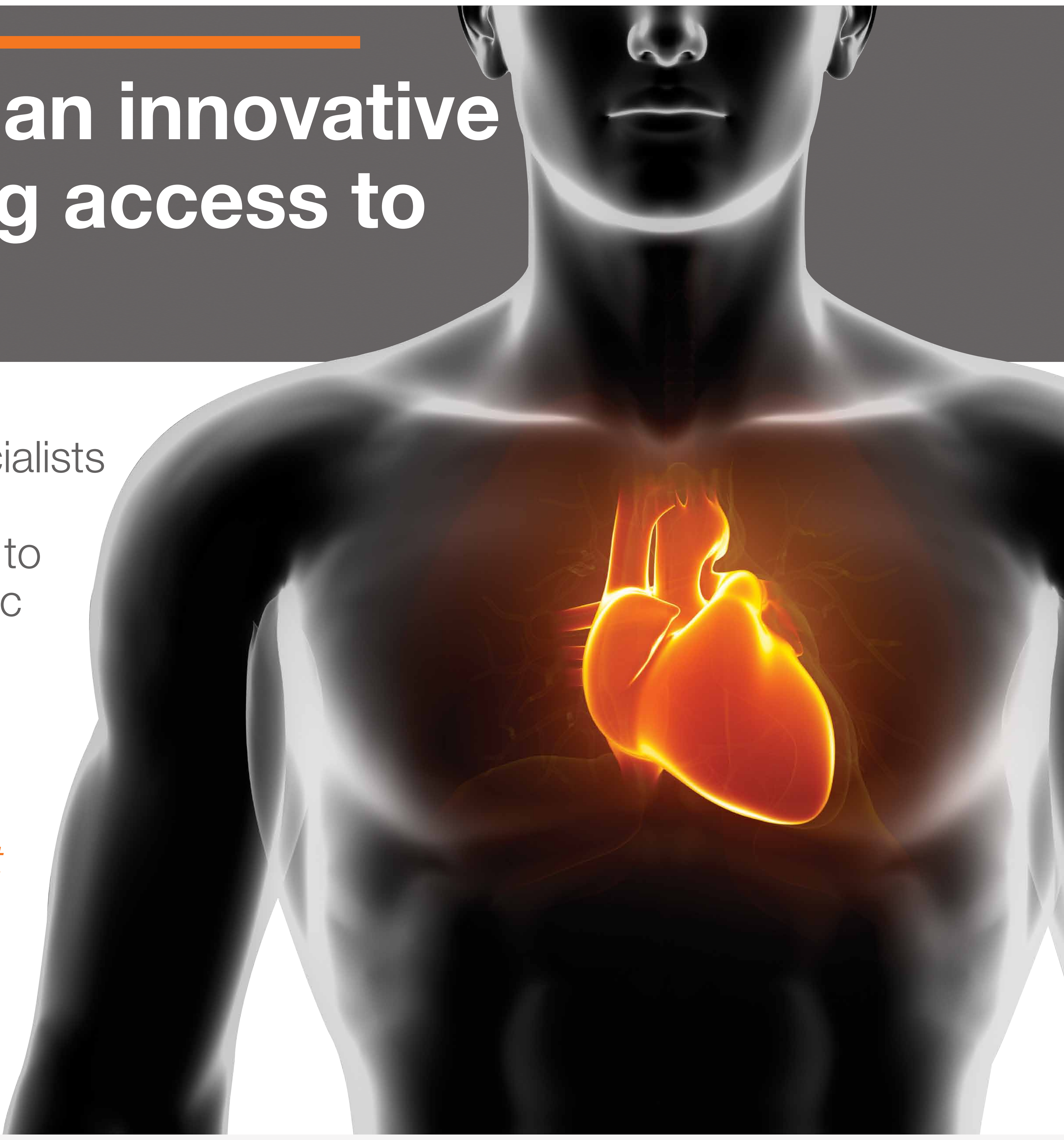
Activate Your Heart – an innovative approach to improving access to cardiac rehabilitation



Activate Your Heart is an online cardiac rehabilitation programme designed by specialists and patients at the University Hospitals of Leicester NHS Trust. The programme aims to help patients who have had a recent cardiac event, or have an existing cardiac problem, manage their condition more effectively.

> *"The great advantage of the Activate Your Heart programme was that I could get on with my working life as normal."*
> **Phil Caldwell**, Activate Your Heart patient

Access to cardiac rehabilitation below target levels

In 2011/12, The National Audit of Cardiac Rehabilitation revealed that just 43% of eligible people accessed a cardiac rehabilitation programme, falling short of the target level of 65% for England.

NICE guidance on secondary prevention of myocardial infarction (MI) recommends that cardiac rehabilitation should be offered as soon as possible to people who have had a MI to help them get back to everyday life as quickly as possible.

To improve the situation locally, University Hospitals of Leicester NHS Trust set out to build an interactive online cardiac rehabilitation programme underpinned by the NICE recommendations. The programme mirrors the traditional format where patients progress through a six-week programme of regular exercise. Patients are given a tailored programme of exercise with access to healthcare specialists through discussion forums, chat rooms and e-mails.

The Trust also adopted a new approach to delivering the educational component of the existing rehabilitation programme. Patient feedback revealed an opportunity to educate patients online through the website and through DVDs rather than in a hospital setting.

Ensure the patient voice is heard

A working group was established to ensure effective communication between the two work streams, for developing the website and delivering the education programme, and this met on a monthly basis. Each workstream held regular weekly project team meetings where issues on progress were discussed and actioned.

Funding for the development of the website was achieved by a Health Foundation SHINE innovation award and the contract was awarded as a result of an invitation to tender. Internal funding was used to develop a DVD for the new approach in delivering education to patients.

Both the online and DVD resources were developed with service user input. Previous service users and current patients were invited to attend focus groups and events were held to gain feedback and end user testing. Patient survey and feedback was sought throughout the development process and into the operational phase of the programme.

Staff training was a key priority throughout the project. Sessions included website familiarisation and navigation, registering patients onto the programme, updating blogs, moderating discussion forums, and answering queries through 'Ask the Expert'.

Helping people live a full and active life

Listening to and involving patients as well as staff, engaging with the hospital consultants, and communicating effectively through regular stakeholder meetings are the key activities that lie behind the overwhelming success of the Activate Your Heart website.

- When asked, 65% of people who completed Activate Your Heart said they would not have attended an out-patient cardiac rehabilitation programme.
- Waiting times for patients accessing their educational component have reduced from 11 to 3 weeks.
- Staff time has been more effectively and efficiently used and over a four week period has released 15 hours band 6 cardiac rehabilitation CR professional time.

Activate Your Heart has helped the Trust generate income by achieving a locally agreed tariff of £481 for every patient who completes the programme. There is also an opportunity to make further savings by reducing the number of readmissions. Local data suggests that readmissions rates are reduced by 50% by participating in a programme of cardiac rehabilitation.

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Bedford Hospitals NHS
NHS Trust

Exercise referral schemes: improving quality of life for cancer patients

Bedford Hospital's oncology unit worked with local commissioners to expand the regional exercise referral scheme to include men with prostate cancer.

> *"Supervised aerobic exercise can really reduce fatigue and other side effects for men receiving androgen deprivation therapy for prostate cancer."*
> **Professor Robert Thomas**, Consultant Oncologist, Bedford and Addenbrooke's Cambridge University Hospitals

Promoting exercise to reduce the side effects of cancer treatment

A study of 440 men with prostate cancer who were referred by Bedford Hospital for radical radiotherapy treatment, showed that 64% were overweight or obese and only 4% of the men reported more than 3 hours of moderate physical activity per week. At the same time, the study showed that more active men suffered significantly lower levels of side effects from their cancer treatment.

This data helped oncologists at the hospital's Primrose Unit realise that supporting their cancer patients to undertake exercise and adopt a healthier lifestyle could help reduce the severity of their treatment's side effects.

In addition, NICE guidance supports this, recommending that men receiving androgen deprivation therapy for prostate cancer should be offered supervised resistance and aerobic exercise twice per week for 12 weeks. This has been shown to reduce many of the long term hormone related side effects particularly fatigue.

Consultant Oncologist Professor Robert Thomas led a number of changes to local practice in order to provide cancer patients with access to an exercise programme to suit their needs.

Engaging commissioners and up-skilling exercise professionals

The oncology team at Bedford Hospital undertook a programme of work to ensure that newly diagnosed prostate cancer patients were supported to undertake exercise, including:

- Producing an information pack and website for patients, explaining the importance of exercise to men and their families.
- Developing a national, Skills Active approved, level four qualification in cancer rehabilitation, empowering gym instructions to address the specific needs of patients with cancer.
- Working with local commissioners to persuade them to expand the regional exercise scheme's referral criteria to include diagnoses of cancer.
- Delivering a series of talks to local GPs, at the hospital, at local gyms, rugby clubs and patient support groups to raise awareness of the importance of exercise for people with cancer.

As a direct result of the oncologists' work with local commissioners, all eight local gyms agreed to start accepting cancer patients with exercise referrals.

The first cohort of exercise professionals completed the qualification in 2011.

Supporting patients to access the service

The Oncology team audited the first 80 prostate cancer patients referred to the exercise service using questionnaires and follow up phone calls. They found:

- Of the 80 patients referred onto a 12 week programme at the local gym, 40% attended one of the eight participating gyms within a month.
- A further 30% attended after a follow-up phone call or encouragement during a subsequent consultation.
- Of these men, all apart from one successfully completed the 12 week programme.
- 94% of men who accessed the exercise scheme were satisfied or highly satisfied with it.

"One of the biggest changes we made was embedding the importance of exercise and healthy living in the culture of the Oncology Unit," said Professor Thomas.

Each year the Bedford project now refers on average 80 patients with different types of cancer into local exercise programmes. The project team has significantly influenced practice around the country: more than 2000 exercise professionals have completed the qualification so far and oncology colleagues at Trusts as far afield as Preston and Liverpool are now also referring cancer patients onto exercise schemes.

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Therapeutic Review: a NICE way to improve evidence-based prescribing

Belfast Health and Social Care Trust sought to improve the quality of care it provides at a time of increasing resource pressures. To do this, it set up a Therapeutic Review steering group, to improve the Trust's use of clinically and cost-effective treatments recommended by NICE.

> *"Setting up a Therapeutic Review group, and regularly auditing prescribing practice, has helped provide a structured, replicable system to ensure prescribing is in line with best practice."*
> **Paula Crawford**, Lead Clinical Pharmacist Musgrave Park Hospital, Belfast Health and Social Care Trust

Improving prescribing of cost-effective treatments

Belfast Health and Social Care Trust is one of the largest Trusts in the UK providing integrated care to around 340,000 in its region, and delivering specialist regional services across Northern Ireland. Like many organisations across the country, the Trust has been striving for ways of providing high quality care amidst a climate of limited resources.

To help achieve this, the Trust set up a Therapeutic Review Steering Group, which aimed to put formal systems in place for ensuring best practice. The group included a range of specialists including commissioners, pharmacists, and a new post of lead Therapeutic Review pharmacist. Together they sought to record, audit and monitor the use of technologies deemed clinically and cost effective by NICE.

The group focused on diseases with a high incidence in Northern Ireland, such as multiple sclerosis, inflammatory bowel disease, and the increasing numbers of patients being treated with biologics and disease-modifying therapies.

It then conducted a series of audits to assess the use of NICE-recommended treatments, identified barriers to change, and agreed action plans with clinicians to build on results from the audits.

Identifying and acting on barriers to change

A baseline audit was carried out to assess prescribing of NICE-recommended medicines. The audit collected data on 10 cases per consultant, and results were presented to service group managers, directors and representatives from the Health and Social Care Board. Any deviation from NICE-recommended practice was highlighted.

Barriers to change of practice were then identified, the main one being a lack of ownership and familiarity among clinicians with NICE guidance. To address this, the Trust set up a medicines management intranet site to promote NICE and evidence based guidance. Individual sessions were also set up with clinicians to validate audit results and address any concerns they had with changing practice.

Further actions following the audit included:

- greater consistency with NICE guidance in the use of biologic agents for rheumatoid arthritis
- greater use of most cost-effective biologics for adults with severe active Crohn's disease
- development of a document outlining more consistent prescribing criteria for the use of disease-modifying therapies in multiple sclerosis
- an action plan to tackle medicines wastage due to non-collection of prescriptions by patients.

Savings through improved prescribing and tackling waste

A number of cost savings were made through:

- the use of NICE-recommended cost-effective biologic treatments for inflammatory bowel disease
- ensuring patients with multiple sclerosis meet starting criteria before starting disease-modifying therapies
- identifying and tackling the significant waste associated with prescriptions for disease-modifying drugs for multiple sclerosis

While there were costs associated with setting up the new post of lead pharmacist, these were offset by savings realised in other areas.

The project highlighted a range of learning points:

- establishment of the Therapeutic Review steering group chaired by the medical director ensured buy-in from representatives across the Trust
- developing an audit flowchart ensured a transparent process that could be easily repeated
- appointing a lead pharmacist to review and coordinate data helped drive improvements and led to cost savings
- meet clinicians face-to-face to discuss deviations from NICE guidance

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Accessible, Responsive Community Healthcare
Birmingham Community Healthcare NHS
NHS Trust

Using NICE guidance to transform access to podiatry services in Birmingham

Faced with growing numbers of people with type 2 diabetes, long waiting times for clinical assessment and lacking an agreed referral process for diabetic foot problems, Birmingham's podiatry team used NICE guidance to turn a failing service around and significantly improve the quality of care for their patients.

"Putting the NICE recommendations at the heart of a new pathway for podiatry services enabled us to bring our waiting times down, manage referrals more effectively and provide better quality care for our patients."

Amanda Cadge, Podiatry Clinical and Professional Lead, Birmingham Community Healthcare.

The pressure on podiatry services and the need for service change

In Birmingham, the prevalence of type 2 diabetes is approximately 75,000 per one million of population. With around 120 new appointments to podiatry clinics every week and 18 month waiting times for new assessments, at any one time the podiatry service could have up to 6,000 people on its waiting list.

Analysing referrals, the podiatry team found that GP practices in the area were referring almost every patient with diabetes to the service. With increasing numbers of patients, the pressure on the service was unsustainable and there needed to be a radical rethink about how the caseload was managed and how patients were referred. The team decided the NICE guideline on managing and preventing foot problems for type 2 diabetes (CG10) could be used to develop a new pathway for the service, which would:

- improve the overall quality of care for patients
- reduce waiting times
- manage waiting lists and referrals more effectively
- save costs for podiatry care and across the wider system

Designing the new referral pathway

Senior staff in the podiatry service and clinicians from neighbouring trusts worked together to develop a new referral pathway. Using the NICE guideline, the multidisciplinary team devised a new pathway for patients which included:

- risk assessment for diabetes patients
- new referral criteria for all patients with foot problems
- a guide to podiatry referrals for all healthcare practitioners
- a podiatry score card to identify if patients were high or low risk

The risk assessment enabled a review of patients on the waiting list to manage them more effectively. The referral criteria and the scorecard helped them identify low risk patients for safe discharge back to primary care. This reduced overall waiting times and ensured patients with acute or high risk problems could be seen more quickly for specialist care.

The new pathway was communicated among GPs and community nursing teams. Training was offered to show how to use the new resources for risk assessment and referrals. Podiatrists were also trained to manage patients' expectations to help them understand why they might not need specialist care. A new non-NHS Nail Care Service was developed for those patients with low levels of need and risk.

Benefits of using NICE guidance innovatively

The service has seen a significant reduction in waiting times. Routine appointments are now seen in 4-6 weeks and urgent referrals for wounds and infections are seen within a week. Estimated cost savings are around £180,000 per year.

Podiatrists in the service feel less pressured and more valued. The improvement in staff morale and quality of patient care is reflected in low levels of sickness and staff turnover and the low number of formal complaints from patients. The non–NHS Nail Care Service has also provided opportunities for independent employment for over 120 carers across the city.

The new pathway enabled the team to use the NICE guidance in a practical way to inform new referral criteria and improve risk assessment of patients. They used the NICE guidance for a particular condition as a tool for a range of professionals to make system-wide improvements. They also found the costing tools, which accompanied the guideline, could be used to show the value of using NICE guidance.

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Reducing antibiotic prescribing for coughs and colds in primary care

Churchill Medical Centre in Surrey implemented a practice-wide programme aimed at patients and clinicians, to reduce ineffective antibiotic prescriptions for upper respiratory tract infections. The programme involved devising simple and consistent messages for staff and patients about the best ways to treat these self-limiting conditions at home.

> *"With so much conflicting information on the internet, patients are turning to GPs even though the majority of coughs and colds will get better by themselves. We want to make sure our team provide evidence-based information and appropriate treatment to their patients."*
>
> **Dr Peter Smith**, GP Principal,
> Churchill Medical Centre

Giving patients the confidence to manage coughs and colds themselves

Antibiotics are not effective at treating common respiratory tract infections, and in 15-25% of patients they can cause harmful side effects. Despite this, prescribing rates in primary care remain high, with GPs sometimes feeling pressured to prescribe ineffective medicines.

Churchill Medical Centre's clinicians were prescribing antibiotics for an average of 40% of patients presenting with upper respiratory tract infection symptoms.

A multidisciplinary team of 'champions' from across the practice was set up to devise key messages based on the NICE clinical guideline on antibiotic prescribing for self-limiting respiratory tract infections (CG69). They created a patient information poster which was displayed in each waiting room and clinical room. The poster highlighted that most of these common illnesses do not require antibiotics, and that treating symptoms at home with painkillers is the best course of action.

All staff, including receptionists, were fully briefed on the key messages in the run up to the project being launched. Clinicians were urged to speak to patients in a positive manner, acknowledging their efforts at home treatment and re-emphasising the key messages.

Supporting GPs to stop or delay antibiotic prescribing

GPs and other clinicians were given an A4 sheet of 'cast-iron' evidence-based messages to give confidently to patients, including:

- Normal duration of common colds, coughs and similar conditions
- Strong evidence on the inefficacy of antibiotics to treat them
- How to treat at home, use of painkillers
- When to call for help

The staff information sheet also included the NICE flow chart summary of upper respiratory tract infection management on the reverse, and patient fact sheets were saved on every desktop so they could be easily printed out.

In addition 'delayed prescribing' was promoted as an option for clinicians to use. This tactic involves giving patients a prescription for antibiotics, but advising them only to collect it from the pharmacy should their symptoms get worse.

"Delayed prescribing can be a useful tool for GPs if confronted with a very sceptical patient who just isn't happy to leave the surgery without a prescription," explains Dr Smith. "In the majority of cases, the infection will clear up on its own and as such, 70% of these prescriptions are never dispensed."

Achieving real reductions in unnecessary prescribing

Prior to launching the programme in November 2012, the team measured prescribing behaviour during the month of October in order to establish a baseline. The same measurements were taken in January 2013 after the programme had been running for two months, to chart progress.

- Antibiotic prescribing for coughs was reduced from 54.5% of patients in October, to 37.7% in January
- Antibiotic prescribing for upper respiratory tract infections was reduced from 32.6% in October to 19.7% in January
- In January alone, 67 patients avoided unnecessary prescription of antibiotics. Over the course of a year this could equate to over 700 fewer antibiotic prescriptions being issued by Churchill Medical Centre.

The success of the programme depended on the buy-in of staff from across the practice, explains Dr Smith: "We kept reinforcing the message to our clinicians. It was also important to involve reception staff from the early stages as they play such a key role, having that first contact with patients on the phone."

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City Health Care Partnership CIC
a co-owned business

Screening for malnutrition in residential care homes

City Health Care Partnership (CHCP) CIC worked with Nutricia, a medical nutrition company, to set up a nurse-led service for identifying and managing malnutrition in local residential care homes.

The new service focuses on regular screening to identify residents in need of nutritional support, and the implementation of nutritional management plans for residents at risk.

> *"We have reduced hospital admissions by around 40% and nutrition issues are now treated much more effectively in our local care homes."*
> **Richard Maddison**, Medicines Development Manager, CHCP CIC

Auditing malnutrition risk

In the UK, 41% of older people living in nursing and care homes are at risk of malnutrition. If left untreated, malnutrition can cause physical health problems including vulnerability to infections and pressure ulcers on the skin.

NICE's clinical guideline on nutrition support in adults (CG32) recommends that all residents in care homes are screened for malnutrition using an appropriate tool such as the Malnutrition Universal Screening Tool (MUST).

Working with Hull's Care Home Medicines Support Team, a Nutricia nurse carried out a baseline audit in five local care homes to determine the prevalence of malnutrition risk, how care plans and nutrition information was documented, and how nutritional supplements were used.

Following the audit, a new local policy for screening and treating malnutrition was implemented, based on NICE guidance.

Regular screening and appropriate treatment

The dedicated nurse carried out monthly screening for malnutrition among all residents in the five care homes, using the MUST tool. After the screening, nutritional management plans were implemented according to risk:

- Food fortification strategies, where calorie intake is heightened through careful menu planning, were recommended for medium risk residents.
- Oral nutritional supplements were prescribed in addition to food fortification, for residents at high risk.
- Residents were referred to a Dietitian if no improvement was seen after 4-6 weeks.

Care home staff were given training on delivering the nutritional management plans and kitchen staff were provided with training in food fortification.

The Care Home Medicines Support Team worked with local GPs to ensure that oral nutritional supplements were prescribed for residents where necessary.

Improving the lives of care home residents

After implementing the new policy for a month, the Nutricia nurse carried out a re-audit to assess the impact on residents. The audit revealed widespread improvements in the detection and management of malnutrition, including:

- Increase in residents screened from 35% to 100%
- Frequency of screening increased to monthly in line with NICE guidance
- Hospital admissions reduced by around 40%
- Pressure ulcers reduced by around 55%
- Infections requiring antibiotics reduced by around 30%
- Residents at risk of malnutrition managed more effectively, with dietary advice and food fortification being used before oral nutritional supplements where appropriate.

Having one dedicated nurse running the programme, alongside a care home support technician, meant that problems of staff turnover and inconsistency of documentation across the five care homes were avoided.

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Derby City Council

Improving community support for people affected by dementia in Derby

Derby City Council has set up a comprehensive support service for people living with dementia, and their informal carers. The service demonstrates how commissioners are using the NICE quality standard to support people to live well with dementia.

> *"The quality standard has helped us assess the effectiveness of the service we provide people with dementia, and their carers. It has been integral to ongoing implementation of our city-wide dementia strategy."*
>
> **Jenny Appleby**, Commissioning Manager, Derby City Council.

Supporting people to live well with dementia

Experiencing memory loss, being diagnosed with dementia, living with dementia and caring for someone with dementia can be an isolating and traumatic time for everyone involved. Having access to information and support is crucial to helping people understand and cope with the disease. It can also enable people to self-manage their condition and live independently, as long as they are able to. Equally important is ensuring that health and social care professionals know about the support and advice they can offer to service users and their carers.

In recent years Derby City Council has greatly enhanced its support for people with dementia, providing a comprehensive service that meets the needs of its diverse population. This new and enhanced service assists people with dementia and their carers, prior to and at the point of diagnosis, and throughout their dementia journey. It aims to provide emotional support and information and is co-located with community mental health services. The service also works closely with memory assessment clinics and other stakeholders such as primary care; social care; and the voluntary and community sector to embed the service as part of the city's wider dementia pathway.

Developing a comprehensive and inclusive service

Analysis showed that existing services were not meeting the needs of service users. For example, only a third of people with dementia were being diagnosed and given support to live with the condition. Without service change the council and local NHS would struggle to cope with a projected 16% rise in people with dementia by 2025.

Through engagement events with stakeholders in the local community, service users and their carers, the team prioritised the key components of a new dementia support service. In particular, feedback from the events had shown a lack of awareness of available support and highlighted poor access to and awareness of services among black and minority ethnic communities.

In response, a joint dementia strategy set out a more inclusive approach and an integrated care pathway that specifically targeted under-represented groups. Providing support and advice for people with dementia was a key part of the new pathway. After a successful pilot, which helped local commissioners to identify further improvements, the service was commissioned for three years. Funded by the Council, the contract has been managed collaboratively with the local Clinical Commissioning Group (CCG).

Partnership working, education and support

The revamped service has been successful in making dementia support more widely available to a larger proportion of Derby's population. The team measured effectiveness over a period of six months and found 75% of those attending memory clinics had made contact and had offers of ongoing support from the dementia service. It has also enhanced access to and provision of statutory services; supporting families and informal carers to cope better with dementia and helping manage admissions to residential care.

Close working relationships across health and social care have been integral to the success of the service. Collaborative working with the CCG, mental health services and the NHS has ensured that the role of the service is understood and the support it offers is valued. Where the team identified gaps in knowledge and skills, they worked with health and social care colleagues to provide education for practitioners to understand more about the needs of service users and the range of support being offered.

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Derby Hospitals NHS
NHS Foundation Trust

Improving early diagnosis and management of acute kidney injury

In line with NICE guidance on acute kidney injury (AKI), Derby Hospitals developed training for nursing staff to recognise symptoms earlier and improve patient outcomes.

> *"By training nursing staff on the medical assessment unit we were able to improve diagnosis and treatment of patients with acute kidney injury and provide safer, more effective care."*
>
> **Catherine Fielding**, Professional Development Adviser, Renal Dialysis Unit, Royal Derby Hospital.

Better recognition and management of AKI

Early identification and treatment of AKI is a key factor in clinical outcomes for patients with the condition. When not identified early, AKI can lead to significant patient harm, morbidity, increased length of stay, renal failure and, in some cases, loss of life. Statistics show that many acutely ill patients are at risk of developing AKI. The renal team at Derby noticed that around 60% of their AKI cases were presenting on admission. In one year alone they saw 4,269 episodes of AKI.

In line with national policy, the Trust had already begun to prioritise AKI. At Derby, a significant number of patients were being admitted via the medical assessment unit (MAU) at the hospital, which assesses patients before they are admitted to wards or other services for further care. The renal team realised that the MAU was a key entry point into the hospital for patients at high risk of AKI. The MAU could therefore play an important role in early identification and initial management of patients presenting with AKI and improve overall patient outcomes for the condition.

Tailored training for nursing staff

Working collaboratively, the professional development adviser from the renal dialysis unit, a renal consultant and the MAU professional development lead surveyed the MAU nursing team to determine any gaps in knowledge about AKI. They developed a training programme based on clinical practice for all nursing staff on the MAU, including healthcare assistants. This was a key recommendation in the NICE guideline on AKI (CG 169).

The training was led by the renal team and delivered on site. It consisted of educational sessions with case studies tailored to the MAU nursing team. It was also planned to fit around their working patterns, with repeat sessions to cover as many staff as possible.

The training aimed to:

- improve knowledge of AKI
- emphasise the importance of initial nursing care for detecting AKI
- highlight the key role MAU could play
- increase knowledge about the role of observations, fluid balance assessment and urinalysis in the detection of AKI
- cover other aspects of care such as catheterisation
- educate participants about the care of patients with chronic kidney disease

Improving clinical skills for better patient outcomes

The team evaluated the project through questionnaires, which were handed out before the training sessions, and again afterwards. They used this 'before and after' feedback to compare data and track improvements in understanding of AKI. The results from the questionnaires showed marked improvements in knowledge about urinalysis, the management of hyperkalaemia, management of blood pressure and the use of analgesia for patients with AKI.

The team also identified a number of key learning points:

- equipped with the right skills and knowledge, nursing staff can play a valuable role in early recognition of AKI
- it is important to be pro-active. It was not clear how training would be received by the MAU nursing team but it was popular
- once trained, nursing staff can use new skills to inform all nursing practice in the MAU and ensure high risk patients are identified and managed early on
- making sure information is tailored to the MAU nursing team is essential for securing 'buy in' for training

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‘Great Expectations’ antenatal education programme promotes healthy lifestyle choices

An evidence-based antenatal education programme in Plymouth is supporting pregnant women to make healthy lifestyle choices in pregnancy, and to provide the best start for their new babies.

Delivered at Children’s Centres across the city, the ‘Great Expectations’ programme covers pregnancy, birth and beyond – including the birth partner’s role and getting breastfeeding off to a good start.

> *“The sessions were relaxed and fun. We got on really well and we all kept in contact even after the course had finished.”*
>
> A mum-to-be who attended the course at Plymbridge Children’s Centre.

Standardising the quality of antenatal education provision across Plymouth

The city of Plymouth faces a number of public health challenges, with life expectancy lower than average for England, 10,400 children living in poverty and significant health inequalities across the city.

A health needs assessment in 2009 identified a lack of continuity in the provision of antenatal care across the city. Although examples of good practice were found, there was a lack of coordination, monitoring, evaluation and governance, and the service offered was not underpinned by robust evidence.

The ‘Great Expectations’ programme was developed in response to these findings. It was led by a multi-agency quality assurance group bringing together representatives from the local Hospital Trust, Plymouth Community Healthcare, CAMHS, the City Council and local Children’s Centres.

Working together with a midwife coordinator, nominated ‘champions’ from these organisations designed content for a six-week programme which was piloted at a children’s centre in a deprived area of Plymouth and then gradually rolled out across the whole city, replacing pre-existing provision.

Supporting mums to make healthy choices

The ‘Great Expectations’ programme is now delivered at all Children’s Centres across Plymouth. It is free to attend and women can sign up by filling in a postcard at their antenatal midwife appointment, in Children’s Centres, the scanning department of the local maternity unit or online.

The course is run at weekends and in the evenings, as well as during the working day, offering women and their partners more choice of when and where to attend. Each week covers a different topic delivered by a different member of the multidisciplinary team as follows:

- **Week one: Great start** – addresses key public health messages for pregnancy including smoking cessation, nutrition and physical activity.
- **Week two: Talk to your bump** – addresses changing relationships, emotional/mental health and the baby’s development.
- **Weeks three and four:** cover normal labour, stages of labour, birth choices, coping strategies, possible interventions and the role of a birth partner.
- **Week five: Welcome to the world** – includes skin-to-skin contact with baby, bonding and establishing breastfeeding.
- **Week six: Ten days and beyond** – introduces the healthy child programme, community resources and child health.

Evaluating the impact of the programme

Throughout the six week course, each session is evaluated at the beginning and end using a ‘confidence ladder’ technique to see how participants’ knowledge and understanding of key issues has increased during the session.

Since 2009 over 5033 participants from Plymouth have taken part in the ‘Great Expectations’ programme. Attendees have recorded increased confidence scores across all areas of parenting, and written feedback reports a high level of satisfaction with the course in preparing them for parenthood.

Plymouth University is soon to begin a three year research project to evaluate the impact ‘Great Expectations’ has had on local women’s choices during pregnancy and after birth, including smoking cessation rates, uptake of healthy start vitamins, continued engagement with children’s centres and breastfeeding rates.

Jan Potter, Public Health Improvement Manager at Plymouth Community Healthcare, said: “We are really proud of the Great Expectations programme – we get great feedback from the women who take part and we think it shows how much you can achieve when different organisations in one city come together to tackle an important issue like maternal and child health.”

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The Leeds Teaching Hospitals NHS
NHS Trust
UNIVERSITY OF LEEDS

Pocket-sized advice for the treatment of angina

Leeds Teaching Hospitals NHS Trust developed an advice card for patients who have angina. Designed to be the size of a credit card, the tool provides handy information to patients on how and when to use a short-acting nitrate during an episode of chest pain.

> *"The value of involving patients was substantial. They helped us develop advice in a format that is relevant, useful, informative, and easy to carry around."*
> **Dr Rani Khatib**, Senior Cardiology Pharmacist and Lecturer, Leeds Teaching Hospitals NHS Trust

Poor knowledge of the use of nitrates for angina

Angina is pain usually experienced at the front of the chest brought on by physical exertion or emotional stress. It is caused by a narrowing of the coronary arteries, leading to the heart not getting as much blood and oxygen as it requires.

NICE guidelines recommend that short-acting nitrates, known as sublingual glyceryl trinitrate (GTN), should be offered to prevent and treat episodes of angina. NICE also recommends that people with stable angina should be advised on how and when to use short-acting nitrates.

At Leeds Teaching Hospitals NHS Trust, patients were being provided with information about medicines that included how to use GTN. However, a baseline audit revealed that many patients who were admitted to the Trust with chest pain and had been already prescribed GTN did not know how to use the drug correctly during an episode. This was because the information was not readily accessible and could not be easily found when most needed.

With only 17% of patients showing full knowledge of GTN, the Trust developed a new approach to delivering information about the drug, which resulted in the production of the pocket advice card.

How did the Trust carry out the project?

The project was split into five phases:

- Phase 1 – Assessment: data was gathered on whether patients with angina knew about GTN or used it correctly when they had an episode of chest pain
- Phase 2 – Development: a handout designed to be the size of a credit card was deemed the most suitable way of providing accessible information about GTN
- Phase 3 – Evaluation: pilot trials were conducted with patients to test the advice card approach and to collate feedback
- Phase 4 – The national picture: a national survey was conducted to evaluate what advice is currently being given, whether healthcare professionals across the country currently assess patient knowledge over GTN, and to gauge whether there is any potential interest in the card
- Phase 5 – National roll out: a card for national use made available to all healthcare professionals who have patients with angina

At the Trust, all patients prescribed with GTN are now given an advice card, offered verbal advice on how to use GTN, and evaluated for their use and knowledge of GTN during admission or clinical review.

Patient satisfaction high, national roll-out expected

Evaluation of the card showed high levels of patient satisfaction. Around 80% of patients found it useful, 83% said it was easy to understand the information provided, and 81% agreed that it is a good idea to present information about GTN on a small, easy to carry card.

The national survey highlighted inconsistencies in the practice of managing patients with GTN. For example, nearly half of participants in the survey advise patients to wait 15 minutes or more after an angina episode before calling an ambulance, whereas NICE recommends calling just 10 minutes after pain is first experienced. Almost 70% of participants did not routinely assess patients' GTN use.

Key learning points from the project include:

- do not take simple interventions for granted: use of GTN was considered simple, but the audit highlighted poor levels of information and patient satisfaction
- evaluate advice given to patients for suitability and effectiveness
- involve patients when developing information and advice – their insight proved invaluable
- support written information with verbal advice
- always assess patient understanding of medicines use

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University Hospitals of Leicester NHS
NHS Trust
Caring at its best

E-learning videos to improve the treatment of feverish children

NICE recommends using its 'traffic light table' of signs and symptoms to help manage children presenting with fever from an unknown source. Leicester Hospitals and Leicester University produced a series of videos to increase knowledge of this resource and improve practice amongst its clinicians.

"Using videos to visually describe NICE guidance, is a helpful way of increasing knowledge, changing attitudes, and improving clinical practice."
Dr Damian Roland, Consultant and Lecturer in Paediatric Emergency Medicine, Leicester Hospitals

Traffic light approach to treating childhood fever

Feverish illness is common in children, with up to 40% of parents reporting that their child has had a fever each year. Fever is also the second most given reason for a child being admitted to hospital. While the majority of cases of fever are due to self-limiting viral infections which can be easily cured, they may also be suggestive of more serious bacterial infections such as meningitis or pneumonia.

Diagnosing a child who presents with fever can be challenging, as it is often difficult to identify the cause. To help clinicians with this, NICE has produced a traffic light table, which recommends actions based on symptoms and risk.

At Leicester Royal Infirmary, it was felt that services for the management of feverish children deserved reviewing. Knowledge of the traffic light system could be increased to ensure best practice, and there was room for standardising clinical practice.

To achieve this, the hospital developed an e-learning package involving a series of videos, which illustrate how the NICE table can help diagnose and treat feverish children.

Visually representing NICE guidance

Leicester Royal Infirmary and Leicester University jointly produced videos for each of the five domains and three risk categories of the traffic light table. The videos visually represented features described within the table. For example, the video for the 'green – low risk' section of the table showed a smiling child responding normally to social cues.

The package was given its own website that was password protected. Users were asked to complete a questionnaire to provide data on demographics, knowledge, attitudes of the clinicians, and usage of NICE guidance. Once the videos had been viewed, users were asked more questions to gauge change in knowledge and attitudes.

A link to the website was distributed to 12 emergency departments based across England, and clinical leads at each site were given admin access to monitor the progress of their participants.

Funding for the project was provided by a doctoral research fellowship grant, provided as part of a research project into educational evaluation.

Improved knowledge, attitudes and compliance with NICE

The package led to a number of observable results such as:

- improved attitudes towards safety, competence, assessment, investigation and management of feverish children
- significant improvements in knowledge of feverish illness based on scores from tests completed after the videos were seen
- trends suggest improved compliance with evidence-based practice

The team feel that using videos to describe NICE guidance can improve knowledge, change attitudes and have a positive effect on influencing behaviour. In addition, nearly 84% of participants agreed that the system was a successful way of boosting knowledge.

The team stress that specialist skills are not required to develop video e-learning tools, as mobile and tablets already have adequate video capturing technology.

Key learning points include:

- engage clinical leads who are responsible for education within Trusts as this can help implement guidance
- ensuring junior doctors are trained in recognising clinical features provided an opportunity for implementing NICE guidance

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Oxford Health NHS
NHS Foundation Trust

Improving psychosocial assessments for patients who have self-harmed

Oxford Health NHS Foundation Trust used NICE guidance to improve the quality of the assessments it provides to patients in emergency departments who have self-harmed. The Trust achieved this by carrying out an audit of its services, and using the results to help redesign and standardise care.

> *"Carrying out a baseline audit proved to be a highly effective way of identifying the ways in which we could improve our psychosocial assessments."*
> **Fiona Brand**, Psychiatric Liaison Nurse,
> Oxford Health NHS Foundation Trust

Psychosocial assessments key to tackling self-harm

Self-harm is common, especially among younger people, and is associated with a wide range of mental health problems such as depression, bipolar disorder and schizophrenia. The risk of dying by suicide 12 months after an episode is between 50 to 100 times higher for people who self-harm than for the rest of the population.

NICE recommends comprehensive psychosocial assessments as an effective way of managing patients who present to emergency departments having self-harmed. These assessments can help identify the personal factors that might have led to the incident, and also ensure patients are provided with appropriate treatments and follow-up care to prevent future issues.

Oxford Health NHS Foundation Trust routinely provided psychosocial assessments at its emergency departments, but it was aware that these could be improved. The assessments often varied significantly in quality depending on who provided them, and were frequently given by out-of-hours trainee doctors who had little or no experience in their delivery.

To standardise and improve the quality of its psychosocial assessments, the Trust ran a series of audits and used the results, together with NICE guidance, to redesign its services.

Audits identified room for improvement

The first audit was carried out in 2010. Results from this suggested staff were not always recording child protection issues or history of abuse. Consequently, the Trust implemented the following actions:

- psychosocial assessment form amended to better reflect NICE guidance
- training in psychosocial assessment given to all new staff, including doctors, during induction
- weekly supervision groups set up
- copies of psychosocial assessment forms made available in the emergency room and on shared drives

Progress in achieving these actions was measured in two subsequent audits carried out in 2011 and 2013.

Results from the 2013 audit found that recordings of a history of domestic abuse and of child protection issues had risen significantly. There was also a significant rise in the recording of psychological characteristics associated with self-harm, from 16% in 2010 to 93% in 2013.

The 2013 audit also demonstrated that the quality of psychosocial assessments provided by trainee doctors had improved significantly in several areas. Specifically, recording of drug abuse increased from 67% in 2012 to 100% in 2013.

Engage staff and encourage discussion

From the 2013 audit, it is clear that the quality of psychosocial assessments has improved, particularly in terms of recording case histories, and this improvement has been witnessed across the team. The project has encouraged discussion about the importance of asking delicate questions related to abuse, and for improved links with the child protection team.

The Trust now also has a comprehensive psychosocial assessment document which better reflects NICE guidance. This form can be easily modified and transferred to other organisations. Student nurses on work placements have had the opportunity to see the psychosocial assessments in action, and to pass this knowledge on to other institutions.

Key learning points include:

- carrying out a baseline audit was an effective way of identifying the main areas for improving the psychosocial assessments
- engage staff, present the audit results in a sensitive way, and offer solutions for improvement in order to create a positive learning experience
- involve the Trust audit team, as they can provide expert advice and guidance
- pilot your audit tool to test whether the data being collected is both valid and reliable

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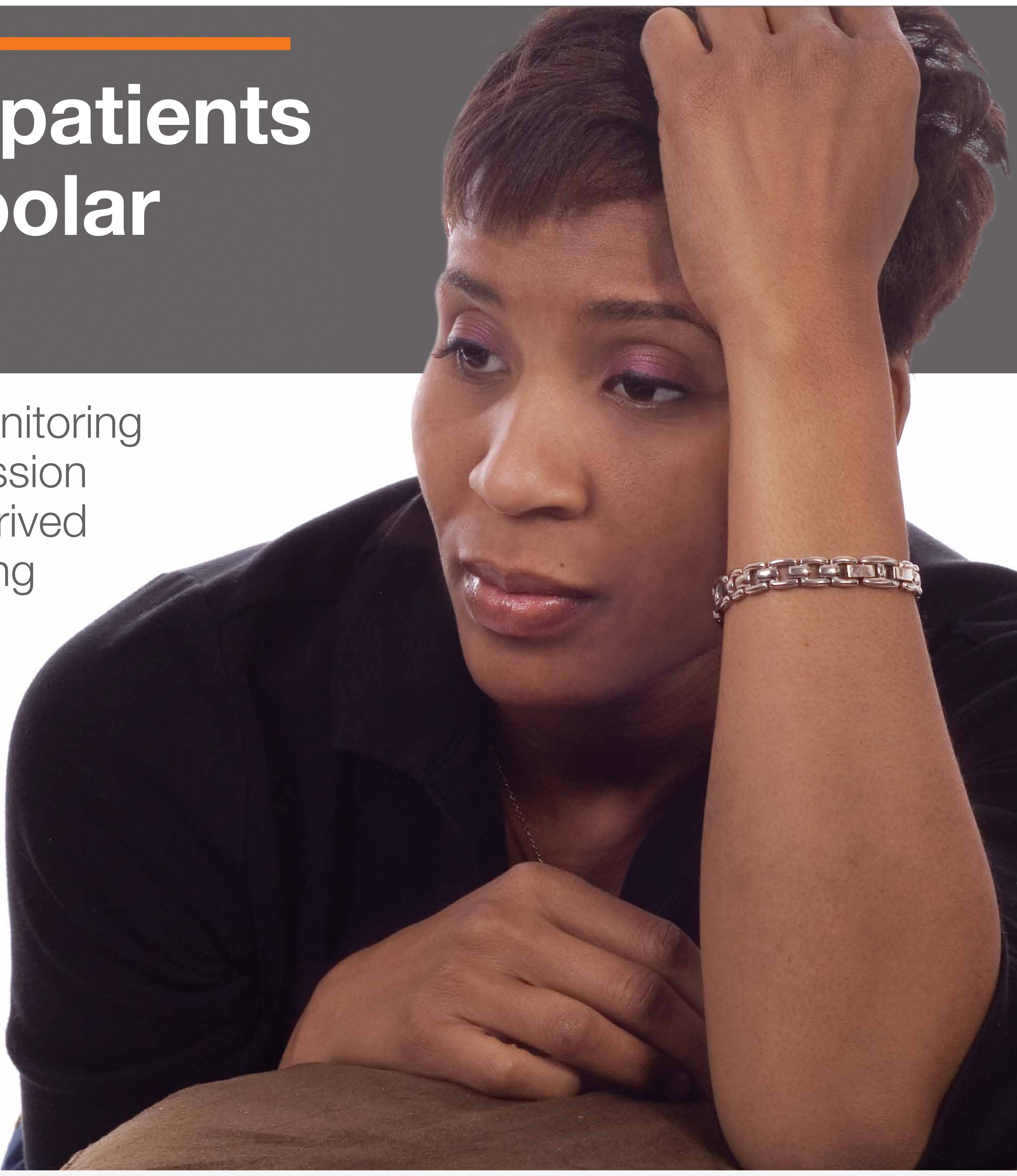
Oxleas NHS
NHS Foundation Trust

Improving the safety of patients with depression and bipolar disorder



Oxleas NHS Foundation Trust improved the monitoring of lithium treatment among patients with depression and bipolar disorder according to standards derived from NICE guidance. Lithium monitoring has long been a problem area for the NHS with some patients harmed because they have not had their dosage adjusted when necessary.

> *"In order to actively monitor treatment you need to know who to monitor and be reminded of it when the time is right"*
>
> **Sarah Elliott**, Specialist Clinical Pharmacist, Oxleas NHS Foundation Trust

The dangers of poor lithium monitoring

Oxleas NHS Foundation Trust provides mental health services to Bexley, Bromley and Greenwich. The Trust identified lithium monitoring as an area where practice needed to improve after taking part in the Prescribing Observatory for Mental Health (POMH) programme.

The Oxleas POMH team comprised representatives from clinical audit, pharmacy, medicine, nursing, and service users. The service user representatives both had personal experience of poorly managed lithium treatment. One had been treated for lithium toxicity in intensive care as a consequence of not having his treatment regularly monitored, and the other service user said he always had to remind his doctors to take bloods for lithium monitoring and that there didn't seem to be a system in place to flag up when his tests were due.

The results of the baseline POMH programme audit backed this up, highlighting that some patients did not have a blood test for lithium levels in the last year.

Oxleas NHS Foundation Trust acted to improve patient care by ensuring monitoring of lithium treatment was in line with the NICE guideline on bipolar disorder which recommends that lithium levels are monitored every three months and assessment of thyroid and renal function every six months.

Developing a lithium database to share test results

A common problem of sharing information between pathology, primary and secondary care was identified by the Trust. Found also at a national level, the National Patient Safety Agency (NPSA) issued an alert around lithium monitoring. This included a statement that there should be an electronic interface between pathology and primary and secondary care to allow the results of lithium monitoring blood tests to be shared easily.

The medical director supported a proposal to the Trust board that Oxleas fund the development and on-going management of a lithium database. The lithium database, designed by a psychiatrist, enables doctors and care coordinators to register their patients on the lithium database via email.

The manager of the database liaises with the local pathology services once a month to obtain lithium results, and certain renal and thyroid function test results for all patients prescribed lithium. This information is uploaded into the database which then identifies all those patients who are due for a lithium blood test. Emails are sent out to the doctor and/or care coordinator for each patient to remind them when a blood test is due.

Doctors started to populate the lithium database in April 2011 and the database was fully operational by September 2011.

Identifying patients on lithium has improved safety

The Trust has identified all patients taking lithium and recorded their details in a central location. A baseline audit identified 251 patients currently treated with lithium. Once the database was fully populated using data from pathology, this number rose to 480.

Improvements to patient care:

- In the most recent audit, conducted in July 2013, the number of patients who had had 4 lithium serum level tests in the last year rose from 35% at baseline to 52%.
- The number of patients who had had at least 2 lithium tests in the past year increased from 78% at baseline to 95%, with the all patients in the sample having had at least one test in the past year.

It is known that personalised reminders have a greater impact on practice than general educational initiatives, and the Trust believes that this may be a factor in the success of the initiative.

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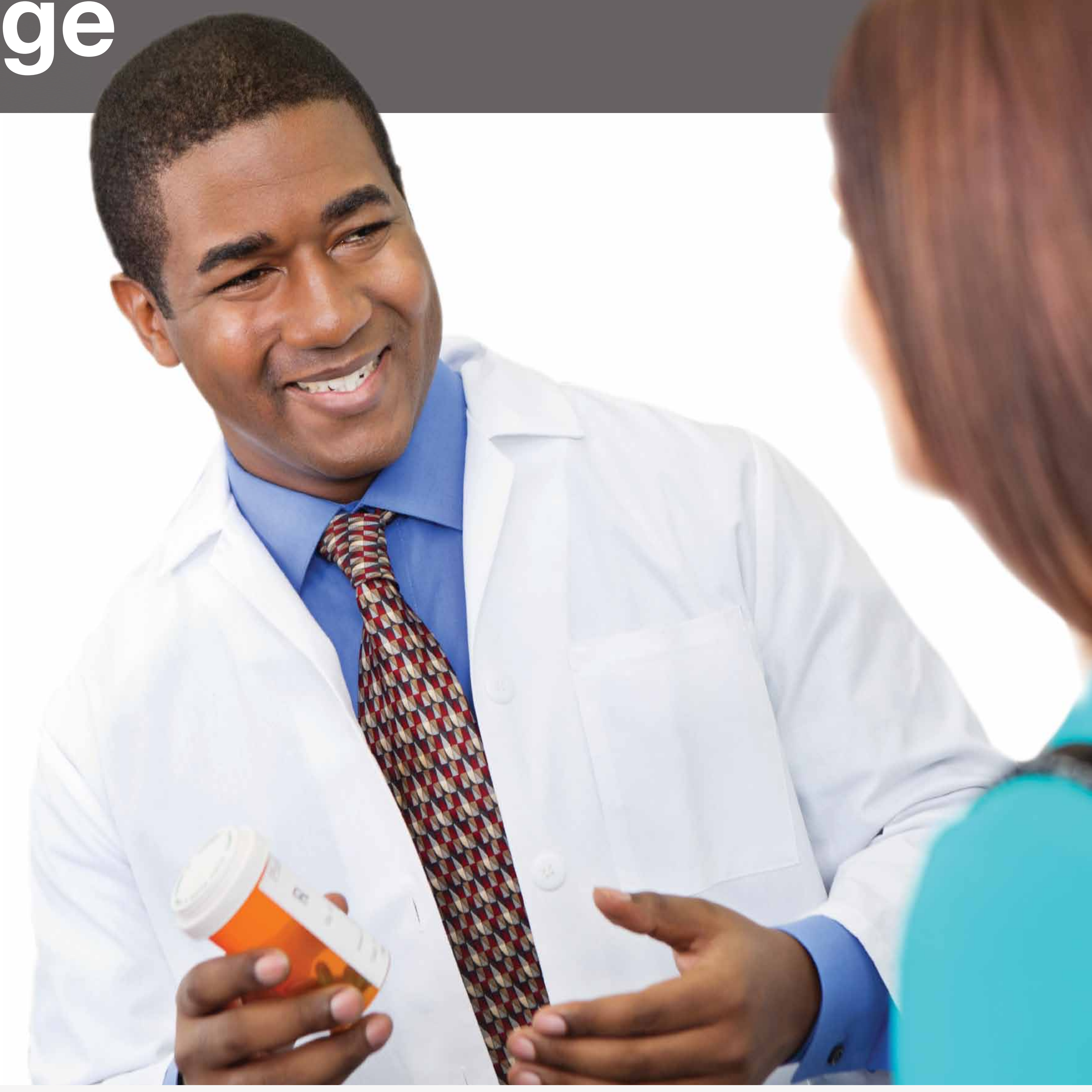
Northern, Eastern and Western Devon
Clinical Commissioning Group
South Devon and Torbay
Clinical Commissioning Group

Improving the management of Patient Group Directions (PGDs) during organisational change

The change from three Primary Care Trusts (PCTs) to Northern, Eastern and Western (NEW) Devon and South Devon and Torbay Clinical Commissioning Groups (CCGs) presented an opportunity for the medicines optimisation teams across Devon to collaborate and review the current process for PGDs in primary care in order to improve efficiency.

"An excellent showcase for what we can do working imaginatively and differently."

Dr Tim Burke, North Devon GP and Chair of NHS Northern, Eastern and Western Devon Clinical Commissioning Group



Collaborative approach to working

PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicine(s), including Prescription-Only Medicines (POMs) to a pre-defined group of patients, without them having to see a prescriber, such as a doctor. PGDs may be appropriate when medicine use follows a predictable pattern, such as for patients attending for immunisation and vaccination, or where patients seek unscheduled care, such as for a minor ailment in a community pharmacy or walk-in centre.

Prior to the collaboration, there were three separate PCTs: NHS Devon, NHS Torbay and NHS Plymouth. Each had their own completely separate arrangements for the development and authorisation of PGDs.

In 2011 these three PCTs merged into a single cluster, which was then followed by the abolition of PCTs and the establishment of CCGs.

Following guidance (which has since been included into NICE good practice guidance), a review of the existing PGD processes was undertaken and it was decided to develop a single collaborative approach to the development of PGDs.

Embrace technology to save costs and improve efficiency

A multidisciplinary group was set up with representation from the three PCTs in order to consider best practice from the three previous areas and consider further changes using best practice guidance.

However, one of the main barriers to working collaboratively across Devon is the vast geographical footprint of more than 2,500 square miles. It is expensive to the NHS in terms of travel costs for all members of the team to travel to a single location, as well as taking up a considerable amount of work time to travel, given the distances involved. As a result, a Virtual Review Panel was created to allow the different teams across Devon to work together without the need to all be physically in the same room.

The Virtual Review Panel makes use of web conferencing, including live document sharing via the internet, video conferencing and teleconferencing, allowing the meetings to be undertaken effectively. This functionality allows for any additional 'extraordinary meetings' to be scheduled at short notice, enabling the CCGs to be reactive as well as proactive.

Reducing variation and ensuring quality

The new approach to PGDs has allowed for increased efficiency, improved governance and a reduction in duplication.

With a combined workforce in four teams across Devon, PGD work can now be distributed evenly, reducing workload for all involved, as the authoring pharmacists can attend the web conference from their desks for only the time that they are needed. The introduction of the group means that there is a high level of debate and scrutiny around PGDs, and there are often amendments which are required before sign off.

The NICE PGD Medicines Practice Guidelines, published in August 2013, have proved to be a really useful resource to support the multidisciplinary group. This was further reinforced by attendance of a representative of the group at the NICE Medicines Practice Guidance away day. The group also used the NICE Good Practice Guidance benchmarking tool to ensure we are following best practice.

The PGD Virtual Review Panel is an excellent example of embracing the current NHS drive for innovative and collaborative ways of working to improve the consistency of care.

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A specialist service for children with autism spectrum disorder and learning disabilities

The Royal Borough of Kensington and Chelsea set up a multidisciplinary Behaviour and Family Support Team (BFST) service focusing on the emotional, behavioural and mental health needs of children with moderate to severe learning disabilities, autistic spectrum disorders and Asperger Syndrome.

> *"Setting up the Behaviour and Family Support Team has helped to address behaviour problems and improve family relationships among children with autism and learning disabilities."*
>
> **Dr Carolina Sharman,**
> Behaviour and Family Support Team

Gaps in care highlighted

A local audit of Child and Adolescent Mental Health Services (CAMHS) showed that families of children with disabilities living within Kensington and Chelsea were not routinely accessing help through existing generic CAMHS services. This highlighted the need for a specialist intervention service which could offer a more accessible, flexible, intensive, outreach, and timely approach.

The BFST was established in 2005 in partnership with Central and North West London Foundation Trust and using NICE's autism recommendations. The aim was to address the management and support of children and young people with autism/learning disabilities - with the expectation that families who had not previously accessed mental health services would be able to do so. It was also hoped that families that may have been seen by generic CAMHS, would be referred to the team, reducing the pressures on the local CAMH services.

The service is available for any child with a moderate to severe learning disability and/or autism spectrum disorder between the age of 5 and 18.

Take a collaborative approach when developing services

As the BFST was a new initiative, setting up the team involved an in depth consultation process with key stakeholders, including service users, as well as research into existing specialist CAMH services. A steering group has met regularly since its inception, ensuring that the BFST continues to offer services that are helpful to families and the network, and continues to evolve.

The BFST was initially funded by a two year government grant, but since 2007 was jointly funded by the Local Authority (75%) and the Primary Care Trust (25%). The service currently costs approximately £294,000 per year.

An important consideration was where the BFST might be located, for example separate to or within an existing generic CAMHS. Joint posts were and continue to be helpful in this process, as was joint working of complex cases with other services. This has resulted in other services understanding the model and how the service differs from existing services. It was also important to secure support at all levels of the organisation.

Improvements in behaviour and relationships

Our trainee clinical psychologist and asssistant psychologist complete an annual audit of the service which has consistently shown that BFST intervention leads to improvement in behaviour problems and relationships with others as measured by the Health of the Nation Outcomes Scales (HONOS-LD) for measuring wellbeing.

A total of 79% of clients were felt to be doing "better" or "much better" at follow-up compared to initial assessment, according to results from our 2012-2013 audit.

Other benefits have included:

- increased understanding of a child's difficulties
- a coherent care plan amongst professionals
- improved relationships with other agencies
- improved relationships within the family

The team believes that a proactive parent/carer group, who were able to lobby for a specialist CAMH service and their continued representation on the multi-agency steering group, has helped keep the focus on the needs of children and their families.

Being positioned physically and strategically alongside the children with disabilities social work team within the Local Authority enabled shared management structures, joined up working and positive working relationships.

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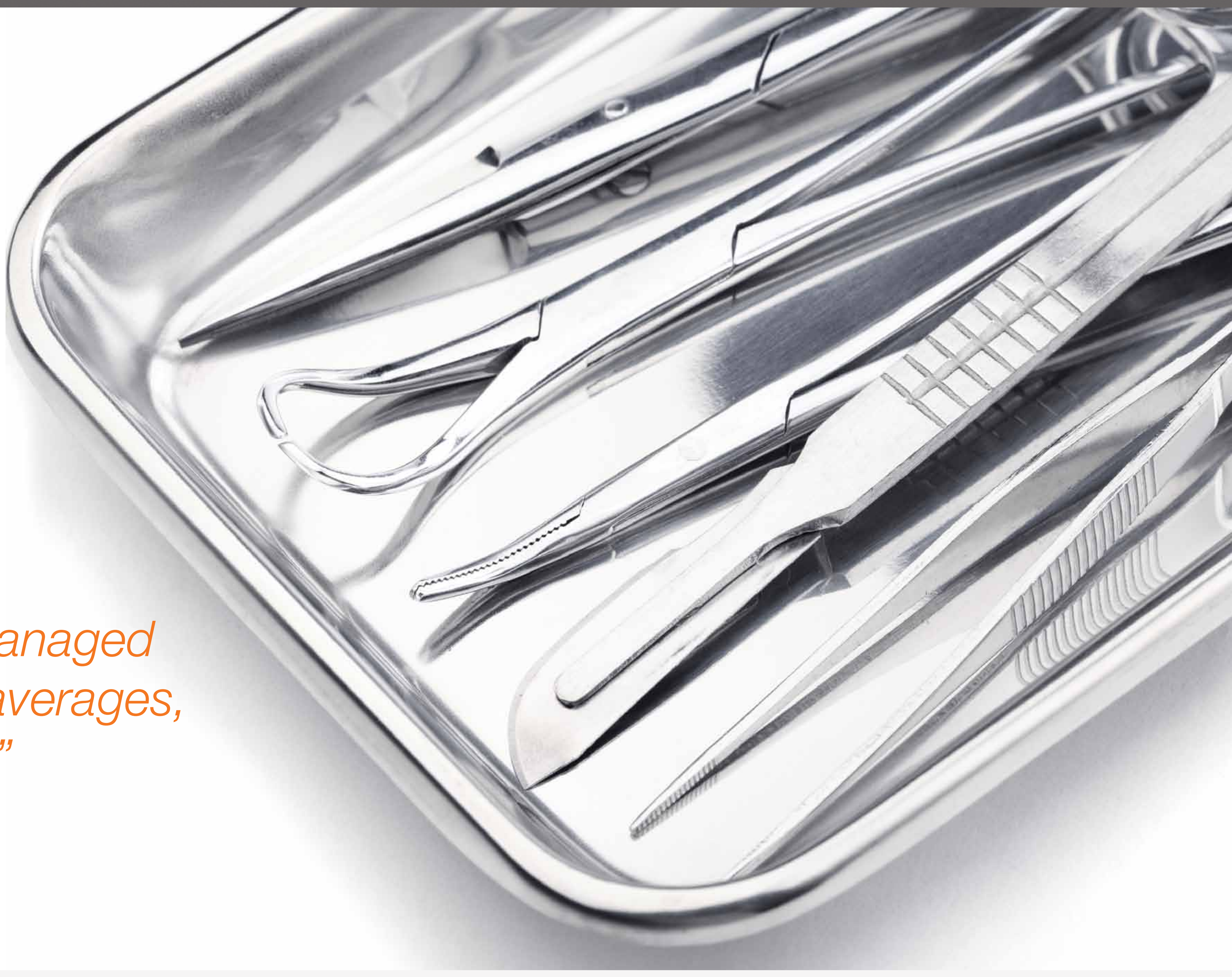
The Royal Liverpool and Broadgreen University Hospitals NHS Trust

Reducing rates of surgical site infection in orthopaedic patients

Royal Liverpool Hospital and Broadgreen University Hospital used NICE guidance to reduce rates of surgical site infection (SSI) in their trauma and orthopaedic surgery units. The hospitals carried out several innovative measures to significantly reduce rates of SSI, and audited the results to ensure continual improvement.



> *"Our project has surpassed expectations – we've managed to bring surgical site infection down below national averages, evolve care, and improve the overall patient journey."*
>
> **William Harrison**, Core Surgical Trainee,
> Royal Liverpool and Broadgreen University Hospitals

Audit reveals unexpectedly high rates of SSI

Surgical site infection is where an infection occurs in, around or deep to a wound after a surgical procedure. SSIs make up around 20% of all healthcare-associated infections. Approximately five percent of patients undergoing surgery subsequently develop an SSI.

The Royal Liverpool and Broadgreen University Hospitals Trust were aware that rates of SSI on the orthopaedic wards were higher than expected. Management of SSI was under-resourced. In addition, both patients and primary care professionals voiced concerns regarding communication with the surgical teams when following up wound problems. Routine data collection for mandatory surveillance of SSI revealed varying infection rates resulting in increased readmission rates.

The hospitals consequently used NICE guidance to conduct a comprehensive review of the patient journey looking at causes of SSI to help redesign their pathway. They aimed to gain an accurate picture of SSI rates; raise awareness of the factors influencing SSI; develop an approach for dealing with them; reduce readmission rates; and improve overall patient outcomes.

An organisation-wide approach to change

An assessment showed rates of SSI and readmission were up to four times higher than the national average, contributing to delayed discharge and higher readmission rates.

Reasons for this included lack of communication between microbiology, surgeons and nurses; inaccurate data collection and interpretation often resulting in 'non-infections' being labelled as 'infections'; and non-implementation of NICE guidance on pre-operative antibiotic prophylaxis.

Consultant leads for SSI were appointed in the orthopaedic and microbiology units with a multidisciplinary team led by two full-time specialist nurses. Every SSI was reviewed to confirm accurate data submission to Public Health England, and complex cases discussed in a fortnightly multi-disciplinary meeting. The elective orthopaedic wards were ring-fenced from non-elective admissions and made antibiotic-free zones. Nurses redesigned a wound dressing protocol, direct ward access was given to patients and healthcare professionals, and an outpatient wound clinic was initiated.

The orthopaedic lead ran a teaching program, which included best-practice advice on hand washing and theatre etiquette as recommended by NICE. NICE guidelines on antibiotic prophylaxis were also implemented.

Significant improvements in several areas

Data from both hospitals were collected and analysed following the new measures. Infection rates fell below national averages in several areas:

- total hip replacement infection rates fell from 1.9% in 2010 to 0.2% in 2013
- hip fracture surgery infection rates fell from 5% in 2010 to 1.6% in 2013
- readmission rates fell to below national averages, helped through establishment of the new wound clinic
- recommended prophylactic antibiotic rate rose from 60% to 95%

The creation of defined SSI leadership roles in both orthopaedics and microbiology improved communication between the teams, instigated coordinated action in reduction of SSI, and educated junior doctors and nursing staff. The multidisciplinary team approach allowed continuous review of the patient journey, exposing shortcomings, and allowed timely intervention to maximise patient care.

This project was not initially funded, rather roles were reallocated, and once improvement was shown, extra funds were made available to support the changes.

Implementing this approach has significantly improved SSI rates and readmission rates, and potentially reduced overall costs.

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Velindre Cancer Centre
Canolfan Ganser Felindre

Information manual improves patients' understanding of opioids prescribed in palliative care

The Velindre Cancer Centre in Cardiff designed a patient information manual to support cancer patients who have been prescribed strong opioids as part of their palliative care treatment.

> *"When patients are started on morphine, they can feel concerned about side effects and taking their medicine correctly. Our patient information manual is designed to answer common questions and alleviate patients' fears about these drugs."*
>
> **Dr Mark Taubert**, Consultant in Palliative Medicine, Velindre Cancer Centre

Addressing patients' concerns and fears

NICE guidelines recommend that when strong opioids are prescribed in palliative care settings, patients should be offered written information/ advice on their medication, as well as verbal information from their doctor.

The Velindre Cancer Centre in Cardiff created a patient information manual to provide simple, clear information about taking fast and slow acting opioids, their side effects and the risk of addiction, and to address patients' fears about these drugs.

"Over the years we have realised that many patients can be scared because they think taking morphine implies they're imminently reaching the end of their lives – our manual reassures patients this is not the case: many patients use morphine for months or years to control their pain and increase their quality of life," explains Mark Taubert, Consultant at the Velindre Centre.

The manual has been adopted by the All Wales Medicines Strategy Group (AWMSG) and received governance approval from two local NHS organisations, Velindre NHS Trust and Cardiff and Vale University Healthboard.

Evaluating the patient manual's effectiveness

The Velindre Cancer Centre audited the effectiveness of their manual using an audit tool designed by NICE. The Centre conducted a survey of 40 inpatients on opioids, asking a series of yes/no questions to determine how much information each patient had received when they began taking opioids.

The first 20 patients questioned had received just verbal information, whereas the second cohort of 20 patients had received the patient manual too. Questions asked in the survey were based on NICE guidance and included:

- Were you told when and why strong opioids are used to treat pain?
- Were you told about safely storing your medicines?
- Were you advised that nearly all patients are affected by constipation as a side effect?
- Were you advised that nausea may occur but is likely to be transient?

The findings of the audit showed that patients who received the manual alongside verbal information were more likely to answer 'yes', and were better informed about their medication from the start.

A measurable improvement in patient awareness

The percentage of 'yes' answers in the group that had received the manual and verbal information was much higher for each subquestion within the survey, compared with verbal information alone.

For example, only 20% of patients who received verbal information alone said they were given information on who to contact for out-of-hours support, compared to 90% of patients who had also received the booklet.

James Holloway, who coordinated the audit, says that the success of the patient manual is partly due to the level of detail included: "Patient information doesn't always need to be in a short leaflet: our booklet is eight pages long. We think our patients appreciate this level of detail on a complex subject. Using a 'FAQs' layout also helps patients skim through to the details and issues that concern them most. We are currently finalising steps to create a user-friendly mobile phone and web based app," he explains.

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NICE Shared Learning Awards 2014

West Belfast Partnership
Páirtíocht Feirste Thiar

Healthy Hearts in the West

HSC Health and Social Care Board

HSC Public Health Agency

Changing behaviour to achieve better health outcomes in West Belfast

In response to poor life expectancy among men and women in their part of the city, West Belfast Partnership Board launched a healthy heart initiative to tackle health inequalities, encouraging citizens to change their behaviour and lead healthier lives.

> *"With support from partners across West Belfast and the help of NICE guidance we have enrolled thousands of people onto programmes, where they take part in physical exercise, eat more healthily and change their lifestyles."*
>
> **Jane Turnbull**, Evaluator / Researcher,
> West Belfast Partnership Board.

A strategy to improve heart health in the community

Levels of cardiovascular disease (CVD), including heart disease and stroke, were higher in West Belfast, an area of severe socioeconomic deprivation, than most of Northern Ireland. Life expectancy of men was lower than the Northern Ireland average (72.3 years compared to 76.8 years) and the same was true for women (78.4 years compared to 81.4 years).

To improve health outcomes and address the social determinants of health inequalities, the West Belfast Partnership (funded by the Public Health Agency and Belfast Local Commissioning Group) launched a healthy heart initiative, with five core objectives:

- raise awareness about CVD risk factors and achieving a healthy lifestyle through local programmes
- strengthen partnerships between community, statutory, voluntary and private sectors to improve heart health
- improve access to preventative, diagnostic,treatment and rehabilitation services for CVD in community settings
- promote self-management for those with CVD
- create care pathways that enable delivery of integrated CVD services

Partnership working to achieve better results

Results from a baseline assessment of heart health in the community showed poor understanding of the risks of CVD, confusing health messages, and that people found it difficult to change lifestyle behaviour (often due to the complexity of the difficulties they face).

Planning days were held with residents and voluntary, statutory and private sector representatives to gauge interest in developing a collaborative, community assets approach to improve heart health. After a positive response, services and stakeholders came together to plan and implement interventions, making best use of existing resources. Partners in the initiative included community groups, leisure centres, schools, youth groups, sports groups, pharmacies, and GPs.

Working with partners, the team used the recommendations in the NICE guideline on behaviour change (PH6) to develop interventions that they could be confident would deliver results.

Among the interventions developed were:

- a fit kids physical activity and nutrition programme
- running healthy living events at workplaces
- weight management and CVD screening programmes in ten local pharmacies
- community heart health champions

Making the best use of community assets

Healthy Hearts has seen impressive results, with high levels of engagement:

- 10,000 plus people (of all ages) participating in community based heart health programmes
- 750+ people accessing the community pharmacy programmes; 161 GP referrals of people with a high risk of CVD
- 250+ people signposted to community heart health programmes
- 640+ people attending workplace health events
- Increased patient take up of Cardiac Rehabilitation Phase 3 Programme

Key learning points include:

- importance of making use of existing assets to avoid duplication and target resources effectively
- preparedness to invest where there are gaps in service provision
- need to identify community champions to disseminate messages and drive forward intervention programmes
- engage with organisations across all sectors, and facilitate equitable partnership working
- benefits of an approach based on core community development principles
- NICE guidance offers practical solutions and can inform a robust evaluation framework

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www.nice.org.uk

NICE Shared Learning Awards 2014

Royal Berkshire **NHS**
NHS Foundation Trust

Over-hauling diabetes care across West Berkshire

Commissioners, providers, healthcare professionals and patients formed a multi-disciplinary, collaborative network to improve the way diabetes care was planned and managed in West Berkshire.

> *“National results and our own analysis presented a strong case for service change. Using NICE guidance we were able to devise better care pathways, improve patient experience and target resources where they were most needed.”*
>
> **Dr Ian Gallen**, Consultant Community Diabetologist,
> Royal Berkshire NHS Foundation Trust

National audit results and the case for change

The national diabetes audit showed poor performance for key aspects of diabetes care in West Berkshire. Although numbers of deaths from diabetes and amputations were relatively low, care processes and achieving therapeutic targets were significantly worse than in the rest of the country.

For example, compared with similar communities, the region was not achieving key targets for glycaemic control, hypertension and lipid management. This put people at risk of developing acute health problems. It also increased demands on secondary care and led to increased costs.

It was clear there needed to be an overhaul of how care was planned and delivered. The Berkshire West Federation, a group of four clinical commissioning groups, established a stakeholder network to drive up standards of diabetes care across the region. This multidisciplinary network, known as Diabetes Sans Frontieres (DSF), had a number of key objectives:

- lessen the burden of diabetes on people in the community
- improve patient outcomes
- reduce referrals to hospital
- bring down costs of diabetes care

Delivering service change

DSF set up a board comprising primary and secondary care, commissioners, patients, diabetes nurses, public health, community nursing, medicines management and community pharmacy.

The board sought to:

- encourage more integrated diabetes care
- use patient views to inform service change
- create a platform for service innovations
- provide a forum to agree service development

Using NICE guidance on diabetes, they developed staff training to break down barriers between providers and ensure care was delivered more effectively. They also commissioned structured education for patients to self-manage their condition more. Among service improvements implemented by the board were:

- integrated community diabetes nurse specialist in secondary care
- patient education programmes
- diabetes foundation course for healthcare professionals
- website for patients, carers and healthcare professionals
- bariatric service with community based weight loss programmes
- care planning tool to engage patients more in their care

Better performance and further innovation

Since they set the network up, the DSF team has seen better results from the National Diabetes Audit with improved scores for their care processes. As well as this they have established a community based diabetes specialist who visits GP practices to support staff, carries out virtual consultations for difficult cases and helps primary care manage referrals to secondary care. They have also seen their prescribing costs reduced.

Also, the care planning tool to improve patient engagement is now installed in over 46% of GP practices in the region and all GP practices are enrolled in a web-based ‘Eclipse’ system which enables patients to look up their own records and results via personal smart cards, so they can self-manage their condition.

The team identified a number of learning points:

- importance of clinical leaders understanding the case for service change and the consequences of not doing it
- vital to create an atmosphere where innovative ideas can be explored
- make use of early or fast adopters of service change to encourage others to get involved
- NICE commissioning guides can be very helpful for implementing service improvement

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Yorkshire Ambulance Service NHS
NHS Trust

Improving the health of people who present to ambulance services due to alcohol misuse

Yorkshire Ambulance Service NHS Trust used the NICE quality standard on alcohol dependence and harmful alcohol use to establish a region-wide alcohol referral pathway. This places the patient at the centre of the care pathway, ensuring they receive the support they need to tackle their harmful drinking.

> *"Someone in my state wouldn't often seek help themselves or are often not in a state to do so. The input from the ambulance crew was invaluable for me and could be for others too."*
>
> **Alcohol referral pathway patient**

A greater public health role for paramedics

Alcohol is one of the leading causes of accidents in the UK. Ambulance clinicians are too often called to pick up the pieces at incidents where someone has become ill or injured as a result of excessive alcohol consumption.

In the first quarter of 2013/14, the Yorkshire Ambulance Service (YAS) attended 10,178 calls where the use of alcohol was suspected. This equated to 5.9% of all calls and has associated costs including ambulance call out, A&E attendance and possible admission.

Many of these patients who misuse alcohol would benefit from further involvement, support and engagement with specialist services. There was an opportunity for ambulance clinicians to have a role in providing this additional support.

YAS created an alcohol referral pathway that promotes the 'Make Every Contact Count' approach - a nationwide initiative to encourage healthcare professionals to use every opportunity to help people stay healthy and reduce system-wide costs to the NHS.

Acting on a patient's history

The alcohol referral pathway was initially established in Sheffield and Rotherham in October 2011. The pathway centres on two of the NICE alcohol quality standard statements around providing opportunistic screening, brief interventions and referral to specialist alcohol services.

YAS has a number of other referral pathways in place which are made through a central hub. Therefore, once agreed with the service provider, it was relatively easy to establish the pathway. A bespoke referral form and operating procedure was produced to collect all the agreed information which is then sent to the provider.

There were some initial concerns from the service providers regarding use of the CAGE screening tool for alcohol problems. However, the importance of using a uniform and simple assessment tool was explained and this led to an agreement to use the CAGE tool Yorkshire-wide.

Having the pathway in place allows ambulance clinicians to act on information gathered as part of the patient's history. Prior to this pathway, the patient's potential alcohol issues would not have been addressed other than via a possible referral from a GP or hospital.

Referral pathway well received

Results and evaluation from the initial roll out in Rotherham and Sheffield revealed that between April 2012 and October 2013 there were 120 patient referrals to alcohol services at an average of over 6 referrals a month. In the previous 7 months, there were 52 patient referrals with monthly fluctuations between 2 and 11.

The pathway was launched Yorkshire-wide in December 2014. In the first 28 days there had been 34 referrals, exceeding the expected one per day. Both clinicians and clinical hub found the referral a simple process.

As the alcohol pathway relies on the patient consenting to being referred, it demonstrates that ambulance clinicians are able to engage with patients at various stages of their alcohol misuse. Patients have also reported that they found their experience of the pathway very positive.

YAS believes that in order to successfully roll out the alcohol pathway, referral systems should be in place to handle the numbers and a central hub should be used. This has allowed YAS to effectively capture and handle data and ensures that the pathway is accessible to clinicians 24/7.

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