other.

The purpose of the MDT is to review patients’ progress, assimilate diagnostic information, and to determine and plan further clinical management of patients’ conditions. As the co-ordinator, my role is to ensure that all of the information needed for decisions about care and treatment to be made is available and that the right people needed to make the decisions are involved. My audit role focuses on data for the National Prospective Blood Cancer audit which includes fields related to these processes.

What did you do when you took up your new role?
This was a new role when I came into post and, working with the team, I had to develop systems to ensure that all of the information needed is available and that we can work efficiently. For the team meetings to be productive and achieve their aim, and decisions to be made about patient management, it’s not necessary for every member of the clinical team to be there. However, the team identified my role as being central to the meeting. The MDT co-ordinator is the person who ensures that all of the information needed to make decisions about treatment is available and ensures that decisions taken at the meeting are recorded and taken forward. As a result, my key duties now include:

• Organising MDT meetings.
• Ensuring that the relevant patients’ cases are brought to the meeting and that the complex range of information needed for decisions to be taken is available.
• Recording information about adherence to standards, consideration of relevant guidelines and time frames.
• Constructing and maintaining a database of the patients discussed and outcomes reached.
• Carrying out audits of case work against prescribed standards.

How long did it take for the changes to be effective?
This system has developed over time from a blank sheet and we have been able to adapt and change as needed, in response to changes in the guidelines and information required. Some MDT members were reluctant to be involved in ‘yet another meeting’ at the start but, over time, have come to...
appreciate how valuable it is.

What results have you seen since making this change?
As my role involves both the co-ordination of the MDT and audit of the work and there is overlap between them, I can feed information automatically into both aspects of my work. This reduces the risk of information being missed.

My knowledge of both aspects allows me to keep all aspects up to date more easily.

The system also helps us to work more efficiently as a group. Team meetings only go ahead if the people who are essential to the outcome are going to be there, allowing the best use of time for everyone concerned.

However, something we have also become aware of is sustainability of the system. My role started out as a blank sheet and I have developed the systems and databases which we use. As a result, it would not be easy for anyone to take over from me. This is something which we need to think about.

Key Points

Barbara highlights some of the key points which she learned since taking on this new role:

- Working together as a team where everyone’s contribution is recognised is key to the team functioning well.
- It can take time for people to get on board with new ways of working.
- Our meetings can only be effective and efficient when all of the required information and key people are present.
- Recognising the ways that different roles can benefit each other helps ensure that information is collected and used effectively.
Case Study 9

Improving the PINNACLE database using process mapping

Ashleigh Stewart is a support assistant in one of the teams responsible for postgraduate medical training in NHS Education for Scotland (NES). In this case study, she describes how the administrative teams used process mapping to identify ways in which the PINNACLE database which they use could be improved.

Tell us a bit about the problem or opportunity which prompted this piece of work:
The PINNACLE database is used by NHS Education for Scotland (NES) to record information about doctors in training. The teams of administrators responsible for recording the information work in four medical deaneries across Scotland.

Version II of PINNACLE was launched around two years ago and, through time, it was recognised that it wasn’t capable of doing everything that was expected of it. As a result of an internal audit, we identified that a more flexible and user-friendly database was needed to ensure that all four medical deaneries were working to single processes. To help make this happen, we needed new, shared business processes and systems.

What did you decide to do?
Process mapping was seen as the best way to identify how to improve the system, as it would allow us to identify all the work involved in the database processes. For this to be effective, it was vital to involve the staff who use PINNACLE and the IT staff who would be responsible for designing the solutions. This meant that the people who were identifying the changes and creating solutions were involved from the start.

How did you go about making the changes?
Ten members of staff attended a week’s course to learn about process mapping. This made sure that we all had the skills and knowledge to do what we were being asked to do. Then all staff involved in the PINNACLE project were divided into teams which contained at least one member from each deanery. This ensured that each deanery had a say in each process.

Forty different business activities were identified within PINNACLE processes. Examples of these business activities included management of user access, auditing, exception reporting, study leave, management of training programmes and the trainee journey, and the recording of educational facilitators. Each team worked on an allocated number of these activities and a process map was produced for each one.

The process maps allowed us to show more clearly where all of the activities fitted together and provided more detail than we had had previously. After we had finished the process mapping, the team looked at the results and could identify where there were gaps and how we could ensure that the processes flowed and fitted together to allow the whole system to work.
The process of process mapping also allowed the user/administrator staff and the IT staff to communicate more effectively. In particular, we as administrators could understand more about the IT staff’s perspective and what they needed in terms of functional requirements.

How long will it take for the changes to be effective?
The change process is still ongoing. So far, it has taken around nine months and documents detailing the changes which are needed will be going to the IT developers soon. It will take them 8 months to build the new database followed by 3 months of user testing. In total the whole process will take around 20 months from start to finish.

Has being involved in process mapping had any unexpected benefits?
The skills and knowledge we gained about process mapping are transferrable and we are already using them in other work.

Working with other administrators and IT staff as part of this project has also helped me to learn more about the capabilities of the database. As a result, I can work more efficiently, compiling reports locating information more easily – in short, letting the database do the work.

Key Points

Ashleigh highlights some of the key points which she learned from being involved in this project:

- Using process mapping gave a clear structure to help us identify where changes needed to be made. It also helped communication between administrative staff and IT staff, where different backgrounds and occupations can sometimes cause blocks.
- Learning about process mapping has influenced how I look at other changes in work and I can take the skills and knowledge gained and use them in other situations.
- Working through this change will have taken about 20 months by the time the work is finished. It’s important to recognise that it takes time to ensure that the right changes are identified and made in the right way for the database to work the way we need it to.

1 For more information about process mapping, see The Administrator’s Guide to the Quality Strategy and Quality Improvement, downloadable from the Administrative Services section of the NES website (http://www.nes.scot.nhs.uk/education-and-training/by-discipline/administrative-services/resources/publications.aspx)
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