Intensive Fostering to promote positive behaviour and support family stability

Action for Children piloted the Intensive Fostering (IF) programme, also known as Multi-Treatment Foster Care (MTFC). Multi-disciplinary teams and specially trained foster families worked intensively with young people placed in care by the Court to reward and reinforce good behaviour, improving their life chances, and returning them to their families where possible.

> *"The scale of support put in place means that the young person is supported much more intensively than usual, resulting in better outcomes for them, and much more cost-effectively than in a 'traditional' fostering scenario".*
>
> **Christina Brandi,** Children's Placements Manager, Action for Children

Achieving good outcomes for the young person

The Anti-social Behaviour Act 2003 gave courts the power to include a fostering requirement where young people's behaviour was to a large extent due to their home circumstances and lifestyle. In 2005, the Youth Justice Board (YJB) commissioned agencies to pilot the evidence-based MTFC intervention.

MTFC is a community-based intervention, in which a multi-disciplinary team works intensively with young people and their families during a placement with specifically trained foster carers. They seek to encourage and reinforce positive behaviours and divert young people from anti-social behaviour and peers who encourage that behaviour.

In line with quality statements from the NICE quality standard on the health and wellbeing of looked-after children and young people, the aim of this project was to ensure that, where it was in their best interests, young people were returned to live with their family; and that any gains made during the placement were retained after completion of the programme.

Specialised training of families and better agency working

Specially recruited IF Carers were seen as integral members of a multi-disciplinary team, which supports individualised programmes for each young person. They received 12-14 hours pre-service training in the MTFC programme and their role and meet weekly with other IF carers on the programme to learn from and support one another. Complementing this, support for carers, families and young people was available 24 hours a day.

The Intensive Fostering team worked to:

- provide the young person with close supervision
- provide the young person with fair and consistent consequences
- provide a supportive relationship with at least one mentoring adult
- minimise association with peers who may be a negative influence

In order to do this, the team in London sought to build relationships with 32 different borough Youth Offending Teams and sought to overcome the difficulties in recruiting foster carers in London.

Real reductions in offending rates and spending

Evaluation by the University of York showed that the MTFC service was successful in preventing offending behaviour of young people in placements in 90% of cases. Also:

- those who had experienced IF were more likely to be engaged in education or training (70% rather than 30% in the study's comparison group)
- over half of the young people returned home to their families
- all young people reported improved relationships with their birth families.
- none of the IF group were in custody or homeless

The University of York evaluation also concluded that on average, IF placements were far more cost effective than custodial sentences given their results and compared to other options IF was still value for money. Secure children's homes cost £215,000 a year and secure training centres cost £160,000 a year but IF costs only £85,000 per year.

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NICE Shared Learning Awards 2015

FH
WALES
Familial Hypercholesterolaemia

Improving the detection rates of familial hypercholesterolaemia (FH) – the silent killer

The All Wales FH Cascade Testing Service was set up based on NICE's FH guidance with the aim of identifying the many thousands of undiagnosed cases of FH in Wales. The team used a combination of cascade testing and a records search using pathology records, as well as educational programmes, to increase detection rates.

> *"Supporting primary care through localised support and pathology searches has enabled a small number of FH nurses to make a big difference to detection rates."*
> **Rhiannon Edwards**, Familial Hypercholesterolaemia Clinical Specialist Nurse, All Wales FH Cascade Testing Service

Thousands of missing FH cases in primary care

People with FH generally have no clinical signs or symptoms for raised cholesterol.

FH severely raises levels of LDL cholesterol which in turn can lead to heart disease and stroke. Roughly half of men with FH, if untreated, will develop heart disease by the age of 55, and one third of women by the age of 60.

Early treatment with statins and lifestyle changes can help to lower the risk of heart disease and improve life expectancy, as well as generating long-term savings for the NHS.

In Wales, it is estimated that there are thousands of undiagnosed cases of people who have raised cholesterol and may be classified as having FH. The All Wales FH Cascade Testing Service was set up based on the recommendations in NICE's clinical guideline on FH (CG71), with the aim of diagnosing 60% (3,600 individuals) of those affected in Wales, over a 10 year period (2010-2020).

A records search strategy needed

Initially, 801 patients were projected to be seen in the first 18 months of the service, but only 371 patients were seen. An FH 'think tank' day was arranged to address why this figure was so low and involved all stakeholders from primary and secondary care, cardiac networks, clinical and management staff.

In addition to carrying out cascade testing for the identification of people with FH, it was decided that a records search strategy was also needed to identify previously unknown patients.

Considering primary care's ability to manage assessment of identifying patients, a strategy was developed to search pathology records for patients with normal triglycerides and LDL cholesterol >6.5mmols/l. Approvals were obtained locally to obtain practice numbers/data on patients with LDL cholesterol >6.5mmols/l and triglycerides <2.5mmols/l. This anonymous data was used by FH specialist nurses to prioritise practices for FH awareness sessions and additional support.

Assess a small number of patients at a time

The new primary initiatives commenced in January 2013, so at the time of the submission to the website it was difficult to assess their true impact. However, recent numbers showed an increase in the number of patients assessed from 775 in 2013/14 to 1,623 in 2014/15. This is 65% higher than the expected number of assessments up to 31st March 2015.

Laboratory cholesterol searches have enabled GP practices to start with small numbers of registered patients to assess for FH. These small numbers make this achievable and effective and the GPs have welcomed the assistance of specialist nurses to identify and see patients within the community, as well as helping to raise awareness of FH among primary care colleagues.

Overall, there needs to be greater awareness of FH in primary care, and so GPs and practice nurses in Wales have been encouraged to take on FH as an appraisal or education topic to support their ongoing education needs.

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Providing women with a safe and effective homebirth service

Birmingham Women's Hospital NHS Foundation Trust commissioned a homebirth team to improve health outcomes for women with a low risk pregnancy by moving them out of the hospital setting and into the community. This frees up resources to invest in other areas such as the increase in complexity of deliveries caused by obesity.

> *"Homebirth is a suitable option for low risk women, especially multiparous women as the evidence shows the outcomes both for Mum and baby are improved."*
>
> **Sarah Noble**, Consultant Midwife,
> Birmingham Women's Hospital NHS Foundation Trust

Benefits of home birth not actively promoted

Although there are a number of benefits to home births, such as women being less likely to require interventions, the existing service was inadequate. The service was often unavailable as staff were pulled into other areas of the hospital. As a result, home births were not actively promoted as neither women nor the midwives were confident in the service being available 24/7.

In 2013, only 23 women had a homebirth - accounting for less than 0.31% of all births in the area. This is amongst the lowest home birth rates in the country.

The consultant midwife and other senior managers at the Trust used NICE's intrapartum care guidance and reviewed homebirth models of care used across the country to base the new service on. As a starting point the best fit was the model that Kings College Hospital NHS Foundation Trust has used to achieve a homebirth rate of 5.5%.

A dedicated homebirth team on call 24/7

A new dedicated homebirth team was created with half of the staff coming from within the trust and the other half from external applicants.

Initially the business plan was based on the costs of having a team of midwives supported by maternity support workers (MSWs). There was an assumption that the support workers could have in-house training and assume the role of a second birth attendant. However, the Cavendish Report (2013) recommended that MSWs receive training through a Higher Education Institution.

This was a short term barrier, as the on call cover immediately reduced capacity by almost 50%. A new curriculum was written and implemented and for this additional funding was granted through the local CCG, at a cost of 45K per year.

Using the Kings College model, the homebirth team carries out two on calls from 08:00-20:00 and 20:00-08:00 with additional day shifts covering clinics.

Winning hearts and minds

The introduction of the homebirth team has proved a success:

- In the first eight months of the service, the rate of home births increased by over 300%
- There have been 212 referrals of which 173 (82%) resulted in a home birth
- Water was the most commonly used analgesia with a 48% water birth rate
- A third of women did not use any analgesia during labour.

Plans are now afoot to turn this 3-year pilot project into a mainstream service.

One of the biggest challenges faced by the team was winning over hearts and minds and changing the perception that mothers and babies do better if they give birth in hospital. The team approached this in numerous ways, with lots of face to face contact, going to children's centres, homebirth groups and hosting tea parties which are an informal way for families to meet other families who have had a homebirth.

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Camden
ISLINGTON
Whittington Health NHS

Improving oral health of children in a deprived London borough

Camden and Islington Public Health aim to improve oral health and reduce oral health inequalities. In line with NICE guidelines, and as part of a wider oral health promotion programme, they commissioned a targeted community-based fluoride varnish programme for children.

> *"We found fluoride varnish programmes, as recommended by NICE, to be an effective way of tackling tooth decay in deprived areas."*
>
> **Mandy Murdoch**, Independent Health Strategist (formerly Senior Public Health Strategist, Camden and Islington Public Health)

Tooth decay common yet entirely preventable

Islington is a densely populated and highly deprived London borough. Dental decay is a significant problem, despite the fact it is entirely preventable. Disease levels are higher than both regional and national levels. It is also more prevalent among socially deprived or excluded groups, who are more likely to experience ill health and poor access to dental care.

Islington Public Health, together with commissioners and providers of dental services, ran a detailed oral health needs assessment, which found higher levels of tooth decay among 5-year olds compared to other London boroughs. Much of this disease was untreated.

To tackle this, a local oral health commissioning strategy – which is aligned with NICE guidance – was developed. This included:

- A "Brushing for Life" programme distributing fluoride toothpaste and oral health advice to parents of young children
- A community-based fluoride varnish programme to further address oral health inequalities

Programme commissioned following successful pilot

The Director of Public Health took on the role of 'oral health champion' to influence the local commissioning agenda and to drive the strategy forward. The local community dental service (Whittington Health NHS) was commissioned to deliver a pilot programme for 10 months in selected children's centres, nurseries and primary schools. A number of other stakeholders worked in partnership to deliver the programme including local dentists and local authority services.

The pilot was successful and a tender process commenced for a 3-year contract. This programme aimed to improve oral health of residents by:

- Providing 2 fluoride varnish (FV) applications per year to children aged 3-10 years that were likely to be at highest risk of dental decay
- Working with parents and carers to obtain high levels of consent for FV
- Increasing the number of children and their families accessing local NHS dental services

Targeted settings receive two visits each year

Between July 2011 and November 2014, the programme achieved:

- 43,035 FV applications
- An average consent rate of 74%
- 93% of consents resulting in FV applications

There was little variation in uptake across settings, suggesting children in the most deprived areas had equal access to the intervention. In addition, a high proportion of children referred by the programme to NHS dental services, received treatment.

Key learning points:

- Identify a champion in each setting and build relationships to ensure good communication
- Visits should be scheduled well in advance
- Encourage settings with smaller populations to attend FV application days at larger settings
- Information leaflets should address specific cultural concerns and be translated into the main local languages
- Work collaboratively and ensure the programme integrates with other health promotion initiatives
- Approaching and speaking to parents informally at school gates was more effective than the more formal parent information sessions

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NICE Shared Learning Awards 2015

Sharing information from Emergency Departments to prevent alcohol related violence

Using anonymised data from the Emergency Department (ED), patients, the NHS, police and the local authority worked together to reduce alcohol related violence in Cardiff. Using the data in this way resulted in law enforcement resources being deployed more accurately and the formulation and implementation of wider policies to tackle alcohol misuse.

> *"Our discovery that most violence resulting in treatment wasn't known to the police meant that, if partners were mobilised to use it, unique information from EDs could improve violence prevention."*
>
> **Professor Jonathan Shepherd**, Oral and Maxillofacial Surgery and Director, Violence Research Group

Sharing anonymised data to tackle harmful use of alcohol

Clinical scientists from Cardiff University's violence and society research group grew concerned about the substantial numbers of people injured in violence, much of which was alcohol related not only in Cardiff but in other UK cities. They realised that unique intelligence related to violence prevention could be made available from EDs. As a result they founded a prototype community safety partnership – now a statutory requirement across Great Britain. This new partnership pooled information from EDs and the police, thus providing a much more accurate picture of violence across the city which could be used to prevent violence more effectively than it could be just on the basis of police intelligence alone.

The director of the research group, a maxillofacial surgeon, brought together NHS, police and city council partners to collect, manage and use this information, track trends in the violence, pinpoint trouble hotspots and target resources for violence prevention and alcohol misuse reduction more effectively.

A statutory partnership to meet the NICE quality standard

In the development phase the partners agreed that the ED data needed to be anonymised and should include the precise locations, times and dates of violence, and which weapons, if any, were involved. The partners met every six weeks to discuss the data, address risks and deploy violence prevention resources through their management structures. This process helped meet key requirements of the NICE quality standard on alcohol: preventing harmful use in the community.

The team's approach, following the Crime and Disorder Act, became the basis of statutory crime reduction. Using the data the partners implemented strategies to tackle alcohol related violence including better targeted police patrols, improved alcohol licensing and better sited CCTV cameras. The city council also implemented prevention strategies to make areas of the city safer for pedestrians, ensure late night public transport was more frequent and mandate the use of safer glassware in licensed premises.

Making Cardiff a safer place by reducing alcohol related violence

Sharing and using this information from the ED is associated with significant reductions in hospital admissions for alcohol related violence and serious violence recorded by the police, relative to similar cities which do not use this information. In light of the data the city council has revised its five year licensing policy. Public health officials are using the data in town hall licensing hearings and in the magistrates' court.

Key learning points:

- Ensure data is anonymised so the NHS can share them without compromising patient privacy.
- Data collection needs to become part of daily working for ED receptionists and included in their standard training.
- The ED reception manager should be a member of the partnership board - to feed back outcomes and communicate the value of data collection.
- Senior clinicians, especially specialists who treat people injured in violence, are key partnership leaders and should be members of the partnership board.

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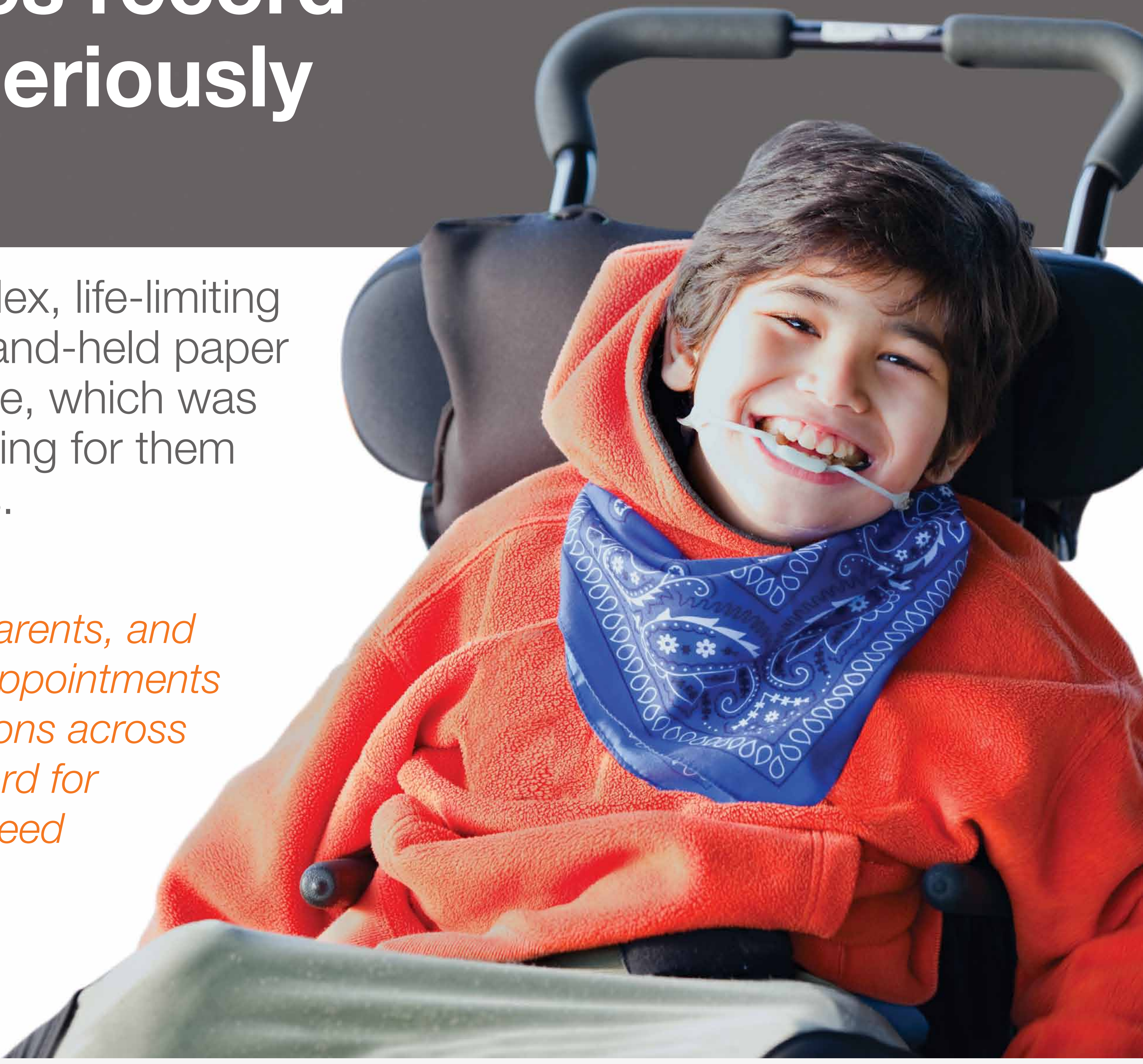
CARE RIGHT NOW
Transforming Healthcare Together

Parent-held medicines record improves safety for seriously ill children

Parents of children in Cornwall with complex, life-limiting medical conditions helped to develop a hand-held paper record of their children's medication regime, which was used by all health and social care staff caring for them across a number of agencies and settings.

> *"Our 'My Medicines' chart was designed by parents, and carried by them to their children's numerous appointments with different health and social care organisations across the county. Having one central medicines record for each child helped cut medication errors and freed up staff time to spend with the children."*
>
> **Steve Turner**, Managing Director,
> Care Right Now Community Interest Company



Urgent need for robust medicines reconciliation

Cornwall Partnership NHS Foundation Trust, which runs paediatric community services for the county, identified an issue with multiple medicines records being held by different agencies for local children with complex needs and at the end of life.

This duplication of records was believed to be a major risk factor for medicines errors and a waste of clinical time. It also meant that parents needed to repeat information about their children's medicines time and again, as they accessed services including inpatient services, tertiary centres, community paediatricians, GPs, specialist nurses, short break houses, homecare services and special schools.

The children in question had complex needs including enteral feeding tubes, ventilation, epilepsy and rapidly-changing medicine charts of over 15 drugs per child, with complex titration regimes.

The Trust commissioned Care Right Now to address this issue, beginning with looking at medicines records used at short break houses. The project quickly expanded to cover the entirety of each child's care pathway.

A child-centred 'My Medicines' chart

At the start of the project a baseline assessment was conducted with parents and staff. It revealed delays in medicines information reaching children's GPs, difficulties obtaining repeat prescriptions, and a lack of confidence in the organisation of medicines services locally.

As a result, a hand-held personal 'My Medicines' chart was designed, detailing all drugs prescribed, doses, formulation, method of delivery and special instructions for each child. Initially designed for use in short break houses, the group quickly saw how useful the chart would be if parents could 'own' it and take it with them to all their children's appointments as a central record.

Steve Turner, Managing Director of Care Right Now said: "It's not unusual for these children to be under the care of at least five different local providers, and with no formally agreed process for medicines management across services, the system was inefficient and needed to change."

Improving safety and incident-reporting

In the first month of the 'My Medicines' chart being piloted in practice, 17 'near miss' medicines errors were captured, reported and resolved thanks to the new cross-agency system. Eleven of these 'near misses' related to problems of communication between different service providers. Previously such errors and near misses were not being logged as incidents or tracked across organisations.

The project was well received by parents and carers, and resulted in improved communication and engagement between different clinical groups and providers, with the child's own GP at the heart of the process.

As a legacy of the project, a Community Paediatric Pharmacist was appointed specifically to work with this group of children with complex needs and their families. The creation of this new Pharmacist post means that there is now one person available to help manage the children's medicines across many different providers and agencies in Cornwall.

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neca services ltd
a matter of substance

Introducing blood borne virus screening and vaccinations in a substance misuse service

Darlington NECA is a needle exchange and substance misuse service that provides recovery and wellbeing support to children and adults who misuse drugs and alcohol. They established routine screening for blood borne viral infections and hepatitis vaccinations.

"Prior to the NECA screening service, people using drugs or alcohol had to go to their GP or hospital to be tested for hepatitis and HIV. By finding a way for non-clinical staff to offer screening, we have been able to test and offer treatment to more people."
Paul Walsh, Regional Treatment Manager, NECA.

Reducing the prevalence of blood borne viruses among high-risk groups

The prevalence of blood borne viruses such as hepatitis and HIV is higher amongst injecting drug users than the general population. Many injecting drug users are not aware that they are infected with a blood borne virus (BBV). Early diagnosis and treatment can have a significant impact on disease course, health outcomes, and morbidity and mortality risk.

In line with NICE guidance for Needle and Syringe Programmes, commissioners for Darlington required a BBV testing and vaccination service in adult substance misuse programmes.

The NECA substance misuse service provides specialist harm reduction and recovery services across the North East, and aimed to offer BBV screening and hepatitis vaccination to all service users. Many testing methods for BBV can be difficult to administer, and often require specialist clinical training. In order to routinely provide BBV testing to all clients, NECA Darlington needed a method that did not require medical or nursing staff to conduct it.

A way for non-clinical staff to provide screening

The Darlington NECA project introduced the virus testing and vaccination service by modelling the service on the screening and vaccination service provided by NECA in South Tyneside, which has similar demographics. The South Tyneside service manager provided training to all practitioners, and re-visits annually for refreshers.

All non-clinical staff were trained to screen clients using dry blood spot testing kits developed by Manchester Royal Infirmary. This is a non-invasive test that can be administered on-site and in community settings. Manchester Royal Infirmary was contracted to provide the testing kits, three days of intensive training, and processing of test results.

Following advice from the NECA Clinical Director, it was decided a combination hepatitis A and B vaccine would be most appropriate for drug and alcohol clients. Six full time nurses were employed to ensure that a qualified member of staff is available to offer this service at all times.

Establishing screening throughout the care pathway

Since the screening programme was set up, Darlington NECA has:

- Screened 211 people, of which 19 were identified as hepatitis C positive and 2 as HIV positive
- Vaccinated 40 clients
- Established referral pathways for clients identified with a BBV, for example to hepatology specialists via the local Trust GUM service

The service is now working to incorporate BBV screening into the admissions process and ensure that it is proactively offered at key stages throughout the treatment pathway.

"Engaging all staff with providing BBV screening was a challenge, many felt uncomfortable using the testing kits," explained Paul Walsh, Regional Treatment Manager at NECA.

"In addition to training, we cascaded information and updates about the rationale for providing screening and vaccination through weekly team meetings, staff supervisions, and case management sessions. We also introduced a BBV champions scheme. Each section of the service has a number of designated champions, who are confident and able to conduct the test without delay."

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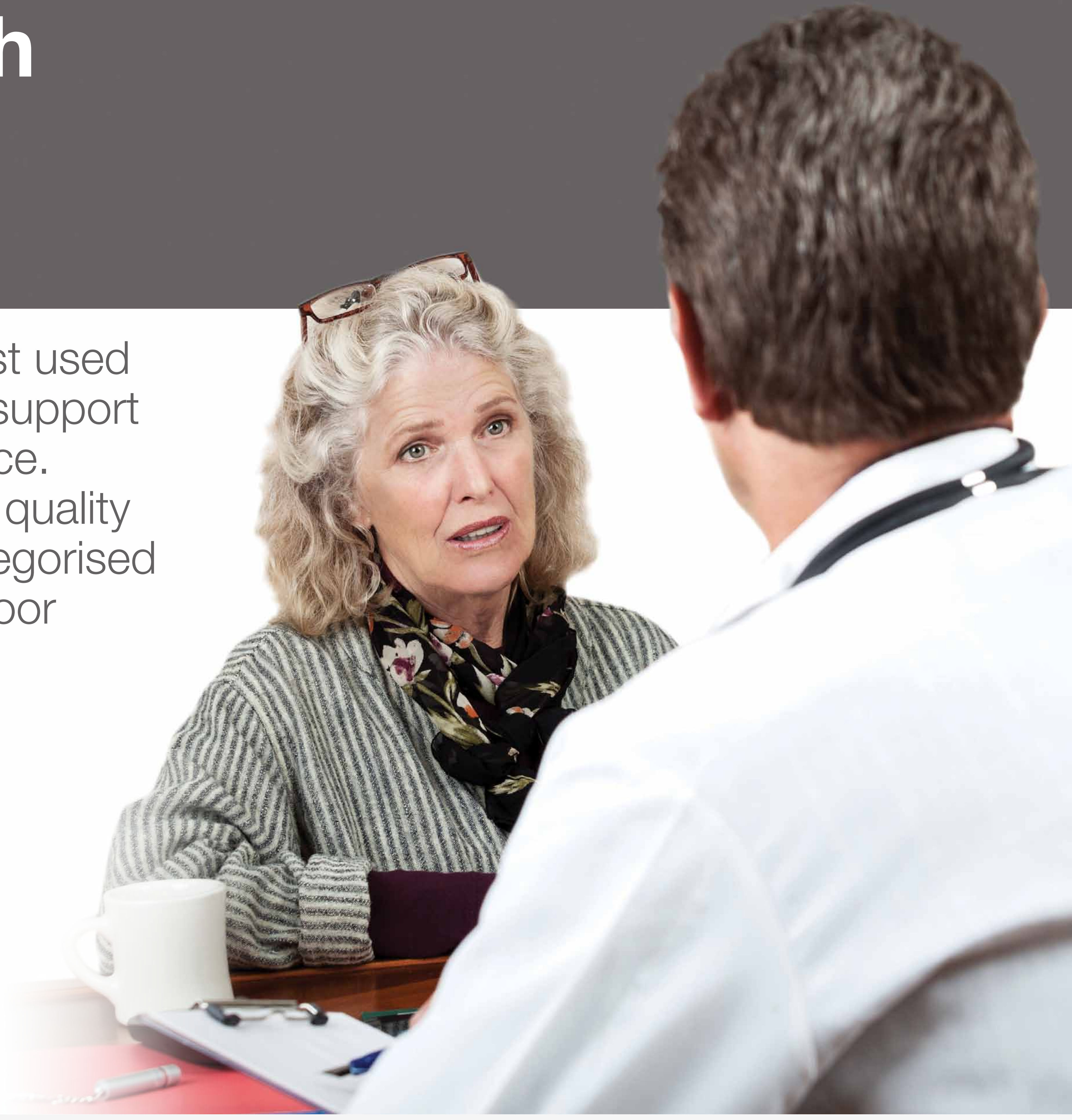
Dorset County Hospital NHS
NHS Foundation Trust

Improving care through complaints

Dorset County Hospital NHS Foundation Trust used every complaint as a learning opportunity to support healthcare staff in improving patient experience. Using the NICE guideline and accompanying quality standard on patient experience, the trust categorised and themed complaints to identify areas of poor practice and solutions to improving care.

"Complaints are our early warning signs of things going wrong. By learning from them we can put preventative actions in place before they become serious incidents."
Sarah Silverton, Patient and Public Experience Lead,
Dorset Country Hospital NHS Foundation Trust



Learning from complaints requires a culture shift

Dorset County Hospital NHS Foundation Trust serves a population of approximately 215,000 people. Over a quarter of the local population is of retirement age and frequently access NHS services for management of long-term conditions.

Typically, about half of NHS complaints relate to patient interactions with healthcare staff, and therefore improving patient experience requires a culture shift. The trust's annual complaints report showed the same themes emerging year on year, indicating that learning from complaints was not truly happening.

The culture shift required in the trust therefore was to see every complaint as a learning opportunity. Most complaint letters contain an emotional journey with positive and negative experiences; thus complaints provide an opportunity to recognise good practice as well as improve services.

However, complaint letters can also bring about emotional responses in staff that can lead to defensive attitudes which prevent learning. Using the NICE guidance enabled staff to be more analytical of complaints in order to learn from them.

Ensuring patients are treated with compassion and dignity

The trust used the NICE guideline CG138 on patient experience of adult NHS services, and the accompanying quality standard QS15, to categorise the complaints and identify themes and areas of poor practice.

The trust identified 5 standards which had the most complaints associated with them, before focusing on standard 1 around compassion as the first area to improve. Standard 1 – which corresponds to the 6 Cs of nursing - states that:

> " Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty."

The trust executive agreed to make ward sisters supervisory, enabling them to be visible and accessible to the team, patients and visitors and to promote this standard. This allowed them to meet with complainants to discuss their concerns and learning was shared with ward staff. This resulted in a sharp fall in complaints associated with this standard.

A sharp fall in complaints

The trust witnessed a:

- 61% decrease in complaints coded to standard 1 in quarter 3 and this was sustained in quarter 4
- 87.5% fall in the total number of complaints escalated to the Parliamentary and Health Service Ombudsman in 2013/14 compared to the previous year.

All patient feedback, including, Friends & Family Test comments and National NHS Survey Programme comments, are now coded to the NICE quality standard for patient experience.

The trust shared its coding methods with St George's NHS Trust to add to their real time patient feedback system. They also shared their coding methods with a further 8 NHS trusts at The WOW! Awards.

A key learning point recognised by the trust was that identifying emotional journeys through complaints opens up emotions in staff. It is important to make staff aware of how they may feel during the process and ensure that they are supported during and after.

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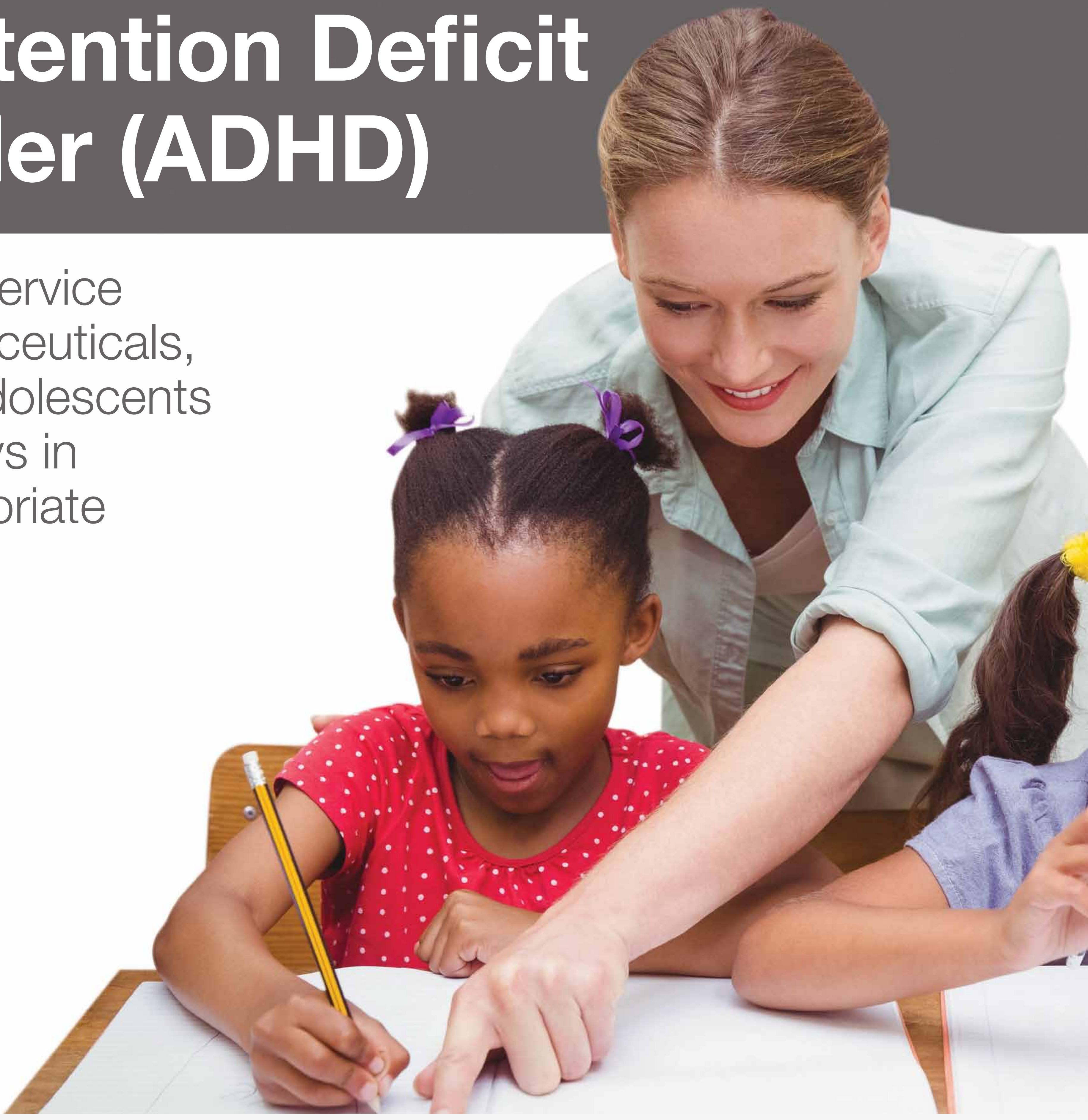
Improving the referral pathway for children and adolescents with Attention Deficit and Hyperactivity Disorder (ADHD)

East and North Hertfordshire NHS Trust used a service improvement toolkit, developed by Shire Pharmaceuticals, to simplify the referral process for children and adolescents with ADHD. The new pathway has reduced delays in diagnosis and improved patient access to appropriate support and care.

“Diagnosis and referral for ADHD involves multiple services, so establishing a simple and consistent pathway was essential. By providing a single point of contact for GPs and patients and their families, referrals could be made more quickly and to the right services.”

Dr Susan Ozer, Consultant Community Paediatrician,
East and North Hertfordshire NHS Trust



Improving multi-agency working in ADHD services

East and North Hertfordshire NHS Trust recognised the opportunity to improve service provision for children and adolescents with ADHD. Audit data and surveys with patients, carers, and GPs showed that some patients were receiving the wrong services and waiting for treatment, due to an inefficient referral process.

The project aimed to facilitate and improve multi-agency working in services for children and adolescents with ADHD. The team decided that a simple and consistent referral pathway for ADHD, and an efficient way to administer it, was needed, to bring the service in line with NICE recommendations for the diagnosis and management of ADHD.

Using a service improvement toolkit to prioritise challenges

An ADHD service improvement toolkit, provided by Shire Pharmaceuticals, was used to systematically identify and prioritise areas for development. The toolkit highlighted several challenges, which included reducing waiting times for treatments, delays in the referral process, and the number of inappropriate assessments.

The toolkit helped them to break the activity down into three stages:

- Identify priorities for improvement by surveying patients, carers, and professionals, and reviewing current service delivery against NICE guidance
- Establish a core steering group to develop the pathway including paediatricians, nurse specialists, school advisors, and psychiatrists
- Launch the pathway and embed it into practice through a series of events for healthcare professionals, schools, and the voluntary sector, as well as specialist training for GPs

The project provided information for patients and their families and carers on the support available and the referral process through a new website and support workshops. An ADHD nurse now acts as single point of contact for families, and provides quality checks for referrals.

Providing a single point of contact for patients and GPs

By providing a dedicated ADHD nurse to act as single point of access for patients and GPs, waiting times for diagnosis and referral were reduced. Extending their responsibilities to include quality checking referrals and ensuring that all pre-assessment work is complete and correct meant that diagnosis can often be completed in one consultation session, without the cost or delay of requesting more information.

Training and support for GPs and a dedicated email service for referral decisions helped to provide clarity on the referral criteria and ensure patients were referred to the most appropriate services.

“In a project such as this, taking a systematic approach is crucial,” Dr Susan Ozer said. “The service improvement toolkit really helped to structure our approach and break the work down into steps, while keeping all stakeholders involved.”

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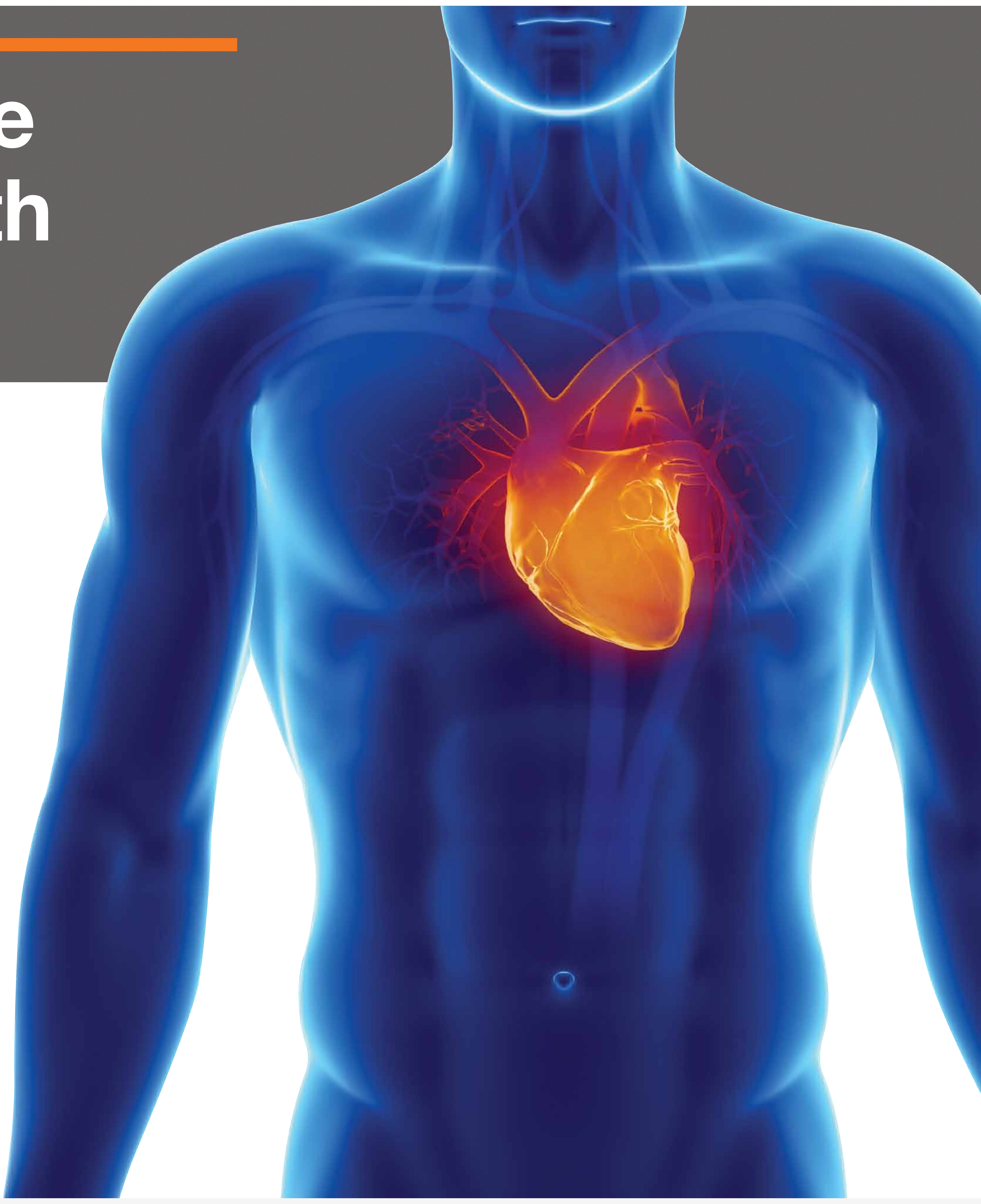
Blackpool Teaching Hospitals
NHS Foundation Trust

Anticoagulation for stroke prevention in patients with atrial fibrillation



Twenty-one GP practices across Fylde and Wyre took part in a project to prioritise medicines optimisation for patients with atrial fibrillation (AF) – a condition which causes a fast and erratic heartbeat, increasing the risk of a blood clot forming in the heart, travelling to the brain and causing a stroke.

> *“Running dedicated AF clinics in GP practices allowed us to give patients direct, easy access to a specialist nurse and a cardiology consultant, who could discuss the risks and benefits of different types of anticoagulant medication with them.”*
> **Lisa Drinkwater**, Clinical Practice Pharmacist,
> Blackpool Teaching Hospitals NHS Foundation Trust

Identifying patients to optimise treatment

NICE’s 2014 atrial fibrillation guidance recommends that people with AF are offered anticoagulant treatment to reduce their risk of stroke - either warfarin or one of three ‘NOACs’ (novel oral anticoagulants), dabigatran, apixaban and rivaroxiban. The guidance also says that AF patients should not be prescribed aspirin to prevent stroke, as evidence shows it is not effective.

In anticipation, Fylde and Wyre decided to focus on increasing appropriate anticoagulation treatment among local people with AF, using the newer CHA2DS2 VASc scores.

To begin, the practice pharmacist team carried out a search of patient records in each GP practice to make sure cases of AF were not being under-reported. They then conducted a baseline assessment of local AF registers, using the GRASP AF tool, to identify whether patients were being prescribed an anticoagulant, aspirin, or nothing at all.

Patients on aspirin and those not currently receiving any form of anticoagulation were then invited to attend a specialist clinic held in a local GP surgery to discuss switching to, or beginning treatment with, an anticoagulant.

GP surgeries host specialist AF clinics

The GP practices ran 10 AF clinics on Saturdays, which were attended by 239 patients in total. At the clinics, patients took part in a group education session about AF and stroke risk, led by a specialist nurse.

The nurse carried out blood pressure and pulse tests with all patients, and calculated their risk of both stroke and major bleeding, using the ‘’HAS BLED” score – because major bleeding is a risk factor associated with taking anticoagulant medicines.

Patients then met with a cardiology consultant to discuss in detail the risks and benefits of the different anticoagulant drugs available. Each patient spent approximately 45 minutes in the clinic in total.

Nurses running the clinics reported that most patients had not previously understood the link between their AF diagnosis and stroke risk. A patient satisfaction survey revealed that 99% found the clinic useful, 85% said they would attend a similar clinic in the future, and 93% of patients would recommend the clinic to others.

Anticoagulation rates increase

The clinics had the following local impact:

- Number of patients not receiving anticoagulation therapy: pre-clinics 39, post-clinics 14
- Number of patients on NOACs: pre-clinics 0, post-clinics 27
- Number of patients on aspirin only: pre-clinics 156, post-clinics 60

At the end of each clinic the recommendations were given to each participating GP practice, which were then recorded together with a summary of the discussion with the patient. Initial findings showed that 36 additional patients had been added to the AF registers and 40 additional people had been anticoagulated.

Some patients were unwilling to start any kind of oral anticoagulation therapy. In each case a clear rationale for refusal was recorded, which will be used to follow-up with these patients at a later date.

Overall the expected annual stroke estimate for the 21 practices fell from 66 to 54, according to the GRASP AF tool.

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Hampshire Hospitals NHS
NHS Foundation Trust

Improving intravenous fluid prescription for adults

Hampshire Hospitals NHS Foundation Trust needed to improve the quality of prescribing intravenous fluids (IV) for adults. They introduced an updated prescription chart to provide guidance and prompts to staff when prescribing and administering fluids.

> *"IV fluid prescription is often seen as routine and delegated to junior doctors who may not be sufficiently trained or experienced. We decided that providing an educational programme alongside the new prescribing chart would help to improve the quality of IV prescribing."*
>
> **Dr Catherine Jordan,** Foundation Year Two Doctor, Hampshire Hospitals NHS Foundation Trust.

Assessing the quality of IV prescribing

IV fluids can have serious and fatal consequences if not prescribed and administered correctly. Additionally, IV fluid prescription is often delegated to junior members of clinical teams, who may not have received sufficient training to do so.

Staff at Hampshire Hospitals NHS Foundation Trust (HHFT) assessed the quality of IV fluid prescription for adult surgical patients. They looked at daily electrolyte monitoring, appropriate volume and electrolyte prescription, documentation of clinical indications, and weight. The audit revealed that some patients were not receiving the correct electrolyte balance, which was associated with the use of balanced salt solutions on general wards.

HHFT aimed to improve the quality of prescribing for IV fluids for adults by providing information and guidance through an IV prescription chart and an educational package. The prescription chart replaced any previous site-specific charts and was updated to include recommendations made in NICE guidance on intravenous fluid therapy.

Providing a step-by-step guide

Using the audit findings, which indicated that some patients were receiving too much sodium and too little potassium compared to NICE guidance, HHFT staff were able to design a new IV prescribing chart.

The Adult Fluid Prescription Chart contains all information on the different constituents of intravenous fluids available. The chart has been designed to provide a step-by-step process to guide all staff involved in the prescription and preparation of IV fluids. It was also intended to provide consistency in recording and monitoring IV fluids throughout the Trust.

Introduction of the prescription chart was supported by an educational programme aimed at key staff involved, particularly junior doctors. All staff involved in the prescription and administration of IV fluids are also encouraged to complete the NICE online learning tool for fluid therapy in adults in hospitals.

Educating junior doctors on safe fluid prescription

HHFT found that introduction of the IV Fluid Prescribing Chart helped to improve documentation of indications for IV fluids and daily electrolyte monitoring. Nearly 90% of patients receiving IV fluids have daily electrolyte and urea monitoring, compared with 54% of patients prior to implementation of the chart. Correct prescribing of IV fluid volume, based on the patient's weight and clinical history, was also improved.

Correct prescription of electrolytes was a key improvement area for HHFT. However, an audit following introduction of the IV fluid chart indicated that patients were still receiving incorrect prescriptions for sodium and potassium. This is being addressed by focusing education for nursing staff and both junior and senior doctors.

"Prescribing and administering IV fluids involves staff from across a range of specialities." Dr Catherine Jordan said. "As well as targeting Foundation Doctors, we worked with the pharmacy department to make sure there is an appropriate range of IV fluids available so that prescriptions can be tailored to the patient's individual needs."

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NHS
Luton
Clinical Commissioning Group

Cambridgeshire Community Services NHS
NHS Trust

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

Using NICE guidance to improve paediatric urgent care

Commissioners and providers of health and social care in Luton re-designed paediatric urgent and emergency care to reduce unnecessary admissions, improve patient experience and ensure value for money across the system.

> *"We wanted to develop a more efficient, seamless service that would better meet the care needs of children and young people, address the concerns of parents and families and improve overall staff satisfaction and working practices."*
>
> **Paula Marie Doherty**, Children's Joint Commissioning Manager
> Luton Clinical Commissioning Group

Working together to reduce emergency admissions

The NHS in Luton was experiencing a comparatively high rate of emergency admissions. A review of the data for the area identified 6 conditions that accounted for 85% of all children's emergency activity.

A multidisciplinary team made up of primary, community and acute health practitioners, and local commissioners came together to tackle the high admission rates and develop new pathways for paediatric urgent care.

The aim was to use admissions data and feedback from service users to develop a seamless service, which would improve quality of care, reduce numbers presenting at the emergency department and provide better value for money.

Key objectives:

- Joint working across organisations
- Develop, test and implement new clinical pathways with input from users
- Identify metrics and set process to measure impact
- Develop consistent messaging and raise awareness about emergency care
- Raise the profile of children's services
- Identify cost savings

Using NICE guidance to develop urgent care pathways

The team organised a series of workshops with staff across the whole system including GPs, community nurses, ED staff, paediatricians (acute/community), paediatric nurses, the ambulance service and health and social care commissioners. At these workshops they mapped the patient journey for specific conditions associated with high emergency admissions, drafted new pathways and developed 'signpost' information about how patients could access urgent and emergency care.

As a result of the workshops the team developed seven urgent care pathways for: fever, bronchiolitis, gastroenteritis, head injury, asthma, seizure and abdominal pain. Where available they used NICE guidance to quality assure the process, develop and agree a methodology for pathway re-design and to help manage any changes in practice resulting from the new pathways.

Feedback from over 40 service users and parents, families and carers at 15 children's centres, was used by the team to shape the final pathways and patient information.

Getting care in the right place at the right time

The new pathways help to ensure that children and young people are treated in the right place, at the right time. Low level illness can now be treated at home or in primary care, which has contributed to a reduction in hospital admissions. The pathways also ensure that children receive urgent care when they need it and there are fewer late presentations.

Using NICE guidance to re-design pathways has improved working practice and clinical decision making. In particular NICE guidance has helped reduce unnecessary diagnostic tests and increase the number of patients being discharged safely.

Key learning points:

- Good partnerships and agreeing a shared vision are vital
- Staff at all levels need to be engaged in the process
- It is easier to re-design care where NICE guidance is available
- Any model has to be reviewed regularly so it can adapt to changing demands
- The input of service users is integral to service change

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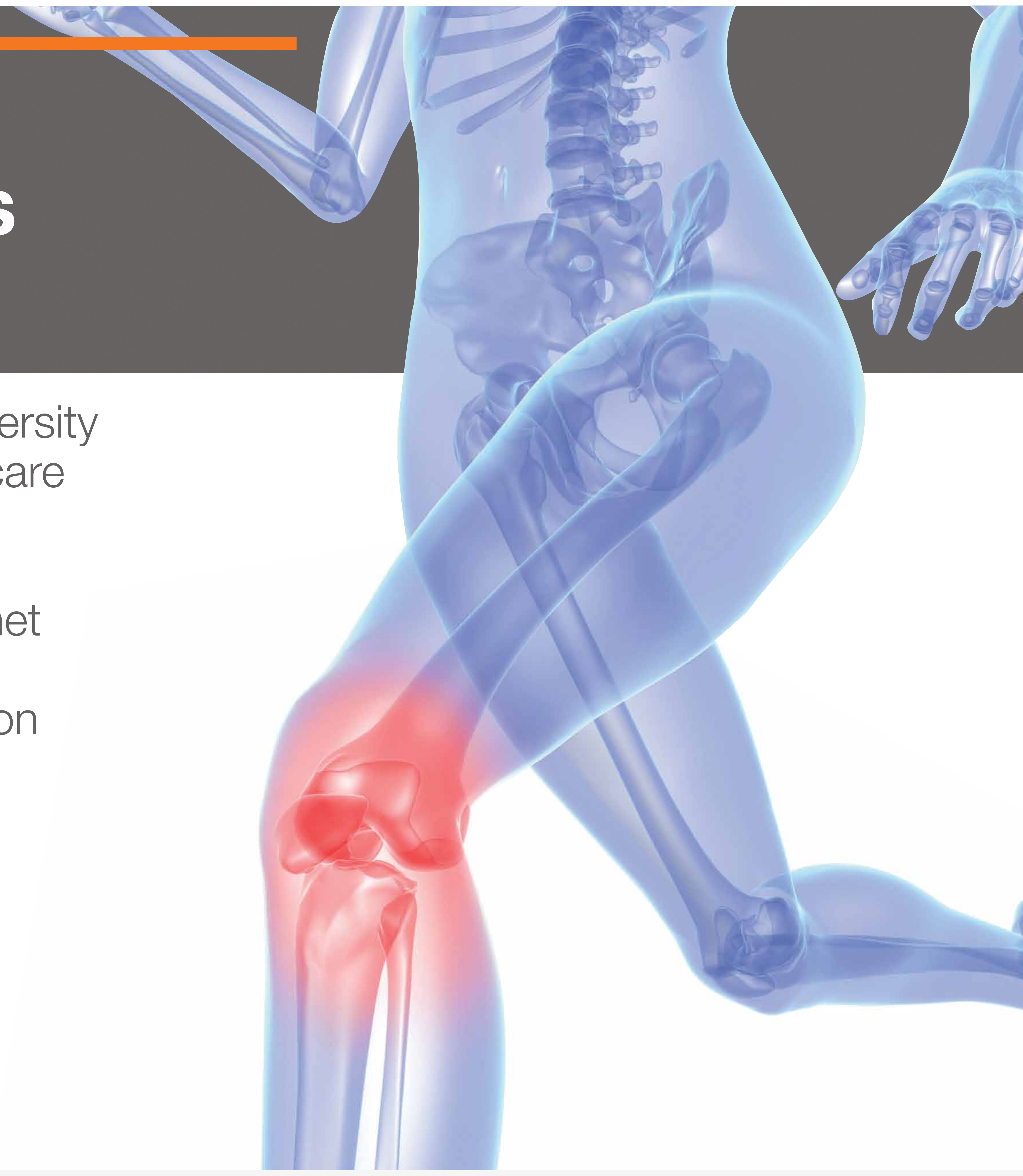
NICE Shared Learning Awards 2015

NHS
Shropshire
Clinical Commissioning Group

Keele
University

A new approach to managing osteoarthritis



NHS Shropshire CCG together with Keele University ran a project to improve the quality of primary care services for people with osteoarthritis.

The project aimed to address a number of unmet training needs among healthcare professionals, improve patient satisfaction, and reduce variation in practice by following NICE guidelines.

> *“Strong clinical leadership, partnership with the Keele’s academic implementation team and support from NICE have been key to this project’s success.”*
> **Mrs Helen Duffy**, Keele University

MOSAIC study reveals gaps in knowledge and variation in care

Over the past two years, a number of GP practices have been working together with patient groups and Keele University to develop the Management of Osteoarthritis in Consultations study (MOSAICs). The study found that 40 per cent of adults with osteoarthritis had reported consulting a GP or practice nurse about joint pain in the last 12 months. Levels of physical activity were lower, and BMI scores were higher in those with joint pain. Pharmacological treatments were more likely to be used among older patients. It also revealed unmet training needs among GPs, and a lack of services and support for self-management for patients. The project led to the development of an osteoarthritis electronic template, and an OA Guidebook.

NHS Shropshire sought to address these gaps in care by implementing NICE guidelines for osteoarthritis. It aimed to integrate electronic consultation templates, run training to improve skills and knowledge around the condition, and introduce patient materials and audit tools to improve self-management.

Implementing NICE guidelines and overcoming barriers to change

To help implement NICE guidelines for osteoarthritis, and improve outcomes for patients with the condition, the project aimed to:

- Embed an osteoarthritis e-template into GP clinical records systems to measure care
- Provide patient information through osteoarthritis guidebook
- Provide training and education for nurses
- Support GPs and practice nurses to deliver a model consultation
- Provide tools to audit the quality of care

A NHS England Regional Innovation Fund helped fund a launch event, 5 clinical champions for a year, and allow practice nurses to attend training. Guidebooks for patients were provided, and the e-template was installed in GP clinical systems.

Some barriers towards the successful implementation of the project aims were anticipated. These included a lack of capacity affecting willingness to engage with new initiatives. These barriers were overcome through a project team that included a CCG GP clinical lead, and clinical champions who engaged with practices locally.

Successful engagement through partnership and collaboration

During 2014, the project has led to:

- Practices actively engaging with the project
- Successful training for practice nurses and GPs
- Installation of the e-template in 100% of the practices

Installation of the e-template allows the CCG to audit NICE interventions and monitor:

- Clinical variation through implementation of a NICE-compliant guide to practice
- Training for GPs and nurses
- Patient satisfaction

Key to the project’s successes were:

- Partnership between the academic implementation team and the NHS in South Shropshire
- Use of NICE guidance and support from NICE’s implementation consultant
- Collaboration with GPs and patients

Challenges have included:

- Frontline practitioners finding time and resources to deliver new initiatives
- Lack of audit support

The project is now working with partners to ensure its approach can work at a national level.

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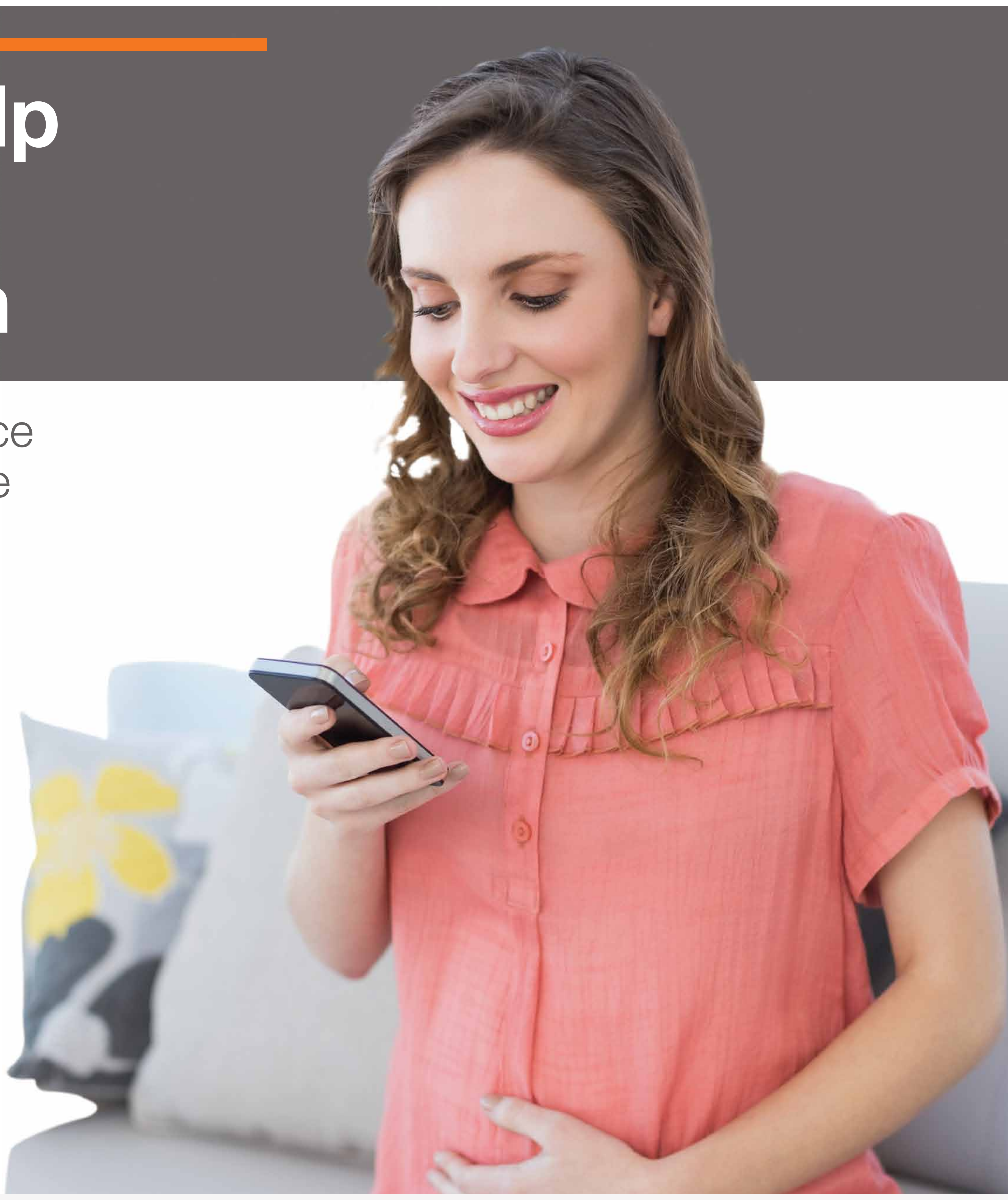
NICE Shared Learning Awards 2015

Portsmouth Hospitals NHS
NHS Trust

My Birthplace

A smartphone app to help women make a decision about their place of birth



Portsmouth Hospitals NHS Trust Maternity Service has developed the 'My Birthplace' app to provide women with national and local data to support their choice about where to have their baby, and to encourage them to consider the full range of maternity services available.

> *"Local women reported that they felt much more aware of the different birth choices available to them, and better equipped to make this important decision"*
>
> **Gill Walton**, Director of Midwifery,
> Portsmouth Hospitals NHS Trust

Giving women the confidence to decide where to have their baby

Portsmouth NHS Trust offers a range of options for place of birth as recommended by NICE guidance on intrapartum care. It strives to enable women to be able to choose between:

- Home birth
- A standalone midwife-led unit
- An integrated midwife-led unit
- A traditional consultant-led labour ward

However, despite this choice, and a flexible midwifery workforce to support 1 to 1 care in labour, not many women were making a conscious decision to give birth outside of traditional labour ward settings.

In 2013 the Trust developed a smartphone app giving women data on clinical outcomes for different places of birth. The project found that without the app, 45% of women decided where to give birth at 12 weeks of pregnancy and didn't revisit this subsequently. However, among the pilot group selected to trial the app, 88% of women had made a supported decision by 36 weeks.

Ensuring an efficient allocation of resources to maximise clinical outcomes

Studies have shown that for low risk women, giving birth is very safe in all settings, with lower intervention rates and higher likelihood of a normal birth when labour starts outside of hospital.

However, many women make decisions about where they want to have their baby early in pregnancy and do not revisit this as it progresses.

This creates unnecessary hospital births for low risk women, linked with increased interventions and inefficiencies in workforce planning.

The Trust wanted to take advantage of the increasing use of technology to improve health outcomes. This is historically limited in maternity services with a reliance on paper information. The 'My Birthplace' app sought to use technology to broaden the range of options in a user-friendly and cost effective way for mums-to-be, which also resulted in fewer clinical interventions and a more efficient use of the full range of midwifery services available.

Involving expectant mothers and midwives in a collaborative process

The app was refined through an iterative process.

- Women were able to use the app at home and then explore their preference with their midwife in the antenatal clinic
- Individual interviews were held and surveys undertaken with women and midwives to understand the utility, applicability and acceptability of the app
- Each stage of app development was checked with healthcare professionals for usability and applicability and their feedback was used to refine the end product
- The app's survey tool, which was embedded in the app and post-pilot surveys, demonstrated that using an app was acceptable in communicating this information to women and midwives and that they valued the evidence-based information.

The project was the first of its kind in a maternity setting, and the app has been rolled out across the service for all women this year, with funding just approved for all Wessex maternity services.

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A dedicated domestic violence support service in A&E

The REACH Domestic Violence service provides dedicated advice, advocacy and support in Guy's and St Thomas' Hospital Accident and Emergency department. The service provides a standardised referral pathway and ensures that domestic violence victims receive sensitive and timely support.

> *"Busy A&E teams can find it very difficult to offer the support that victims of domestic violence need. By offering a 'one-stop shop' for advice and referrals, REACH is able to improve care for both victims and other A&E patients."*
>
> **Laura Stretch**, REACH Service Manager

Recognising the need for a dedicated domestic violence service

Many hospitals offer domestic abuse services in their maternity departments, where victims of domestic violence and abuse can be identified and referred for specialist support.

The staff at Guy's and St Thomas' NHS Foundation Trust recognised the need for a dedicated service for both male and female victims of domestic violence in the Accident and Emergency department, where it may be identified or disclosed that abuse is occurring. In busy A&E teams, identification and support for victims of domestic violence can be variable and depend on a number of factors. This includes how busy the department is, which members of staff are available, and if they have received training.

NICE guidance on domestic violence and abuse (PH50) recommends that frontline staff are trained to recognise the signs of domestic violence and abuse, and to ask relevant questions to help people disclose their experiences. REACH provides domestic violence awareness training to all Trust A&E staff.

Working with A&E staff to provide a seamless service

The REACH service supports both patients and Trust staff and students, and accepts referrals from any part of the hospital. The service is also dedicated to supporting those who may experience difficulties accessing services, including those in same-sex and transgender relationships.

REACH provides:

- Training for all new A&E nurses, doctors, and placement students
- A standardised referral pathway for staff to follow
- Ongoing support once victims have been discharged from A&E
- Support to Trust staff who are victims of domestic violence and abuse
- A multi-lingual staff member

The REACH team worked with A&E staff to provide support during busy periods and out of hours. "We saw a 200% increase in referrals during the World Cup," explained Laura Stretch, REACH Service Manager. "We extend our hours during busy periods, such as bank holidays, Christmas, and New Year's Day, and REACH services are available between 8am and 6pm to allow for a handover period between REACH and A&E night staff."

Improving immediate care and long-term support

Before REACH there was no standard service for domestic violence victims. By providing training and a 'one-stop shop' for advice and support, REACH has simplified the referral pathway. This means that victims are able to get the support they need quicker, freeing up clinical staff to treat other patients.

REACH also provides ongoing support to patients after they have been discharged from A&E. The REACH team works closely with partners in Child Protection and Safeguarding Adults' and other relevant local services when additional servies are required. Less than 5% of REACH service users experience repeat domestic violence incidents and almost 50% of REACH clients report their experiences to the police, compared to just 16% of unsupported victims.

Laura Stretch said "REACH has significantly improved long-term support for domestic violence survivors of all ages. We refer people aged from 13 to 89, which really shows the need for more services that accept a diversity of referrals."

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NICE Shared Learning Awards 2015

One + all | we care
Royal Cornwall Hospitals NHS
NHS Trust

A NICE approach to managing urinary incontinence in women

Royal Cornwall Hospitals NHS Trust found that its care for women with urinary incontinence (UI) was irregular and inconsistent. It ran an audit to check compliance with NICE guidance, and consequently improved the care pathway and health outcomes for women with symptoms of UI.

> *"Our simplified referral pathway, based on NICE guidance, has led to cost savings and a reduction in unnecessary treatments for women with urinary incontinence."*
>
> **Farah Lone**, Lead Consultant Subspecialist Urogynaecologist, Royal Cornwall Hospitals NHS Trust

Regular training needed to maintain care

Urinary incontinence (UI) is a common symptom that can affect women of all ages. While rarely life-threatening, incontinence can seriously influence the physical, psychological and social wellbeing of those affected.

Royal Cornwall NHS Hospitals NHS Trust ran an audit to check whether it was complying with NICE recommendations on UI. Following this it found that regular education and training was needed to ensure regular compliance. Specifically, referral for conservative measures needed re-emphasis every 4 to 6 months. NICE recommends that invasive therapy for overactive bladder (OAB) or stress urinary incontinence should only be offered after review by a multidisciplinary team (MDT). Yet, the Trust had no MDT and so reviews were not being provided before surgery was offered.

A second audit to assess compliance with NICE guidelines on referral to secondary care found that women who had not received conservative measures were being sent back to primary care. This added to waiting times, inconveniencing both patients and doctors at the Trust.

Referral pathway simplified and GPs trained regularly

The Trust also observed several barriers to the implementation of NICE guidance. For example, the pressure to speed up the time in which patients are seen often meant guidance was bypassed. Inadequate referrals meant lengthy waiting times to see consultants, and of 50 primary care referrals, 12 were rejected disappointing both patient and GP.

To overcome these issues, and those highlighted in the audits, the Trust:

- Developed an 'Easy Step Guide' for referral to simplify the complex referral pathway
- Arranged regular teaching sessions every 6 months for GPs
- Conducted a rolling audit each year on compliance with NICE guidance on UI, and disseminated results to staff
- Recruited a urogynaecology nurse specialist

An MDT has now been set up to ensure review before invasive treatment for OAB or SUI. The MDT consists of consultants, physiotherapists and specialist nurses and now meets on a regular basis.

Greater compliance with NICE means less unnecessary testing

A re-audit following the project found 99 per cent with compliance NICE guidance on urinary incontinence. One consequence of this greater compliance is that the Trust no longer performs urodynamic testing before starting conservative management. By avoiding this unnecessary test patients are less likely to pick up urinary tract infections. They are also less likely to experience the physical and emotional stress that comes with such consultations.

Key learning points include:

- 'Make it easy' – following an easy pathway makes it easier for referrers and for patients and is more likely to lead to success
- 'The human factor' – people are likely to default back to old routines. Regular education and training was found to improve outcomes and break habits
- 'It's never too soon to start' – the MDT meet on a voluntary basis, yet its success suggests it will be incorporated into the Trust's workstream

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NICE Shared Learning Awards 2015

Tameside Hospital NHS
NHS Foundation Trust

Everyone Matters at Tameside Hospital

New Alcohol Liaison Service transforms hospital's approach to alcohol misuse

Tameside Hospital NHS Foundation Trust set up a Hospital Alcohol Liaison Service, based on NICE guidelines, to work with patients identified as harmful or dependent drinkers. The new service has reshaped the hospital's approach to alcohol treatment, and has reduced the number of patients presenting at the hospital with alcohol-related harm.

> *"Our new Alcohol Liaison Service and outpatient detox clinic has completely changed the way we care for people who misuse alcohol. New standard processes have been embedded across the Trust and patients are identified and referred into the right recovery service for them more quickly and easily."*
>
> **Kerry Lyons**, Hospital Alcohol Team Leader,
> Tameside Hospital NHS Foundation Trust

Identifying and supporting harmful drinkers

Tameside Hospital serves a population of 250,000, of which 22% are binge drinkers. In 2012/13 there were 2,149 alcohol-related A&E attendances, representing a 52% increase over five years.

To tackle this, the Trust set up a Hospital Alcohol Liaison Service (HALS) in April 2013. Within its first weeks of operation, the newly appointed HALS team carried out a needs assessment which identified Trust-wide inconsistences in the management of harmful drinking.

Problems identified across the hospital included: variable prescribing of Chlordiazepoxide for assisted alcohol withdrawal; variable clinical outcomes; high re-presentations to A&E amongst harmful drinkers; staff reporting some discomfort in discussing alcohol misuse with patients being treated at the hospital for other clinical reasons.

The HALS team was set up to accept referrals from across the hospital's inpatient and outpatient clinics – not just to treat patients presenting at A&E as a result of alcohol-related harm.

Swift assessment and referral into appropriate services

The HALS team provide specialist assessment and intervention from 8am – 8pm, seven days per week. Patients identified as being potentially harmful drinkers are guaranteed a HALS assessment within four hours of being referred to the service.

Patients requiring post-discharge support are referred by the HALS team into appropriate community services. Those requiring urgent detoxification post discharge are referred to an outpatient detoxification clinic at the hospital which has been innovatively set up by the HALS nurses. The detox clinic uses a Chlordiazepoxide prescribing pathway in line with NICE's recommendations.

Patients in crisis who are identified as 'frequent attenders' to A&E are closely managed by a newly established multi-agency Complex Care Identification group, which meets monthly.

Frontline staff across the Trust received training in approaching the discussion of harmful drinking with patients, which helped ensure that people needing support were identified and referred to HALS in a timely fashion.

Successfully reducing levels of harm

Within the first 16 months of the service being operational, 1,600 patients were screened and assessed by the HALS team. Only 55% of these patients were admitted to the hospital as a direct result of their alcohol misuse – the other 45% were patients who were attending the hospital for other reasons.

Kerry Lyons, HALS team leader, said: "80 percent of the people we assessed were categorised as having an 'escalating risk' associated with their drinking. In effect a large proportion of our work has been early intervention, supporting people to curtail excessive drinking before it causes serious harm."

Of the more urgent cases that were referred to the on-site detox clinic, 70% of patients have remained abstinent in the 6 month period following detoxification.

Engaging with community services and hospital staff was key to the project's success, making the service available 12 hours per day, seven days a week, means that hospital staff have access to ongoing guidance and support.

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Education programme promotes self-managed walking for patients with peripheral arterial disease

Researchers from York, Stirling and Sheffield Universities worked with clinicians from Sheffield Teaching Hospitals NHS Foundation Trust to develop an education programme for patients with intermittent claudication – a painful condition caused by narrowing or blockage of the main blood vessels supplying the legs. The programme supports patients to manage their symptoms and improve their quality of life.

> *"The SEDRIC programme was shown to increase patients' walking capacity and their quality of life after six weeks. Our pilot scheme suggests that a structured education programme could make a real difference to the lives of people with intermittent claudication."*
> **Dr Garry Tew**, Research Fellow, The University of York

Supporting patients to manage a painful condition

Intermittent claudication is a painful symptom of peripheral arterial disease (PAD), which occurs when blood flow to the leg is reduced as a result of the hardening and narrowing of the arteries. It can cause severe discomfort and leg cramps when walking. The best ways to treat the symptoms of claudication include stopping smoking and taking more exercise.

The NICE guideline on diagnosis and management of lower limb PAD recommends that patients are given both oral and written information about their condition including what causes it, what risk factors they can control, and what treatment options are available.

Based on this recommendation, researchers and clinicians from York, Stirling and Sheffield worked with 32 patients to design an educational workshop called Structured Education for Rehabilitation in Intermittent Claudication (SEDRIC).

The SEDRIC programme focused on the importance of self-managed walking to control symptoms, and was piloted among patients from Sheffield's Northern General Hospital.

Designing a group-based education workshop

The three-hour SEDRIC workshop is split into three sections:

1. **The patient story**
   Giving patients the opportunity to share their thoughts and ask questions about their condition, including diagnosis, symptoms, causes, consequences, and treatments.
2. **The professional story**
   A trained educator delivers key information about intermittent claudication to the patients, as recommended by NICE. Topics covered include causes of pain, potential complications and risk factors.
3. **Walking**
   The main section of the workshop focuses on promoting the benefits of walking as a means of managing and reducing symptoms. The educators talk to patients about the importance of regular walking exercise, goal setting, action planning and self-monitoring. Patients are also shown how to use a pedometer to keep track of their daily step counts.

Two weeks after the workshop, all patients receive a personal call to review their progress and discuss any barriers they are facing in changing their exercise habits.

Pilot scheme shows workshop is a success

The researchers recruited 23 patients from Sheffield to take part in a pilot trial of the SEDRIC programme in 2013/14. Fourteen patients were randomly allocated to take part in the workshop, and 9 patients were allocated to a control group.

Six weeks after attending the workshop, patients showed on average a 45 metre increase in 6 minute walking capacity compared to the control group. Those who attended the workshop also reported an improvement in disease-specific quality of life and showed higher scores for speed and distance using a standard Walking Impairment Questionnaire.

Dr Garry Tew, Research Fellow at the University of York said: "Our initial small-scale trial of the SEDRIC education programme showed that it was a success with patients able to walk further, and for longer, only a few weeks after having completed the course. We are now applying for funding to run a much bigger study across 10 NHS Trusts and involving 360 patients."

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Pharmacist-led medication reviews for reablement service users in Islington

Whittington Health set up a new service to provide at-home medication reviews for people who were receiving care from the local social services reablement team. The project saw the integration of a clinical pharmacist into social services for the first time, and aimed to support people who had been discharged from hospital to take their medicines safely and optimally at home.

"Patients were more likely to talk about wider unmet health and social care needs in the comfort of their own homes. This meant I could refer them into other services where appropriate."

Patricia McCormick, Specialist Domiciliary Care Pharmacist, Whittington Health

Responding to service users' medication problems

The Islington Social Services reablement team provides planned, short-term, intensive support to people who have been discharged from hospital. The service focuses on helping people to regain their independence and look after themselves in their own homes.

Anecdotal reports suggested that medication-related problems were frequently encountered by members of the reablement team, but traditionally there was no pharmacist input to the team to resolve these issues.

In 2012 Whittington Health established a new clinical pharmacist post to address this, dedicated to carrying out medication reviews in service users' homes.

The newly appointed pharmacist was co-located within the social care team, and provided a source of expertise for social care colleagues with questions about medicines' use.

The new pharmacist service aimed to optimise the safe and effective use of medicines to reduce medication errors, improve clinical outcomes, and avoid adverse drug reactions.

Tackling polypharmacy and empowering people to make decisions about their care

From April 2012 when the pilot began, to 31st December 2014, the newly appointed Specialist Domiciliary Care Pharmacist conducted 203 medication reviews in service users' homes.

In a typical case study example, 70 year old Mrs X was referred to the reablement team after a hospital stay for an infective exacerbation of bronchiectasis. She felt the large number of medicines she was prescribed were making her unwell, and was recommended for a medication review. As a result of her meeting with the pharmacist:

- Old medications worth over £1,500 were removed from her home
- Duplicate prescriptions (including statins, vitamin D supplements and prophylactic antibiotics) were rationalised, reducing the number of daily pills she had to take
- Anti-hypertensive and anti-diabetic medication doses were reviewed

After these changes were made Mrs X reported that she felt more able to manage her medications herself.

Overcoming barriers to integrated working

At first, referrals to the new pharmacist were quite low, due to a lack of understanding about what the new service could provide among both social care staff and service users.

To tackle this, the pharmacist started to attend and contribute to bi-weekly reablement team meetings. She also co-located in the reablement team offices. A service users' leaflet was produced explaining the benefits of medication review.

Enabling the pharmacist to access social services IT systems made the service much more efficient, but this took some time to achieve.

"Visibility and promotion of the service among social care colleagues was essential to its success," said Specialist Domiciliary Care Pharmacist Patricia McCormick, "We have demonstrated that service users' independence can be supported – rather than hindered - with medicines, if their use is optimised."

The service is now heavily subscribed, with two further clinical pharmacists recently appointed to conduct medication reviews in nursing homes as well as patients' houses.

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NHS
Wigan Borough
Clinical Commissioning Group

Peer review to optimise medicines management

The Medicines Management Team in Wigan implemented a Medicines Optimisation Peer Review programme to change prescribing behaviour in GP practices and ensure medicines usage was safe, evidence-based and cost effective. This approach enabled the team to improve overall performance, engage better with GPs and deliver savings across the CCG.

> *"We wanted to improve patient safety and prescribing performance across our patch and ensure clinicians could discuss medicines management issues confidently and openly with their peers in a supportive environment."*
> **Linda Scott,** Associate Director for Clinical Services

Changing practice and keeping up to date with NICE

From regular visits to GPs the Medicines Management Team (MMT) in Wigan saw there was a need to change prescribing practice and keep prescribers up to date with latest guidance from NICE. Technicians from the MMT highlighted they would benefit from support from the senior team to discuss NICE recommendations and the evidence base behind them. The team realised that with better engagement with prescribers and support from senior team members they would get more out of their visits to GP practices.

The team identified three key barriers to overcome:

- Engage prescribers in a shared vision to encourage changes in practice and uptake of NICE guidance
- Raise awareness of new guidance and allow time to raise concerns and discuss the evidence base
- Change prescribing behaviour and encourage GPs to share best practice

To tackle these issues and improve patient safety and outcomes, the MMT developed a Medicines Optimisation Peer Review (MOPR) programme.

Getting more out of medicines management meetings

The MOPR programme consists of annual meetings which bring 5-6 practices together from a CCG locality to discuss prescribing issues. The sessions are facilitated by senior pharmacists and GP clinical champions. The aim is to influence prescribers' decision making, ensure prescribing is safe, evidence- based and cost effective, reduce variation in prescribing behaviour, implement NICE guidance and improve patient outcomes.

Topics for discussion at the meetings are based on NICE guidance, prescribing data and local priorities. In a supportive environment, prescribers are encouraged to share views, challenge and debate decisions taken by others and reflect on their prescribing behaviour. Each practice is also asked to choose three key areas to work on in the next twelve months, which allows them to take an approach that best suits their needs. MMT technicians then follow up with them to ensure changes are fully implemented.

Improving performance, saving costs and freeing up resources

The MOPR approach has enabled the team to work with prescribers to address key issues and make savings across the patch. In particular it has helped to reduce antibiotics usage and improve antimicrobial stewardship in line with current and draft NICE guidance. It has also contributed to savings and productivity targets; freeing up resources to invest in new treatments and services and implement NICE guidance.

Key learning points were:

- Select topics that have been agreed with GP Clinical Champions
- Fully understand the NICE guidance and the evidence base
- Ensure key messages for GP practices are consistent and the MMT is aware of them
- Gather intelligence from the ground to anticipate issues and identify priorities for discussion
- Listen to practices to understand what they need to implement changes and support them to change behaviour
- Following up with practices is essential to securing meaningful changes

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