SUBJECT: PERSON-CENTRED HEALTH & CARE

1. SITUATION

The purpose of this paper is to update Lanarkshire NHS Board on local progress with the National Person-Centred Health & Care Programme (PCHCP).

2. BACKGROUND

The Quality Alliance Board and Health & Social Care Management Board at Scottish Government agreed the establishment of a National Person-Centred Health & Care Programme to bring coherence, energy and focus to the real drive towards putting people back at the centre of health and care services in Scotland.

At the heart of this programme is the drive to elevate the patient/family/service user and provider experience. The overall objective is that by 2015 all relevant health and care services in Scotland are centred on people, evidenced through improvements in Leadership, Care Experience, Staff Experience and Co-Production. This is an NHSScotland-wide programme, led by and delivered in partnership with Healthcare Improvement Scotland (HIS) and other key stakeholders from within and across the public and 3rd sectors in Scotland.

The recent publication of the Francis Report 2013, which follows on from the public inquiry into care at Mid Staffordshire NHS Foundation Trust, has also highlighted many of the key components which make up the primary drivers of the Leadership, Care Experience, Staff Experience and Co-Production arms of the PCHCP.

3. ASSESSMENT

In May 2013 the Scottish Government Person-Centred Health & Care Programme (PCHCP) held its second national learning set. The aim of this two day session was to bring people together from a variety of backgrounds to listen, observe and share learning around the values, behaviours and approaches that will help to ensure that people are always at the centre of their health and care. NHS Lanarkshire senior and frontline staff were in attendance as were a small number of colleagues from both North & South Lanarkshire councils.

Measurement Framework

One of the challenges of this programme is the ability to provide a tangible method for measuring improvement. This is a critical part of testing and implementing changes. To date across the United Kingdom there is no system that has used improvement methodology to measure person-centred care. Fundamentally, the measurement approach must also be measured through the eyes of people and focus on person-centred outcomes, not just system focused outcomes. An opportunity was taken as part of the national event to discuss this, and a measurement template was made available to assist executive and operational
leads to consider what the PCHCC intend to measure in the first instance (Appendix A). Locally we are now working to ensure that we have systems in place to respond to the data collection requirements and are able to demonstrate progress using improvement methodology techniques.

The focus of the initial measurements will be around the ‘Must Do With Me’ / ‘What Matters to You?’ approach, examples of which are included in the questions within the measurement framework (Appendix A). Within NHS Lanarkshire we have met to consider how we can, where possible, utilise existing patient experience data (Appendix B) from a variety of sources such as:

- LanQuil P
- Acute ward dashboard
- Care environment observations
- Patient Experience Indicators
- Better Together
- Patient Opinion – Every Voice Matters

Patient Opinion is an online portal via which patients are able to post their experiences of the NHS and to which NHS Boards can respond. Prior to appearing on the website, all potential postings are moderated by Patient Opinion.

Following a pilot with self-selecting Boards in 2011 the Cabinet Secretary for Health and Wellbeing announced in March 2013 that all NHS Boards would participate in a national roll-out funded by the Scottish Government.

Postings on the Patient Opinion website are anonymous and it can at times be difficult to identify the service being commented upon or when the experience took place. Consequently it can be challenging to make a meaningful response.

NHS Lanarkshire registered with Patient Opinion in early May 2013. Since then responses have been posted to 100% of patient stories directed to NHS Lanarkshire by Patient Opinion:

- Smoking at the entrance to Monklands Hospital
- Concerns about the nursing assessment and record-keeping in relation to partner’s care at Monklands Hospital
- Relative contracted infection following surgery in Glasgow; posting mentioned a subsequent admission to Monklands Hospital but it was unclear as to whether there were any issues about the care received there
- Patient unhappy with management of ENT condition in Glasgow, Monklands Hospital and Wishaw General Hospital
- Attitude of nursing staff in Psychiatry at Hairmyres Hospital.

In each case, either a response has been provided or the person has been invited to contact a named member of staff.

Care Experience - Local Tests of Change (PDSA Cycles)

In addition to the above, staff are also being encouraged to undertake small tests of change within their own care environment with the aim of making care and services more person and family centred. Some examples of these are:

- Flexible Visiting Times – pilots in wards across the Acute Hospitals
• Timed slots for patients receiving follow-up visits from LTC nurses
• Must Do With Me – incorporated into new Personal Care Record
• Impact of noise on patients within an Acute ward environment
• Improving fluid balance monitoring
• Trial of patient involved bedside staff handover
• Enhancing PCC – review of nursing documentation within Shotts Prison
• House Held records for LTC patients
• Improving consistency of wound assessment documentation in LTC patients
• What can we do to improve your stay? Acute Hospital

While all of these staff generated initiatives are valuable and to be applauded, one of the challenges to date is in the understanding of what is truly a person-centred improvement. A number of those trialled so far are patient-focused service improvements, which although in themselves bring positive benefits, may not necessarily be person-centred. It is important therefore to raise staff awareness of how they might focus specifically on the individual in order to understand their needs, aspirations and to address any concerns they may have. Techniques such as the use of the ‘Must Do With Me’ questions can help formulate an assets-based approach which can ultimately make the persons care and recovery a more positive experience for them.

Leadership & Staff Experience

Work continues locally within the Leadership & Staff Experience arm of the PCHCP notably with two recent areas of activity in regards to the NHS Scotland Staff Survey and the local Embedding Values work which focuses on the Organisational values of Fairness, Respect, Working Together & Quality. Additional areas of focus include:

• Organisational Development (OD) plan being updated to ensure alignment with the NHSL strategic framework – A Healthier Future (AHF) which sets out the ambition of the Board over the next 7 years to match the 2020 Vision and meet the Quality Ambitions of Person-Centred, Safe & Effective Care
• Revised staff governance framework in place and monitoring proposal under consultation nationally
• On-going work in regard to communication, policies, alignment with Workforce 2020
• Leadership and management development in place
• Leading Better Care
• Integrated learning strategy
• Induction/PDP/e-KSF/Leampro
• Libraries
• NMAHP PDC/Med Ed/OD
• NMAHP pilot re values based recruitment
• Management walk rounds
• Equality & Diversity impact assessments
• Healthy working lives
• Employee counseling
• Dignity at work
• Whistle blowing policy
• Speak Up for Our Reputation Campaign
Co-Production

As previously acknowledged there is already a significant amount of existing work going on across NHS Lanarkshire in relation to Co-Production (detailed below). However more recently NHS Lanarkshire colleagues have been working with third sector partners to prepare our Engagement Matrix response to Scottish Government and are focusing on the work of the Mental Health team, the Lanarkshire Recovery Network and Lanarkshire Links. Additionally the work being done around Reshaping Care for Older People and Community Capacity Building will be identified in the report as ‘high impact areas of local collaborative improvement’.

Other examples of existing work:

- Early Years Collaborative
- Managed Care Networks
- Anticipatory Care Planning
- Well Connected (Social Prescribing)
- Personal outcomes based approach in community care
- Talking Points approach

As identified in our last Board update, there is general agreement that strong examples of co-production are evidenced more in community, mental health, maternity and early years and less so in the acute settings. Consideration requires to be given as to how co-production work within the acute division can be strengthened. The national PCHCP have indicated that the Health & Social Care Alliance (Scotland) have been commissioned to lead on the co-production aspect of the programme and further information is awaited on this. The importance of stakeholder engagement as part of the overall programme and in particular in the area of co-production has been highlighted and liaising and working through the Chairs of the two local Public Partnership Forums (PPF) is considered essential.

Care Assurance Board

A Care Assurance Board (CAB) has been established and is scheduled to hold its first meeting in September 2013. The CAB will provide an overarching care assurance system which promotes the provision of a culture where care is consistently person-centred, clinically effective and safe, for every person, every time, and where caring behaviours will have at their heart the NHS Lanarkshire organisational values of fairness, respect, working together and quality.

NMAHP Symposia

An opportunity was taken at the NMAHP Symposia in November 2012 and May 2013, to focus on aligning A Healthier Future, themes from The Mid-Staffordshire NHS Public Enquiry Report (Francis Report), Professionalism, and Person-Centred Health & Care. Around 150 delegates attended on each occasion including the Board Chair and non-executive directors. Overall the feedback has been extremely positive and the impact of a first-hand account of care delivery by the brother of a service user was extremely powerful and thought provoking.

Scoping of Person-Centred Care Resources

Dr Kathleen Duffy, NMPDC has undertaken a scoping exercise to consider what learning opportunities or resources there are available both locally and nationally to support staff
with this agenda. In collaboration with the Person Centred Health and Care Lead the intention is to develop a pathway to enable signposting and, where appropriate, embedding of some of the resources to support possible tests of change.

4. **RECOMMENDATION**

The Board is requested to note the progress in regard to Person-Centred Health & Care within NHS Lanarkshire.

5. **FURTHER INFORMATION**

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Introduction

Measuring person-centredness is on one level challenging, and on another very simple. The data is all around us every day, the experiences and stories of people who use services and support, and the stories and experiences of the people who deliver services and support. Our challenge is to design a systematic, sensitive, method for collecting this data comprehensively, bringing to light the information contained within it, and then using it to focus on the needs of people and drive improvement. We need to listen in different ways and at different points and we need to listen with the intent to engage and understand.

This initial measurement framework has been developed for testing and adapting with the core elements of the Person-Centred Collaborative. These are improvement measures for use by teams in a local context. To obtain outcome measures teams should use the “Care Experience Toolkit” or equivalent. These measures will complement the annual national survey and also align with the overarching national Quality Measurement Framework.

It is important to note that whilst quantitative measurement in the form of survey data will form the underpinning outcome measures, this alone will be inadequate to provide a complete picture. Therefore, a broad approach to measurement should be adopted that includes stories, focus groups and other forms of informal feedback such as social media. There is great value in triangulating all of these different sources of feedback as well as existing system measures such as staff turnover, vacancy rates, formal complaints, etc.

The measures suggested in this framework are the process, outcome and balancing measures for local teams, organisations and boards participating in the Person-Centred Improvement Collaborative to use in their improvement work at a local level.

Important questions to consider when collecting data are:

- What are we collecting and why?
- Is our focus on collecting and using real-time data for improvement, data collected and owned by teams?
- Are we making best use of the data already collected? (do we use the data as effectively and efficiently as possible?)
- Measurement is fundamental to improvement work. If we don’t measure we can’t tell whether a change is an improvement, but measurement doesn’t need to be onerous – as much as possible it should be embedded in routine daily work so that everyone does a little. We need to be curious about how it feels to be on the receiving end of the services we provide, we need to collect as much as we must and as little as we dare, and if we haven’t already, we need to start!

The measures are set out as follows:

- Outcome measures and process measures followed by balancing measures
- Measure Name
- Identifier (a unique identifier for each measure)
- Measure type
- Frequency

A few general guidelines:

- Look at the data collection processes that already happen reliably and consider how you could use these processes to help you collect some person-centred data.
- Don’t leave data collection up to one person, share it amongst the team.
- Make contact with improvement experts in your organisation so that you have someone to help you, especially in the early stages.

This framework will be updated as required and participants informed.
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<thead>
<tr>
<th>Measure Name</th>
<th>Identifier</th>
<th>Operational Definition</th>
<th>Data Collection Guidance and further info</th>
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<tr>
<td><strong>Care Experience: outcome measures (CEO)</strong></td>
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</table>
| Overall experience of service provided. | CEO1       | **Measure:** % of people report a positive experience of the service.  
**Aim:** 90%  
Data collection from multiple sources and methods:  
• focus groups  
• stories, social media  
• formal / informal feedback  
• observations of care, walk-rounds  
• Proxy feedback (families & carers)  
• etc  
Triangulated with experience survey data:  
Example: current Picker guidance on overarching experience question:  
Q. Overall...  
I had a very poor experience  
I had a very good experience  
0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10  
In this example a “positive experience” would be 6 or above.  
In a five option Likert scale a “positive experience” would = 4 or 5 (i.e. “agree” or “strongly agree”)  
| o Don’t spend too much time trying to find the perfect measure. Test and adapt as you go along.  
| o Keep surveys short.  
| • Start with a small number of questions  
| • Ask questions in a simple rating scale or “agree / disagree” format  
| • Leave some space for free-text comments  
| • Weekly, purposive sampling (i.e. ask min of 5-10 people per week)  
| • Allow for unsolicited feedback  
| • When selecting samples different team members should select the sample each week to help reduce the effects of bias  
| • Remember to collect data from other sources of feedback and triangulate with your survey data.  
Stories, comments, compliments, collected from social media, focus groups, observations of care, etc, etc.  
| | | | |
| Personal outcome goals. People get the outcomes (or care) they expect. | CEO2       | **Measure:** % of people say they got the outcome (or care / support) that they expected.  
**Aim:** 90%  
Data collection from multiple sources and methods:  
• focus groups  
• stories  
• formal / informal feedback  
• observations of care  
• Proxy feedback (families & carers)  
Triangulated with experience survey data:  
Emphasis of question may vary depending on setting:  
• “Are you getting.....” “Did you get....”  
| As above.  
(see examples below and links to further examples)  
|
| What matters to you? | MDO1 | Measure: % of people who say that we took account of the things that were important to them  
Aim: 90%  
Data collection from multiple sources and methods:  
- focus groups  
- stories  
- formal / informal feedback  
- observations of care  
- Proxy feedback (families & carers)  
Triangulated with experience survey data:  
Question asked on experience survey using a simple rating scale or “Agree” “Disagree” format:  
Q. During my stay I felt that staff took account of the things that were important to me. |
| Who matters to you? | MDO2 | Measure: % of people who say we took account of the people who were important to them and how much they wanted them involved in care or treatment.  
Aim: 90%  
Data collection from multiple sources and methods:  
- focus groups  
- stories  
- formal / informal feedback  
- observations of care  
- Proxy feedback (families & carers)  
Triangulated with experience survey data:  
Question asked on experience survey using a simple rating scale or “Agree” “Disagree” format:  
Q. I felt that staff took account of the people that matter to me, and of how much I wanted them to be involved in my care or treatment. |

| | | o Collect some baseline data before you start so that you can measure the effect of the “Must do with Me” interventions as you start testing  
| | | o Local teams to develop short postcard surveys for people using their service.  
| | | • Start with a small number of questions  
| | | • Ask questions in a simple rating scale format  
| | | • Leave some space for free-text comments  
| | | • Weekly, purposive sampling (i.e. ask min of 5-10 people per week)  
| | | • Different team members select the sample each week to help reduce the effects of bias  
| | | o Remember to collect data from other sources of feedback and triangulate with your survey data.  
| | | • Stories, comments, compliments, collected from social media, focus groups, observations of care, etc, etc. |
| What information do you need? | MDO3 MD03a | Measure: % of people who say that they had all the information they needed to help them make decisions about their care or treatment  
Aim: 90%  
Data collection from multiple sources and methods:  
- focus groups  
- stories  
- formal / informal feedback  
- observations of care  
- Proxy feedback (families & carers)  
Triangulated with experience survey data:  
Question asked on experience survey using a simple  
Q. I felt that I had all the information I needed to help me make decisions about my care or treatment.  
Could also ask question about “understanding” for this element |  
- Remember to collect data from other sources of feedback and triangulate with your survey data.  
Stories, comments, compliments, collected from social media, focus groups, observations of care, etc, etc. |
| Personalised Contact | MDO4 MD04a | Measure: % of people who say that staff took account of my personal needs and preferences  
Aim: 90%  
Data collection from multiple sources and methods:  
- focus groups  
- stories  
- formal / informal feedback  
- observations of care  
- Proxy feedback (families & carers)  
Triangulated with experience survey data.  
Could also ask specific questions as below:  
Q. I was able to contact this service (or staff) at a time that suited me:  
Q. I was able to contact this service (or staff) in a way that suited me:  
This question will need to be adapted, or may have limited application depending on the nature of the service you provide. i.e.  
- Primary Care = screening  
- Acute Care = care rounds  
- Social Care = drop in service  
- Use of technology or novel methods of contact |
**Nothing about me without me**

Service users are routinely given the opportunity to be involved at the level they choose in any communications, handovers or transitions of care that are about them.

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<tr>
<th>MDO5</th>
<th>Measure: % of people who say they were involved as much as they wanted to be in communication / transitions / handovers about them</th>
<th>Aim: 90%</th>
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<td>Question asked on experience survey using a simple “Agree” “Disagree” format:</td>
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<td>Q. I was given the opportunity to be involved as much as I wanted to be in any communication or discussions about</td>
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**Question sensitivity will need to be developed for this element.**

This question will need to be adapted depending upon the type of service you deliver i.e.

- Acute hospital = shift handovers
- Continuing care = case conference

- **Remember to collect data from other sources of feedback and triangulate with your survey data.**

Stories, comments, compliments, collected from social media, focus groups, observations of care, etc, etc.

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**Care Experience: “Must do with Me” process measures (MDP)**

| What matters to you? | MDP1 | Measure: % of care records or equivalent with personal outcome goals recorded | Aim: 95%
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<td>o Responses / narrative from service users who say they were asked what was</td>
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Look at existing reliable data collection processes and use these to help you collect this measure.

- Select a purposive sample of care records or service users (5-10 per week minimum)
- Try to select from a variety of service users
- Ask a different person to collect the samples each week to help reduce the effects of bias
- It would be very useful to ask a questions about the “Must do with Me” elements in your real-time experience surveys (see web-links to examples below)

| Personal outcomes inform care / support | MDP1a | Measure: % of care plans that include personal outcomes or responses that say we took account of them in care or treatment | Aim: 95%
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<td>o Denominator = total number of records reviewed or service users spoken too</td>
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This differs from CEP1 in that it is not enough to simply record a set personal outcome goals. To get maximum benefit from this process the personal goals should then be used to form a personalised care or treatment plan.

- Teams can test and adapt ways to record a set of personal outcome goals
- Look at existing tools and frameworks
- Consider Talking Points example
- Test and adapt using PDSA cycles
- See web-links below to other examples
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<td>Who are the people that matter most</td>
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<td>MDP2 Measure:</td>
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<td>shared decision making tool, etc)</td>
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<td>Examples of tools &amp; surveys to help</td>
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<td>Person-Centred extranet</td>
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<td>People using your service are reliably</td>
<td></td>
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<tr>
<td>asked “how” and “when” they would</td>
<td></td>
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<tr>
<td>like routine contact to be organised</td>
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</tbody>
</table>
| Involves in handovers, transitions & communications | MDPS | **Measure:** % of handovers / transitions / communications that involve the people they are about  
**Aim:** 95%  
**Examples:**  
- Weekly observation or check of 5 handovers / knowledge transfers / letters  
- Was the person who was the subject of each handover actively included in the process Y or N? | This aspect will look different depending on the type of service you provide, i.e.  
- Community care  
- Primary care  
- Acute care  
Explore ways to involve people in information exchanges concerning their health and care. Think about:  
- letters  
- handovers  
- results  
- etc |
|-----------------|--------|-------------------------------------------------|-------------------------------------------------|
| Person-centred walk rounds | CEP1 | **Measure:** Number of walk rounds per month  
**Aim:** 1 per week  
**Plus:** issues raised / actions taken log  
Walk rounds can take the form of:  
- Team walk-round  
- Volunteer led walk-round  
- Facilities team walk-round | Count the total number of walk- rounds.  
Keep a log of the issues raised on the and record how they are being addressed.  
Point of care teams can chose to combine CEP1 & CEP1a and alternate between observations of care and walk- rounds. The aim should be to have at least two opportunities in each month where a member of the team, a service user, a volunteer, etc. Is provided with an opportunity to view the service through new eyes. |
| Observations of care | CEP1a | **Measure:** Number of observations of care per month  
**Aim:** 1 per week  
**Plus:** issues raised / actions taken log  
- An observation of care lasts for 15 - 20 minutes  
- Sit in one place and record sights, sounds, smells, words heard and used, etc  
- Record no. of improvements opps. Identified  
- Record no. of improvements actioned | o Aim to carry out one observation of care per week.  
o Carry out observations at different times of the day and on different days of the week  
o Ensure that different members of the team carry out the observations – be creative about who you ask  
  - Ask people who are not members of your team to do an observation of care  
  - Ask service users and / their families to participate  
o Keep a record of issues identified and improvements made as a result. |
| Care Experience: balancing measures (CEB) | | | |
| **Staff willingness to recommend this as a place to work.** | CEB1 | **Measure:** % of staff who would recommend this as a place to work.  
**Aim:** 80% or 50% increase from baseline at the end of year one | o Data collected as part of Staff Experience work stream.  
o Teams develop and test frequent feedback tools for staff.  
o Collect data at least monthly initially  
**Rationale:** A number of studies in the NHS and the private sector show that staff engagement, as defined by commitment, a belief in... |
the organisation, a desire to work to make things better and `to go the extra mile’ is associated with good quality of care and with higher service user satisfaction (DoH 2011)

| **Formal complaints** | CEB2 | **Aim:** 20% reduction in formal complaints or Local teams: 300 days between formal complaints Use of existing ISD data / local data. | Some healthcare providers in NHS Scotland have reduced formal complaints in the last two years. Learning from these organisations will be shared. Examples of other health and social care providers who have reduced formal complaints by focusing on care experience will be shared. **Rationale:** In 2011/12 33% of NHS Scotland complaints related to staff. Of these 82% were about attitudes, behaviour and oral communication (ISD 2012). Care Experience work using the 5 “Must do With Me” elements focuses on improving communication, relationships and shared decision making between service providers and service users. If these elements are implemented reliably, the need for service users to resort to the formal complaint process should be reduced. |

**Leadership for Person-Centred Care: structural measures**

| **Comprehensive real-time feedback systems (service users)** | LSM1 | **Measure:** elements of service / depts with real-time feedback systems in place for service users **Aim:** 100% by Dec 2015 | Short term structural measures until aim achieved |
| **Service user advisory groups** | LSM2 | **Measure:** elements of service / depts with service user advisory groups **Aim:** 100% by Dec 2015 | A service user advisory group (also called Patient & Family Advisory Council) is a group comprised of people with lived experience of a particular service who advise staff on improvement. Further detail and examples available. |
| **Comprehensive real-time feedback systems (staff)** | LSM3 | **Measure:** elements of service / depts with real-time feedback systems in place for staff **Aim:** 100% by Dec 2015 |

**Leadership for Person-Centred Care: process measures**

<p>| <strong>Leadership walk rounds</strong> | LPM1 | <strong>Measure:</strong> total number of walk rounds <strong>Aim:</strong> min one for each leader per week | Structured walk rounds that focus on engaging with the lived experience of staff and service users |
| <strong>Observations of care</strong> | LPM2 | <strong>Measure:</strong> total number of observations of care <strong>Aim:</strong> min one per week for each leader | Observations of care typically last 20-30 mins |
| <strong>Shadowing</strong> | LPM3 | <strong>Measure:</strong> total number of shadowing events <strong>Aim:</strong> two per month for each leader comprising of one shadow and one reverse-shadow | Shadowing service users and members of staff in the organisation Reverse shadowing: inviting service users / other members of staff to shadow the leader |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Round 1 (May – Aug 2011)</th>
<th>Round 6 (Jan – Apr 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall are you happy with the food and drink you receive?</strong></td>
<td>83% 86% 93%</td>
<td>94% 98% 91%</td>
</tr>
<tr>
<td><strong>If you need help with eating and drinking, do you get it in a way that</strong></td>
<td>100% 99% 99%</td>
<td>100% 96% 88%</td>
</tr>
<tr>
<td><strong>is acceptable to you?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Did you know who the nurse in charge of the ward is?</strong></td>
<td>89% 56% 76%</td>
<td>71% 69% 63%</td>
</tr>
<tr>
<td><strong>Are you involved as much as you want to be in the decisions about your</strong></td>
<td>84% 86% 88%</td>
<td>83% 91% 95%</td>
</tr>
<tr>
<td><strong>care?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do all the staff tell you the same things?</strong></td>
<td>89% 81% 83%</td>
<td>86% 87% 85%</td>
</tr>
<tr>
<td><strong>Are you given enough information so that you can make choices about your</strong></td>
<td>86% 86% 92%</td>
<td>87% 90% 96%</td>
</tr>
<tr>
<td><strong>care?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you know what is planned for your care?</strong></td>
<td>77% 84% 76%</td>
<td>73% 89% 89%</td>
</tr>
<tr>
<td><strong>Are you happy with the amount of information about your care / condition</strong></td>
<td>96% 91% 94%</td>
<td>87% 94% 95%</td>
</tr>
<tr>
<td><strong>which staff give to you and your relatives?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need help to clean yourself does a member of staff help you quickly</strong></td>
<td>98% 100% 100%</td>
<td>100% 94% 93%</td>
</tr>
<tr>
<td><strong>and with respect?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you feel that staff listen to you?</strong></td>
<td>97% 93% 99%</td>
<td>100% 99% 97%</td>
</tr>
<tr>
<td><strong>Do you feel that you can ask questions about your care and that they are</strong></td>
<td>95% 91% 96%</td>
<td>98% 98% 97%</td>
</tr>
<tr>
<td><strong>answered as fully as possible?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In planning for you going home have you been given enough information</strong></td>
<td>92% 90% 96%</td>
<td>82% 92% 96%</td>
</tr>
<tr>
<td><strong>about what will happen after you leave hospital?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you understand why you are taking your medicine(s)?</strong></td>
<td>93% 93% 96%</td>
<td>100% 94% 94%</td>
</tr>
</tbody>
</table>