

NICE Shared Learning Awards 2018



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Foreword

For over a decade NICE's Shared Learning Awards have showcased examples of how NICE guidance and standards are being used to improve care across health organisations, local authorities, social care providers and the voluntary sector.

We received over 75 submissions this year for the 2018 awards. The quality of the case studies was particularly strong which made our panel's task of selecting the top 20 in this booklet very challenging.

The panel selected 20 projects that clearly demonstrated how NICE guidance and standards had been used to change and improve services, with strong evidence of the impact this had on patients, service users, and the wider health and care system. The transferability of the projects was also considered to be important so that others elsewhere can learn from and replicate success.

Of the 20 projects highlighted in this booklet, three were selected as finalists for the 2018 Shared Learning award:

- The Yorkshire & Humber Academic Health Science Network – for their efforts to embed faecal calprotectin diagnostic tests into their work to support people with inflammatory diseases of the bowel
- Bedfordshire Community Health Services – who have developed a new 'Food First' approach to prevent malnourishment among care home residents
- East Berkshire Clinical Commissioning Group – for working to reduce the incidence of urinary tract infections through better hydration in care homes.

More detail on all 20 of the projects featured in this booklet can be found in the NICE Shared Learning Collection (www.nice.org.uk/sharedlearning), a searchable resource that contains hundreds of examples showing how NICE guidance and standards have been used to improve care across a wide range of health and care settings.

We encourage submissions to our Shared Learning Collection throughout the year. Each year all newly-published examples are considered for our Shared Learning Awards.

If you have used NICE guidance or standards to improve care, we want to hear from you. Tell us your story and you could be in with a chance of winning the NICE Shared Learning Awards in the future. We look forward to receiving your entry for next year.

"The Shared Learning Awards are such an important aspect of our work. For everyone who works for and with NICE it is great to see the impact that our work has on real people."

Professor David Haslam,
Chair, NICE

"It was a wonderful experience and bought credibility to the scheme. I will be encouraging people to apply for the next Shared Learning Awards."

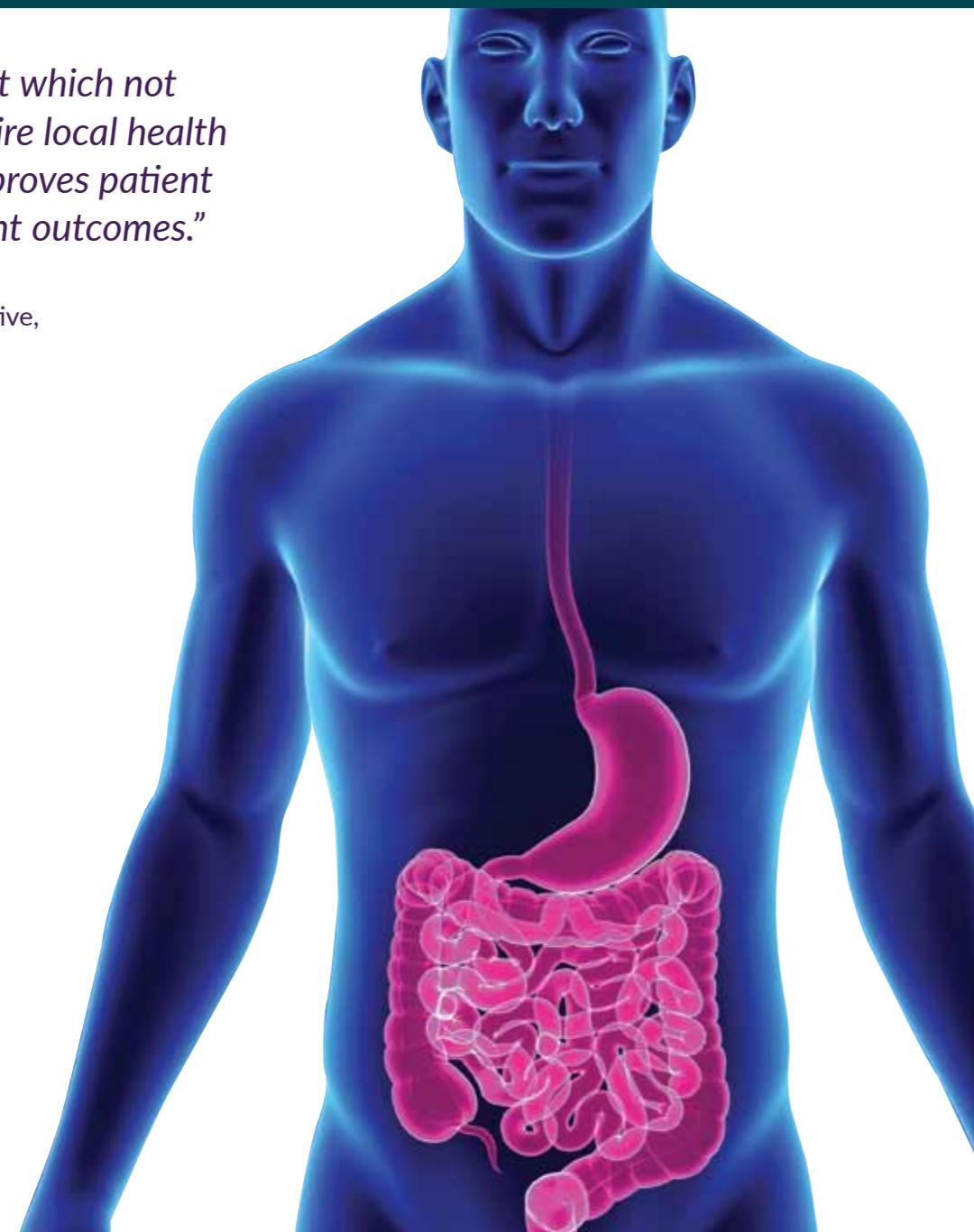
Michelle Turton,
Mansfield District Council (2017 Winner)

A faecal calprotectin care pathway to support diagnosing inflammatory bowel diseases in primary care

A new care pathway to support the wider use of faecal calprotectin testing within primary care, was created by Dr James Turvill at York Teaching Hospitals NHS Foundation Trust. The Yorkshire & Humber AHSN developed a suite of resources to enable easy and swift implementation of the pathway into primary care and its continued use by GPs.

"This is a great project which not only supports the entire local health economy but also improves patient experience and patient outcomes."

Richard Stubbs, Chief Executive,
Yorkshire & Humber AHSN



What we did and why

Uptake of NICE diagnostics guidance DG11, which recommends using faecal calprotectin testing to diagnose inflammatory bowel disease in primary care, has been low. The criteria for endoscopy referrals in the guidance has led to a high number of patients with Irritable Bowel Syndrome – and not bowel disease - being unnecessarily referred to secondary care.

In 2014, Dr Turvill took part in a NICE adoption project, designing a new pathway to address this. The Yorkshire & Humber AHSN then enabled the implementation of the pathway, which included increasing the cut off level for endoscopy referrals, and providing GPs with risk assessment tools to support them to use their clinical judgement on whether a referral is necessary.

The aims of the pathway were to:

- Reduce the pressures in secondary care for endoscopy services and gastroenterology outpatient appointments.
- Improve patient experience by supporting quicker diagnoses and enabling patients to be treated in primary care where possible.
- Provide cost saving benefits for the local health economy.

Outcomes and impact

The AHSN, York Teaching Hospitals NHS Foundation Trust and Vale of York CCG co-created a pack of resources designed to help other local organisations implement the new pathway as easily as possible. These included: business plans, templates for GP systems, and educational videos and materials.

The pathway increased the specificity of the test whilst maintaining its sensitivity. The health economic evaluation completed by York Health Economic Consortium (YHEC) verified this and demonstrated that per 1,000 patients tested the improved pathway:

- Prevents 147-262 colonoscopies.
- Saves £100K - £160K.

Patient feedback on the pathway included:

- "The test was enough to confirm that it is nothing more than IBS."
- "The calprotectin test is better than a colonoscopy."

What we learnt

Different companies make faecal calprotectin tests and it is important to know which ones are being used by GPs. We compared three different tests and although there are small differences in the results they provide, they are all suitable for use in our pathway.

We found that clinical champions were vital for educating GPs. Ensuring GPs understood the new pathway and why it had been changed ensured good adherence.

Another challenge was ensuring GPs understood that faecal calprotectin testing should not be used if cancer is suspected, and that faecal immunochemical tests (FIT) for cancer are on a separate pathway.

The AHSN network is supporting the implementation of this project nationally and is keen to share the resources developed in York with other Trusts and CCGs across England.

We found that clinical champions were vital for educating GPs. Ensuring GPs understood the new pathway and why it had been changed ensured good adherence.

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The Food First team: tackling malnutrition in care homes using a sustainable, non-medicalised approach

The Food First team works collaboratively with care homes in Luton, Bedfordshire and Hertfordshire Valleys to improve the identification and management of malnutrition. The team empowers care home staff to meet their residents' nutritional needs and preferences for real and familiar foods. This has resulted in NHS savings of £4 for every £1 invested.

"I'm proud to work with a team who challenge the status quo, are creative and strive for the best, but who also listen, involve and learn from others to promote excellence in nutritional care."

Vittoria Romano, Food First Team Lead,
Bedfordshire Community Health Services



What we did and why

Malnutrition costs health and care services an estimated £19.6 billion each year in England, with 50% of this attributed to people aged over 65. Locally, up to £1.4 million per year was spent on prescribed nutritional products for a population of 600,000.

35% of care home residents are estimated to be at risk of malnutrition.

We decided to focus on implementing NICE quality standard QS24 in this setting.

Initial baseline data collected from approximately 3,500 care home residents in Hertfordshire Valleys showed:

- Approximately 50% had an incorrect malnutrition risk score calculated.
- 95% did not have a nutritional care plan detailing their individual needs and preferences.

At the outset of the project, the priority for commissioners was to reduce spending on prescribed nutritional products, whereas care homes were anxious to meet CQC regulations and provide the best care possible.

To address both objectives, the Food First team provides a training, audit and certificate scheme for care home staff at all levels, alongside individualised dietetic reviews for residents where required. Overall the Food First team promoted the idea that malnutrition is everyone's responsibility.

Contact: Vittoria Romano

Outcomes and impact

Outcomes of the Food First project after one year's activity in Hertfordshire included:

- A 25% improvement in correctly calculating malnutrition risk.
- A threefold increase in provision of nutritional care plans detailing individuals' needs and preferences.
- Increased staff confidence (from 31% to 91%) in using the 'MUST' malnutrition screening tool.
- £200,208 savings on prescriptions with no negative impact on population malnutrition risk.

Long term implementation in Luton and Bedfordshire has achieved:

- 80% of care homes are certified, indicating compliance with NICE quality standards and CQC guidelines.
- 76% of residents gained or maintained weight 6 months after dietetic intervention (2017/18).
- 56% of residents had a reduction in their malnutrition risk 6 months post intervention.

Feedback from care home staff and managers included:

- "I gained a lot of knowledge on this training and will be able to put this into practice."
- "Very good training to improve our residents' food and drink intake."
- "Will use this information to help service users."

What we learnt

The Food First model of care has been successfully transferred to a number of local organisations, avoiding duplication, saving set-up costs, and sharing resources and leadership.

Cost savings resulting from the project have enabled further investment in the team, which has grown from one part-time dietitian in 2009 to 10 dietetic colleagues today. Continued investment has seen sustained local cost savings, despite increased spending nationally.

Our data adds to the growing evidence that a food first approach, coupled with a comprehensive training programme, can produce system-wide benefits. The incentive of a Food First certificate, which care homes proudly display, encourages behaviour change and more effectively leads to culture change than merely increasing knowledge.

The Food First Team is highly valued and supported locally, including great stakeholder collaboration from service users, care home staff and GPs.

Referencing national guidelines reduces ambiguity and provides support for difficult conversations. The team have learnt constant evolution of the service is essential to ensure an effective, efficient, relevant service that continues to achieve good outcomes.

Reducing incidence of Urinary Tract Infections by promoting hydration in care homes

A multi-disciplinary quality improvement project to reduce the incidence of Urinary Tract Infections (UTIs) or UTI-related hospital admissions by promoting hydration and optimising UTI management in East Berkshire care homes.

"Keeping it simple means it's not only easy to implement, but also easy to sustain."

Sundus Jawad, Prescribing and Care Homes Support Pharmacist, East Berkshire CCG



What we did and why

Dehydration is a common cause of hospital admission for care home residents and increases the risk of UTIs and other complications including confusion, falls and Acute Kidney Injury (AKI). UTIs in the elderly are often over-diagnosed and over-treated. Our project links in with the national focus on antimicrobial stewardship which aims to reduce inappropriate prescribing of antibiotics for UTIs in primary care.

The multi-disciplinary project promoted evidence-based prescribing and UTI management by implementing a number of NICE recommendations in areas including:

- Improving the correct diagnosis of UTIs and the need for a full clinical review in over 65 year olds (NICE QS90).
- Optimising UTI management and antimicrobial prescribing (NICE QS61).
- Reducing UTIs through improving hydration in care homes (NICE NG22).
- Raising awareness of AKI (NICE QS76, CG169).
- Raising awareness of antimicrobial resistance (NICE NG15).

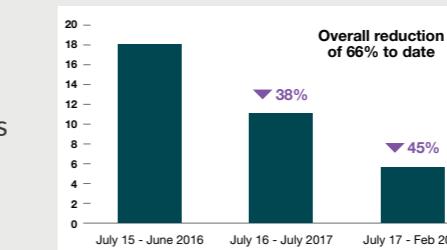
Other objectives included:

- Improving residents' overall wellbeing.
- Promoting patient choice.

Outcomes and impact

The project demonstrated a reduction in UTI hospital admissions and UTIs requiring antibiotics. Benefits included significant cost savings as well as freeing-up valuable GP time.

UTI admission to hospital [data Jul 2016-Feb 2018]



UTI requiring antibiotics:

On average the incidence of days between UTIs in care homes increased from 1 every 9 days at baseline to 1 every 52 days since the project commenced. One care home was UTI free for 243 days.

The care homes demonstrated sustained compliance (99%) with providing seven structured drinks rounds each day. Care staff benefited from the 'hydration training' which raised awareness of the risks of dehydration in the elderly and how this can lead to serious conditions such as AKI, UTIs, falls and antimicrobial resistance.

What we learnt

Integrated working and involving a range of stakeholders including the patients and their families is crucial from the outset.

Raising hydration awareness resulted in improved health and wellbeing, and staff gaining better understanding of the risks of dehydration in the elderly and antimicrobial resistance. We also raised awareness amongst care staff of the risks to kidney function posed by certain medicines.

Structured drinks rounds are designed by care home staff, are easy to follow and low-cost to implement. The drinks rounds became a social point of the day for residents and the simplicity and minimal cost of this project meant it was easy to implement and easy to sustain.

"The drinks trolley totally refreshes up my day."

Care home resident

"The training has given us an understanding of WHY it's important to ensure that residents have enough fluids – it's looking at the whole system, not just a drink."

Care home manager

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Improving medicines optimisation for care home residents

To maximise patient benefits from medication, reduce inappropriate polypharmacy and improve medicines safety, Wigan Borough CCG employed a team of pharmacists and pharmacy technicians to work with GP practices and care homes. Medicines optimisation was improved by implementing medication reviews and safe handling of medicines within care homes.

"This team has improved the quality of care provided to our care home residents and reduced inappropriate polypharmacy, resulting in improved patient outcomes and CQC ratings."

Anna Swift, Senior Assistant Director of Medicines Management, Wigan Borough CCG



What we did and why

UK research suggests care home residents may benefit most from medication reviews because:

- Inappropriate prescribing may occur in 50–90% of older people living in care homes.
- 68% may not have regular medical review.
- 44% may not have regular medication review.

The Care Quality Commission (CQC) and Local Authority had identified issues in Wigan regarding the safe handling of medicines in our care homes, resulting in poor CQC ratings.

The CCG, working closely with the Local Authority, GP Practices and care homes, had two main aims:

1. Improve medicines optimisation for care home residents by undertaking medication reviews.
2. Proactively prevent safeguarding incidents and improve CQC ratings by working with care home staff to review systems and policies, provide education and training, and implement national guidance.

Outcomes and impact

Between August 2014 and March 2017 medication reviews were carried out with 749 residents. Advice was provided to care home staff on monitoring and actions to take following any changes. Updates were provided to the dispensing community pharmacy.

Key clinical areas for review included:

- Polypharmacy and pill burden.
- Medication associated with falls.
- Antipsychotics in dementia.
- Osteoporosis.
- Atrial fibrillation (AF) related stroke.
- Proton pump inhibitors.
- Inhaler technique.

29 care homes were supported to improve the safe use of medicines. The NICE social care guideline SC1 baseline assessment and observed medicines rounds were used to inform this process. Key support areas included:

- Appropriate storage.
- Medicine Administration Records.
- Administration/documentation of topical products and thickeners.
- Controlled drugs.
- High risk medication e.g. anticoagulants.
- Administration of 'when required' medication.

What we learnt

Our approach has improved medicines optimisation over and above medicines review: 13 homes have improved their CQC ratings following support from the team and seven have been supported with service improvement plans.

Medication reviews have addressed inappropriate polypharmacy, achieving a 16% reduction in the number of prescribed regular medications. Improvements in a number of key quality prescribing indicators and patient safety have led to better patient-focused care and savings of £710,000.

Learning points:

- Developing the role of the care home pharmacy technician has been particularly successful. By adding this role to the team we have ensured a better use of skill sets and improved the outcomes of the team in a cost effective manner.
- Collaborative working with the Local Authority is essential.

Although face-to-face medication review with a GP can be challenging due to time pressures faced by GPs, we have found this to be the more successful approach.

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Delivering family-focused multi-disciplinary care for children with spasticity

We created a network of parents, health professionals, researchers and commissioners to create a joined-up, family-focused service that effectively manages the risk of hip dislocation, to improve posture, comfort and function for children with cerebral palsy.

"Hearing families and young people speak about their experiences at the Neurodisability Network day has helped drive change."

Rachel Rapson, Physiotherapy Clinical Manager, Torbay and South Devon NHS Foundation Trust



What we did and why

Children with cerebral palsy (CP) have large numbers of health professionals involved in their care, with multiple appointments and care plans. We mapped the current service to create an evidence-based postural management care pathway. We also launched an annual Neurodisability Network day, inviting professionals, parents, service users and researchers to share good practice.

Torbay and South Devon NHS Foundation Trust was an early implementer of the proposed national Cerebral Palsy Integrated Pathway (CPIP) to identify the risk of hip problems. Our radiology department established a dedicated hip surveillance clinic with consistent positioning, measurement and reporting of Reimer's hip migration percentage (HMP). To reduce multiple appointments, we developed joint orthopaedic, paediatrician and physiotherapy clinics and produced single reports and care plans.

Postural management workshops were offered to parents and carers and a physiotherapist was trained to deliver botulinum toxin injections to improve timely access to spasticity management.

The Neurodisability Network day has provided free training to professionals and carers, and has enabled parents and service users to have their voices heard.

Outcomes and impact

We audited our project's compliance with NICE guidance (CG145) in order to ensure safe service delivery.

Our dedicated hip surveillance clinics have been welcomed by parents, as they have more time, the children are more relaxed and better positioned for higher quality x-rays.

The clinics allow earlier identification of hip problems. 58 children with CP/spasticity are now on the hip screening pathway with reduction of risk of hip dislocation from 28% to 5%.

The joint clinics reduced the number of appointments for families and enabled parents to speak up and make informed decisions about their child's care with all the relevant professionals in one place, working together. Children now have better access to botulinum toxin with the introduction of injections under local anaesthetic and parents are involved in the design and management of several research projects for children with CP.

The NICE CG145 audit tool helped to improve the delivery of postural management training for carers and parents. We created training videos to deliver this information in a more accessible way.

By networking, using common standards and responding to families' views, we have enabled service improvement within the present situation of significant financial constraint, in a sustainable way.

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What we learnt

Mapping existing services with parents, health professionals and commissioners helped us establish a new care pathway and network. Memorable talks delivered by parents and young adults who use the services helped drive change. Parents have felt able to give us useful feedback about difficulties with access to services for children with CP.

CPIP assessment has started to highlight opportunities for earlier interventions aimed at reducing longer term complications. Our physiotherapist and orthopaedic surgeon are now working towards developing local outpatient injection and spasticity management clinics.

The NICE CG145 audit tool helped to improve the delivery of postural management training for carers and parents. We created training videos to deliver this information in a more accessible way.

By networking, using common standards and responding to families' views, we have enabled service improvement within the present situation of significant financial constraint, in a sustainable way.

DeAR-GP: Dementia Assessment and Referral to GP

Research shows 75% of care home residents have dementia, and many of these residents are undiagnosed. In 2015, the Health Innovation Network (HIN) worked with three care homes in south London to co-design DeAR-GP, a **Dementia Assessment and Referral** tool that aims to increase identification of possible dementia, and subsequent diagnosis rates.

"Dementia diagnosis rates in care homes are low in some areas. DeAR-GP empowers care workers to identify care home residents living with memory problems for review by their GP."

Aileen Jackson, Head of Mental Health, Health Innovation Network, Academic Health Science Network South London



What we did and why

There is a disparity between the number of care home residents who are likely to have dementia and those with an actual diagnosis. This limits their opportunities to make informed choices, receive appropriate care and access treatments. HIN carried out a feasibility study informed by the NICE quality statement on memory assessment services: *'People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia'* (QS1).

The study aimed to increase the identification of possible dementia and subsequent diagnosis rates in residential homes by co-designing a dementia case-finding tool. Focus groups were held to ascertain care workers':

- Knowledge/understanding of dementia.
- Experience of providing dementia care.
- Preferences of a selection of brief cognitive tests.

We then tested the resulting case-finding tool to establish:

- Whether care workers have the skills and understanding to use it autonomously.
- What proportion of those residents identified were subsequently diagnosed with dementia by a clinician.

Or found to have a previous diagnosis not previously known or shared with the care home.

Contact: Aileen Jackson

Outcomes and impact

The focus groups with care home workers revealed that the tool needed to:

- Be uncomplicated and easy to follow.
- Be paper-based.
- Include an initial case-finding question to prevent indiscriminate screening of residents.
- Include an observation chart.
- Include the AMT-4 cognitive test.
- Include a referral letter to clinicians.

"To diagnose, the GP is the one. But to notice, it's those that are close to him: the relatives or the carers (workers) or the nurse."

Care home worker,
south London.

DeAR-GP includes a screening question, 8 observations and the AMT-4 Test. It was tested in 3 care homes: 23 residents were identified who were showing significant signs of memory loss but did not have a diagnosis of dementia.

On review by clinicians, 87% were either:

- Diagnosed with dementia.
- Referred to the memory service.

Or found to have a previous diagnosis not previously known or shared with the care home.

What we learnt

On review, clinicians diagnosed 12 residents (52%) with unspecified dementia and referred three (13%) to memory services. Five residents (22%) were found by the clinicians already to have a diagnosis which was unknown to the care homes. No further action was taken with one resident (4%) who had a normal cognitive score when assessed by a clinician, and two (8%) were not reviewed by the clinicians because they were physically unwell at the time.

HIN's feasibility study showed that after a short training session, the care workers were able to use the dementia case-finding tool appropriately with residents who they believed to show signs of dementia but did not have a diagnosis of dementia.

Care workers felt empowered by the tool. It helped their communication with clinicians and made it more robust.

DeAR-GP is an efficient way to start the process of identifying care home residents who may have dementia. It can be used by care workers confidently and effectively. The study aimed to increase the identification of possible dementia and subsequent diagnosis rates in residential homes.

Head of Mental Health
Health Innovation Network

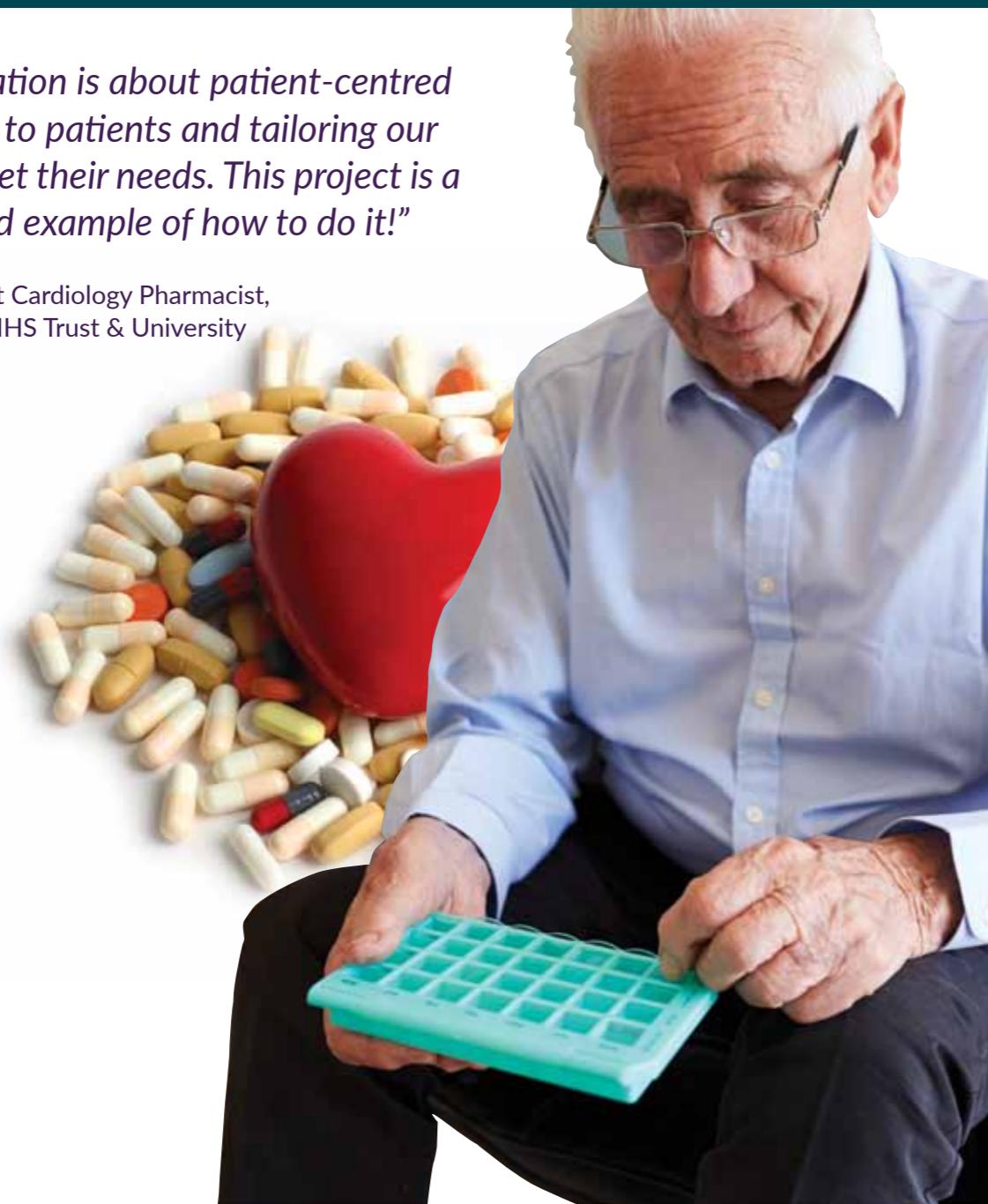
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Re-engineering the medicines optimisation pathway for patients after a heart attack

Through a collaboration between cardiology and pharmacy, this project successfully improved outcomes for patients after Myocardial Infarction (MI) - commonly known as heart attack. We introduced consultant pharmacist-led medicines optimisation clinics which applied the principles of medicines optimisation and medicines adherence to improve the patient experience, maximise benefit from the cardiac secondary prevention medicines and reduce cardiovascular risk factors.

"Medicines optimisation is about patient-centred care, listening more to patients and tailoring our consultations to meet their needs. This project is a successful real world example of how to do it!"

Dr. Rani Khatib, Consultant Cardiology Pharmacist,
Leeds Teaching Hospitals NHS Trust & University
of Leeds.



What we did and why

NICE and other guidelines recommend optimisation of drug therapies for secondary prevention in patients who have suffered a MI. Audit showed that over 60% of our post-MI patients were not getting the NICE recommended doses of secondary prevention medicines (SPM) and 40-50% were not adhering to at least one of the SPM. These missed opportunities increased the risk of cardiac hospitalisations and mortality.

In a collaboration between cardiology and pharmacy, with support from AstraZeneca, we established a consultant cardiology pharmacist-led post-MI medicines optimisation clinic which ran in parallel with a consultant cardiologist.

The aim was to optimise SPM and reduce risk factors in line with NICE guidelines.

The objectives were to:

- Provide a comprehensive medicines review based on the principles of medicines optimisation.
- Enable patients to share their medicines-taking experience and provide the necessary support to maximise benefit from SPM and reduce harm.
- Adopt a patient-centred approach and shared decision making strategies.

Contact: Dr. Rani Khatib

Outcomes and impact

Prior to attending the new service, post-MI patients were sent the My Experience of Taking Medicines Questionnaire (MYMEDS) to identify any medicines-related issues.

In clinic patients were triaged to see a consultant cardiology pharmacist, cardiologist, or both depending on their needs. The new consultation style focused on meeting patients' individual needs and patients were provided with a medicines and risk optimisation plan, which was shared with their GP and cardiac rehab.

Over 500 patients were reviewed in the first year. Data was collected at different time points to assess the impact of the programme.

Key findings:

- Improved patient experience: they felt more involved, their needs were met and concerns were addressed.
- Increased levels of SPM optimisation: optimal ACE inhibitors (from 16% to 74%) and optimal beta blockers (from 6% to 46%) after one visit.
- Adherence to SPM at 3-6 months post-clinic improved significantly (40-70% drop in non-adherence).
- Improved persistence to SPM 12 months post discharge (90% versus 66%).

"I have never sorted and talked about my medicines in this way. Everything was discussed in length and all my questions were answered and covered fully."

Patient Y

Key learnings:

- Collaboration and multidisciplinary working is central to the delivery of medicines optimisation in practice.
- Patient-centred care is about listening more to patients and tailoring the consultations to meet their needs.
- Pharmacists working alongside other healthcare professionals can deliver real world medicines optimisation.

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What we learnt

Major outcomes:

- ▲ capacity► 44% reduction in waiting time for first outpatient cardiology review.
- 40-55% reduction in Acute Coronary Syndrome re-admission rates in 30, 60 and 90 days post-discharge compared to previous year.
- 12 months persistence to NICE recommended SPM improved significantly versus standard care (90% versus 66%).
- All patients surveyed found the clinic valuable and would recommend for other patients with heart disease.

"Can't recommend this service highly enough."

Patient X

"I have never sorted and talked about my medicines in this way. Everything was discussed in length and all my questions were answered and covered fully."

Patient Y

Engaging to improve: outcomes of the Young Adult Diabetes Clinic restructure

Achieving improved clinical outcomes in young adult diabetes care has been possible by adopting a culture of engagement, patient-centered care, flexibility and using peer support to complement clinical care.

"As our service users are the real experts, it was not surprising that we would attain improved results once we started listening to their valuable advice."

Dr. Reza Zaidi, Consultant Diabetologist and project lead, Royal Liverpool & Broadgreen University Hospitals NHS Trust



What we did and why

Nearly 2,500 people with type 1 diabetes (T1D) live in Liverpool, with a significant number being young adults (YAD) of 19-25 years old.

Unfortunately, this age is associated with frequent clinic disengagement and increased hospital admissions: at the end of 2015, our YAD clinic non-attendance and T1D-related hospital admission rates were rising steadily.

To improve care and outcomes, a number of changes were made in early 2016, in accordance with NICE's diabetes guidance (NG17 and NG18), and quality standard QS140 on transition from children's to adults' services:

- Structured Clinic Pathway established.
- Joint multidisciplinary clinic appointments.
- Telephone reminders of appointments.
- Pre-clinic questionnaires.
- DIASEND® use in clinic for data download.
- Patient leaflets created, containing key team contacts and useful web links.
- Database of all patients in YAD clinic was created.
- LIVT1D – Liverpool's first peer-support group for people with T1D - was created.

Outcomes and impact

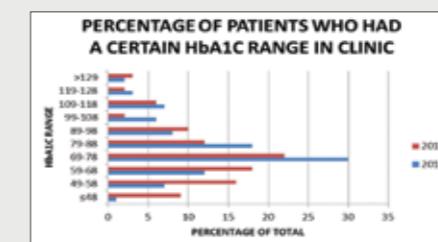


Fig 1: In 2016, a fourfold rise in people achieving NICE recommended target diabetes control (HbA1c <48mmol/mol) was seen.

	2015	2016
Clinical non-attendance rate	47%	32%
Financial gain	£3,663	

Fig 2: Clinic non-attendance rate reduced in 2016. 65% of YAD attended two or more appointments in the year.

% of clinical cohort admitted to hospital with:	2015	2016
Diabetic ketoacidosis	15%	8%
Severe hypoglycaemia	4%	2%

Fig 3: Reduction in YAD hospital admissions in 2016 resulted in cost savings for the hospital of £11,336.

Contact: Dr. Reza Zaidi

Consultant Diabetologist
Royal Liverpool University
Hospital

What we learnt

Restructuring the young adult clinical service with a more flexible, patient-centred and multi-disciplinary approach has brought about improvements in: clinic attendance rates; patients achieving target average blood glucose levels (HbA1c); percentage of annual checks carried out; and a reduction in admission rates of diabetes-related emergencies amongst our clinic cohort.

Improving the delivery of high quality of care in the future will be possible by working through the following 3 areas:

Systematic quality improvement through clinical outcomes: regular data collection for complications, admissions and clinic attendances through local and national audits.

Assessing expectation and satisfaction: arranging interactive opportunities for regular YAD feedback to further improve clinic experience and service.

Broadening the programme scope and reach: sharing outcomes of peer-support with neighbouring trusts and charities to work collaboratively and use positive outcomes to influence commissioning on a wider scale.

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Optimisation of intravenous fluid prescribing: framework for changing practice through education and audit

The objective of our project was to improve the prescribing of intravenous (IV) fluids for adult inpatients on medical and surgical wards, in line with the NICE guidance for intravenous fluid therapy in adults in hospital (CG174) published in 2013.

"This guidance outlined protocols for IV fluid administration along with recommendations for training and education, with a focus on more consideration for prescribing fluids specific to patients requirements."

Dr. Vinita Mishra, Consultant Chemical Pathologist,
Royal Liverpool & Broadgreen University Hospital NHS Trust



What we did and why

IV fluids are given to patients in hospital to stop them becoming dehydrated and to make sure they have the right amounts of fluid, salts and sugars in their blood. In 2015 our Trust appointed an IV fluid lead and following on from her work implementing new local guidelines for IV fluid prescribing, a team of healthcare professionals was set up to continue ongoing work in this area.

The main aims of our project were: to eliminate inappropriate IV fluid prescriptions; to create awareness among hospital staff of fluid and electrolyte pathophysiology; to educate and train of junior doctors on IV fluid management in the hospitalised patients.

To change practice we needed to change the culture of fluid prescription. We achieved this through staff education and awareness-raising.

Our IV fluid team had a broad level of disciplines and experience including a medical consultant, specialist registrar, nurse consultant, senior pharmacist and foundation trainee doctors.

Outcomes and impact

To improve education on IV fluid prescribing, regular teaching from a Consultant Chemical Pathologist was introduced and delivered to junior medical staff within training programmes - such as the foundation doctors' programme. Teaching sessions were offered within individual departments, as were e-modules for staff.

In 2015 we introduced a user-friendly IV fluid flow chart which was displayed on posters on the wards, and available in a phone application and in the laboratory handbook available through our intranet.

To improve the documentation of plans for IV fluids, we created a '24 Hour IV Fluid Plan' form which was integrated into the electronic notes system being introduced across the Trust.

A rolling audit was commenced, designed around the NICE guidance (CG174) on IV fluids, with the aim of monitoring progress in improving IV fluid prescribing and also giving feedback on performance.

What we learnt

Educating junior doctors has been key to our project, with the introduction of IV fluid prescribing as part of mandatory training during the foundation programme led by senior clinicians.

A varied team was vital to our goals.

Input from senior nursing staff improved fluid monitoring for patients, and pharmacists could advise what interventions would be practical, along with making different fluids available across the Trust.

Working in our multi-disciplinary team, we were able to benefit from different areas of expertise.

Key messages:

- There has been an improvement in prescribing appropriate IV fluids since the March 2016 audit and consistency since the September 2016 audit.
- The results on weekends are comparable to those on weekdays.
- We have seen a 29-fold increase in use of dextrose/saline within the Trust since IV fluid education began in 2015.

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Modern Innovative SolutionS Improving Outcomes iN Asthma Breathlessness and COPD (MISSION ABC)

MISSION ABC proactively identified at-risk patients with respiratory symptoms within 10 GP practices across Hampshire. Clinics were held in the community promoting multi-sector integration. Patients were rapidly assessed, educated and managed by a specialist respiratory multi-disciplinary team. The aim was to optimise care, reduce healthcare costs and improve patient outcomes.

"The successful application of NICE guidelines requires a fresh approach that is patient-centered and integrates both specialist intervention and innovation throughout the patient pathway. MISSION ABC demonstrates how this can be achieved with outstanding clinical outcomes."

Professor Anoop J Chauhan, MISSION ABC (MABC)
Project lead, Director of Research and Innovation
at Portsmouth Hospitals NHS Trust



What we did and why

The burden of asthma and COPD on the healthcare system cannot be under-estimated. The current patient journey for people with uncontrolled respiratory disease is convoluted, expensive, time-consuming and is associated with poorer outcomes and reduced quality of life.

We identified patients in GP practices who were at risk from uncontrolled disease, or with no diagnosis and respiratory symptoms. At community-based, one-stop multi-disciplinary clinics, patients had their diagnosis reviewed, the reasons for poor disease control explored and their medications optimised.

All patients were offered personalised self-management plans reinforced with education. For patients where the diagnosis remained unclear, a follow-up hospital-based 'investigation clinic' was delivered shortly afterwards by the same multi-disciplinary team.

Community healthcare professionals attended respiratory education events, and novel technologies were used to ensure sustainable patient self-management.

Our project was based on recommendations in NICE guideline NG80 and CG101.

Outcomes and impact

A total of 27,853 patients diagnosed with asthma, COPD or symptoms of breathlessness with no respiratory diagnosis were identified across 10 GP practices. Following an electronic audit search, 998 were identified with uncontrolled symptoms, of whom 356 attended MABC. A further 85 patients attended the follow-up Investigation Clinic in hospital.

The table below shows that MABC clinics led to a reduction in unscheduled healthcare utilisations:

	Mean/patient At Baseline	Mean/patient At 6 month	Av. percentage reduction
Unscheduled GP usage	1.75	0.62	-65%
Exacerbations	0.96	0.42	-56%
OOH calls	0.08	0.02	-75%
ED visits	0.04	0.02	-50%
Hospital admissions	0.03	0.00	-100%

"I feel like I've been listened to today. Over the years I have had various treatments but nothing has improved my condition. Today it seems as if there may be another route to finding out how to better manage my condition."

Patient

What we learnt

We employed a continuous improvement model using feedback from patients, practice staff and our own clinical team to adapt the process during project delivery, which contributed hugely to its enormous success. Challenges of integrating services between primary and secondary care included difficulties accessing data and differences between computerised patient record systems.

The importance of education and continuous learning was emphasised by unanimously positive feedback following our education events.

"There are multiple benefits for patients - care is delivered closer to home, interventions are made earlier, and their care is co-ordinated among all parties. The multi-disciplinary mode of working together also up-skills the primary care team."

Dr Leung, GP Lead

Throughout the MABC project we developed a portfolio of material including treatment guidelines and patient-facing literature. We also developed a free MABC website (www.missionabc.uk) and training programme to help others who wish to embark on similar projects.

Contact: Professor Anoop J Chauhan

Director of Research and Innovation
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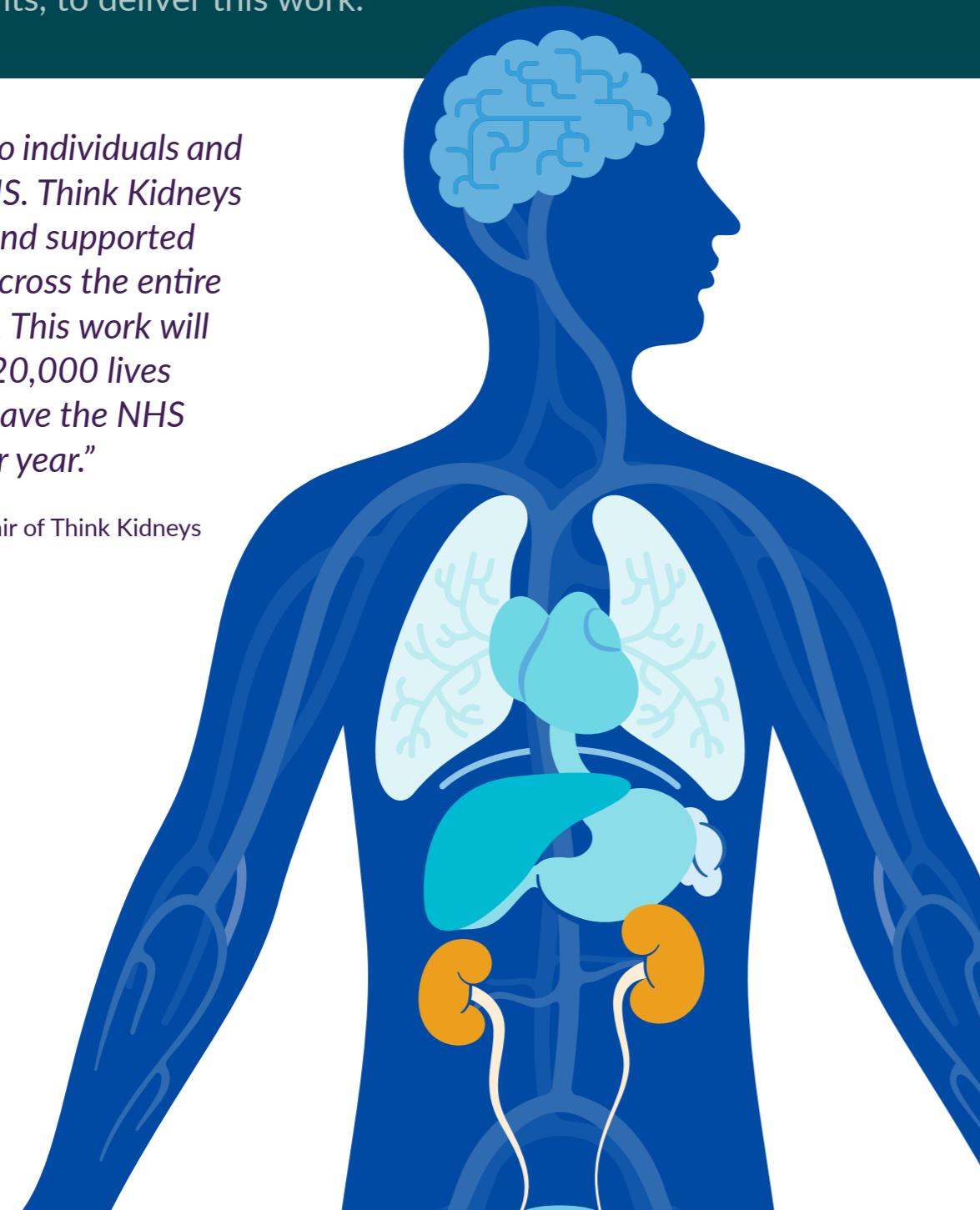
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Think Kidneys: a national programme with the aim is of reducing avoidable harm caused by Acute Kidney Injury (AKI)

AKI has been recognised as a global health issue and safety challenge. In England, it costs £1 billion and is associated with more than 100,000 deaths each year, yet is potentially avoidable. The NHS is the first health system in the world to attempt to tackle AKI with a system-wide approach. Think Kidneys has involved hundreds of people from across the NHS, including patients, to deliver this work.

"AKI is harmful to individuals and costly to the NHS. Think Kidneys has developed and supported improved care across the entire NHS in England. This work will support saving 20,000 lives every year and save the NHS £200 million per year."

Dr. Richard Fluck, Chair of Think Kidneys



What we did and why

Established a programme board under the name 'Think Kidneys.' The objectives were:

- To support commissioners and organisational leads in driving and championing the need to improve AKI care.
- To provide clinicians and patients with education, information about AKI.
- To establish the data flows to allow successful audit and quality improvement.

Activities included:

Commissioning levers - Think Kidneys supported NHS England to release a level 3 patient safety alert on AKI, mandating improved biochemical analysis for potential AKI. It later introduced a national quality scheme to improve communication between primary and secondary care for cases of AKI.

Guidance - A wide range of guidance and best practice has been produced and is available via www.thinkidneys.nhs.uk. This includes NICE products, patient education material, guidance for medicines management and a variety of care settings.

Data flows - Working with clinicians, laboratories, software providers and the Association of Biochemists, the approved AKI detection algorithm was introduced across England and regular data returns to the UK Renal Registry commenced.

Contact: Dr Richard Fluck

Consultant Renal Physician
Royal Derby Hospital

What we learnt

The Level 3 Patient Safety Alert was issued in June 2014 for implementation by March 2015



Over the past year there have been more than 24,000 visits to the Think Kidneys website, including 3,500 to the resources and approximately 500 people clicking on links to the NICE guidance.

We currently have 142 pathology laboratories (out of 160) submitting data to the UK Renal Registry.

The UK Renal Registry now keeps the largest database of episodes of AKI in the world. Over 90% of pathology labs in England return data to the Registry on a regular basis. This master patient index provides a rich picture of the extent and impact of AKI on the population, and will provide the backbone of systematic improvements to come.

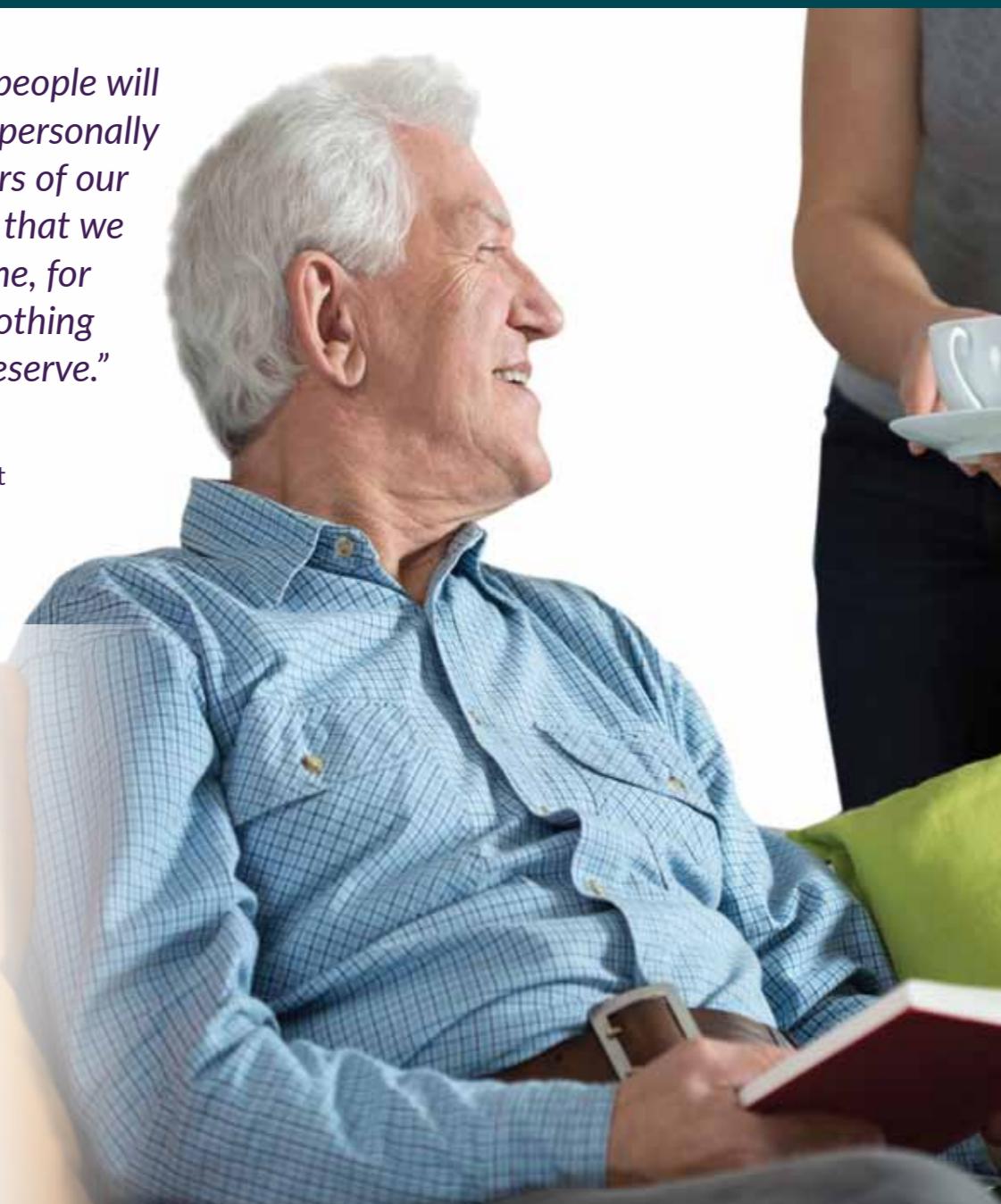
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Improving quality of care in residential care and nursing homes

Healthwatch Isle of Wight published a report entitled 'Home from Home' making clear recommendations to commissioners and providers to improve the quality of care in local residential care and nursing homes, following increasing feedback from the public.

"The care of older people will affect us all either personally or through members of our family, so it is vital that we get it right, first time, for everyone. This is nothing less than people deserve."

Joanna Smith, Manager,
Healthwatch Isle of Wight



What we did and why

In 2015 the local Healthwatch on the Isle of Wight received an increasing amount of public feedback relating to poor standards of care in nursing and care homes on the island. Quality of care in these settings was also chosen by the public as a priority during Healthwatch Isle of Wight's annual prioritisation survey 2015/16, indicating that this was a topic that the public wanted us to look at in more depth. So we decided to focus on this.

Approximately 400,000 people live in care homes in England and there are around 900 people on the Isle of Wight currently living in a residential care or nursing home.

We know that promoting residents' wellbeing will have a wider effect on local health services,

A person who is well supported - both physically and emotionally - will be less likely to be admitted to hospital or to require urgent primary care.

We spoke to residents and their families and conducted 13 'enter and view' visits to care and nursing homes. We also conducted a survey of registered home managers to understand the pressures they face on a day to day basis.

Outcomes and impact

We published a report entitled 'Home from Home' with clear recommendations to providers and commissioners. We also hosted the first Isle of Wight Care Awards to celebrate outstanding practice in care homes and to share good practice.

As a result of our report, the local authority restarted their quality monitoring visits to care homes, enabling them to pick-up concerns early on. An integrated quality surveillance group was established, with membership from the CQC, the local authority, Healthwatch Isle of Wight and the Isle of Wight CCG. The CCG has recruited a quality lead who provides practical support to care home managers.

A managers' network has been established along with quarterly newsletters to social care managers with links to support and training courses. As a result of these initiatives, the CQC rating for care and nursing homes on the island improved dramatically, with 69% of all care and nursing homes receiving a good rating, 30% requiring improvement and no homes rated as inadequate.

What we learnt

We learnt that adult social care has the power to transform people's lives so we must all believe that outstanding is not only achievable, but essential to the wellbeing of older people.

It is crucial that quality is systematically and continuously reviewed by providers, commissioners and regulators. This helps to ensure that nursing and residential care homes adapt and evolve to meet the changing needs of the people they support, and to provide a culture and practice that delivers a high standard of care.

Leadership is key to the success of any care home and managers should be supported and seen as key professionals in local health and care systems.

NICE guidance and standards provide a clear way of establishing what 'good' is and can be applied throughout all health and care services. We used NG22 to design our 'Home from Home' report.

Service providers and commissioners must listen to people's experiences of care to ensure that services are developed in conjunction with people's needs and expectations.

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The Joint Pain Advisor approach for knee and hip pain

The Health Innovation Network AHSN in south London has developed a physiotherapy-led service staffed by 'Joint Pain Advisors' to provide easier access to better care for people with osteoarthritis (OA) of the knee and hip. The service supports them with information, education and exercise to better manage their condition.

"The Joint Pain Advisor approach allows many more people with joint pain to benefit from NICE advice. Our service enables patients to help themselves live better lives – in less pain, able to do more, with a better quality of life."

Professor Mike Hurley, Clinical Director
MSK Theme, Health Innovation Network.



What we did and why

In older people, chronic knee and hip pain caused by OA is very prevalent and impairs mobility, function and quality of life. The majority of people with OA are managed in the community by their GP, with only a very small minority having joint replacement surgery. GPs have limited time and expertise to support patients with uncomplicated OA.

Patients' health beliefs, behaviours and lifestyles, including being overweight or inactive, combined with avoidance of everyday activities/movements that might make their pain worse, are all risk factors for developing and exacerbating joint pain. Enabling GPs to implement NICE guidance on managing OA, such as effective lifestyle coaching, would require additional training and more frequent, longer consultations.

The aim of our project was to evaluate whether a primary care intervention, led by Allied Health Professionals (AHPs) delivering person-centred, holistic, practical lifestyle coaching in line with NICE Guidance was a feasible, more effective way to manage patients' knee and/or hip pain. Two physiotherapists experienced in managing musculoskeletal conditions were recruited to the Joint Pain Advisor role, working across six primary care surgeries in Lewisham, south London.

Outcomes and impact

498 people used the service over an 18 month period. The mean age of participants was 65 years (range 40-93 years), mean weight 87 kg (range 49-157 kg), 82% had knee pain, 18% had hip pain and many patients had both.

- Participants were invited to a series of four 30-minute appointments: initial (baseline) assessment; follow up at 3 weeks, 6-8 weeks and a final review at 6 months.
- Baseline measures of pain, function, quality of life, physical activity, waist circumference and body mass were collected at the initial appointment and reviewed at follow up appointments.
- The Joint Pain Advisors taught simple self-management strategies and used behaviour change techniques (motivational interviewing, goal setting, action/coping planning) to support participants to alter their lifestyles.
- Feasibility and effectiveness of the service was evaluated using quantitative and qualitative methods.

What we learnt

AHPs are well placed to provide effective, efficient and better care for people with uncomplicated OA. People want to know more about their condition and be more involved in their care, and they respond well to tailored support and advice.

Our evaluation showed improvements in clinical outcomes and reduced costs:

- 18% reduction in pain.
- 2kg reduction in weight.
- Physical activity increase of 2 days a week.
- 15% increase in mental wellbeing.
- 21% fewer GP consultations for hip or knee pain.
- Reduction in referrals to musculoskeletal physio-therapy and imaging.

"Changing beliefs and behaviours requires coaching from practitioners with sufficient knowledge, expertise and time to provide effective, practical information, advice and on-going support. When delivered effectively, people can adopt lifestyles that improve clinical outcomes."

Amy Semple, Senior Project Manager, Health Innovation Network.

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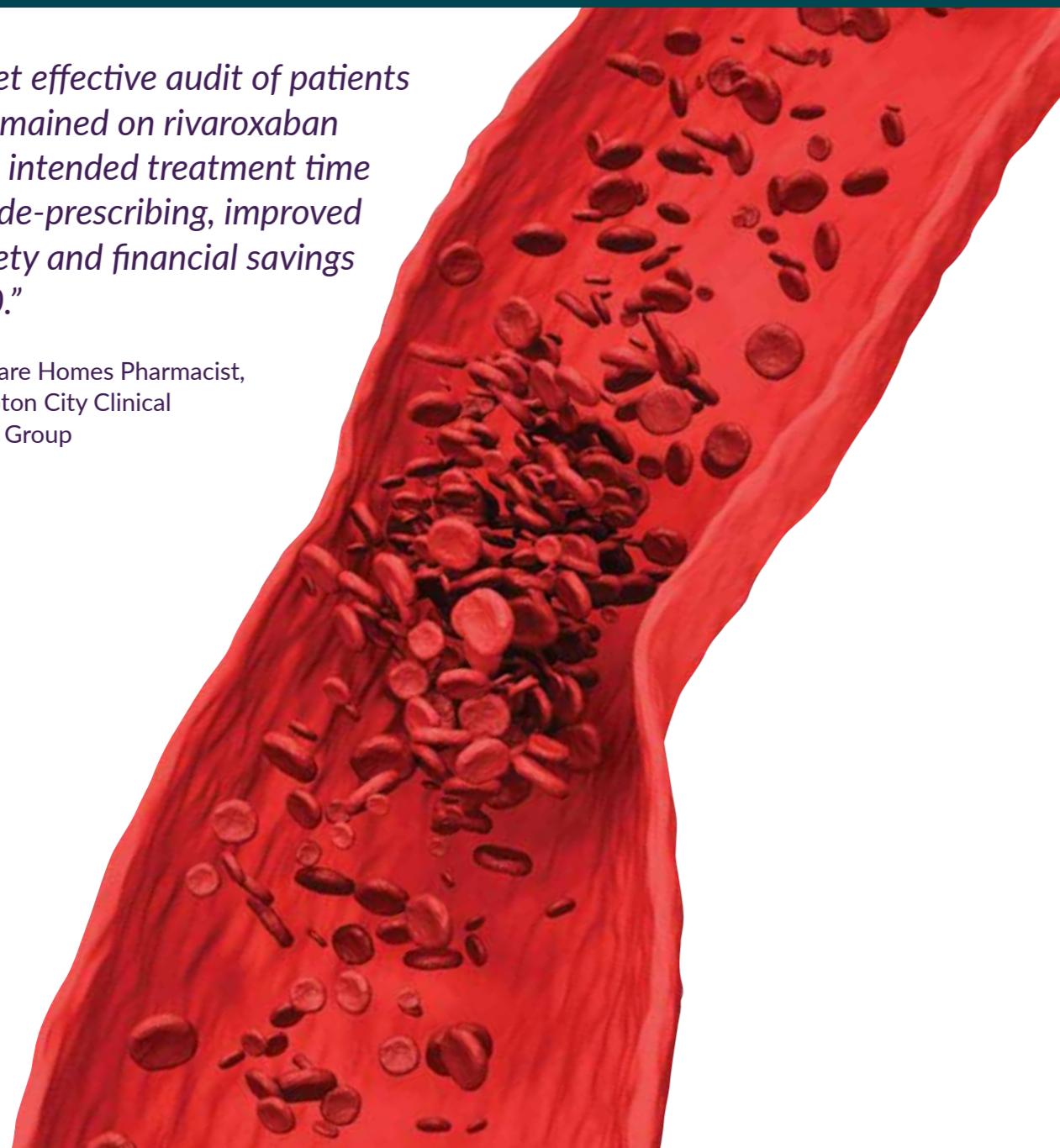
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Tackling overprescribing of rivaroxaban in primary care

An audit of rivaroxaban prescribing in Southampton showed that patients were taking the drug longer than necessary following knee or hip replacement surgery, deep vein thrombosis (DVT) and pulmonary embolism treatments.

"A simple yet effective audit of patients who had remained on rivaroxaban beyond the intended treatment time resulted in de-prescribing, improved patient safety and financial savings of £19,000."

Sue Wakelin, Care Homes Pharmacist,
NHS Southampton City Clinical
Commissioning Group



What we did and why

Rivaroxaban (Xarelto®), a DOAC (direct oral anticoagulant) has a prescribing trend that has steadily increased since becoming available for multiple conditions in 2012. It now has six licensed indications, with four different dosages and at least five possible durations of therapy, according to the condition being treated.

Anecdotal evidence suggests that patients have inadvertently remained on rivaroxaban long term when it was only indicated for short courses, e.g. deep vein thrombosis (DVT) treatment, or after hip replacements in older patients in care homes.

The purpose of this audit was to ensure rivaroxaban was being prescribed for the correct duration by GPs in Southampton.

An audit tool was written by the medicines management team based on NICE Guidance NG5, TA170, TA261, TA287, TA335 and SC1. Data collection was undertaken by GP practices in Southampton City CCG, as part of the Prescribing Incentive Payment Scheme 2016-17.

Data was collected on patients prescribed rivaroxaban, with the exclusion of atrial fibrillation (AF) patients (whose preventative treatment is usually life-long).

Additionally, 33 patients had "end dates" added to their rivaroxaban repeat prescriptions to prevent overprescribing in the near future. It is unknown what further savings this additional intervention made.

Contact: Sue Wakelin

Outcomes and impact

In the initial audit, 27% (328 patients) were prescribed rivaroxaban for conditions other than AF:

- 32% of the patients resided in care or nursing homes.
- Of that group, 8% (26 patients) were inappropriately overprescribed rivaroxaban according to the intended duration. A further three new patients were found to be overprescribed rivaroxaban in the re-audit, 4 months later.
- The total number of patients whose rivaroxaban was stopped as a result of the audit cycle was 29.
- This led to £19,000 cost savings.

It is essential for GP practices to have robust systems in place to ensure all patients prescribed DOAC medication have the intended treatment duration clearly documented and readily accessible during the generation of repeat prescriptions.

What we learnt

The complexity of rivaroxaban's licensed indications has resulted in patients being over-treated. This is exacerbated by the fact that rivaroxaban is also prescribed to prevent stroke in patients with AF, which is a life-long treatment.

The importance of documenting therapy duration has clearly been shown. Whereas patients previously anticoagulated with warfarin would have regular, planned contact with healthcare professionals (for their INR blood tests), patients on rivaroxaban have no such co-ordinated follow-up. Our audit has shown that reviewing and stopping short term rivaroxaban medication can sometimes slip through the net.

It is essential for GP practices to have robust systems in place to ensure all patients prescribed DOAC medication have the intended treatment duration clearly documented and readily accessible during the generation of repeat prescriptions.

The principles of this audit relate to all DOACs. Eliminating AF patients from the audit via read codes reduced the audit sample down to a workable size.

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Developing and implementing the Newcastle Adolescent and Young Adult (AYA) Transitional Care Service

The aim of this project was to improve AYAs' experiences of transition to the adult rheumatology service, by providing age-appropriate care in an age-appropriate environment. Although this is a rheumatology specific service, it has the potential for application to other chronic diseases.

"Transitional care services should recognise AYAs as a unique patient group. They are often a challenging group of patients to manage but ultimately are also extremely rewarding to look after."

Dr Martin Lee, Consultant rheumatologist,
Newcastle-Upon-Tyne Hospitals



What we did and why

In 2014 I conducted a small action research project, utilising patient questionnaires to gain an understanding of what AYAs felt about the adult rheumatology service.

Research demonstrated that AYAs would value a transitional care service with some continuity between paediatric and adult healthcare.

I began redesigning and redeveloping the AYA service into a transitional care service, to fit with the needs of the patients.

The objectives of the project were:

- To evaluate in more detail what AYAs felt about the pre-existing service.
- To create a transitional care service.
- To audit this service against NICE guidance (NG43 and QS140) and European (EULAR) standards and recommendations for transitional care.
- To empower a group of AYAs who attend the transitional care service to present research data at the national rheumatology conference.

Outcomes and impact

- I began attending adolescent clinics at the Great North Children's Hospital in order to meet AYAs who were transitioning across to adult services.

- I set up a peripheral clinic working alongside a rheumatology specialist nurse in a local primary care setting. This allowed me to run clinics in the evening which were easily accessible to AYAs.

- I set up and began chairing regular North East Adolescent Rheumatology meetings in order to build a network of interested rheumatologists.

- I applied for, and obtained, a pharmaceutical grant that allowed me to employ a social scientist to conduct some robust qualitative research looking at what AYAs wanted from a transitional care service and to implement further changes.

- This research was presented at the British Society for Rheumatology's annual conference by AYAs who attended the transitional care clinic.

- The service was audited against NICE transitional care guidance (QS140 and NG43) and European standards of care.

What we learnt

Results from the qualitative research evaluating what AYAs want from a transitional care service can be separated into three main themes:

The approach to AYAs: they value the interpersonal approach of the local transitional care service.

Physical space and environment: AYAs value the flexibility provided by the local transitional care clinic in a primary care setting.

What YAs want from a YA service: they identified several key elements that they view as important in a transitional care service i.e. access to peer support and a flexible appointment structure.

Key learning points:

- AYAs should be recognised as a unique and distinct patient group.

- AYAs should be treated within their wider psychosocial context.

- AYAs value being provided with flexible, person-centred healthcare in a non-hospital setting, which contributes to normalising their condition and increasing their confidence in self-management.

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Improving the quality of nutrition support services for patients across North Derbyshire

The North Derbyshire Nutrition Project improved the quality of nutritional care provided to patients at risk of malnutrition. 51 general practices in the area were audited over 18 months to assess whether oral nutrition supplements were being appropriately prescribed.

“Malnutrition is a significant health concern, affecting more than 3 million people in the UK. This project has provided a better understanding of the prevalence of malnutrition and current prescribing practices across North Derbyshire.”

Kelly Robinson, Prescribing Support Dietitian,
Chesterfield Royal Hospital NHS Foundation Trust



What we did and why

Oral nutrition supplements (ONS) are clinically effective at reducing malnutrition when appropriately prescribed. It is estimated that nationally health and social care could save between £172 and £229 million per annum with fully implemented, high quality nutritional pathways.

Expenditure on ONS across North Derbyshire and Hardwick CCGs was approximately £1.1 million during 2014-2015: an increase of approximately 24% from 2012/2013.

In partnership with local GPs, the North Derbyshire medicines management team and Chesterfield Royal Hospital NHS Foundation Trust, the North Derbyshire Nutrition Project aimed to:

- Assess the current ONS provision to ensure appropriate evidence-based ONS prescribing, in line with NICE guideline CG32.
- Raise awareness of nutrition risk screening, using the Malnutrition Universal Screening Tool (MUST).
- Improve the quality of nutritional care provided to patients at risk, in line with NICE quality standard QS24.
- Raise awareness of the local nutrition support pathway, emphasising a “food first” approach.

Outcomes and impact

The project audited all 51 general practices across North Derbyshire rather than focusing solely on the highest spending practices.

Medicines management technicians generated searches for all patients receiving ONS on repeat prescription or who had an acute issue of ONS within the past six months.

The Nutrition Support Project's two full time prescribing support dietitians (PSDs) assessed the appropriateness of current ONS prescriptions by reviewing the medical journal entries of these patients on SystmOne or EMIS. Decisions were then made whether ONS prescriptions should be continued, discontinued or reviewed. A telephone or home assessment was carried out when further information was required.

Inappropriate ONS prescriptions were rectified by changing to a more clinically and/or cost effective alternative, increasing or reducing the dose, or discontinuing ONS. A recommended plan for the ongoing management of appropriate ONS prescriptions was also created.

What we learnt

- 1,430 patients were included in the audit (patients under the age of 18, and those with gastrostomy feeds were excluded, as were those who had their ONS discontinued by a GP or had transferred general practices).

- The results indicated that approximately **30% of ONS prescriptions were inappropriate for the patient's existing nutritional needs**.

NICE guidance and standards had not consistently been adhered to across North Derbyshire.

- **Substantial cost savings of £182,203.36 were generated by rectifying inappropriate prescriptions (equating to £46,000 per 100,000 patients).** Preliminary findings have identified similar savings per practice from a re-audit cycle.

The results indicated that approximately 30% of ONS prescriptions were inappropriate for the patient's existing nutritional needs.

- Annualised cost savings per practice were sent to all general practices in a report and verbal feedback and training was also offered.

- SystmOne and EMIS prescribing tools are being developed by primary care staff in conjunction with the North Derbyshire medicines management team.

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Innovative ways of engaging with BME communities

In 2012 a gap in the Birmingham Healthy Minds service was identified as impacting on Black and Minority Ethnic (BME) women with language barriers. These women found their choice of treatment limited and were unable to further engage with Birmingham Healthy Minds. Tripta Sidhu and Kulsuma Begum, local Psychological Wellbeing Practitioners (PWPs), set up a South Asian Women's Group to tackle this issue.

"Adapting traditional CBT face-to-face therapy to engage women from BME communities with innovative ways, has been proven to be effective."

Tripta Sidhu, Psychological Wellbeing Practitioner, Birmingham Healthy Minds



What we did and why

Our South Asian Women's Group focuses on delivering psycho-education of common mental health problems, such as depression and anxiety, to women of the south Asian sub-continent who may not have been offered, or may have struggled to engage in, other therapy groups delivered in English.

Within the IAPT service psycho-education groups were not tailored or adapted for ethnic minority groups whose language and literacy levels prevented their engagement in therapy. 28.79% of the population served by Birmingham and Solihull Mental Health Foundation Trust are from BME communities.

The initiative aimed to:

- Address the gap in service provision and to increase engagement of the local BME community, providing a choice of treatment within IAPT primary care.
- Develop a culturally sensitive treatment group, where patients felt their ethnic, cultural and spiritual beliefs were acknowledged.
- Overcome language barriers and literacy issues that usually prevent the uptake of group interventions.
- Increase the confidence of PWPs in delivering skills in languages other than English.

This project was informed by recommendations in NICE guideline NG CG90.

Contact: Tripta Sidhu

Outcomes and impact

We offered an eight week course of three hour-long sessions facilitated by two PWPs speaking Urdu, Hindi, Punjabi and Bengali.

Using CBT adapted interventions, we encouraged engagement of the women during their time in the group with activities and crafts to illustrate the positive impact of such activities on mental health, such as healthy eating, plant therapy and gentle hand massages.

We aimed to work effectively within cost restraints in an IAPT service.

The responses of women who attended the sessions included:

"I have learnt I am not the only one and there is help out there."
"Now I've understood that depression is not a black magic."
"I didn't know what mental health is but I always thought something was wrong in my stomach."

Having the choice to meet as a group engaged south Asian women and produced effective recovery measures (December 2017, recovery rate of 80 %).

What we learnt

The incorporation of psycho-education around somatic symptoms within the session content and exploring the links between mental health and physical health proved successful.

However, a lack of confidence and insufficient training for PWPs to facilitate groups in south Asian languages and limited knowledge of culturally sensitive activities to engage this group, was a barrier.

The project team learned the importance of:

- Adapting material for the group sessions according to patients' literacy needs.
- Involving carers.
- Sign-posting to other relevant organisations to maintain recovery.

Difficulties and challenges we faced:

- It is very time consuming to complete the necessary outcome measures due to patients' limited literacy levels.
- Despite the project, somatisation for depression within the Asian community within primary care still remains problematic.

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Implementing early and structured rehabilitation for patients admitted to critical care

A multi-professional rehabilitation team was established to promote early and enhanced rehabilitation for patients admitted to critical care. The structure of rehabilitation delivery was based on key recommendations from NICE CG83, including key workers for all patients and individualised rehabilitation programmes for those at high risk.

"This project demonstrates the impact of utilising key recommendations from the NICE guideline for critical illness rehabilitation to improve both the short and long term outcome of patients experiencing a period of critical illness."

David McWilliams, Consultant Physiotherapist,
University Hospitals Birmingham NHS Foundation Trust



What we did and why

Patients admitted to critical care suffer significant loss of functioning, with muscle loss as high as 20% in the first seven days of admission for those in multiple organ failure. Consequently, although mortality from critical illness is improving, survivors often suffer from prolonged weakness and psychological problems.

A quality improvement project was implemented with the aim of facilitating earlier and more structured rehabilitation within critical care, in order to improve patient outcomes.

This project involved engagement with key stakeholders and provision of education sessions around the safety and effectiveness of structured rehabilitation. As part of this process a multi-professional rehabilitation team was established to promote early and enhanced rehabilitation for patients admitted to critical care.

The structure of rehabilitation delivery was based on key recommendations from NICE guidance CG83, including key workers for all patients and individualised rehabilitation programmes for those at high risk of the physical and psychological consequences of critical illness.

Contact: David McWilliams

Outcomes and impact

Following implementation, significant improvements were seen in the rehabilitation service within critical care, with rehabilitation starting earlier and delivered more consistently.

Results of data analysis showed:

- Improved mobility and functional independence.
- Reduction in both critical care and total hospital length of stay, freeing up bed capacity in both areas.
- Reduction in the average duration of invasive ventilation.
- A significant reduction for both in-hospital and 3 year mortality.

Patient feedback has been excellent:

"I really can't thank the physio team enough. Before I left one of the doctors saw me walking around and said 'I never expected to see you like this Mr Brown' because I'd been in such a bad state when I came in."

"I used to dread the physiotherapy sessions but they were so patient and really helped to keep me motivated. My legs were very weak so they had me do exercises in the bed every day until I was able to stand up and get in a chair."

What we learnt

The results of this project have demonstrated that rehabilitation in critical care has the potential to significantly improve patient outcomes and recovery from critical illness.

Physiotherapists are ideally placed to take a leading role in this area, creating efficient pathways of care and improving capacity within the NHS.

Implementing a new service model is challenging but with perseverance, education and a clear plan to evaluate outcomes, a great deal can be achieved.

This project was introduced at a time when physiotherapy funding was being reduced and rather than simply saving posts it has managed to prove the vital worth of physiotherapy and actually created new ones.

This project highlights the importance of attaching tangible measures to therapy structure and outcomes. The use of a daily score to track mobility helped to prove the added benefit of introducing the critical care rehabilitation team, helping to demonstrate the role of physiotherapists in improving overall outcomes.

Consultant Physiotherapist
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#KnowYourDrops revolutionises eye drop compliance to achieve medicines optimisation in ophthalmology

NICE guidance estimates up to 50% of medicines prescribed for long term conditions are not taken as recommended. In August 2016 Moorfields Eye Hospital NHS Foundation Trust launched the pharmacy-led #KnowYourDrops campaign to improve patients' medicines adherence and therefore treatment outcomes and their quality of life, in line with NHS Five Year Forward View and Carter Report.

"#KnowYourDrops puts patients at the heart of decisions of their care. All healthcare professionals must work together to introduce change to improve compliance and patient outcomes in ophthalmology."

Sarah Thomas, Lead Pharmacist Moorfields Eye Hospital
NHS Foundation Trust



What we did and why

Through pharmacist-led patient engagement we identified gaps in our care model: we found that patients would like more education about eye drop techniques and a channel to openly discuss their difficulties in using their ophthalmic preparations. Our staff knowledge and skills were lacking in this area. We therefore launched the #KnowYourDrops campaign to:

- Raise awareness of compliance amongst patients and healthcare professionals.
- Offer greater support to promote best eye drop techniques.
- Reduce barriers to poor compliance.
- Improve patient safety and quality of life.
- Help reduce financial burden to patients and the NHS.

After an initial pilot, we replicated the model across all Moorfields sites.

#KnowYourDrops pharmacy-led consultation clinics are now embedded and currently run by pharmacists, technicians and pre-registration pharmacists, working closely alongside the multi-disciplinary clinical team. We also lead educational workshops and external teaching programmes to share and extend the model across boundaries.

Contact: Sarah Thomas Lead Pharmacist, Fiona Chiu Associate Chief Pharmacist, or Cathy Kitney Senior Technician

Outcomes and impact

We received overwhelmingly positive feedback from our patients/carers and staff and the project met all initial objectives. 100% of patients/carers found the pharmacist-clinic improves the way they put in eye-drops; 100% felt more confident in putting in eye-drops and 95% would like more pharmacist-clinics to help improve their care and quality of life.

Feedback from healthcare professionals and stakeholders was positive, with outcomes at subsequent patient visits including increased compliance and improved technique.

We also saw reduced polypharmacy, reduced side effects, reduced appointment frequency, avoidance of surgery, reduced need for carers to assist with administration, reported increased dignity, quality of life and independence.

Additionally, data showed that patients were unable to correctly assess their eye drop technique, with 3% rating their technique as 'poor' and 97% rating themselves 'fair/good/ very good/excellent.' However when assessed at the pharmacy-led clinic 97% of patients had drops running down their faces, and 30% accidentally poked their eye with the nozzle.

What we learnt

The main learning is that medicines optimisation in ophthalmology is widely overlooked. Although patient support is recommended, there is a lack of concrete guidance from professional bodies or training for healthcare professionals to support compliance, and no standardised patient support is given.

This results in poor compliance, and in some cases – i.e. glaucoma - vision loss.

However this can be tackled with:

- Compliance support guidance.
- A standardised model of care.
- Embedded ophthalmic medicine use reviews.
- Improved availability and awareness of compliance aids.
- Change in culture.
- Research for outcomes and quality of life.

For others facing similar challenges, we recommend:

- Remaining patient focused, identifying local/clinical needs and tailoring accordingly.
- Using champions in each clinic to embed culture shift and implementation.
- Sharing patient stories with other patients.
- Providing accessible information for patients.

Moorfields Eye Hospital NHS Foundation Trust

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Post-operative transfusion practices in hip fracture patients

In 2014, we decided to look at our transfusion practice in Warrington hospital, a 600 bed district general hospital. The cohort we chose to investigate was patients with a fractured neck of femur – commonly known as a broken hip. We completed a full cycle audit looking at blood transfusion practices in these patients, which generated quality improvement within the Trust.

"Transfuse and Check."

**Joanna Craven, FY1 Doctor,
Warrington and Halton Hospitals
NHS Foundation Trust**



What we did and why

Every day, 4,000 UK hospital beds are occupied by patients with hip fractures. Severe anaemia is a common post-operative complication in these, often frail, patients and many require a blood transfusion.

In 2014, we set up a transfusion collaborative task and finish group.

The group consisted of clinicians and transfusion department specialists. The overall aim of the project was to implement the NICE guideline (NG24) and quality standard (QS138) on transfusion.

Our objectives were to:

1. Implement the three transfusion standards covering the threshold, target and dose of transfusion.
2. Implement the four quality standards relating to 'one unit transfusions' and the need to check the patient's haemoglobin pre- and post-treatment.
3. Introduce our strategy of "transfuse and check."
4. Audit the outcomes of the transfuse and check strategy.

Outcomes and impact

We initially carried out a retrospective cohort study. Transfusion practices in our cohort were mostly non-compliant with NICE guidance. The audit outcomes were discussed at the orthopedic and critical care audit meeting. There was wide support for introducing a "transfuse and check" strategy, to ensure haemoglobin was checked before and after every transfusion.

We developed a programme to deliver transfusion teaching for doctors and nurses. The new changes were highlighted in our hospital newsletter "Bloody Matters". The "transfuse and check" protocol was endorsed by the Hospital Transfusion Committee. We introduced a point-of-care Haemoglobin testing device (Haemocue) to our trauma ward, to support the delivery of the new strategy.

Following implementation, we re-audited practice. There was a significant improvement in compliance with NICE guidelines. Since introduction, our Trust-wide "transfuse and check" protocol has reduced liberal transfusion of post-operative fractured neck of femur patients. As a result we have reduced red blood cell transfusion costs and reduced the number of units transfused per patient.

What we learnt

- Start with a team: we developed a collaborative team approach with a small number of enthusiastic clinicians working with transfusion specialists.
- Clarify aims and objectives: we focused on the evidence base and on the current NICE guidelines and standards.
- Have a clear simple strategy: we developed a strategy which in our case we called "transfuse and check."
- Develop a policy with the Trust transfusion committee.
- Audit with a developed database: in this case, the National Hip Fracture Database and the Hospital Transfusion Database (MOLIS). This is almost essential for providing quality data for good Quality Improvement.

A point-of-care haemoglobin testing device (Haemocue) was introduced to our trauma ward. Although it was a useful initiative by our transfusion team, we still needed a laboratory sample so it was probably unnecessary.

Communicating with and educating those involved in patient care was one of the most important steps for improving compliance with the guidelines and overall patient care within the Trust.

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