Enabling health and social care improvement

Living and dying well with frailty collaborative

Learning Session 1

19 September 2019

#LWiCFrailty

GLA0919
Welcome!
Housekeeping

- No fire alarms
- Toilets
- Filming/photography
- Breaks and lunch
Our mission

...to improve how teams identify and enable people aged 65 and over to live and die well with frailty in the community.
Mr Lucas
Collaborative structure

IHI Breakthrough Series whitepaper, 2003
Learning session 1

Today’s learning session will prepare you for the first action period
Learn about Quality Improvement and Measurement
Learn from other teams in Scotland and share your work
Use your learning to develop a plan of your next steps
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>09:30</td>
<td>Welcome</td>
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<tr>
<td>09:45</td>
<td>Living with frailty in the community – a personal experience</td>
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<td>10:15</td>
<td>Getting to know each other better</td>
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<td>10:30</td>
<td>Comfort break</td>
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<td>10:45</td>
<td>Learning about improvement</td>
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<td>13:00</td>
<td>Lunch</td>
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<tr>
<td>13:30</td>
<td>Learning from across Scotland</td>
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<tr>
<td>14:30</td>
<td>Team planning time</td>
</tr>
<tr>
<td>16:00</td>
<td>Close</td>
</tr>
</tbody>
</table>
A personal experience of frailty
Introduction to Slido

1) Sign on to the wifi
   (Password = GLA0919)

2) Open your internet browser
   (safari/explorer/google)

3) Visit www.sli.do or www.slido.com
Introduction to Slido

Every Question Matters.
The Ultimate Q&A and Polling Platform
Company Meetings and Events

# Enter event code

Join

Slido uses cookies to allow us to give you the best experience. You can view or change your cookie settings in

LWiCFrailty

Wifi: GLA0919

Visit www.sli.do or www.slido.com
‘Liking’ Questions & Polls

[Images of mobile app screens showing the process of asking questions and liking polls]
Let’s give it a go! 😊
Q  How many people over the age of 65 in Scotland are severely frail?

A  51,662
B  22,124
C  13,647
D  8,063

£500,000

And that’s just the 5% of over 65 year olds!
What percentage of these people are known to have an ACP recorded in KIS?

$1,000,000

Based on......
Temperature Check
10 mins

• In your away teams please introduce yourself and finish the sentence:

“I want to be involved in the frailty collaborative because...?”

• Please enter your words into the slido poll and move onto the next person

Consider:  
- Why is it important to you?  
- What specific skills / knowledge can you offer?  
- What can be gained from this work?  
- Why is this important to our citizens?
Summary

There are no questions asked yet.

Ask the first one!
Measurement for Improvement

Scott Purdie and Nathan Devereux
I'm not sure if it's worked or not. How will I know?

Hmmm! If the force you cannot feel, DATA you must use
Introduction

By the end of this session you will...

- Be familiar with the 3 core measures of the collaborative
- Understand why using data for improvement is beneficial
- Understand why plotting data over time is so important
3 Core Measures

A shift from unplanned to planned activity and an increase in anticipatory care planning.

- Rate of unplanned bed days per 1000 over-65 population (National)
- Rate of unscheduled GP home visits per 1000 over-65 population, (Local data)
- Percentage of Key Information Summaries for frail population (Local data)
Different Uses of Data

Measurement for accountability
Measurement for research
Measurement for improvement

Why do we need data for improvement?
Why do we need data for improvement?

- To understand what needs improved
- To understand variation
- For testing changes
- For monitoring progress
- To tell the story of your improvement journey
Averages before and after a change

Results for 3 units

Does this show an improvement?

Maybe!
“When you have two data points, it is very likely that one will be different from the other.”

W. Edwards Deming
Run Charts

Display data to make process performance visible

- Time is along the X axis
- Centre line is the median
- Your measure on the Y axis

Chart showing a run chart with data points and median line.
Baseline data

Can you get data back in time?

If not start collecting data ASAP
Example of Data Collection Tool

Will help to show impact of changes

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<thead>
<tr>
<th>Team</th>
<th>Practice</th>
<th>Index</th>
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<tbody>
<tr>
<td>LDWF1</td>
<td>Rate of unplanned hospital bed days per 1,000 pop for patients aged 65+</td>
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<th>Number of unplanned hospital bed days 65+</th>
<th>Practice</th>
<th>Population 65+</th>
<th>Rate of unplanned bed days per 1,000 pop 65+</th>
<th>Annotation</th>
<th>Baseline</th>
<th>Extended</th>
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Measurement Submission Overview

- Share your data on a monthly basis, including the three core outcome measures
- Overview of the collaborative produced each quarter
- Additional measures can be added to the data collection tool
Roles and responsibilities
Thoughts and Questions?
What data will you need locally?
By the end of this session you will...

- Be familiar with the 3 core measures of the collaborative
- Understand why using data for improvement is beneficial
- Understand why plotting data over time is so important
Next steps

- Data collection tool will be made available
- Work as a team to agree your measurement plan
- Clarify your roles and responsibilities
Learning about improvement methods

Workshop on the essentials of quality improvement to support you through the frailty collaborative

Tom McCarthy- Improvement Advisor
Michelle Church- Improvement Advisor

Improvement Hub
Enabling health and social care improvement

#LWiCFrailty
GLA0919
By the end of this session you will...

• Understand a bit more about the change package
• Receive an introduction to some of the theory of how we spread improvement and some of the potential challenges
• Recognise the importance of adapting things to suit where you work
• Explore your roles in spreading improvement
• Know where you can get more help
Love Story
A love story…
STANDING ON THE SHOULDERS OF GIANTS
The Living Well with Frailty Driver Diagram

**Outcome**

- People 65 years and over with frailty, will experience a good life and death, including more time at home or in a homely setting.

**Primary driver**

- Identify people aged 65 and over living with frailty in the community.
- Support people living with frailty to plan for their future care needs, and when appropriate, death.
- Support people living with frailty to access preventative support in the community.

**Secondary drivers**

- Case find people at risk using the e Frailty Index
  - Create diagnosis for frailty
  - Multi-dimensional assessment
  - Monitor change and deterioration over time
- Anticipatory care planning conversations, including recording information in the Key Information Summary
  - Carer’s assessment
  - Informal/Adult carers support planning
- Essential activity for all members of the collaborative

- Key worker
- Exercise interventions and physical activity
- Lifestyle and nutritional interventions
- Polypharmacy review
- Reablement
- Vaccinations
- Community-based geriatric services
- Palliative and end of life care

- Communication and collaboration within a multi-disciplinary team, including a multidisciplinary review
  - Understand what support is available in communities and how to access support
  - Use quality improvement methods, including data over time, to drive improvement

- Develop effective multidisciplinary team working focused on person-centred, preventative care.

- Reduce unplanned hospital bed days
- Reduce unscheduled GP home visits
- Increase use of anticipatory care planning and Key Information Summary
What do you think?

1. Get into small groups (approx 3-5 ish)
2. Discuss what you have just heard about the change package
3. We’ll take a couple of points of feedback from the room
What next?
Spreading change: diffusion of innovation

We believe we are here

The Model for Improvement

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Act | Plan
---|---
Study | Do

Act - Plan - Study - Do - Act
You are already starting to use this!!!

Model for Improvement
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Aim
Measures
Ideas
Sequential Tests

Project Charter
Using PDSA Cycles to embed change

Learning through the PDSA approach increases the degree of belief that the change idea works locally.
Tell your story

What?
Build evidence that your change ideas work

Why?
For scale up to work, others will need to be convinced your change ideas work

How?
Working as a team, learn through measuring your ideas in practice
Simulation

**Aim:** Longest spin

**Measure:** Time of spin

**Tools:** Coins, timer (phone), PDSA worksheet, run chart

**Approach:** In teams run cycles using different coins, spinning technique, person and surface. Nominate scribe and timer.

**Beware:** PDSA cycles are not about tasks (don’t need a meeting to decide who is spinning...)
## Simulation

<table>
<thead>
<tr>
<th>#</th>
<th>Plan</th>
<th>Do</th>
<th>Study</th>
<th>Act</th>
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<tbody>
<tr>
<td></td>
<td><strong>What questions? Theories?</strong></td>
<td><strong>Prediction</strong></td>
<td><strong>What do you see? How Long?</strong></td>
<td><strong>How did what you see match prediction?</strong></td>
</tr>
<tr>
<td>1</td>
<td>Large coins last longer</td>
<td>10p = 10 seconds</td>
<td>Started to wobble. Time = 7</td>
<td>No, Three seconds short. Large Size/weight</td>
</tr>
<tr>
<td>2</td>
<td>2p will spin longer</td>
<td>2p = 10 seconds</td>
<td>Started to lose spin fast. Time = 8</td>
<td>Two seconds short. Size may be more important</td>
</tr>
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</table>

**Data Collection on a Run Chart**

![Run Chart](chart.png)
The King of Sweden’s Lion
The King of Sweden's Lion
Summary: 5 key messages

1. **Look at the change package.** We are standing on the shoulders of giants. There is lots of evidence out there of what can help improve practice. Take ideas and shamelessly plagiarise. Help us add to the change package.

2. **Beware of the spread trap.** Think about how we can embed new ways of working into everyday practice.

3. **Use improvement methodology** to build belief. Use tests of change to implement. Adapt your ideas as you go. Engage with people e.g. your home teams, people using services and relatives/ carers

4. **Tell your story.** You will need to gather data (quantitative and qualitative) satisfy yourselves that changes are leading to improvements.

5. **Ask for help:** the LWIC team will be delighted to support you.
Next Steps

1. Review the change package as a team and consider the essential and optional change ideas.
2. Plan where you want to start. What is your preferred change idea for your system? Why?
3. Think about how you are going to spread changes in your system. How will you convince yourselves and others that a change is an improvement?
4. Consider what help do you need? What skills are available in the team and what do you want additional support with?
5. Be prepared to share your learning.
Checkout

Write on a post it note your key lightbulb moment from this session and leave on a flip chart.
References and Further Reading

- Slow Ideas: *Some innovations spread fast. How do you speed the ones that don’t?*, Atul Gwande
  [https://www.newyorker.com/magazine/2013/07/29/slow-ideas](https://www.newyorker.com/magazine/2013/07/29/slow-ideas)
- Adapt: why success always starts with failure, Tim Harford (2011)
- King of Sweden’s Lion: [https://www.iflscience.com/plants-and-animals/this-is-the-hilarious-result-of-an-18thcentury-guys-attempt-to-stuff-a-lion/](https://www.iflscience.com/plants-and-animals/this-is-the-hilarious-result-of-an-18thcentury-guys-attempt-to-stuff-a-lion/)
- Quality Improvement Zone, NES Education for Scotland (NES)
  [https://learn.nes.nhs.scot/741/quality-improvement-zone](https://learn.nes.nhs.scot/741/quality-improvement-zone)
# Learning from across Scotland

<table>
<thead>
<tr>
<th>Table</th>
<th>Topic</th>
<th>Speaker / Details</th>
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<tbody>
<tr>
<td>1</td>
<td>Virtual Community Wards</td>
<td>Karen Simpson, Aberdeenshire</td>
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<tr>
<td>2</td>
<td>Learning from an enhanced community service</td>
<td>Rebecca McLaren &amp; Eileen Downham, Angus</td>
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<tr>
<td>3</td>
<td>Oban living well project</td>
<td>Pauline Jesperson, Argyll and Bute</td>
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<tr>
<td>4</td>
<td>Challenges in raising the profile of eFrailty Index</td>
<td>Roddy Ireland, East Renfrewshire</td>
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<td>5</td>
<td>What has been happening.......Frailty at the front door and ACP</td>
<td>Kim Britton, Dumfries and Galloway</td>
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<td>6</td>
<td>Improving Frailty Care at Midlock GP Practice</td>
<td>Ken O’Neill, Glasgow City</td>
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<td>7</td>
<td>Developing the approach to frailty- bringing the learning from the MDT in to primary care</td>
<td>Emma Cummings, Inverclyde</td>
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<td>8</td>
<td>Progress to date in North Lanarkshire</td>
<td>Liz Kearny, North Lanarkshire</td>
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<td>9</td>
<td>The electronic frailty index in Midlothian HSCP</td>
<td>Jamie Megaw, Midlothian</td>
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<tr>
<td>10</td>
<td>Integrated care teams and community nursing</td>
<td>Amanda Taylor, Perth and Kinross</td>
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<td>11</td>
<td>Locality response service</td>
<td>South Lanarkshire</td>
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<td>12</td>
<td>Rockwood clinical frailty scale – experience in West Dunbartonshire</td>
<td>Fiona Wilson, West Dunbartonshire</td>
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<td>13</td>
<td>Answering your questions on SPIRE and eFI</td>
<td>Thomas Monaghan, Living Well in Communities Mike McCabe, ISD</td>
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<td>14</td>
<td>Living and dying well: the ambulance service contribution</td>
<td>Andrew Parker and Vicky Burnham, Scottish Ambulance Service</td>
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<td>Physical activity and its role in prevention and treatment of frailty</td>
<td>Eileen McMillan, Health Scotland</td>
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<td>15</td>
<td>The housing sector’s role in meeting the needs of people living with frailty</td>
<td>James Battye, People, Place and Housing (HIS) Ann Murray, TEC Telecare Sarah Robertson and Stephen Harkins, Fire and Rescue</td>
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Team Working - It’s over to you

Objectives
At the end of this session you will have:

• the opportunity to **reflect** on today’s learning and plan as an AWAY TEAM
• the opportunity to produce a **revised draft** of your project charter [**final version due: 18th October**]
• produced a **concise list of actions** with clear roles and responsibilities.
Why have a project charter?

Antoine de Saint-Exupery (1900-1944)
What makes up a good project charter?

- Aim
- Rationale
- Scope
- Changes
- Measures
- Team & Leadership

Adapted from noun project art. Created by ‘BomSymbols’.
Why is a project charter important?

- Clear (SMART) co-designed aim
- Connects the WHOLE team (home & away)
- Leadership commitment & Team ownership
- Manages expectations
- Clear roles and responsibilities
- Plans what needs to be done by when
- Identify and mitigate possible risks
### Primary driver

**Identify people aged 65 and over living with frailty in the community.**

- Case find people at risk using the e Frailty Index
  - Create diagnosis for frailty
  - Multi-dimensional assessment
  - Monitor change and deterioration over time

**Support people living with frailty to plan for their future care needs, and when appropriate, death.**

- Anticipatory care planning conversations, including recording information in the Key Information Summary
  - Carer’s assessment
  - Informal/Adult carers support planning

**Support people living with frailty to access preventative support in the community.**

- Key worker
  - Exercise interventions and physical activity
  - Lifestyle and nutritional interventions
  - Polypharmacy review
  - Reablement
  - Vaccinations
  - Community-based geriatric services
  - Palliative and end of life care

**Develop effective multidisciplinary team working focused on person-centred, preventative care.**

- Communication and collaboration within a multi-disciplinary team, including a multidisciplinary review
  - Understand what support is available in communities and how to access support
  - Use quality improvement methods, including data over time, to drive improvement

### Secondary drivers

- Essential activity for all members of the collaborative

---

### Outcome

People 65 years and over with frailty, will experience a good life and death, including more time at home or in a homely setting.

- Reduce unplanned hospital bed days
- Reduce unscheduled GP home visits
- Increase use of anticipatory care planning and Key Information Summary

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### Summary

- Identify people aged 65 and over living with frailty in the community.
- Support people living with frailty to plan for their future care needs, and when appropriate, death.
- Support people living with frailty to access preventative support in the community.
- Develop effective multidisciplinary team working focused on person-centred, preventative care.
What resources are on your tables?

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional interventions</td>
<td>Reablement</td>
<td>Bed based intermediate care</td>
</tr>
<tr>
<td>Exercise and physical activity</td>
<td>Polypharmacy review</td>
<td>Community-based geriatric services</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>Primary care MDT</td>
<td>Palliative care</td>
</tr>
<tr>
<td>Reduce alcohol</td>
<td>Falls management</td>
<td>Hospital at home</td>
</tr>
<tr>
<td>Reduce social isolation</td>
<td>Anticipatory care planning</td>
<td>Anticipatory care planning</td>
</tr>
<tr>
<td>Housing adaptations</td>
<td>Immunisation</td>
<td>Adult carers support planning</td>
</tr>
</tbody>
</table>

- Mild
- Moderate
- Severe
What resources are on your tables?
What resources are on your tables?

<table>
<thead>
<tr>
<th>Action /Activity</th>
<th>By When?</th>
<th>Away Team Member Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Alec</td>
</tr>
<tr>
<td>1) Brief the Home Team</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>2) Meet with LIST</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>3) etc....</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>4) etc....</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) etc....</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

R = Responsible       A = Accountable       C = Consulted       I = Informed
YOU!

Credit for noun project logos: ‘parkjisun’ & ‘Georgiana Ionesca’
For the remainder of session (till 4pm)

• Please work in your teams to discuss and refine your project charter.
• Plan your next steps as team using the Action Plan-RACI

You may wish to discuss:
- Your SMART aim
- What cohort of citizens/patients will you be focusing on?
- The change ideas you plan on testing
- How will you measure these?
## Team planning

<table>
<thead>
<tr>
<th>Table</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Angus</td>
</tr>
<tr>
<td>2</td>
<td>Perth and Kinross - North West Perthshire Cluster</td>
</tr>
<tr>
<td>3</td>
<td>Perth and Kinross – Kinross, Bridge of Earn, Errol and Abernethy Cluster</td>
</tr>
<tr>
<td>4</td>
<td>Aberdeenshire</td>
</tr>
<tr>
<td>5</td>
<td>Highland and Western Isles</td>
</tr>
<tr>
<td>6</td>
<td>Midlothian</td>
</tr>
<tr>
<td>7</td>
<td>Glasgow City</td>
</tr>
<tr>
<td>8</td>
<td>Clackmannanshire and Stirling</td>
</tr>
<tr>
<td>9</td>
<td>East Dunbartonshire</td>
</tr>
<tr>
<td>10</td>
<td>West Dunbartonshire</td>
</tr>
<tr>
<td>11</td>
<td>Dumfries and Galloway</td>
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<tr>
<td>12</td>
<td>North Ayrshire - Arran Medical Group</td>
</tr>
<tr>
<td>13</td>
<td>North Ayrshire - Largs Medical Group; Cumbrae Medical Practice</td>
</tr>
<tr>
<td>14</td>
<td>South Ayrshire</td>
</tr>
<tr>
<td>15</td>
<td>South Lanarkshire</td>
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</table>

## Queen Elizabeth Suite

<table>
<thead>
<tr>
<th>Table</th>
<th>Team</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Argyll and Bute</td>
</tr>
<tr>
<td>2</td>
<td>East Renfrewshire</td>
</tr>
<tr>
<td>3</td>
<td>Inverclyde</td>
</tr>
<tr>
<td>4</td>
<td>North Lanarkshire</td>
</tr>
<tr>
<td>5</td>
<td>Renfrewshire</td>
</tr>
</tbody>
</table>
Collaborative timescales

19 Sept
27 Feb
June
Oct
On your marks, get set.....

✓ Share your learning with your Home Team

✓ Start your tests of change

✓ Document your progress and record data over time
Safe journey