Blackburn with Darwen's integrated Wellbeing Service: making what we have work better

The Wellbeing Service has created a single point of access for all referrals from either professionals (health and wider) or individuals who may require some support or intervention on a wide range of health issues, as well as picking up the wider determinants of health.

"We wanted to make referrals into healthy lifestyle schemes easy for everyone. We built on existing resources to deliver a more integrated service that puts behaviour change and person-centred approaches at its heart."

Alison Abbott, Wellbeing Service Manager, Blackburn with Darwen Borough Council

What we did and why

NICE guidance about behaviour change recommends that programmes should be based upon sound knowledge of community needs and to build on existing skills and resources.

In early 2013 the Council, in partnership with the CCG, commenced discussions around how the organisations could take a more systematic approach to self-care and long term condition (LTC) management and deliver a more integrated service to the public – a new 'Wellbeing' Service – rather than a range of individual service offerings.

The aims were:

- To create a simple and clear access point to support citizens to make healthier lifestyle choices rather than the multiple, traditional, single issue services that cause confusion for both referrers and patients alike
- To reduce health inequalities by helping people to make the changes they want in their lifestyle to improve their health and wellbeing by offering practical advice and supported signposting into appropriate services

Outcomes and impact

By remodelling existing resource we were able to create a wellbeing hub where all referrals are channelled through to our hub advisors. These advisers have the necessary skills to offer brief advice and use motivational interviewing to assess the person's readiness to change and initiate a process of shared decision making.

Health Trainers also play an important face to face role, providing information, support and guidance to individuals wanting to make changes towards a healthier lifestyle. Behaviour change and motivational interviewing are their speciality.

By working in this way we have:

- Identified and engaged with individuals from priority communities or groups as determined by local health evidence
- Supported training and development of health champions and volunteers
- Offered advice and support around healthy lifestyles and the wider determinants of health to people
- Provided supported signposting into partner agencies such as Age UK, Shelter, and Lancashire Mind, in order to provide a truly holistic approach to improving health and wellbeing

What we learnt

The Wellbeing Service performs against targets set by Public Health. These targets include reaching a predefined volume of brief interventions and more in-depth contact with the public with some target population groups identified within that. Subsequently the targets are then focused around the quality of outcomes with individuals, how working with the service has improved their wellbeing and maintaining change.

- By creating a single point of access for our healthy lifestyle services we have increased incoming contacts by 400%
- We have delivered almost 2000 one-to-one interventions with over half of all clients living within the top 20% most deprived wards
- The service is now achieving almost three times the volume of brief interventions and double the volume of face to face engagements with the public and recording more detailed and relevant outcomes in the process

Alison Abbott said: "We know that focusing on the whole person, including the wider determinants of health, is making a difference to peoples' lives because they tell us so; 76% report improvements in their mental health too.

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Meaningful activity for older people in care to improve their wellbeing

Alive! has developed a wide range of innovative activity sessions, shaped by older people in care homes and day centres, which improve their mental health and wellbeing. The content includes music, song, poetry, art, dance and gentle movement, sharing works of art from museum collections, creative use of iPads for reminiscence and bringing schoolchildren in to exchange stories, paint and make short films with older people.

"Every older person should be recognised as an individual who has a story to tell, the need for connection and purpose, the right to choices, and the ability to enjoy life."

Simon Bernstein, Chief Executive, Alive!

The Alive! approach

There are over 400,000 older people living in residential care in the UK, 80% of them living with some form of dementia. Hard-pressed social care staff do not always have the time, skills or resources to engage them in meaningful ways.

Alive!'s mission is to put older people's wellbeing at the heart of care across the UK. Over the last eight years, while working in 450 care homes in nine counties across the south and south-west of England, we have developed tools and techniques enabling over 10,000 older people to shape the content and direction of activities, so they are meaningful and interesting.

- We provide high quality, person-centred activity sessions, which combat loneliness, anxiety and depression in care homes, day centres and other care settings
- We use our specialist knowledge and experience to train social care staff, building their capacity and confidence to develop more meaningful activity and relationships with older people as part of their everyday interactions

Alive!'s work successfully delivers aspects of NICE QS30 Dementia: independence and wellbeing and QS50 Mental wellbeing of older people in care homes.

Improved mental health and social interaction

All our sessions are dementia friendly. We encourage gentle movement with energising and relaxing activities, we support hands-on use of digital apps to make music or revisit a hobby and enable people who struggle with verbal communication to experience comforting touch and sensory stimulation.

Our work was independently evaluated in 2015 by Willis Newson and the University of West of England. The report states:

"Alive! activities impact positively on the mental and emotional wellbeing of those who participate. They provide enjoyable activity, enabling social connections between residents and staff within the care settings, and giving participants opportunities to demonstrate skills, knowledge and to experience a sense of pride and achievement. Activities are observed to provide a 'lift' to the physical and mental energy levels of the older people who take part."

We are now implementing an evaluation framework, which uses the Arts Obs tool recommended by Public Health England, and feedback from care home managers to help develop session content and delivery.

Modelling best practice

An important part of our activity sessions is to motivate care staff to use new ideas in their own work. We also provide on-the-job coaching to embed best practice. Feedback has consistently demonstrated:

- 95% of older people's mood is improved after an Alive! session
- 88% of care homes said their residents were more engaged following an Alive! session
- 87% of Alive! training course attendees reported an increase in knowledge

We have learnt:

- To put participant involvement and choice at the centre of our sessions
- To be rigorous in recruiting and training session presenters, ensuring they know how to be 'with' rather than 'doing to' people living with dementia
- The value of building relationships with care managers and their staff, especially those providing activities who are frequently isolated and under-resourced

We are regularly told by care staff that we are able to connect with people who are normally very hard to reach, that people who do not normally interact at all thoroughly enjoy our sessions, and that their effects can last days.

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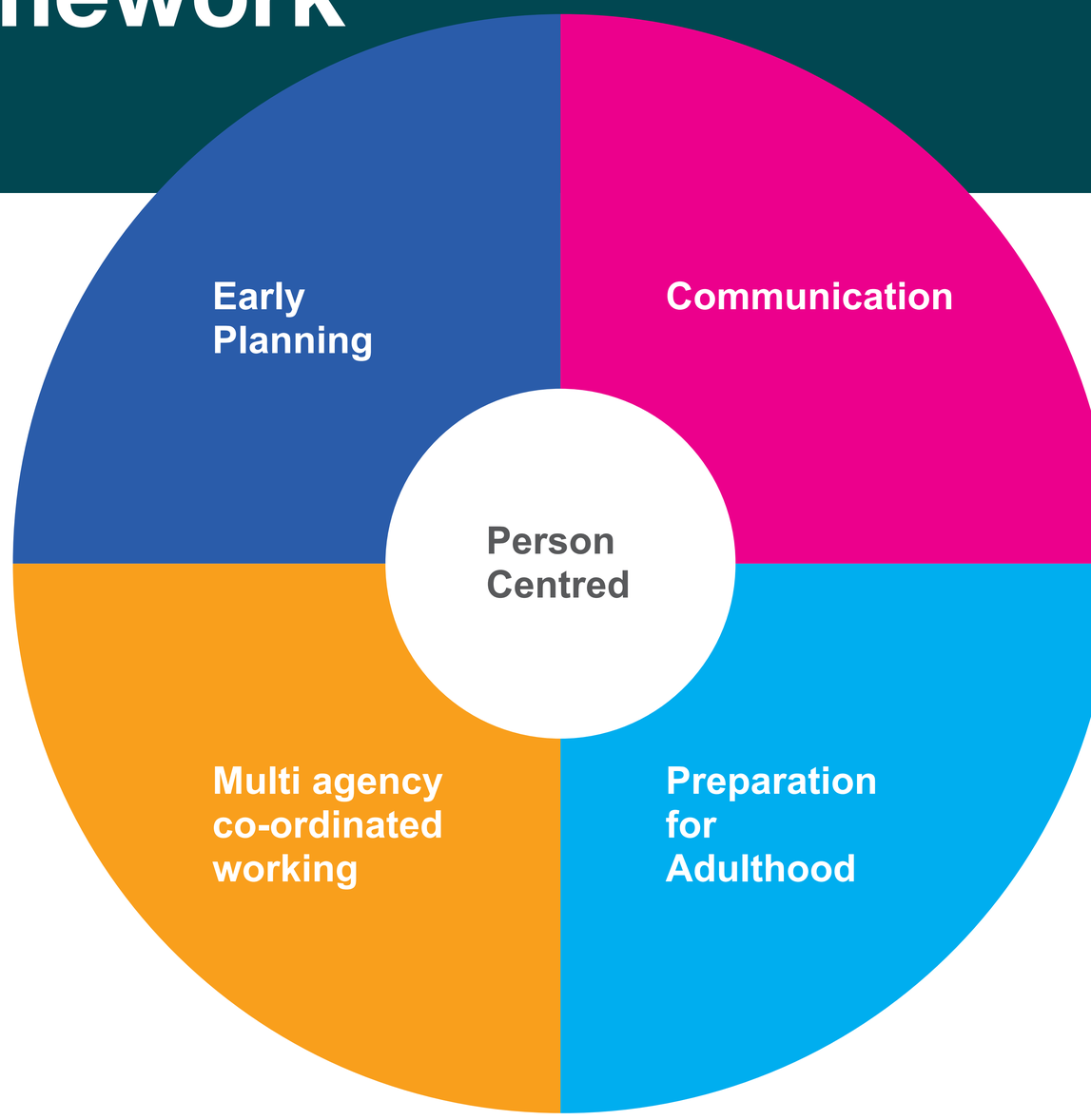
NHS
Health Education England

Learning Disabilities Transition Pathway Competency Framework

The Learning Disabilities Transition Pathway Competency Framework, developed by Health Education England, in partnership with Skills for Health, is a workforce development tool. It supports staff working with young people in transition from children's to adults' services by identifying the knowledge and actions required to ensure a smooth transition.

"Implementation of the Framework will support a well planned, person centred, seamless transition for young people and families."

Carolyn Knight, Programme Manager, Health Education England/Staffordshire County Council



What we did and why

The transition from children's to adults' services can be a difficult and challenging time for young people with learning disabilities and their carers.

Our aim was to improve the planning and delivery of care during transition, and young people's experience of transition, by supporting the development of staff within the transition workforce.

To help organisations identify the development needs of those who work in services with young people in transition we produced a workforce development framework that:

- outlines the **components of effective education and training** for those working with young people in transition
- supports **competency based learning and development** programmes.

A wide range of professionals from across the West Midlands, who work with young people in transition, were involved in the development of the Framework along with **young people with learning difficulties** who were in transition from children's to adults' services.

Outcomes and impact

The Learning Disabilities Transition Pathway Competency Framework was developed.

The Framework provides a consistent quality standard for the training and development of professionals who support young people in transition. It identifies things that people who provide learning disability services during transition need to **know** and **do** to ensure a smooth transition.

The Framework will:

- support a well planned transition for young people
- provide a consistent standard for the skills, knowledge and competencies required in transition
- enable better understanding of the development needs of the workforce
- enable effective training for those working with young people in transition
- support the implementation of **NG43 Transition from children's to adults' services for young people using health or social care services.**

http://bit.ly/LDTransitionFramework

What we learnt

Getting transition right is important for young people, carers and professionals.

The implementation of the Learning Disabilities Transition Pathway Competency Framework, and a ***consistent approach to workforce development*** across all agencies, can help improve the transition process and the experience of transition for young people and carers.

The Framework can support the development of successful transition teams.

The Framework will enable:

- Managers of services to:
  - better understand the development needs of the workforce
  - maximise the contribution of the existing workforce
  - identify new ways of working
  - identify the need for, and development of, new roles
- Education Commissioners
  - to support competency based learning and development programmes
- Service Commissioners
  - to help describe service models, develop specifications and assurance activities.

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NICE Shared Learning Awards 2017

Supporting Health And Promoting Exercise (SHAPE) in young people with psychosis

The SHAPE programme, developed by Worcestershire Early Intervention in Psychosis Service with University of Worcester, aims to provide young people with psychosis a lifestyle and exercise intervention with enhanced physical health screening and monitoring to reduce the risk of cardiometabolic disorders.

"Young people with psychosis are a high risk group for cardiometabolic disorders and premature death. SHAPE offers a comprehensive healthy lifestyle programme to assess risk, prevent weight gain, promote physical health and improve life expectancy."

Professor Jo Smith, Professor of EI and Psychosis and SHAPE Programme Lead, University of Worcester

What we did and why

Young people with psychosis have higher rates of obesity, premature cardiovascular disease and death compared to non-psychotic peers due to smoking, weight gain and adverse changes to metabolic regulation linked to antipsychotic medication and unhealthy lifestyles. NICE (NICE CG178; NICE CG155; NICE QS80; NICE QS102) recommends systematic physical health screening and monitoring for CVD risk, particularly for individuals prescribed antipsychotic medication, and combined lifestyle interventions focused on healthy eating, physical activity and smoking cessation.

SHAPE is a bespoke physical health monitoring and intervention programme for young people with early psychosis. The programme was designed by a collaborative team of EIP clinical staff, clinical psychologists, nutritionists, exercise physiologists and health trainers.

Aims of the programme are to:

- Support young people with psychosis to make lifestyle choices informed by an understanding of their greater risk for obesity, cardiovascular disease and metabolic disorders
- Provide access to healthcare in a positive and socially inclusive environment embracing the importance of 'ordinary lives'

Outcomes and impact

SHAPE offers comprehensive physical health monitoring and a 12-week lifestyle and exercise therapy programme comprising:

- 45 minute education sessions on healthy lifestyle behaviours (smoking cessation, healthy eating, mood management)
- 45 minute exercise session (group aerobic and resistance training and low impact activities such as pilates)
- Individual goal setting

Group based exercise sessions encouraged participants to sample a range of physical activities while reducing social isolation by encouraging peer support within and outside of SHAPE sessions.

SHAPE programme evaluation:

- Comparison of anthropometric data (BMI, waist circumference), lifestyle behaviours (smoking, substance use, diet and physical activity) and clinical measurements (resting heart rate and blood pressure, blood lipids, HbA1c and prolactin)
- Focus group interviews to assess impact and monitoring of programme adherence and barriers to participation

"The sessions have been worthwhile …I have gotten more fit and I have lost weight."

"Because of the nutrition side of things, I'm trying to concentrate more on healthy eating."

What we learnt

Participants had elevated anthropometric and clinical markers at baseline, indicative of increased CVD risk. Following intervention at 12 weeks (n=26) and 12 months (n=16), no change was evident in mean BMI, waist circumference, or any other clinical variable. Positive impacts on lifestyle behaviours were maintained where 7 participants reported eating ~400g of fruit/ vegetables daily, 2 ceased substance use, 2 ceased alcohol use, 4 ceased smoking and 5 were less sedentary at 12 months follow up.

SHAPE supported young people with psychosis to:

- Attenuate their physical health risk following a 12 week exercise and lifestyle intervention and sustained at 12 months follow up
- Make positive lifestyle behavior changes leading to weight maintenance and sustained improvements in physical health
- Improve confidence and self esteem while reducing social anxiety, which improved social functioning and mood

Service user involvement in programme design and feedback provided an iterative service improvement loop and enhanced programme evaluation.

www.mySHAPE.org.uk

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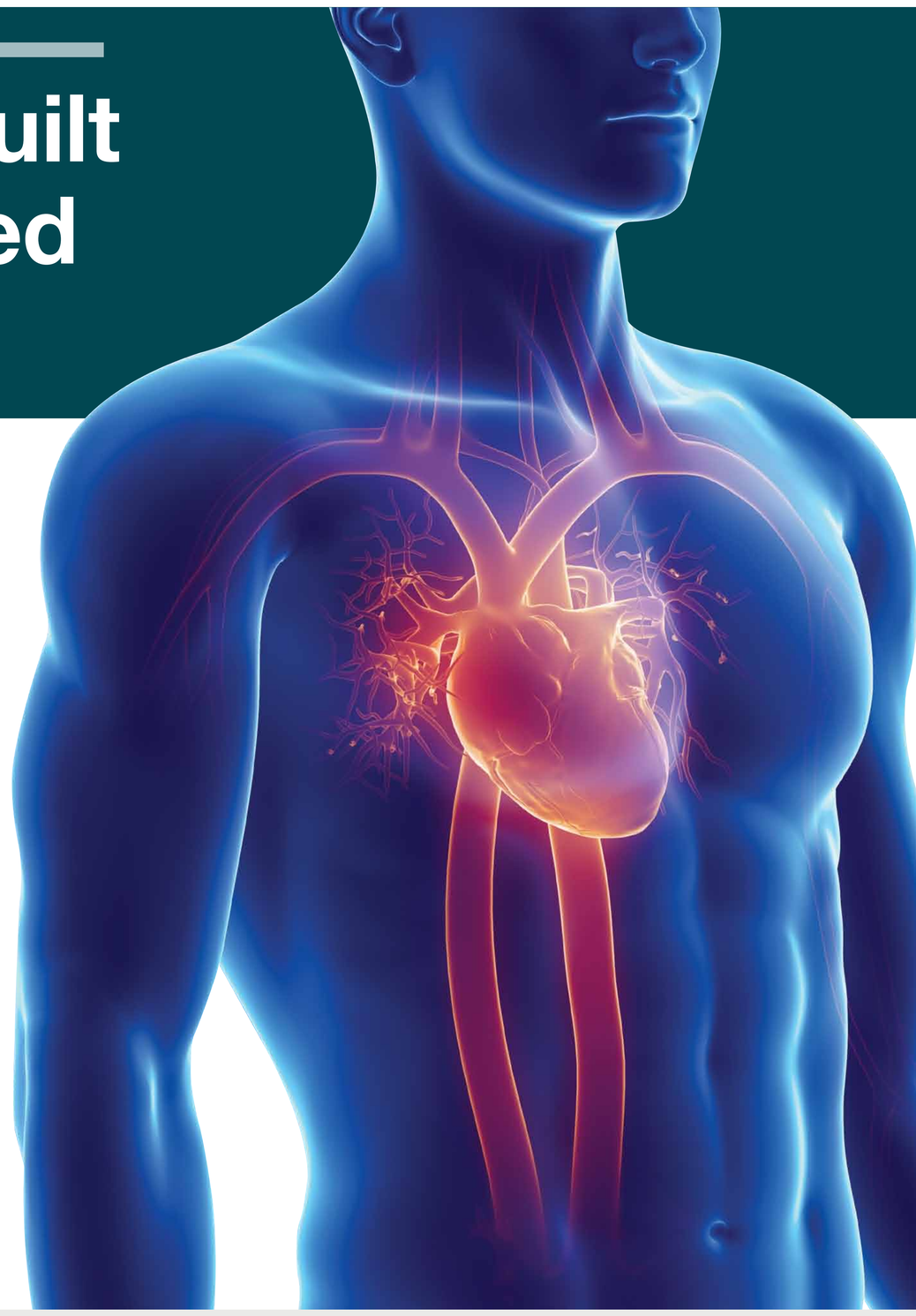
www.nice.org.uk

NICE Shared Learning Awards 2017

Kent Surrey Sussex Academic Health Science Network

Quality and Patient Safety Collaborative

A person-centred pathway built around coordinated integrated systems for improvement



The Kent Surrey Sussex Academic Health Science Network (KSS AHSN) Heart Failure project was established in 2010. It aligns with NICE quality standards and the Best Practice Tariff (BPT) to benchmark process measures through monthly reporting of the National Heart Failure Audit (NHFA) dataset.

"This is a clinically led and data driven quality improvement programme. It aims to tackle variation in care for heart failure patients, improve outcomes and provide a strong platform to discuss and ultimately make key recommendations to providers and commissioners."

Jen Bayly, Cardiovascular Lead for KSS AHSN

What we did and why

We created data dashboards to help demonstrate the existing great work already being delivered; this can be used to strengthen services going forward.

We want to provide others with the information in our dashboards that link quality (the process measures) with outcomes (admissions, LOS, mortality) and finance (Best Practice Tariff and outcome cost modelling).

The uptake of the QPSC care bundle has included 9 KSS provider Trusts who achieved an Appropriate Care Score (ACS) of 63% in Q1 up to 76% in Q4, (averaging 71% over the first year). The ACS gives an indication of the amount of bundle interventions a patient could have received with 100% being all.

Outcomes and impact

In 2016/17, designed as an incentive to improve adherence to NICE guidance, a new mandatory BPT for non-elective admissions for heart failure was introduced. The QPSC dashboards deliver a quarterly trend to track for each Trust whether the BPT will be achieved.

Early positive results

In the top three Trusts to apply the QPSC care bundle within the KSS region, admissions reduced by a combined 190 patients fewer than baseline forecasts. This could account for a potential cash-releasing saving in the region of just over half a million pounds based on the average cost of heart failure admissions in those specific hospitals.

In the top performing Trusts LOS reduced by just over half a day equating to potential gain in capacity of 452 bed days. In the three Trusts reporting the biggest improvements in mortality the estimated mortality fell by 35 lives combined against baseline.

What we learnt

We believe the QPSC Heart Failure Project has made a difference to our population in the Acute and Community Trusts across Kent, Surrey and Sussex, but there is more to do and support is needed to share our learning and move the project out of region.

Building on firm foundations and experience of the past seven years, this project is ready to scale. KSS AHSN has set out a plan to spread this innovation through collaborative working and delivery of the monthly dashboard reports, giving Acute and Community Services a robust tool to demonstrate how the services they deliver improve quality, reduce variation, place patients at the centre of change and deliver value for money.

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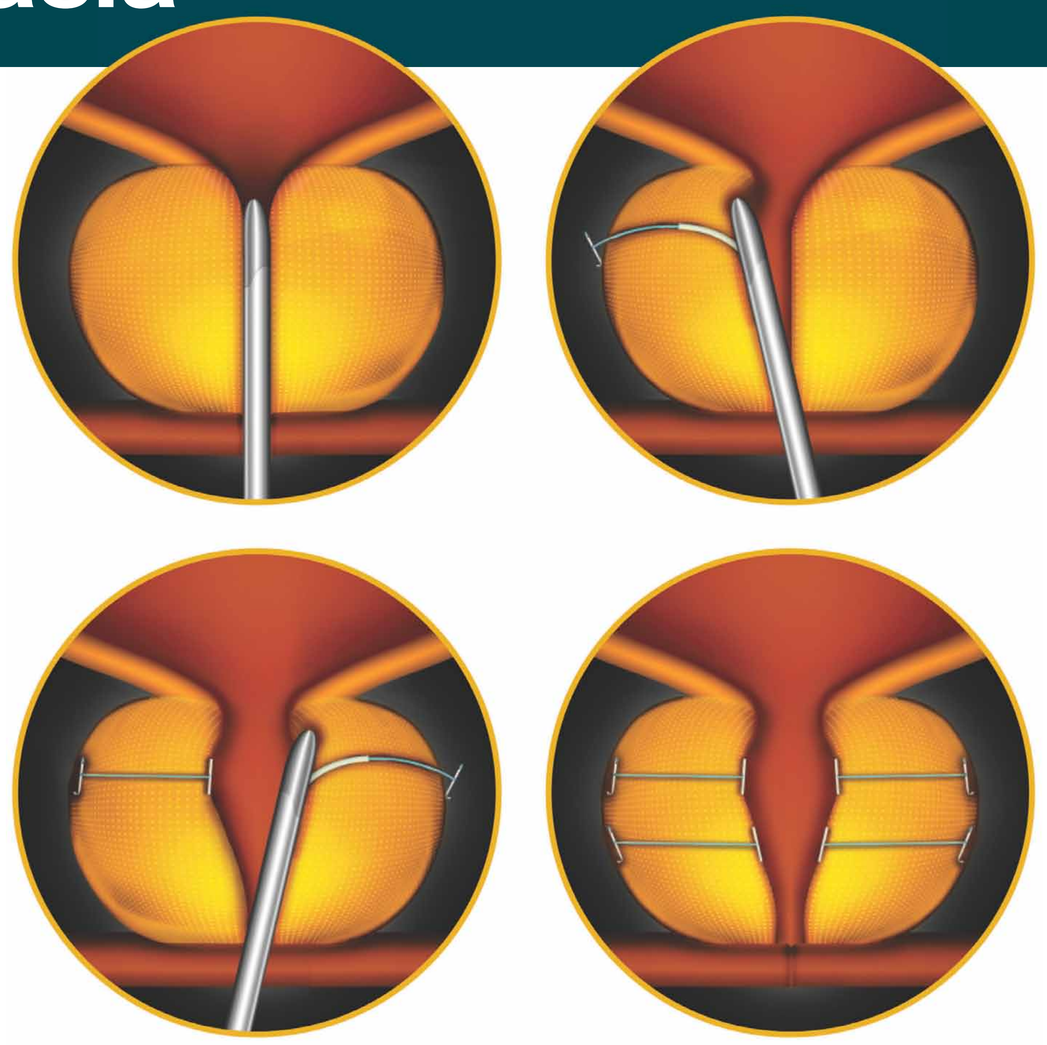
Norfolk and Norwich University Hospitals NHS Foundation Trust

UroLift – An ambulatory treatment for Lower Urinary Tract Symptoms of Benign Prostatic Hyperplasia

At Norfolk and Norwich NHS Trust, the Urology team were looking to create an ambulatory treatment pathway for lower urinary tract symptoms (LUTS) from benign prostatic hyperplasia (BPH). UroLift is a proven treatment, which is recommended by NICE as a cost saving alternative to current surgical options.



"UroLift is a paradigm shift in BPH care; it is cost saving for the Trust, the patients benefit and we are freeing up inpatient bed and theatre capacity for cancer patients."

Mr Mark Rochester, Consultant Urologist, Norfolk and Norwich University Hospitals NHS Foundation Trust

Aim: increase capacity and reduce complications

NNUH is a busy teaching hospital with a large tertiary catchment area and an increasing elderly population. It has significant pressures on waiting times for urological procedures, especially for cancer, and there is an urgent need to free up theatre capacity and inpatient beds.

The current surgical treatment offered to men with LUTS secondary to BPH at NNUH – transurethral resection of the prostate (TURP) or holmium laser enucleation of the prostate (HoLEP) – are effective at relieving the symptoms, but they can be associated with significant post-operative complications, which can prolong length of stay, delay recovery, and can also require further intervention. Permanent side effects can include sexual dysfunction and urinary incontinence.

Guided by NICE recommendations, NNUH introduced Urolift, an ambulatory surgical treatment option for men with LUTS from BPH, with the objective of increasing theatre capacity and reducing pressure on inpatient beds, offering greater treatment choice and reducing complications from existing surgical intervention.

Outcomes and impact

NNUH offers a 'one-stop' urology clinic. Patients with LUTS undergo a flexible cystoscopy to determine suitability for different surgical options, and those who require surgery are offered a choice of surgical options. UroLift procedures are performed in the Day Procedure Unit. Local anaesthetic is now routine, with very occasional light sedation if required. Two to four UroLift implants are used, depending on the size of the prostate. No catheter is used and patients are discharged as soon as they have voided – normally after a couple of hours. No routine discharge medication is prescribed. Patients are followed up by telephone at 3 months.

Over 90 patients have been treated with UroLift. The results of an audit of the first 12 months of the service are shown in the table.

Procedure	No. of procedures (Jan-Dec 2016)	Average length of stay	Theatre time - patient turnaround (mins)	Anaesthetic (local/ general)
UroLift	87	3.5 hours	25 mins	LA (85%), GA (15% -First few cases only)
TURP	164	3 days	56 mins	GA (100%)
HoLEP	149	17 hours	72 mins	GA (100%)

Straightforward, ambulatory treatment for LUTS from BPH

The majority of patients requiring surgical intervention for their BPH symptoms would be clinically eligible for UroLift, however some patients are not suitable due to the size of their prostate (over 100ml) or the presence of a large obstructive median lobe. Average number of implants required is less than 4. Occasionally, with a large prostate, 5 or 6 are required.

At the 3-month follow-up, patients had significant improvements in key clinical parameters. Complications are very rarely seen and are very minor compared with TURP.

The UroLift procedure is straightforward and easy to learn, without requirement for additional resources apart from the UroLift implants. It can be easily performed under a local anaesthetic, enabling quick turnaround in theatre (7-8 cases can be done in an afternoon list). Unlike other surgical options for LUTS, UroLift is a true ambulatory procedure, where patients are discharged without a catheter after only a few hours and require minimal follow-up. Data collection and audit is very important to demonstrate patient outcomes and benefits, as well as efficacy savings.

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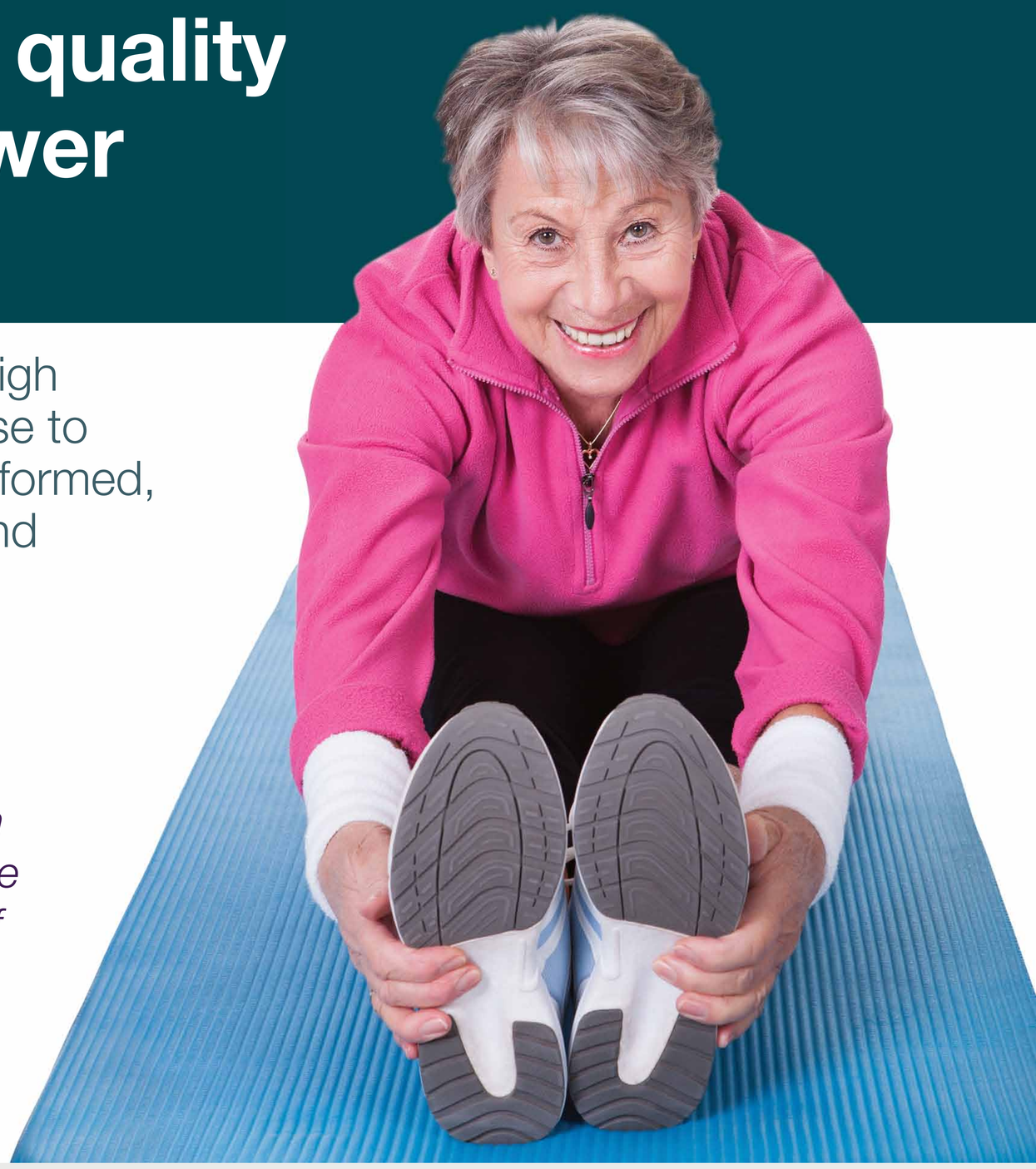
NICE Shared Learning Awards 2017

Staffordshire and Stoke on Trent Partnership NHS Trust

OASIS Group: improving quality of life in patients with lower limb osteoarthritis

OASIS was set up to create a cost effective yet high quality and efficient treatment pathway in response to new NICE guidelines. A 6 week programme was formed, focusing on education with a holistic approach and exercise to improve strength and fitness.



"The OASIS model is a simple but effective one, which allows patients living with OA to become more effective at independently self managing and dispelling some of the myths and fear surrounding the condition."

Emma Busby, Physiotherapy Assistant Practitioner, Staffordshire and Stoke-on-Trent Partnership Trust

OASIS defusing the time-bomb of lower limb arthritis

Osteoarthritis problems already cost £250 million per year and have the potential to be a time-bomb for the health economy, with an aging population that wants to remain active.

NICE guidance (CG177) states that exercise should be the core treatment for people with OA and include local muscle strengthening and general aerobic fitness.

The Integrated Physiotherapy Orthopedic and Pain Service (IPOPS), part of Staffordshire and Stoke-on-Trent Partnership (SSOTP) Trust, built upon the foundations of an existing rehab group to develop a programme with appropriate exercises at its core, alongside key education about osteoarthritis.

Overall project objectives:

- Increase function and reduce pain
- Reduce referrals to secondary care
- Empower patients to confidently self-manage their condition
- Provide a suite of documentation and patient education handouts/leaflets to facilitate understanding
- Implement evidence-based exercise regime targeted at improving muscle strength, aerobic fitness and function

Cost effective project has positive impact

Over an initial 12 month period, patient and clinician feedback was collected to help develop the programme into a high quality and enjoyable patient journey from diagnosis to self-management, whilst remaining cost effective and time efficient.

The programme, led by physiotherapy assistants at two community hospital sites, increases availability for local patients and incurred no initial set up costs.

Each session was 60 minutes, combining various exercises set out into 10 stations and education with a different topic each week. Each patient attended once per week for the 6-week period. The exercise component has evolved to include a graded approach to each station, to create a more bespoke style for each individual.

Impact on patient outcomes has been unquestionably positive with feedback showing:

"I now feel more confident and I am managing the pain well"

"Helped me to understand the importance of continued exercise"

"Now I feel a different person"

Improved function, pain and quality of life for patients

The project has been closely monitored with a mix of audits, PDSA's (Plan, Do, Study, Act), functional and pain data scores, patient satisfaction and stories.

Complete 2016 data shows:

- Reported pain scores reduced in 63% of patients
- Oxford Knee/Hip outcome scores improved in 64%
- 96% of patients improved in at least 1 functional measure
- 93% improved in at least 2

With an average group size of 6 patients per 6 week course, the cost saving made per year is £3691.38 vs. a normal course of 1:1 physiotherapy for the same duration.

Shaun Roberts said: "feedback so far has been extremely positive, and several other services from all over the country have already been in touch about adopting the model."

The future for OASIS is to be the main treatment for lower limb OA, thus increasing self-management and reducing 'frequent flyers' and referrals to secondary care.

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NICE Shared Learning Awards 2017

NHS
Guy's and St Thomas'
NHS Foundation Trust

The HiPQIP: Hypertension in Pregnancy Quality Improvement Project

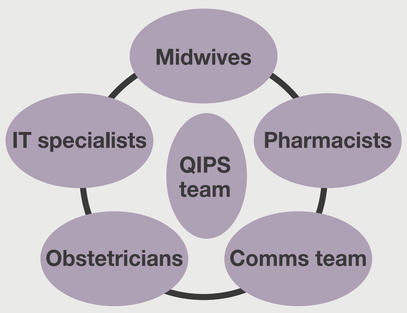
Our HiPQIP aimed to improve care and outcomes for pregnant women with chronic hypertension using a multidisciplinary approach. We involved the women in developing the service and transformed their care.

"The HiPQIP brought us together and dramatically changed the way that we care for these women. I am really proud of the service that we now offer."

Lucy Chappell, NIHR Research Professor/Consultant in Obstetrics, King's College London/ Guy's and St Thomas' NHS Foundation Trust

What we did and why

In 2015 we investigated and reported on a serious incident where a woman with chronic hypertension had an eclamptic fit and a stillbirth. We wanted to do more than just deal with what had happened – we wanted to transform the care that women received. Our clinic was set up using a multidisciplinary approach and we aimed to see women with chronic hypertension within one week of referral.



We started the HiPQIP with modest aims – but became more ambitious as the project went on. Supporting each other through the project, allowing everyone to have a voice and make suggestions was vital to our success. We had monthly meetings to drive the project forward with work to be undertaken in between, and encouraged observers to see what we were doing.

Having the Quality Improvement & Patient Safety team on board made quality improvement accessible, and gave us a framework to work with. We used NICE quality standard 35 to underpin our service.

Outcomes and impact

As a direct impact of the QIP we delivered:

- A new dedicated antenatal clinic for women with chronic hypertension
- Referral pathways
- Antenatal care pathway
- Postnatal care pathway
- Antenatal leaflets
- Postnatal leaflets
- Online information for women
- Online information for healthcare professionals
- Medication initiation guidance
- Medication titration guidance
- Discharge letters

We measured our outcomes and impact through:

- PPI meetings to listen to women's views
- Clinic surveys of quality of care
- Audit (and re-audit) against NICE quality statements
- Designing automated data downloads for quarterly review of clinical outcomes

In the first year of the HiP clinic, 97% of women had a live birth and there were no avoidable stillbirths after 24 weeks of pregnancy. The photograph above shows one of the women who had a baby with our clinic. This was a particularly precious and special baby for this mother.

What we learnt

We learnt to continuously evaluate whether we were achieving what we set out to do and to respond if we weren't.

Involving the women has been key: *"I always felt like I was an active participant of my care – part of the solution to my illness."*

We will continue to check we are delivering high-quality care – but we have also been asked to look at the care of women with new hypertension in the second half of pregnancy so we have a new challenge to take on!

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Mansfield District Council's
Advocacy, Sustainment, Supporting
Independence and Safeguarding Team

ASSIST Early Hospital Discharge Scheme – reducing bed blocking and improving the transition from hospital to home

In Mansfield and Ashfield integrated working between clinical practitioners, social workers and housing teams has unblocked thousands of beds and saved the NHS £1.4m last year.

"If one were to scale up this work it would be massive across the UK. Savings of this magnitude would go a long way towards funding 7-day secondary care."

Dr Mark Holland, President to the Society for Acute Medicine

Tackling bed blocking head on

As the national epidemic of bed blocking cripples health authorities across the UK, in Mansfield positive action is being taken to work with adults at the point of admission to free up staff time in A&E by signposting people with social needs.

The multi-disciplinary team also works together on the wards of the hospital to identify and work with inpatients who are fit to go home but may need assistance to do so. A reduction in bed blocking and saving medical staff time are integral to this project. But there are additional benefits in the transition and patient aftercare that make the project, including the prevention of homelessness.

"The front door service is essential for our patients. Patient care would be affected if this service was to stop."

Robert Comins, Therapy Team Leader ED/EAU

Saving time and money and improving lives

The project, funded by the district council, county council and CCG has seen real benefits on the wards of Kings Mill Hospital and expedited the transfer of 1,129 patients, reduced bed blocking by 5078 days and saved £1.4m to the NHS locally, in just nine months.

District council housing staff work daily with social care workers and medical professionals at Kings Mill Hospital. Every day they identify vulnerable patients in need of additional support to return home, for example the installation of Life Line, property alterations or temporary accommodation in a dedicated respite unit.

"The integrated discharge team facilitate safe, effective and timely discharges. It is essential that the service continues so that we can work together to facilitate hospital discharges, prevent delays in discharge and help prevent hospital readmission."

Vicky Tilbrook, Discharge Liaison Nurse Specialist

Improving health outcomes for patients

The ASSIST hospital discharge scheme helped some of the most vulnerable patients within the hospital care system. Most cases are a complex combination of social and welfare need and can be solved through early intervention at admission.

ASSIST clearly demonstrates the opportunities in bringing hospital, housing needs and social care into a whole system provision. On hospital wards, this project tackles the national issue of bed blocking with visible results. It has the potential to be emulated across the UK to improve patient care and generate considerable savings to the health and social care budget.

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NICE Shared Learning Awards 2017

Salford Royal NHS
NHS Foundation Trust

An exercise programme to increase pain-free walking and improve quality of life for peripheral arterial disease (PAD) patients

In Salford a structured exercise programme was developed as a collaboration between the vascular triage service and the cardiac rehabilitation team. It was specific for our PAD patients and complied fully with NICE. This has significantly improved non-surgical treatment options for our patients, reduced surgical interventions, improved overall patient outcomes and saved costs incurred by surgery.

"Uptake of the exercise programme has been excellent. The individualised approach has empowered patients to make important lifestyle changes which could delay the progression of PAD."

Pamela Smith, Vascular Specialist Podiatrist,
Salford Royal Foundation Trust

Community podiatrists develop an exercise programme for patients

For our podiatry led vascular triage service (VTS) to fully comply with NICE guidelines, commissioners supported us to develop a structured exercise programme specific to peripheral arterial disease (PAD).

We discovered that the cardiac rehabilitation team (CRT) in Salford is a multidisciplinary team consisting of specialist nurses, physiotherapists, occupational therapists and specialist exercise trainers. Commissioners were supportive and keen for us to develop a supervised exercise programme with the CRT aims:

- For the VTS to institute a supervised exercise programme for patients in Salford who have PAD and symptoms of intermittent claudication (IC)
- To provide an education component to increase patients' awareness of PAD, associated cardio-vascular (CV) morbidity and mortality and the importance of making lifestyle changes
- To provide exercise advice specific to PAD patients:
  - Within a local community setting which is convenient for patients to attend
  - To improve patient concordance and empower them to make healthy lifestyle choices

Collaboration for a PAD specific programme

When investigating the development of a structured exercise programme we decided it would be beneficial to incorporate our PAD patients into an existing established exercise programme.

Meetings were attended by the clinicians and manager of the vascular triage service, the cardiac rehabilitation manager, the vascular surgeon from CMFT and the commissioning manager.

The NICE guidance was referred to and attendees agreed to:

- Develop a business plan to provide support for 2 hours a week for 3 months for patients with symptomatic PAD
- Include an individual assessment initially and agree on an individualised exercise plan
- Support patients to make lifestyle changes
- Develop education literature for patients and the CRT website
- Develop an inclusion/exclusion criteria
- Agree gatekeepers for referral

On completion of the programme it was agreed that:

- CRT would send a summary of the patient's results to the vascular triage service
- Vascular triage service would undertake a post-exercise programme telephone consultation

Improves patient outcomes and frees up surgeons' time

- 89 patients agreed to a referral to the exercise programme
- 54 completed the 12 week programme (61% uptake)
- 35 failed to complete the programme (39%)
- Of the 54 who completed the programme 39 (72%) reported improvement in intermittent claudication symptoms. 13 (24%) reported no change and 2 (4%) had deteriorated
- Of the 15 who reported deterioration or no improvement of their IC symptoms, 9 (17%) were referred to the vascular surgeons

These initial results of the programme indicate a high level of patient satisfaction and prevention of unnecessary surgical intervention.

When setting up an exercise programme for PAD patients we suggest the following:

- Investigate and visit the cardiac rehab programme in your Trust
- Check the professions involved in the programme. Are there: registered nurses, qualified exercise trainers and physiotherapists, and occupational therapists?
- Check uptake and drop-out rate. Is there anyone with experience of claudication and PAD? Is there an educational component to the programme?

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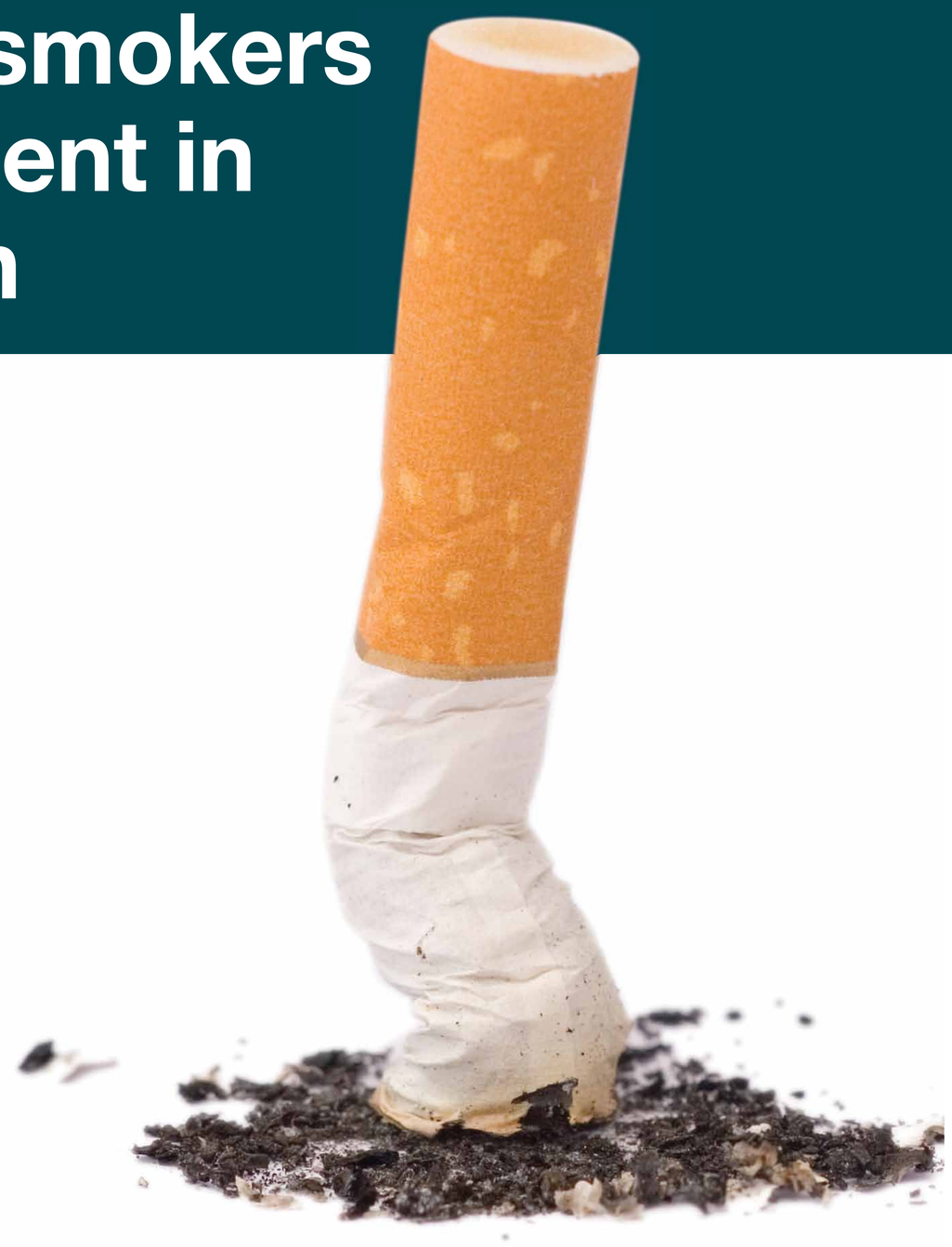
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Innovative ways to support smokers requiring nicotine management in a mental health organisation



Tees, Esk and Wear Valleys NHS Foundation Trust looked for innovative ways to support smoking cessation whilst implementing the NICE guidance, one of these being the offer of free e-cigarettes on admission to hospital for service users requiring nicotine management.

"The identification of smokefree champions greatly supported the team to reinforce key messages regarding the positive benefits of smoking cessation for service users and staff."

Lesley Colley, Project Lead Nicotine Management and Smoking Cessation, Tees Esk and Wear Valleys NHS Foundation Trust

Free disposable e-cigarettes made available at first point of contact

An internal review against the NICE PH48 Guidance was conducted in 2015 and demonstrated the need for a project to support guidance implementation. A Project Lead was identified and led to the set-up of a dedicated Nicotine Management and Smoking Cessation Steering Group.

Tees, Esk and Wear Valleys NHS Foundation Trust identified clear objectives with regards to the implementation of a smokefree policy which would look to protect the health of mental health service users whilst promoting a healthy working environment and accessible smoking cessation support for staff.

A further element of the project was to link with service users and staff to gain feedback to support the identification of preferred nicotine containing products to support both nicotine management and smoking cessation within inpatient services. Following feedback the Trust made available all nicotine replacement therapies whilst also offering free disposable e-cigarettes to service users during initial assessment.

Challenging myths whilst providing latest evidence to support smoking cessation

The main aim of the project was to support the reduction in years lost by going completely smokefree trust-wide in all buildings and grounds. Staff proved to be one of the biggest barriers to successful implementation of the policy.

Key project objectives identified by the Nicotine Management and Smoking Cessation Group included:

- To challenge myths
- To support the reduction in service users and staff smoking rates
- To reduce second-hand smoke exposure
- To increase staff knowledge related to smoking and its effects on health
- To review all smoking cessation/nicotine management aids
- To review and update the current smokefree policy
- To engage service users and carers to support the project
- To develop information leaflets for service users, carers and staff

Early consultation with service users, carers and staff allows for successful implementation of the smokefree project

Although staff proved a significant barrier to the Trust going smokefree, with continued training opportunities and time available to listen and support staff, the Trust went completely smokefree on 9th March 2016.

Work continues to provide regular training sessions whilst also addressing ongoing issues and concerns with regard to mental health and smoking.

Key elements include:

- Early preparation
- Involvement of service users and carers
- Identified programme of training for staff
- Identification of smokefree champions
- Allowing service users and staff the opportunity to support the project
- Operational group resilience to continually progress the project
- Clear guidance within the policy in relation to contraband, search and restraint

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NICE Shared Learning Awards 2017

Sheffield teaching Hospitals NHS
NHS Foundation Trust

Residential Oral Care Sheffield (ROCS)- a comprehensive domiciliary dental service for adults in care homes

In Sheffield, local General Dental Services (GDS) work in partnership with Community Dental Services (CDS) to provide an oral health needs assessment and any necessary dental treatment for all consenting adults in residential and nursing care homes. Oral healthcare training is also provided for care staff.

"ROCS is a great example of improving access to dental care for this 'hard-to-reach' group. It fits in well with 'Commissioning Guidelines for Special Care Guidelines (2015)' - GDS & salaried service working together."

Gill Heyes, Specialist in Special Care Dentistry
Community and Special Care Dentistry

What we did and why

The project began in 2005 following an idea by a Dental Advisor in Sheffield and a Senior Dental Officer in Gerodontology working in Community Dental Service (CDS).

Initially 5 General Dental Practitioners (GDPs) and CDS took part in the ROCS project and it was supported by Dental Public Health and Modernising Dentistry Options for Change.

The aim of the project was to:

- Design and evolve a domiciliary dental care scheme to improve oral healthcare for patients living in a residential and nursing care home setting
- Design and evolve a scheme to be attractive to GDPs in the future to increase coverage of oral health provision in residential homes

We also wanted to improve oral health by developing oral health promotion in care homes. To encourage homes to take part in the ROCS project, care home managers were contacted by the dental practice that would potentially be looking after the dental care for their home. This was followed up by an oral health care training session for staff about mouth care and the ROCS project.

The dental practice carries out an annual screening for residents followed by treatment requirements. For patients with complex medical issues or for treatment that cannot be carried out within the home the patient is referred to CDS.

Outcomes and impact

There are now 10 GDPs and the CDS providing dental care for 78 out of 82 care homes in Sheffield, with a total of 3579 individuals who are in receipt of this service.

The Oral health Promotion Team provide oral health care training every 2 years and we work in partnership with Hygiene Therapy students in delivering the training.

The project has also:

- Improved the quality of oral health care and patient experience
- Provided an oral health needs assessment screening for all consenting clients in care homes and integrated this into their care plan
- Promoted partnership working between dental health professionals and care home staff
- Enabled dentists to explore innovative approaches to the delivery of oral health care to an elderly client group in a domiciliary setting

The ROCS service is in line with recommendations 1.2 and 1.4 in the NICE guidance for Oral health for Adults in Care homes (NG48).

What we learnt

- Partnership working is key for a service like ROCS to be successful. Community and Special Care Dentistry, NHS England, Public Health England, University of Sheffield and General Dental practitioners worked together with care home managers in order to provide this comprehensive service to care homes
- Where it works well, the care home staff become part of the ROCS team, working with us to help maintain good oral health for every resident
- The service has faced challenges with regard to funding. It has been agreed that ROCS dentists can convert units of dental activity to an agreed number of sessions and agreed number of homes and patients to be seen annually
- Efficiency could be improved by using skill mix within the dental team, including hygiene therapists with direct access and dental nurses with extended duties to provide fluoride varnish application
- The accuracy of reporting data is important and is reliant on the ROCS dentists providing the information needed

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East Lancashire Hospitals NHS Trust

NICE Shared Learning Awards 2017

refertopharmacy

Get the best from your medicines and stay healthy at home

The world's first fully integrated Hospital to Community Pharmacy referral system

Refer-to-Pharmacy allows patients to be referred for a post-discharge medicines adherence consultation, or for medicine regimen changes to be communicated for improved safety. The aim is to help patients get the best from their medicines and to stay healthy at home.

Hospital Admission Notifications are also sent to reduce medicines waste.

"Refer-to-Pharmacy is reducing medicines waste and readmissions rates. It's quick, easy to use, and has exceeded my expectations."

Neil Fletcher, Director of Pharmacy
East Lancashire Hospitals NHS Trust

Community Pharmacists can improve medicines adherence post-hospital discharge

The New Medicine Service and post-discharge Medicines Use Review improve medicines adherence and health outcomes, but only if a community pharmacist knows when their patient has discharged from hospital.

Signposting patients proved ineffective and electronic referral seemed an obvious solution. It had to be quick and easy to use to be acceptable to the hospital pharmacy team, and a copy of the discharge letter had to be attached for a meaningful consultation to occur between community pharmacists and their patients. Refer-to-Pharmacy was developed to meet this brief.

To help spread the concept the Royal Pharmaceutical Society produced a 'Referral Toolkit' based on the Refer-to-Pharmacy development.

NICE Medicines Optimisation guidance (NG5) recommends providing community pharmacists with discharge letters 'where possible'. Refer-to-Pharmacy makes this *routinely* possible for every eligible patient.

Outcomes and impact

The system went live on 29.10.15 and has continued to be developed, so now *Home Visit* referrals can be made to a domiciliary pharmacy team (for housebound patients); and *Hospital Admission Notifications (HAN)* are sent for care home residents and monitored dosage system (MDS or 'blister pack') users to prevent unnecessary dispensing and to reduce medicines waste.

To the end of March 2017 a total of **8435** referrals have been made. These constitute:

- Monitored Dosage System **2798** (33%)
- Medicines Use Review **1925** (23%)
- Information only **1504** (18%)
- New Medicine Service **1052** (12%)
- Care Home **964** (11%)
- Home Visit since 28.6.16 **102** (2%)

HANs went live on 23.2.17 and to the end of March 2017 these were the outcomes:

- **22** referrals prevented unintentional prescribing errors
- **122** items were not dispensed/wasted (average item value approx. £10)
- **27** hours have been saved

Readmissions at 28 days, and for the same diagnosis, in Jan-Oct 2016 decreased by 139 patients compared to Jan-Oct 2015 (pre-R2P). The 'Carter Report' estimates it costs £3,500/ admission to care for each admission.

Referring *every* eligible patient *is* possible

By designing Refer-to-Pharmacy around the needs of the hospital and community pharmacy teams, the system has now become a standard service with referrals taking a few seconds to make and receive.

Feedback from hospital and community pharmacy users has been used to make both ends slicker, promoting the twin philosophies of *Every Eligible Patient: Referred* and *Every Referred Patient: Accepted*. In March 2017 **307** (62%) referrals were accepted by community pharmacists, only **25** (5%) referrals were rejected or couldn't be completed, with **162** (33%) pending hospital discharge or acceptance.

Social media has helped raise awareness of Refer-to-Pharmacy via Twitter, Facebook, YouTube, e-newsletters, a mobile 'app' and a webpage (www.elht.nhs.uk/refer).

Since going live Refer-to-Pharmacy has received four awards including the 2016 Patient Safety Award for Best Emerging Technology or IT.

By April 2017 several other hospitals were preparing to deploy Refer-to-Pharmacy.

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NICE Shared Learning Awards 2017

SOUTHAMPTON Children's Hospital

NHS University Hospital Southampton NHS Foundation Trust

Implementing transition care locally and nationally using the 'Ready Steady Go' programme

Without effective transition mortality and morbidity increases for young people (YP) moving from paediatric to adult services. Southampton Children's Hospital transition steering group developed Ready Steady Go (RSG), a suite of resources, to deliver high-quality, sustainable, cost-effective transition for YP across sub-specialties. RSG empowers the YP to manage their healthcare.

"Empowering patients by equipping them with the knowledge and skills to manage their condition is key to successful transition. RSG can be used for all patients with a long-term condition regardless of speciality and age."

Dr Arvind Nagra, Consultant paediatric nephrologist and clinical lead for transition, Southampton Children's Hospital

What we did and why

- Evidence shows YP and families are not properly supported through the transition process. The transition process is often variable and good practice guidance is not always implemented
- Studies show that effective transition between paediatric and adult care improves long term outcomes and patient experience
- Many of the issues faced by YP with a chronic medical condition, regardless of sub-speciality, are generic
- A transition steering group was established at Southampton Children's Hospital to develop and implement a generic transition programme, RSG, to address these concerns. The RSG programme is sustainable and cost-effective
- RSG ensures the medical, psychosocial and vocational needs of the young person are addressed by following a structured and adaptable framework
- The RSG programme empowers the YP by equipping them with the skills and the knowledge needed to manage their healthcare in children's services and highlights any on-going issues to the adult service

Outcomes and impact

- RSG resources were developed by the transition steering group. These included:
  - RSG tools, RSG documentation, print-ready pdfs
  - RSG patient information video by patients/ carers
  - RSG implementation guide published in Archives of Disease of Childhood
  - a transition policy
- RSG was promoted through staff briefings, workshops and posters in clinic
- '11+ clinic weeks' for patients aged 11+ were established to introduce YP to RSG, share resources and encourage the multi-disciplinary team to incorporate RSG into routine clinical practice
- RSG resources were widely shared and available free of charge with hospital Trusts, strategic clinical networks and patient organisations across the UK through:
  - emails
  - local and national RSG educational study days
  - presentations at conferences and meetings
  - www.uhs.nhs.uk/readysteadygo
- On-going support is provided to all using/ wanting to use the RSG programme

What we learnt

- RSG is being implemented in sub-specialities across the UK, enabling the delivery of the over-arching principles in the NICE guidance (NG43)
- Diabetes-related hospital admissions more than halved for those using RSG. More YP attended clinic appointments in adult services vs those that did not use RSG (78% compared to 54%)
- A sister programme, 'Hello to adult services', developed by the steering group, is being adopted in adult services continuing delivery of patient empowerment and holistic care
- Countries overseas have expressed an interest in using RSG with a plan for local adoption
- Reluctance to the RSG programme was overcome through education and finding solutions to address concerns and misconceptions about transition
- 'Transition Champions' are needed to promote and embed RSG for successful transition and implementation of best practice guidance
- *"Education and the availability of the RSG resources were essential for successful implementation of RSG"*

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NICE Shared Learning Awards 2017

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

New IV fluids…very NICE: quality improvement in IV fluid prescription

With NICE CG174: *Intravenous fluids in adults in hospital*, the Warrington Acute Care Team hoped to produce a transformational change and embed a new culture based on the 10 clinical audit standards of the NICE guideline and on the 2 principles of balanced solution and patient-centred prescription.

"Right patient, right fluid, always."

Dr Roshni Khanijau, Foundation Year 2 Doctor
Warrington and Halton Hospitals NHS Foundation Trust

Specialist team can improve IV fluid prescription

The NCEPOD report in 1999 highlighted that a significant number of hospitalised patients were dying because of infusion of too much or too little fluid. Warrington and Halton Hospitals Foundation Trust was committed to addressing this.

The aims for improving fluid prescribing were to embed the NICE guideline CG174: *Intravenous fluid therapy in adults in hospital* into Warrington Hospital culture, including the principles of balanced solution and patient centred prescription, and the CG174 10 clinical audit standards of care.

In 2015, the Acute Care Team produced an IV fluid policy based on the new NICE guideline CG174. A novel idea to design an IV fluid prescription chart around the 10 standards in NICE's Clinical Audit tool was implemented. The new IV prescription chart was introduced to the Trust in May 2016. The new chart is a daily chart and has information to help in prescribing and assessment.

A novel strategy based on NICE principles and standards

Various methods were used to implement changes within hospital culture. These included:

- A poster placed on the door of the IV fluid cupboard on each ward
- The Acute Care Team wore a newly designed IV fluids t-shirt
- A new survival guide for the Foundation doctors: Five Fluid Facts for Foundation
- A new critical incident reporting tool
- NICE IV fluids e-learning sent to Foundation doctors to complete
- Newly-designed IV prescription chart
- Accessible guidance via: App store/nhs-whhemh/policies/iv fluids
- Training programme
- Communication programme
- IV fluid pumps

In October 2016, six months after the new chart was in place and with the new foundation doctors embedded in the Trust we did a one day point prevalence audit including all patients on IV fluids on the wards. The results of this were very positive.

Warrington Acute Care Team changes culture of IV fluid prescription

- A clear move away from use of 0.9% saline was demonstrated with increased use of 0.18% saline with 4% glucose and Plasma-Lyte
- More appropriate weight based prescribing was seen, with a significant increase in use of pumps (93% of patients)
- Poor documentation of an ABCDE approach or indication for fluids on prescription charts was noted
- Find the right enthusiastic team to deliver. We are lucky to have our ACT who we mobilised to introduce the changes quickly
- Clarify the aims and objectives. We should make clear that we want to achieve the NICE core values of patient centred quality care
- Ensure that equipment is available - in this case IV pumps
- Design an IV fluids chart based on the 10 standards making it easier to measure outcomes
- Have a collaborative approach with pharmacy.
- Policy review by drugs and therapeutics committee
- Target foundation doctors

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NHS
Guy's and St Thomas'
NHS Foundation Trust

Improvement of patient safety and savings through better Surgical Site Infection (SSI) surveillance

A standardised approach to SSI surveillance in line with PHE recommendations was successfully implemented for 9 surgical specialties from 2009. This approach enabled practice review and targeted interventions in line with NICE SSI prevention guidelines. These actions led to statistically significant SSI reductions and potential cost savings through SSI avoidance.

"The adoption of a multidisciplinary approach eased data collection burden and improved patient safety and experience through SSI reduction. SSIS is now embedded within existing clinical governance structures to facilitate continual surgical pathway scrutiny using NICE guidance."

Lilian Chiwera, Lead Nurse – Infection Control Surveillance
Guy's & St Thomas' NHS Foundation Trust

Robust SSIS improves SSI rates

Guys & St Thomas' introduced an initiative to improve patient safety through effective Surgical Site Infection Surveillance (SSIS).

This project sought to:

- Establish local SSI benchmarks and then identify potential practice concerns
- Use NICE SSI guidelines in any improvement initiatives
- Standardise practice along patient's surgical pathways to improve quality, safety and efficiency in line with organisational targets
- Establish a strong SSIS leadership and adopt multidisciplinary team (MDT) collaboration
- Implement recommendations from NICE SSI Quality Standard 49 to further reduce SSI incidence at a time it was thought the irreducible minimum for some specialties had been reached
- Standardising SSI detailed investigations in line with NICE SSI QS49
- It was a collaborative effort between infection control and clinical teams

Using MDT collaboration to review practice against NICE SSI guidance is critical

An initial audit of practice of surgical pathways identified poor NICE SSI guidance compliance and triggered various actions:

- Standardisation of SSIS processes & active campaigns
- Active monthly feedback of SSI data including effective use of an email core group for SSI communication
- Standardisation of preoperative skin decolonisation
- Standardisation of preoperative skin preparation and tight theatre discipline
- Standardisation of wound care protocols and active asepsis competencies for clinical staff
- Standardised guidelines in line with NICE recommendations
- Patient information leaflets for preoperative skin decolonisation and post-op wound care

NICE SSI prevention guidelines & effective SSIS improves patient outcomes & saves money

Surgical specialty	2009/Start Annual Total SSIs (%)	2016 Annual Total SSIs (%)
Adult cardiac surgery	55 (5.4%)	14 (1.2%)
Paediatric cardiac surgery	42 (12.1%)	3 (0.7%)
Paediatric spinal surgery	12 (8.3%	0 (0.0%)
Vascular surgery	35 (8.8%)	11 (1.6%)
Gynaecology surgery	20 (3.7%)	19 (3.3%) Increased complexity of cases
Adult GI surgery	89 (10.4%)	40 (3.0%)
Paediatric/Neonatal GI surgery	9	10
C-sections (validated quarters)	64 (13.3%)	38 (6.8%)
Orthopaedic surgery	18 (2.7%)	5 (0.6%)

Over £1m estimated cost savings

Key learning points:

- Overcome challenges through a resilient patient focused approach
- Feedback SSI data widely to get engagement
- Invest time in active campaigns to promote a patient safety initiative
- Don't re-invent the wheel - embed SSIS and NICE guidance within existing clinical governance
- Great opportunity for generating huge cost savings

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The challenges of implementing NICE guidelines on suspected cancer: recognition and referral

Implementing NICE guidance can be daunting – here's how we did it in Pennine Lancashire, which consists of two CCGs, one Acute Trust, 89 GP practices, 300 GPs and 540,000 residents.

"With extremely high cancer incidence and death rates in my practice, I was determined to make a difference."

Dr Neil Smith, GP Cancer Lead, Pennine Lancashire

What we did and why

With high social deprivation, poor cancer outcomes, increased emergency presentations, late stage diagnoses and poor survival rates we needed to work together to make a difference, so we:

- created a local NICE Implementation Group, with 12 tumour subgroups
- consulted stakeholders
- held an MDT event for 150+ professionals
- created a shared learning resource for GPs
- co-produced patient information with patients for patients
- created a local call to action: "think cancer" for every clinician, and every patient
- partnered with Macmillan Cancer Support and other voluntary organisations
- collaborated with universities
- Worked with and supported Cancer Research UK
- worked with the North West Coast Strategic Clinical Networks

Outcomes and impact

- 100% of practices are fully engaged
- Referrals for suspected cancer have increased
- In 2015/16 all local health organisations achieved all cancer waiting times
- Overall improvement in patient satisfaction
- Greater patient engagement with services
- Patients are now seen, diagnosed, and treated sooner

Cancer services are now award winning:

- 2015 Macmillan Innovation Excellence award
- 2016 HSJ National Patient Safety Award
- 2016 North West Leadership Academy Award

What we learnt

- Consider using retrospective data analysis
- Review and redesign new care pathways
- Create new referral forms with buy-in from everyone
- Provide and ensure access to urgent investigations
- Engage and co-produce with patients, carers and stakeholders
- Provide GP education and resources to support GPs
- Consider finances and financial planning.
- Consider organisational development and workforce planning
- Consider capacity expansion
- Create a domino effect: our local action and development improved local outcomes which led to us influencing improvements regionally and which, in turn, enabled us to share best practice and influence improvements nationally

NHS East Lancashire Clinical Commissioning Group
NHS Blackburn with Darwen Commissioning Group

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Central Manchester University Hospitals NHS
NHS Foundation Trust

Impact of pharmacist involvement in Enhanced Recovery surgical pathways in improving patient care

Originally pioneered in Denmark, Enhanced Recovery (ER) has been championed across the UK since 2002 by the Department of Health. Undertaken by a NICE scholar, this quality improvement project set out to demonstrate how pharmacists can add to ER pathways to improve patient care in those undergoing major surgery.

"Active pharmacist involvement throughout the patient's journey, from the time they are listed for surgery through to discharge, resulted in a significant reduction in length of stay and post-operative complications - an invaluable contribution."

Neetu Bansal, Lead Enhanced Recovery Surgical Pharmacist,
Central Manchester University Hospitals NHS Trust

Pharmacists play a key role in ER pathways

The aim of this project was to demonstrate the impact pharmacist involvement can have on ER and similar pathways by implementing the NICE guidance on medicines optimisation [NG5].

ER pathways were first introduced within the Trust in 2008. Although the pathways rely heavily on medication-related interventions both before and after surgery, patients are not reviewed by a pharmacist until after surgery. By that time it is often too late to make any changes to perioperative drug management.

The project was undertaken in patients undergoing colorectal surgery. Baseline data was collected on the service with patients seen in a nurse led pre-admission clinic and followed up post-operatively by the ward pharmacist.

Data was collected on 52 patients over an 8 month period. There was no documentation of the perioperative drug advice in nearly 70% of patients. Furthermore, 12% of patients could have benefited from medicines optimisation prior to surgery.

Shared decision making with the patient was employed

A 'virtual' pharmacist clinic was set up to review high risk patients preoperatively with the aim of getting them in the best possible state for surgery. The pharmacist ascertained whether the patient needed to be contacted pre-operatively based on the patient's ASA (American Society of Anaesthesiologists) grade and drug history.

Interventions at this stage included:

- providing appropriate perioperative advice to the patient over the telephone
- Identifying possible areas for medicines optimisation and discussing these with the surgeon / anaesthetist and GP
- Setting up a text messaging service to send patients a 'reminder' about which medication(s) to stop two weeks prior to surgery
- post-operatively, patients were reviewed on a daily basis by a dedicated ER pharmacist with the aim of reducing post-operative complications

The project was promoted to key stakeholders via regular briefings at multidisciplinary team meetings.

Pro-active review led to improved patient outcomes

Once the service had been set up, there was a further collection of data on 50 patients over an 8 month period.

There was a significant reduction in the median length of stay by three days and a reduction in the total number of post-operative complications following pharmacist intervention.

The main reduction in post-operative complications were:

- Improved levels of nausea and vomiting
- Better pain control which potentially led to a reduction in the incidence of bowel ileus,
- Better management of high output stomas leading to a reduction in the incidence of dehydration and acute kidney injury

Following this project, funding has been secured for additional pharmacy posts to extend the service to other surgical specialities.

"Patient engagement was key in the success of this project as we involved them in their care right from the start. It is also important to get key stakeholders on board quite early on in the project," Neetu Bansal said.

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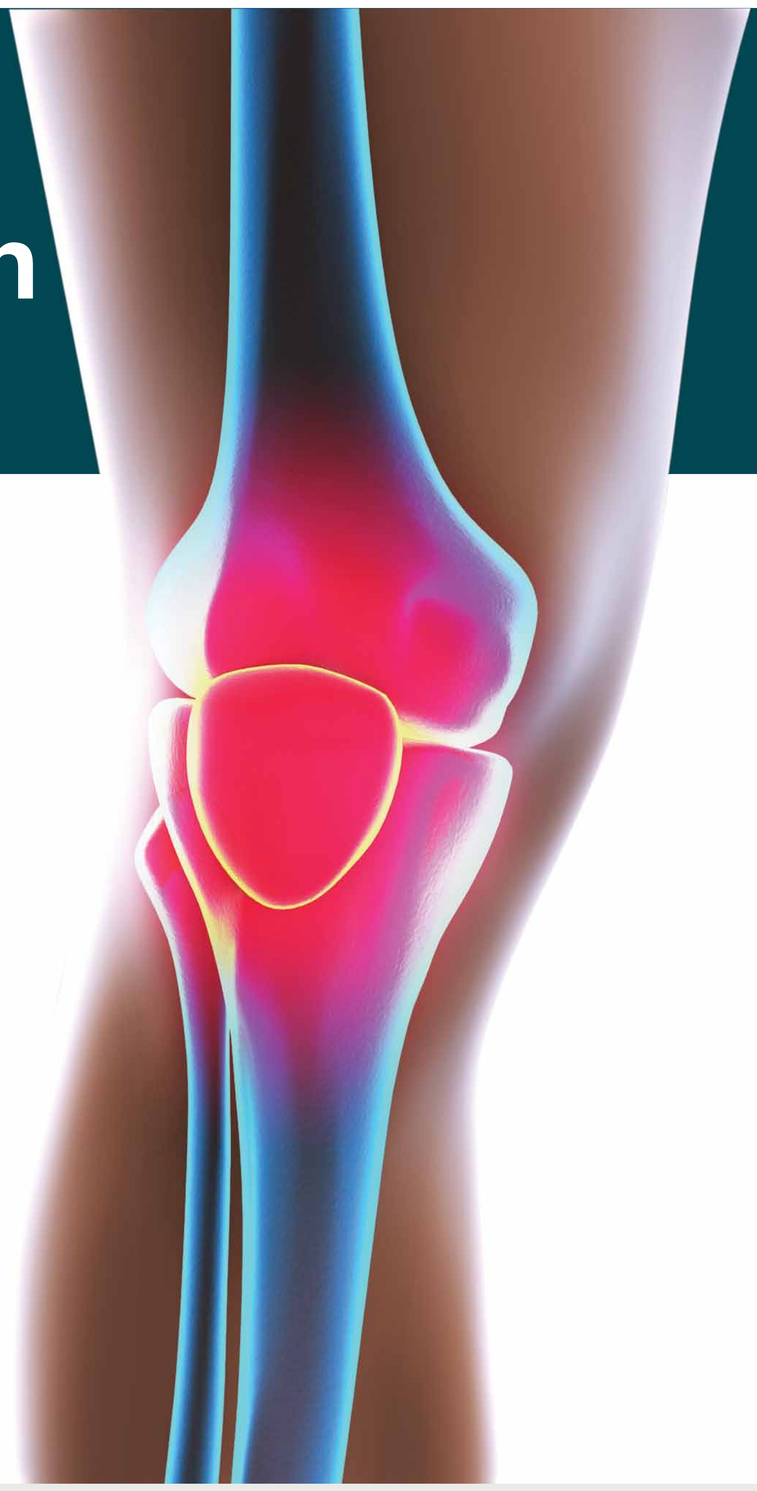
NICE Shared Learning Awards 2017

Central Manchester University Hospital NHS
NHS Foundation Trust

Optimising high-cost drug use and supporting a clinical research agenda in rheumatology



The introduction of a rheumatology virtual biologics clinic (VBC) at Manchester Royal Infirmary provided a mechanism to change the prescribing of biologic therapies, facilitate cost savings and service efficiencies, and improve clinical research recruitment.

"The VBC has facilitated an MDT review of all high-cost drug prescriptions in our department, prompting better prescribing, improved data collection and a better patient experience."

Dr Ben Parker, Consultant Rheumatologist,
Manchester Royal Infirmary

High-cost drugs in rheumatology

Biological therapies for rheumatological conditions represent a significant and rising cost to the NHS. Inappropriate and/or inefficient prescribing of these drugs places a significant financial burden on the NHS.

The process of initiating biologics is complex and varied, resulting in variation in prescribing patterns and uptake of prescribing innovations.

Patients starting a biologic therapy are often a key target population for clinical research studies, which offer potential cost savings by providing biologic therapies and associated care outside of NHS funding streams. However, many barriers impede recruitment, such as lack of opportunity to identify potential recruits at the point of prescribing.

In 2013, the rheumatology community in Greater Manchester developed a comprehensive biologic prescribing pathway to support optimised prescribing and begin to address these issues.

The clinical rheumatology MDT at MRI undertook a QI approach to change the biologics service and implement the prescribing pathway.

Optimising high-cost drug prescriptions

Plan, Do, Study, Act (PDSA) cycles of rapid change were used to test and implement changes after mapping the existing service. These focused on systems, data collection, and the integration of clinical and research teams.

A weekly 1-hour MDT meeting (VBC) was established to 'virtually' review all patients starting a new biologic.

- Attended by a Consultant Rheumatologist, Specialist Nurse, Research Nurse, and Specialist Pharmacist
- Standardised documentation facilitated evidence-based drug choice, collection of audit data, and an easy to complete safety checklist
- Each patient starting a biologic is now 'virtually' reviewed by the MDT to ensure prescribing is compliant with regional pathways, limiting variation in practice and optimising drug choice, whilst maximising prescription of the least expensive biologics
- All patients are also 'pre-screened' for potential research opportunities and recruited at a subsequent group education session

Improving research recruitment and saving money

Service Performance and Outcomes

- Compliance with the GM pathways reached >95% within one month
- A 50% increase in research recruitment was observed after one year
- A biologics database, updated in real-time, records core quality data allowing real-time audit of practice

Financial Performance and Outcomes

- Implementation of the prescribing pathways and increased recruitment into trials resulted in cost-savings of £113k in the first 6 months
- Additional revenue was generated from enhanced recruitment to clinical studies
- Administrative support for the VBC was obtained later, whose funding was based on clinical nurses seeing extra patients in place of biologic-related administration
- Fewer consultation visits are now necessary prior to biologic initiation, resulting in a reduction in the median treatment delay from 59 days to 16 days

Ben Parker says: *"Changing behaviour is hard; make it easy to do the right thing."*

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NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust

Incorporating NICE guidance into the sepsis care pathway at Tameside to improve patient care and safety

At Tameside, a sepsis screening sticker and care bundle in line with new NICE guidance (NG51) was introduced to improve care and outcomes for patients presenting with, or developing, sepsis at the Trust.

"It was recognised that we needed to improve patient care in relation to sepsis. NICE guidance informed the improvement work. The Trust has a strong culture of patient safety from executive to front line staff. It is this approach that has enabled the improvements in sepsis care."

Mr Brendan Ryan, Medical Director/ Consultant in Emergency Medicine, Tameside and Glossop Integrated Care NHS Foundation Trust

Improving the identification and timely treatment of sepsis

Sepsis is a life threatening condition that arises when the body's response to an infection causes injury to its own tissues and organs. Sepsis leads to shock, multiple organ failure and death, especially if not recognised early and treated promptly.

In January 2015, Tameside & Glossop Integrated Care NHS Foundation Trust was identified as a significant mortality outlier for sepsis.

A project was set up that aimed to improve care and outcomes for patients presenting with, or developing, sepsis at the Trust, leading to a reduction in sepsis related mortality.

A multi-disciplinary team was formed and a lead clinician for sepsis was identified by the medical director.

When the project started, NICE was in the process of developing its clinical guideline for sepsis (NG51). Throughout this development period, each revision of the guidance informed the improvement work in the Trust.

Engaging stakeholders

The project group obtained feedback from staff on existing care bundles, which were said to be 'too long' and 'too broad'.

A new care bundle and a sepsis screening sticker were developed and launched. A training programme was developed for all clinical staff.

All staff were provided with the orange Sepsis Trust 'diagnosing sepsis' card. Both this and the screening sticker encourage staff to use three simple steps to consider: "could this be sepsis?"

A specialist sepsis nurse was appointed to drive through the change and to support the clinical teams in implementation.

The launch of the care bundle was timed to coincide with the new intake of junior doctors to ensure that frontline doctors had the awareness and relevant training from the start of their placement.

At launch the slogan 'You said, we did' was used to demonstrate that the Trust was actively listening to staff on the front line. The involvement of staff provided ownership of the care bundle throughout all stages of development to implementation.

Improved time to antibiotic administration

The tools introduced support staff to identify sepsis early and ensures that patients receive the correct treatment in a timely manner.

The Commissioning for Quality and Innovation (CQUIN) measure of administration of antibiotics within 1 hour of presentation, for patients presenting with signs and symptoms of red flag sepsis, increased from 44% in Quarter 4 of 2015/16 to 90% in Quarter 3 of 2016/17.

100% compliance for screening patients presenting to ED has been maintained, with use of the sticker providing assurance that staff are thinking: "could this be sepsis?"

The Trust is no longer a significant mortality outlier for sepsis.

In addition to good stakeholder engagement, barriers to implementation were minimised because the Trust is patient safety focused and has a good culture for change.

The project was strongly supported by the executive team, championed by the medical director.

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