SIFS FLASH REPORT Cohort 13 Lauren Stevenson

QI Project Team:

Lauren Stevenson
Pharmacist

QI Project Aim:

To ensure that 100% of patients living with HIV over the age of 40 are, or have been, offered a statin before the end of 2025 in line with recently updated BHIVA (British HIV Association) guidance for the primary prevention of cardiovascular diseases in people living with HIV.

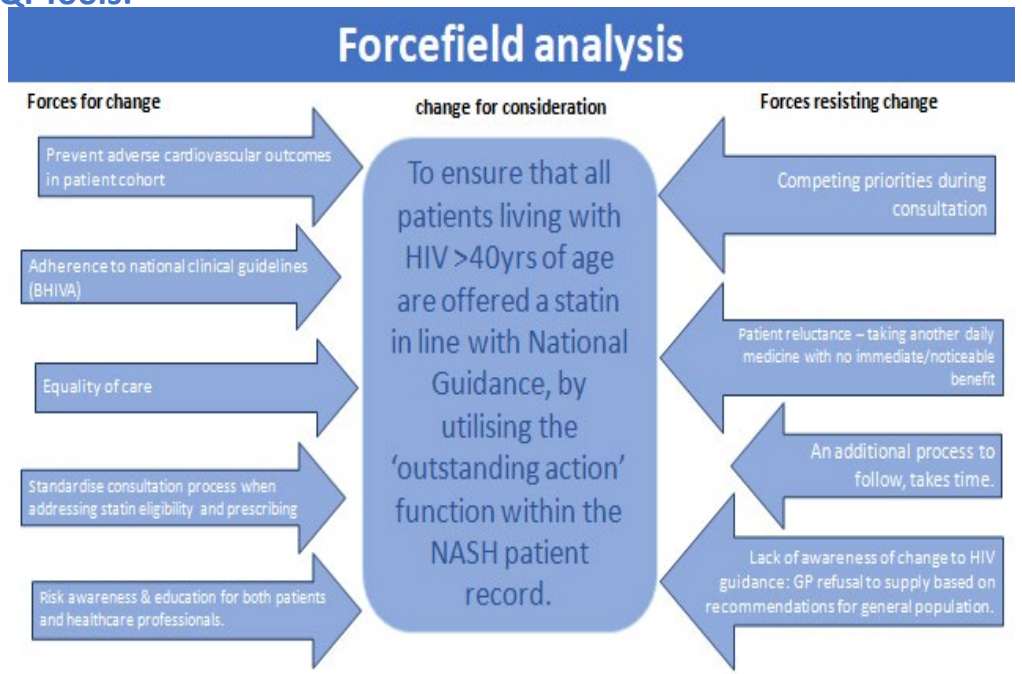
Stage of QI Journey:

Testing changes

Change Idea I am going to test below:

I am going to utilise the 'outstanding actions' function within the NASH HIV system to highlight the need for intervention. This can be tracked and reports pulled for numbers. It will serve as a prompt during consultations.

QI Tools:



ACT

I suspect that I would plan to adopt this change idea, and I believe the rest of the team will be on board with this. It is easy to implement and acts as an effective reminder/prompt to discuss statin use during consultations with eligible patients. This function is under utilised and could be used for other aspects of care , especially if this project helps to normalise use of the function. However, depending on the patient and situation, the prompt may be missed. So, while I would plan to adopt this change, I am starting to consider other changes we could also make to help reach the national target.

PLAN

Test: Following identification of eligible patients within clinic blocks, update the patient record with an 'outstanding task' note about statins. This will appear in the consultation review tab within the NASH system to prompt discussion with patient.
Tasks: Inform MDT. Ensure task marked 'complete'.
Predictions: This will have a positive impact, patients will have been pre-identified, saving time, and the prompt will be visible to the clinicians at clinic appointments.

STUDY

Yet to fully assess the impact of the intervention as there are still a couple of weeks to run. I am however aware from post-clinic MDT discussions that some patients have since been offered and accepted a statin. Will confirm if this is a direct result of the intervention.
I have the option to run a report to determine the number of outstanding actions on the system but need to figure out a way to make this helpful until I am confident that all eligible patients have been captured.

DO

I had initially planned to run the test with one clinic block for one of the ID consultants but decided to do so with each clinician block over a period of 5 weeks as the number of eligible patients identified initially was low.

Area of Learning: The importance of starting small and including the wider team, also understanding our 'system' before doing anything. I had initially thought this project was my responsibility to plan and implement, but I learned quickly that success for a team requires more input than from one person alone. Learning about the whole QI journey in depth will be hugely beneficial for future project work.
Successes: Engagement from the HIV MDT, proactive approach to meeting national targets was welcomed. Clinicians aware of change idea, hopefully in time more 'outstanding action' notes will be actively followed up. Test of change was small, not overly demanding of clinician's time, but effective when seen in the review tab.
Challenges: Competing priorities during consultations as often patients come with a specific or ongoing issue to discuss at appointments. If time is limited, there may not be sufficient time to discuss the option of starting a statin. Also, some clinicians do not complete the review documentation during the consultation, and therefore the 'outstanding action' to highlight need to offer a statin is only noticed once the consultation has ended. Time consuming to identify all eligible patients as this involves reading patient notes in depth and checking ECS records. Moving forward will need to ensure the whole MDT take responsibility for identifying patients who require intervention.

FLASH REPORT Cohort 13 Ann Williams

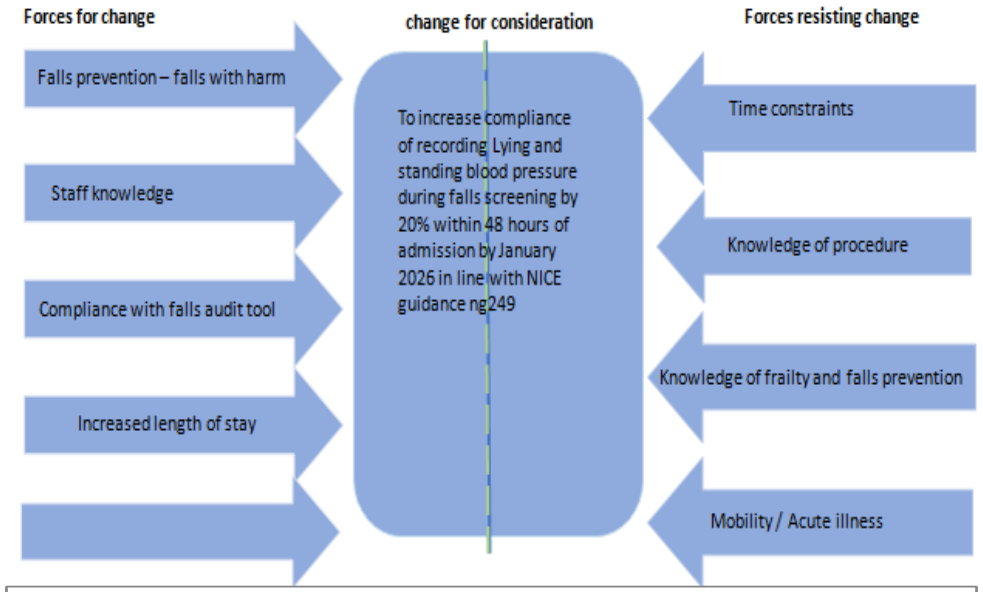
QI Project Team:
Broadford Ward

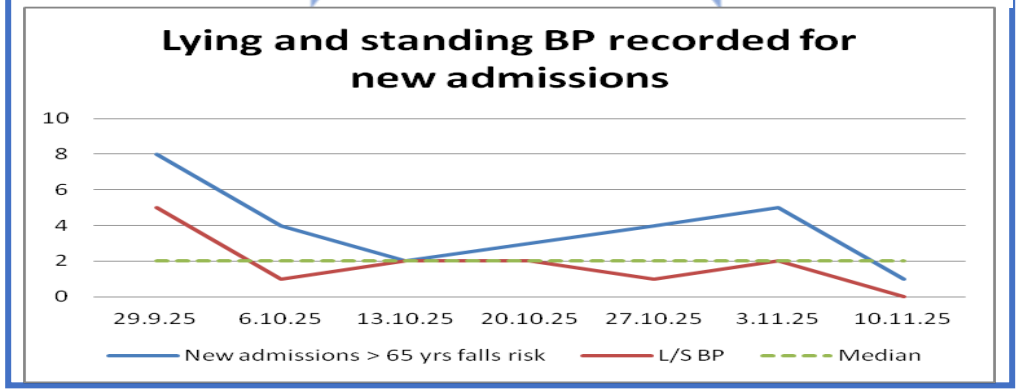
QI Project Aim: To increase compliance of recording Lying and standing blood pressure during falls screening by 20% within 48 hours of admission by January 2026 in line with NICE guidance ng249

Stage of QI Journey:
Testing the change

Change Idea I am going to test below:
Cycle 1: Staff education

Forcefield analysis





ACT

Do you plan to adapt/adopt/abandon?

Adapt

- **continue with work so far adding in personal 1:1 with staff.**
- **Look at ways L/S BP measurement can be part of usual ward routine, for example when getting patients up for their wash, or when being seen by physiotherapist.**

PLAN

Test: Promote L&S BP through staff education
Tasks:

- **Small educational display on white board outlining the importance of L&S BP**
- **How to guide attached to all obs machines**
- **Survey staff / collect data (completed assessment)**

Predictions: Some improvement in understanding of the need to do L&S BP, improved recording, barriers highlighted

STUDY

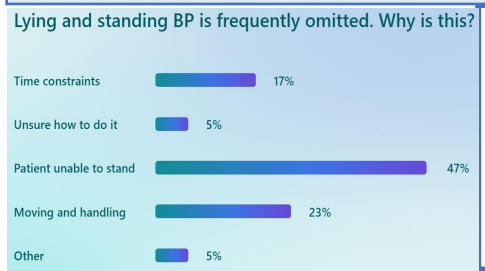
How do your predictions compare to what happened?

- **L/S BP is not embedded in falls prevention on the ward.**
- **It was hoped that raising awareness of why it is important to do it would have improved the data.**
- **More data needs to be collected.**

DO

Write what happened when you ran your test

- **A number of patients were unable to stand therefore unable to test.**
- **Not all patients had a documented note to say L/S BP could not be done and the reason why?**
- **If a patient had documented evidence of a L/S BP being attempted or unable to due to mobility, then this would have been a positive result.**



Area of Learning: Learning how to use the various tools and finding out how to use Microsoft forms was a bonus. Being able to review, understand and explain data to my colleagues.
Successes: The QI course has been a great experience, giving me lots of ideas to take QI projects forward in a systematic way rather than trying to do everything at once.
Challenges: Time constraints due to staffing shortages. Staff stress and receptiveness to improve.

SIFS FLASH REPORT Cohort 13 Lindsay Tinney

QI Project Team:
Occupational Therapy Team, Badenoch & Strathspey

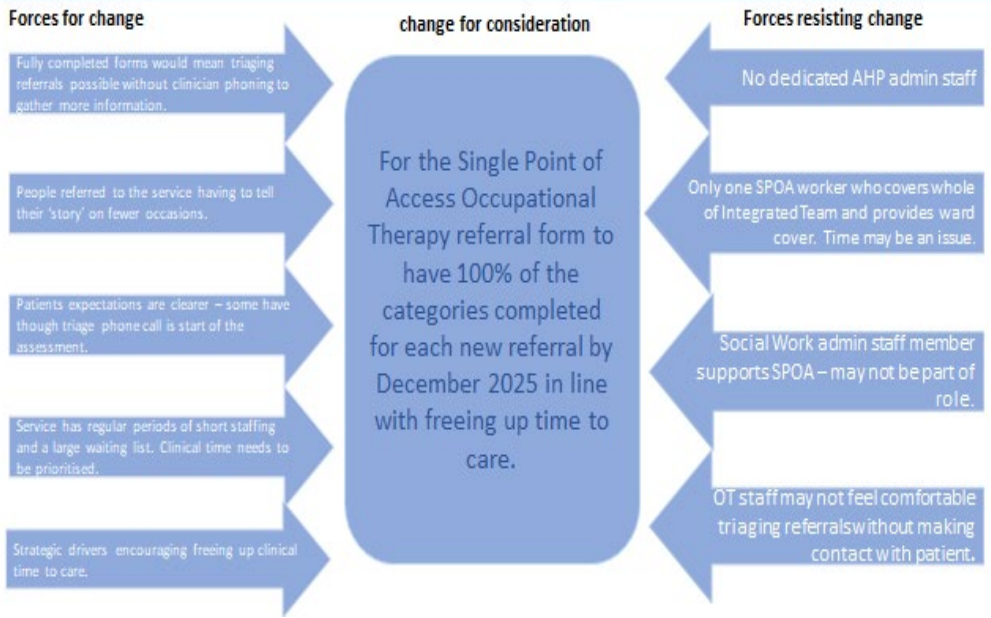
QI Project Aim:
For the Single Point of Access Occupational Therapy referral form to have 100% of the categories completed for each new referral by December 2025 in line with freeing up time to care initiatives.

Stage of QI Journey:
Testing Changes

Change Idea I am going to test below:
By completing an education session with SPOA and SW admin staff to increase understanding of the need for all categories to be completed.

QI Tools Used:

Forcefield analysis



ACT Do you plan to adapt/adopt/abandon?
Adopt – Education Session re OT SPOA referral form for all new admin staff.
Adopt – prompt card for admin staff (balancing measure)
Adapt – next test to measure if having increased % completion of SPOA referral form has impacted clinician time/need for triage phone calls.
Next cycle will need to consider OT Duty worker response.

PLAN
Test: Complete an Education session with SPOA and SW admin staff to increase understanding around SPOA OT referral form.
Tasks: Plan the Education Session, Carry out the Education Session, Monitor completion rates before and after Education Session.
Predictions: Admin will provide further insights re full completion, SW admin role may not include SPOA tasks, only phone cover during SPOA absence, lack of time, overall the completion rate will increase.

STUDY How do your predictions compare to what happened?
Predictions – Education session was received well as predicted, understanding around need for the information was received well as predicted, SW staff member proactive where uncertainty re SPOA roles was not correctly predicted, prediction re lack of time incorrect as time didn't impact completion, prediction re increase of completion was correct as completion rate has increased from below 50% to 87.5%.

DO
Write what happened when you ran your test
- Planning the Education Session was straight forward.
- Difficult to complete session with both staff together, so had to be completed as individual sessions.
- Positive engagement and feedback from both admin staff members.
- Insights given to why full completion not been achieved previously, including feeling self conscious, people not wanting to provide information to admin staff, uncertainty based on previous referral pathways
- Admin staff created their own prompt card to have by the phone.

Area of Learning: Learning for me has mostly been around the QI Journey. The course has really helped me understand the processes of the QI journey, learning about the QI tools and the importance of data to allow change to be meaningful. The mix of online, face to face and presenting components worked well to keep the course interesting but also to consolidate learning effectively.
Successes: Successes include increased understanding re the OT referral process and what comes next for the admin staff involved in receiving initial enquiries. The admin staff making their own flash card to prompt the questions they need to ask was a very positive outcome (balancing measure). At the point of identifying the problem/aim statement the % completion rate for the SPOA form was below 50%. Following the education session (change) the % completion of the SPOA form was 87.5% which is a significant improvement toward 100% aim. I have a project starting which I now feel much more prepared for and look forward to proactively using QI techniques and tools within this new project.
Challenges: I signed up to the course in a rare period of full staffing for the team. There was significant staffing difficulties which developed just before starting the course. It was a challenge to prioritise project work over clinical work when so short staffed. However, persevering through this time was important as I could see that the outcome of the project should help free up clinical time, which in turn helps when the team is short staffed. Implementing the change happened much later than I'd hoped, so more time for completion of the PDSA cycle needed to identify if the change was successful.

SIFS FLASH REPORT Cohort 13; Morven Shone

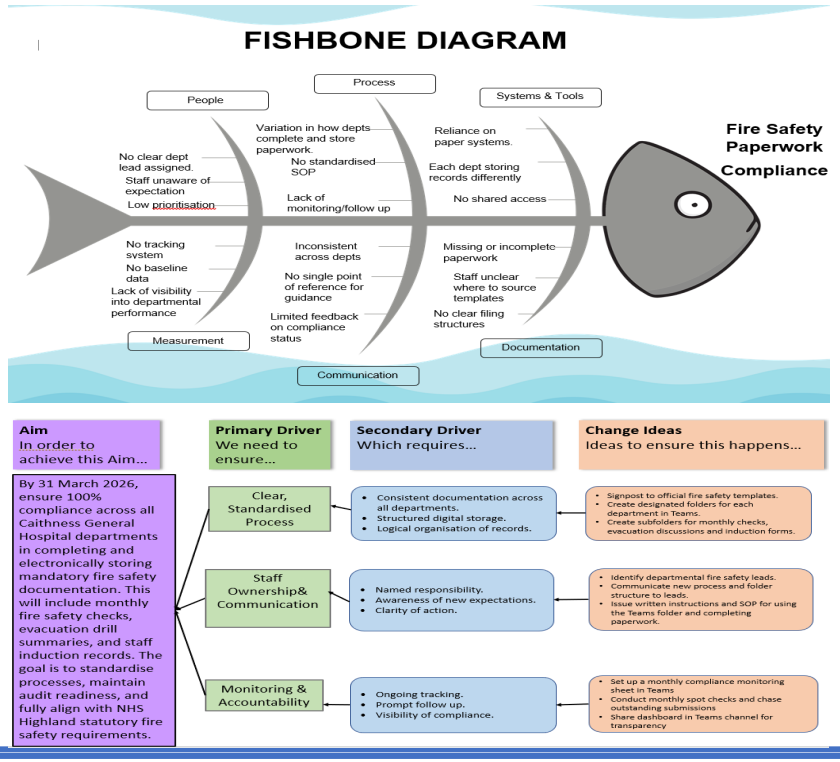
QI Project Team:
CGH SLT

QI Project Aim: By end of March 2026, ensure 100% compliance across all CGH Departments in completing and electronically storing mandatory fire safety documentation. Goal is to standardise processes, maintain audit readiness and fully align with NHS H statutory fire safety requirements.

Stage of QI Journey:
Spread

Change idea: Establish a standardised electronic system for storing fire safety records and monitoring departmental compliance.

QI Tools Used:



ACT

The Fire Safety Advisor saw the value of the new system early on, and now it's being rolled out at other NHS sites. I'm continuing to review progress each month, support departments that need help, and look at ways to make the process even easier.

PLAN

I noticed that departments were inconsistent in how they completed and stored fire safety records. To fix this, I created a Teams channel with clear folders and templates for everyone to use. I checked my plan with the Fire Safety Advisor to make sure it would work for everyone.

Measures:
Outcome: % compliance across departments.
Process: Timeliness of submissions
Balancing: Impact on staff workload

STUDY

Some departments were unsure about using Teams or worried about the time needed to upload old records. I offered support and spoke to staff individually to help them get started.

- In month one, 17 out of 18 departments completed their checks on time.
- In months two and three, 16 departments did.
- In month four, 15 departments did.

The same departments missed out each month—some did the checks but didn't upload the documents, while others didn't do the checks at all. I gave feedback, reminded them of the new process, and raised ongoing issues with the Fire Safety Advisor. I also made it a regular item at monthly governance meetings.

DO

- First, I tested the new system with the Admin Department, who gave positive feedback. Then I tried it with Facilities, who suggested a few tweaks, which I made.

Area of Learning: Importance of providing clear, step by step guidance for Teams document uploads to avoid errors and confusion. Need for ongoing communication and reminders to ensure departments complete both checks cand compliance spreadsheet. Early engagement with Fire Safety Advisor to validate process and make practical adjustments.

Successes: New system makes it much easier to identify which depts have completed monthly checks, ensuring fire audit readiness. Positive feedback received from department leads and Fire Safety Advisor. The pilot is now potentially being rolled out within Raigmore.

Challenges: Staff were initially unfamiliar with uploading documents in Teams which caused delays and errors. Certain departments did not follow instructions for saving and deleting previous records. Some departments completed checks but failed to update the compliance spreadsheet. Required additional guidance and adjustments after pilot phase and feedback from Fire Safety Advisor.

Next Steps – Continue monthly reviews to monitor compliance and gaps. Follow up on issues identified during audits and explore the possibility of automated reminders via Teams.

SIFS FLASH REPORT Cohort 13 Rebecca Robertson

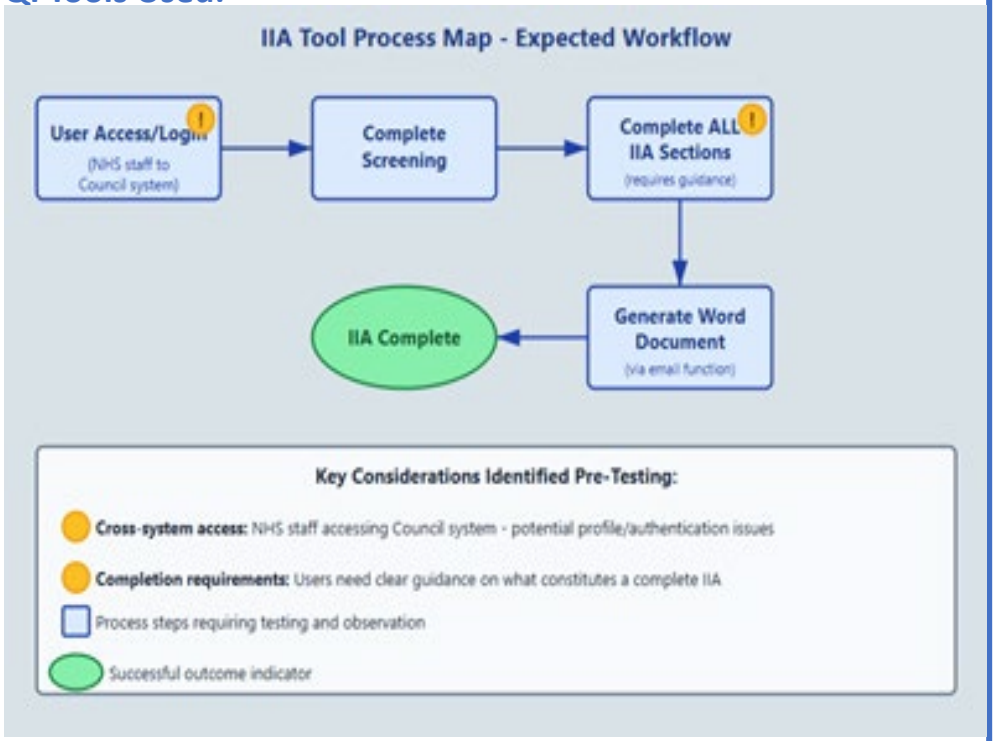
QI Project Team:
Argyll & Bute HSCP Public Health and Argyll & Bute Council

QI Project Aim: **By November 2024, test whether the Council's Integrated Impact Assessment (IIA) Tool is suitable for HSCP use, ensuring staff can complete an IIA to meet statutory Equality and UNCRC duties, and identify issues needing resolved before wider rollout.**

Stage of QI Journey:
Testing - First test cycle; wider rollout planned pending updated guidance.

Change Idea I am going to test below: Test whether HSCP staff can successfully use A&B Council's IIA Tool to complete an Integrated Impact Assessment from start to finish.

QI Tools Used:



ACT

Adopt: Use of the IIA Tool for HSCP Integrated Impact Assessments. Updated guidance that explains the need to complete all sections before the email function works.
Adapt: Work with NHS IT to ensure HSCP staff profiles are recognised by Council systems. Add a troubleshooting section for login and email issues.
Abandon: None at this stage - the tool remains viable for rollout.

PLAN

Test: Test the usability of IIA Tool with HSCP staff completing an Integrated Impact Assessment.
Tasks: Ask two Health Improvement Leads to complete a test IIA. Observe access issues. Check screening, sections, and final email works. Identify barriers to completion and usability problems.
Predictions: Staff able to complete most of IIA. Issues around access/workflow, may require more guidance.

STUDY

How do your predictions compare to what happened? Predictions accurate: HSCP staff able to complete most of IIA, but usability issues emerged. Key learning: Access failures caused by NHS Microsoft profiles not matching Council requirements and users unaware every section must be completed before the final email output triggers. Updated guidance clarifies completion requirements. The tool is suitable for HSCP purposes once users have correct access and clear instructions.

DO

Write what happened when you ran your test: Maggie attempted to test the tool but was unable to access it due to an incomplete NHS Microsoft profile - revealed IT configurations required for all future HSCP users. Jenny was able to log in, complete screening, and complete an IIA. She could not generate the final "Email Word Doc" output. I worked with her and identified the cause: one required section was not fully completed. Once corrected, the tool worked successfully.

Area of Learning: Human Factors & Systems Testing
Successes: We successfully tested the Council's Integrated Impact Assessment (IIA) Tool with HSCP staff and confirmed it meets our Equality and UNCRC duties. Testing identified a usability issue with the email function when sections were incomplete; once clarified, I updated HSCP guidance and the tool worked correctly. Testing highlighted essential IT actions needed for wider rollout. **Challenges:** One tester could not access the system due to their NHS Microsoft profile not being recognised, showing dependency on correct IT setup. Another tester completed an IIA but could not generate the final Word document until all sections were finished, reinforcing the need for clearer guidance and IT readiness. **Next steps:** Resolve IT profile issues before next test cycle and trial updated guidance with new users.

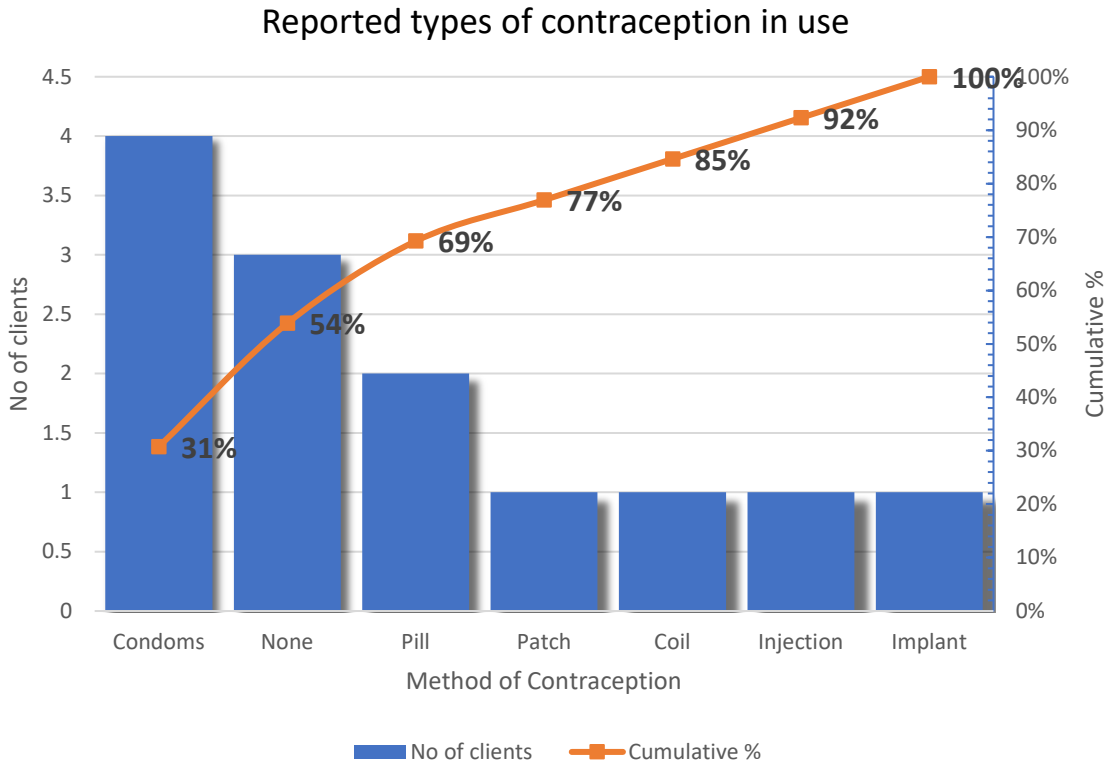
FLASH REPORT Cohort 13 Beth Gray

QI Project Team:
Beth Gray, Family Nurse Partnership

QI Project Aim:
By December 2025, 80% FNP clients on caseload A at highest risk of unplanned pregnancy will have received a brief intervention in relation to contraception choices, aligning with FNP Highland's improvement plan 2025/26.

Stage of QI Journey:
Testing changes

Change Idea:
Delivery of contraception brief intervention to clients at highest risk of unplanned pregnancy.



ACT

Adapt

- Use videos
- Free motivational interviewing style discussion
- Focus use of infograph to highlight difference between current method and potential choices
- Ensure message delivered consistently re hormones if concern for client

PLAN

Test: Utilise contraception's choices videos and infographs to discuss coil and implant

Tasks: Ensure access to materials (print out/device)
Develop spreadsheet for data collection
Develop client feedback form

Predictions: Client will feel more informed about the coil/implant
May result in request for sexual health referral

STUDY

Client completed feedback questionnaire – found intervention helpful and easy to understand & felt more informed – 0/10 prior and 10/10 after
Likely to use coil/implant - 0 prior and 8 after
No referral to sexual health
Client reflected that the infograph was a large influencing factor in her consideration of LARC
Nurse felt communication style was too directive in limiting info to coil and implant. Client didn't mention this but happened to be interested in method directed to discuss. Videos took up a lot of time in visit
Client had concern re hormones – discussed natural occurrence and low doses

DO

Intervention was delivered to client – shared videos on implant and coil and reviewed infographs on coil, implant and compared with infograph for current method of contraception

Offered referral to sexual health and reminded of referral process

3 further PDSA cycles were completed with the brief intervention evolving based on client and nurse feedback. The brief intervention now consists of using an online short quiz "what's right for me", a client led MI discussion of contraception choices and use of the infographs to compare the clients current method of contraception to methods highlighted from quiz completion. Testing has expanded to caseload B and the successes highlighted in the data have been replicated.

Area of Learning: Maintaining integrity of MI principles were important. Multiple PDSA cycles help pinpoint required adjustments and assess their usefulness. Use of the pareto chart aided in narrowing down the target group which made the project feel more manageable.

Successes: Reframing messages about hormonal contraception has been well received by clients and nurses. Use of infographs has had the most significant impact from client feedback. 40% increase in referrals for long acting reversible contraception (LARC) in caseload A. Caseload B has seen similar results. Clients have reported that the information is useful and easy to understand and there is an increase in consideration of LARC.

Challenges: Client's variability in engagement during visits, time pressures, it remains unknown whether the successes seen in early testing will be sustained and whether they will result in a reduction of unplanned second pregnancies amongst FNP clients.

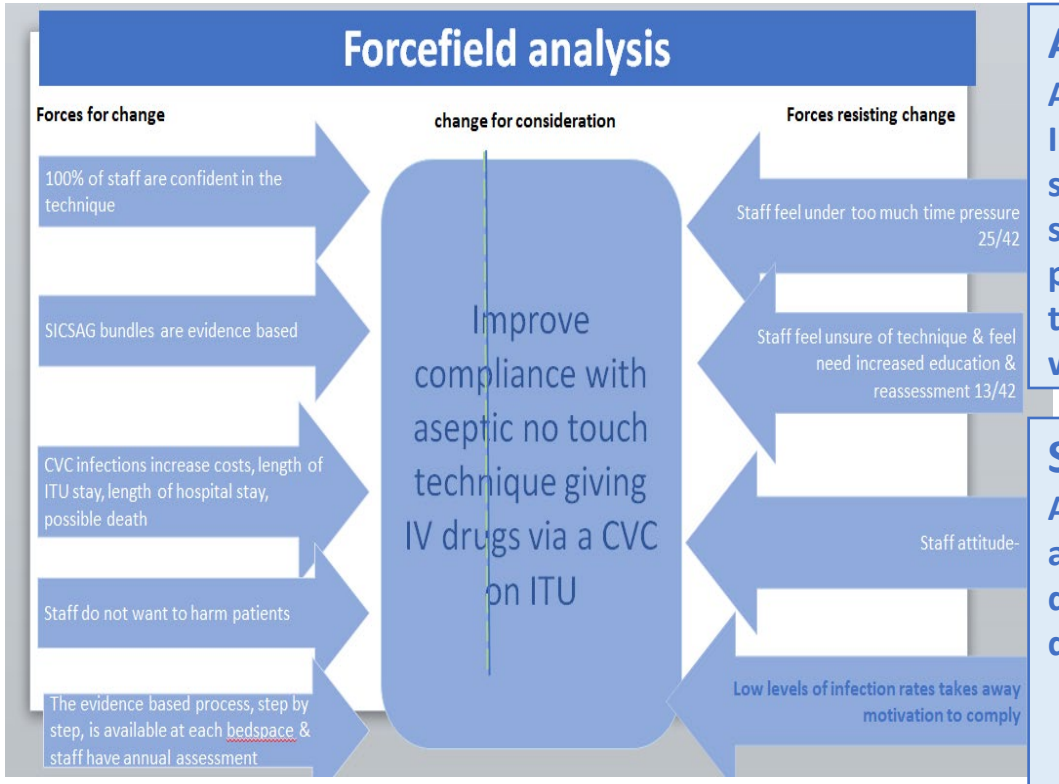
FLASH REPORT Andrew Silversides SIFS Cohort 13

QI Project Team:
ITU Raigmore nursing team

QI Project Aim: To achieve 100% in aseptic no touch technique (ANTT) when giving drugs via central lines, by 31/12/25, to achieve Scottish Intensive Care Society's standards of care bundles for CVC's.

Stage of QI Journey:
Testing changes

Change Idea I am going to test below:
I will add a reminder to the safety brief to all staff to follow the ANTT correctly & not to use the red trays for packaging/ non-clean items, & by raising awareness that should increase compliance



ACT

Adapt
I will continue to put a reminder on the safety brief, but not all the time to avoid staff switching off to the message. I will also plan to speak to staff on an individual basis to point out omissions in their practice when seen

PLAN

For one week I will have a reminder on the safety brief regarding the main area of non-compliance, ie. Putting non-clean items in the clean red tray. I will then measure if this changes practice by observing 10 drug administrations to see if this increases compliance

STUDY

As predicted, by reminding staff each day about the proper procedure, full compliance did increase, but only from 10% to 40%. This did not meet the aim of 100% compliance.

DO

I have now observed 10 IV drug administrations. Of these 10, 4 were fully compliant compared with only 1 out of 10 which were observed before the intervention

Area of Learning: The whole course was a great area of learning. I now have a good understanding of the QI process & how I can use this to implement future changes on my Unit whether large or small. I have learnt how to use various QI tools, how to analyse data, & also how to do Microsoft forms surveys which I found to be a great way to accumulate staff feedback
Successes: My Microsoft forms survey was very successful with a reply rate of nearly 60%. It gave me a valuable insight into why staff do not comply fully with the ANTT. This has identified areas I can work on in the future, eg. 60% of staff report time pressure as a major factor in non-compliance, but putting packaging in the red trays, the main observed area of non-compliance, does not actually save any time.
Challenges: Staff attitude is the biggest challenge. From my survey, staff believe they are already compliant & are under too much time pressure to change their practice, & this may be difficult to overcome.

FLASH REPORT Cohort 13 April Sutherland

QI Project Team:

- April Sutherland – Dietetic Service Manager, Raigmore Hospital
- Rosalin Caithness, SCN Ward 7A
- Ward 7A nursing staff

QI Project Aim:

To increase the number of completed Malnutrition Universal Screening Tools upon admission to 80% on ward 7A by December 2025 in line with the Healthcare Improvement Scotland Food, Fluid and Nutrition Standards, 2014

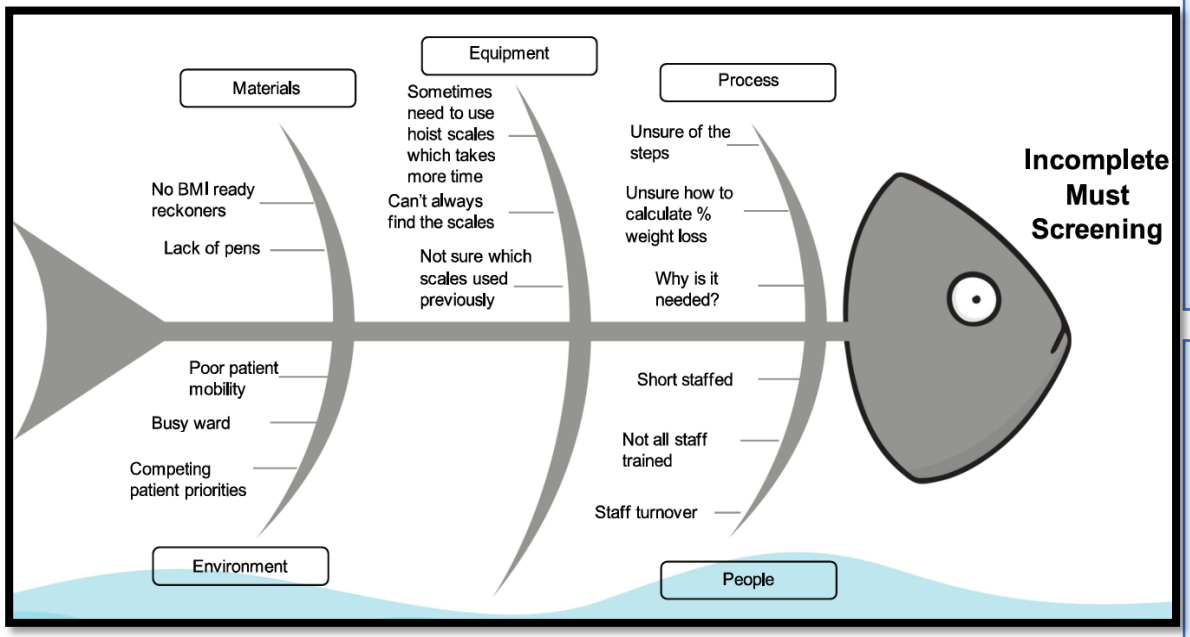
Stage of QI Journey:

Testing changes - PDSA cycle

Change Idea I am going to test below:

1. Raise awareness of MUST by highlighting need for completion on handovers/safety brief and QI board
2. Use a QI board with information to share at huddle
3. Have ready reckoners for BMI and weight loss in every patient file
4. Have a set day for weighing patients and completing MUST scores on the ward – SCN to communicate with staff and will re-audit in a month

QI Tool - Fishbone



ACT

1. Adapt change to increase presence of MUST on ward to try and increase compliance
2. Adapt plan as still some progress to be made
3. Achieved 80% aim but not maintained one week later therefore agreed to adapt plan

PLAN

1. Use handovers and safety brief to remind staff about completing MUST
2. Complete the QI board on the ward to include why MUST is important, how to complete and some ready reckoners
3. BMI and weight loss ready reckoners made available in all patient files
4. Rosalin to do a poll with staff to see which day they wish to set for weights and MUST scoring and then implement – in progress

STUDY

1. Compliance rose to 40%. Often % weight loss was not completed leading to incomplete scores
2. Compliance increased to 60%
3. Compliance increased to 80% and staff happy that they have the tools available. One week later it dropped to 60% despite no changes being made. I was off sick and there was less dietetic cover so less reminders about MUST. Also, a new QI project has started on the ward which may have impacted the focus

DO

1. Discuss fishbone diagram with staff. Predict that MUST compliance will improve as currently at 0% compliance
2. QI board filled with information next to where the huddle takes place. Some ready reckoners made available on the board. Predict that score will increase further
3. All files have the appropriate ready reckoners available so that nursing staff have all required tools available in file. Predict that compliance improves.

Area of Learning: Huge learning curve about QI in general but I was surprised to find some of the barriers to completing MUST screening and the lack of knowledge around malnutrition. In terms of my own learning, keeping QI small and doing it in small chunks has made QI feel so much more achievable. I find it difficult to accept that MUST is not a mandatory TURAS module for nursing staff. I've learned lots about national reporting and FFNC standards during this project

Successes: Going from 0% to 80% over the course of 2 weeks was a real success! The staff seemed motivated to take MUST forward at the ward level and seeing the improvement gave them a real boost. It was also a pleasure to work with a SCN who was motivated to make improvements. Being able to contribute to the work of FFNC group at Raigmore.

Challenges: I struggled to give the QI the time it needed initially but I think this was because I was thinking too big for my project. When I had a solution fall into my lap for that problem and I had to change direction completely, things started to make more sense. Keeping the momentum going with the need for MUST completion on the ward has been difficult when I've not been around. Nursing staff have such a difficult job with acute, competing demands that I can understand that MUST is further down the list. However, now that nursing staff are aware that it is a national measure, I'd hope that it is kept at the forefront of their lists!

FLASH REPORT - Cohort 13 Margaret MacDonald – Ops Lead

NHS Highland Vaccination Service
Service Delivery Centre

Stage of QI Journey: PDSA 1 Testing Change - Collaboration with key stakeholders.

QI Project Aim: Increase service user feedback from 0% to 60% by April 2026. This will be achieved through automated Customer Satisfaction Feedback surveys. This aligns with Complaints, Feedback, Care Opinion, NHS Highland's Engagement Framework. Together We Care Strategy and Annual Delivery Plan.

Change Idea I am going to test below:
Automated Service User Feedback Survey supported by M365 Forms and Outlook.

AIM	Primary Drivers	Secondary Drivers	Change Ideas
Increase Service User Feedback from O% to 6O% by April 2026. This will be within NHS Highland's Service Delivery Centre to achieve this. This aligns with Complaints, Feedback, Care Opinion, Together We Care Strategy and Annual Delivery Plan.	**Shared Vision, People & Culture**	Whole service inclusive shared vision & purpose. Feasible Colleague Service User feedback is acted upon.	Create process SOPs outlining improvement expectations from staff.
	Safe, Efficient & Effective Supporting Systems and Processes	Equitable digital and non-digital user friendly inclusivity. Service User Satisfaction feedback opportunities.	Create digital & develop paper based Service User Feedback Survey. Use MS Forms, Outlook. Explore AI Co Pilot Automated Survey Agent.
	Effective Communications & Engagement	Standardised Feedback processes & associated SOPs. Support locality Vaccinating Teams to take ownership and implement safe Service User improvements.	Identify common themes. Mitigate potential risks. Implement Feedback audit review meetings with Vaccination Service multi-disciplinary teams.
	Data Protection/GDPR	Communications & Engagement Plan.	**Create &develop a Vaccination Service Improvement Action Plan**
		Information Governance. Identified Responsible Officer.	Responsible Officer to establish safe information handling awareness sharing both excellence & areas of improvement. Maintains awareness.

ACT

Adapt & Adopt – PDSA 1
Amend following initial test of change feedback Survey questions.
Roll out automated Customer Satisfaction Survey.
Embed within the Service generic email auto reply.
Collate relevant data by Theme.

PLAN

Objective: to use the Feedback Survey form and for it to effectively capture service user feedback.
PDSA 2 - roll out and use the Service User Feedback Survey across the wider Vaccination Service.

Predictions: 60% service users will use the digital form and it will be an effective and efficient tool in terms of capturing service user experience.

STUDY

Analyze relevance of the data received.
Analyze participant feedback in terms of ease of usability/ time taken to complete.
Analyze any issues and/or risks i.e. technical difficulties based on feedback.
Identify unpredicted anomalies i.e. data duplication
Assess for collaborative strategies to streamline processes across the wider service.
Assess equitability and digital inclusivity.

DO

Service Delivery Centre used the feedback survey to test data flow and to ensure all relevant data was captured for analysis.
Implement Feedback audit review/meetings with wider Vaccination Service Ops Lead colleagues.
Create service processes and associated SOP/s.
Create and establish non-digital and enhanced digital Survey roll-out at community clinics i.e. posters with embedded QRs codes.

Area of Learning: Understanding QI tools framework in terms of breaking down a largescale project into manageable and testable aims to progress though through related PDSA cycles. This has allowed me to focus the project to one area of the Service initially, prior to adapting & adopting the change across the whole service.

Successes: Change Aim was extremely welcomed as presently no routes of Feedback to improve service deliverables. This was met with enthusiasm to participate and roll out across the wider Vaccination Service.

Challenges: Time management due to nature of my role and mentorship constraints. Isolation. Mentorship.

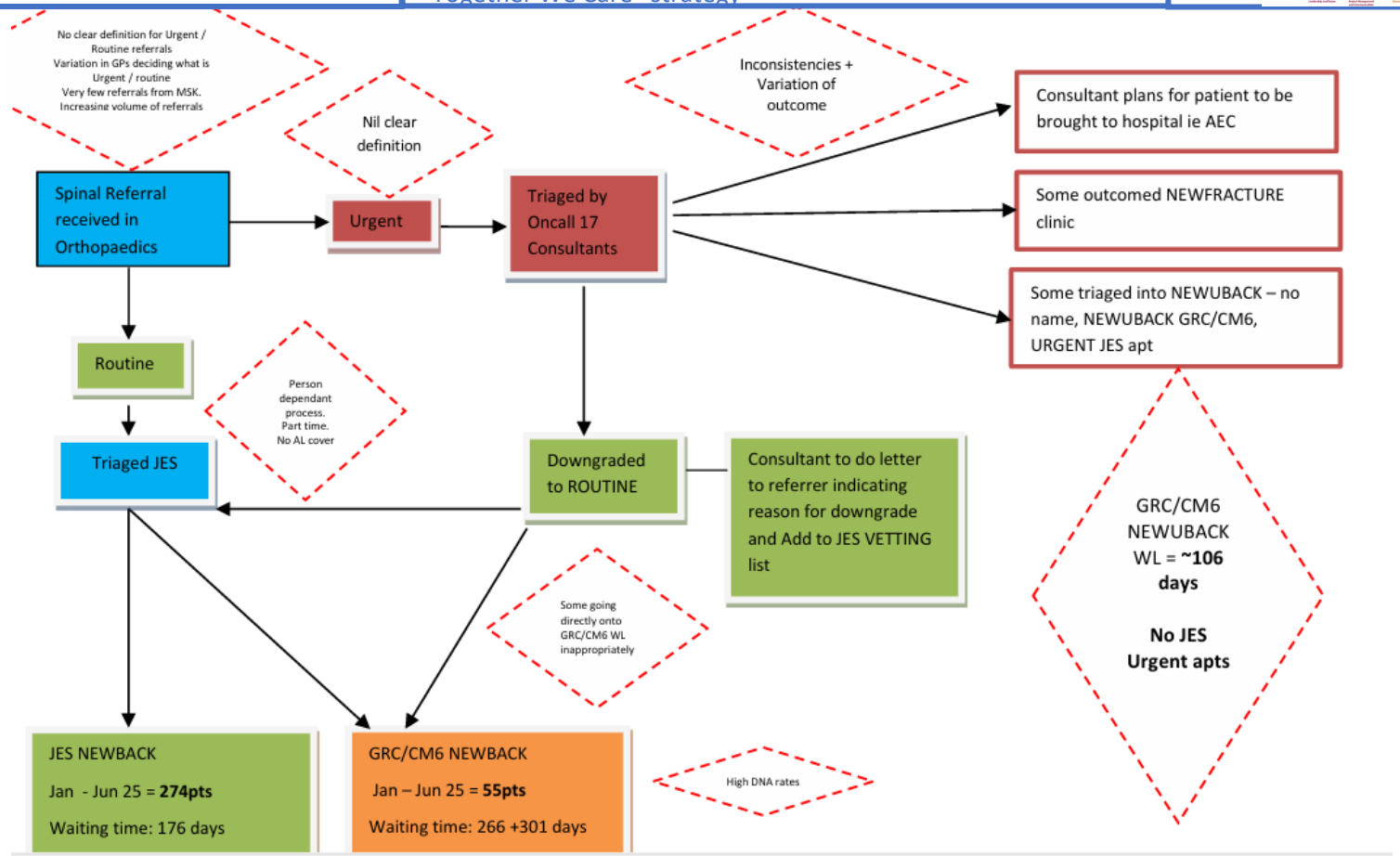
FLASH REPORT Cohort 13 Joanna Surtees

QI Project Team:
NHS Orthopaedic Spinal Service

QI Project Aim:
To reduce the waiting list for urgent Spinal Surgeon appointments from 4 months to < 6 weeks by May 26, by formalising routine verses urgent orthopaedic vetting criteria for consistent clinical decision making to align with the NHS Highland "Together We Care" strategy

Stage of QI Journey:
Implementing changes

Change Idea I am going to test below:
Cycle one: Test a new Urgent Spinal Vetting Aid Memoire for on-call consultants



ACT

Adapt document based on feedback.
Valued / helpful comments

Continue to review:

- **Feedback from another Consultants using the new criteria**
- **Feedback from patients**
- **Monitor WL time for Spinal Surgeon appointments**

PLAN

- **Meeting with 2 Spinal Surgeons and head of Elective Orthopedics 25/09/25 to discuss Spinal Pathway**
- **Modify existing Orthopedic Vetting Process Map for spinal patients**
- **Urgent Vetting Aid Memoire discussed at Orthopedic Audit afternoon 01/12/25 with all available Orthopedic consultants**

STUDY

Feedback from consultant was mostly positive. Suggested changes to the document taken on board and will adapt for the next cylce of testing.

DO

- **Consultant identified to trial Aid Memoire with spinal patients referred into spinal service during on-call date and provide feedback**

Area of Learning: Exploring use of QI tools and measures in large complex systems. Breaking down processes into areas where small meaningful changes can occur.
Successes: Busy department, yet still able to create relationships and foster improved ways of working
Challenges: Time, multiple stakeholders, challenging clinical presentations.