THINK... INNOVATE...CO-CREATE...SHARE...CHANGE

Comisiwn Bevan Commission

Bevan Academy for Leadership & Innovation - 2016/17 showcase

*"**Bevan Academy** . . . where people, professionals and organisations come together to innovate and co-create"*

THINK... INNOVATE...CO-CREATE...SHARE...CHANGE...

Contents:



Foreword:

With Bevan Commission Chair Professor Sir Mansel Aylward

The Commission has had very busy, and productive, year. We are continuing our work to become the leading international think tank providing independent expert advice and intelligence on health and social care - not only here in Wales - but on an international stage.

We have retained our important relationship with Wales's Cabinet Secretary for Health, Wellbeing and Sport, but we have also focused our energies on developing our work with health-focused organisations both across the UK and internationally. Since the establishment of the Bevan Commission in 2008, our membership and work programmes have grown considerably and we are now informing health systems in countries such as Australia, New Zealand, Canada, the US, Belgium and Scandinavia.

Our move to Swansea University's School of Management at the Bay Campus last year has also provided us with the infrastructure, resources and drive to preserve the Commission's independence and allowed us to tap into the university's thriving environment of innovation, research and collaboration.

We are continuing our work to create strong health leaders and innovators, turn ideas and enthusiasm into action, develop a quality system approach to service improvement and integrate Prudent Healthcare into practice.

The Bevan Academy for Leadership and Innovation is now an integral part of the Bevan Commission. The Academy not only provides a dynamic learning and development environment to support inspirational leadership, innovative ideas, new ways of working and action research,

"We want to support people to come together and form a community – sharing ideas, enhancing skills and collaborating to make health and care better"

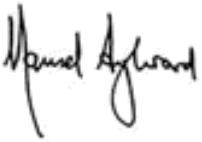
but also importantly informs the Bevan Commission's thinking and is our vehicle to translate thinking into action, at pace.

We are proud that the Bevan Academy is a place where people, professionals and organisations come together to think through, co-create and experiment in a non-competitive environment.

The Academy established the Bevan Exemplar programme. Our Exemplars are all NHS Wales staff and their projects aim to improve efficiency, health outcomes and drive the application of Prudent Healthcare.

I am delighted to be able to showcase the innovation produced by our second cohort of Exemplars.

Their passion, enthusiasm and focus shows us that by encouraging collaboration, learning and by supporting innovation, we can indeed create a more sustainable, prudent health service right here in Wales.



What is the Bevan Commission?

With Bevan Commission & Academy Director Helen Howson

The Bevan Commission is an independent and authoritative think tank made up of international experts who challenge current practice and work with others to find solutions to create a sustainable health and care system ***fit for the future.***

The Bevan Commission is a community of like-minded people who are committed to improving health and care, where a wide range of knowledge and experience is welcomed and shared and where there are no limits on innovative ways of working. At the heart of all our thinking, is the concept of ***Prudent Healthcare.***

Prudent Healthcare started life as a piece of work led by the Commission. Today it has moved from being a much-debated topic to actually being applied to NHS services and patient care. ***Prudent Healthcare*** is about using the finite resources of the NHS wisely and doing *"everything appropriate"* rather than *"everything possible".*

Prudent Healthcare is based on four key principles:

►Achieving health and wellbeing with the public, patients and professionals as equal partners;

►Caring for those with the greatest health need first, making the most effective use of all skills and resources;

►Doing only what is needed, no more, no less – and do no harm; and,

►Reducing inappropriate variation using evidence-based practices consistently and transparently.

The Bevan Commission's ambition is to ensure all four principles are considered at the same time to help create a social movement for change both inside and outside the NHS.

To be able to improve and sustain health and wellbeing in Wales we must look for a new solution and be brave enough to pursue it.

The Commission, in its latest series of White Papers titled ***'Exploiting the Welsh Health Legacy',*** is calling for a joined up, prudent and social model which takes account of the wider social determinants of health and helps people achieve their maximum wellbeing. Moving away from the more traditional medical model of care.

This new model is based on the concept of ***Prudent Healthcare*** and the application of its principles. It recognises the shared responsibility of society starting with the individual. This new prudent and co-operative Model of Health and Wellbeing promotes innovation, new ways of thinking and working, and explicitly places the responsibility of improving population health and wellbeing across society as a whole.

We believe that only this shift of shared responsibility between people, the NHS, local government, academia, the third

sector and indeed the private sector can truly support every person in Wales stay healthy and well - for as long as possible.

We realise this will require joined up thinking in practice as well as across policy and organisational and professional boundaries.

The Commission is continuing to promote, embed and action the values of Prudent Healthcare in all our work.

We believe ***Prudent Healthcare*** can change the way health services are used and provided. However, it has to be more than an idea and a set of principles.

In order to make a real practical difference, the Commission is working with health boards, Welsh Government, patients, academia, third sector and industry to:

➔Create and support strong health leaders and innovators;
➔Turn ideas and enthusiasm into action;
➔Encourage collaboration;
➔Promote disruptive thinking which challenges the status quo;
➔Respond to the health needs of Wales; and,
➔Integrate Prudent Healthcare into practice.

Bevan Commission was established in 2008 on the 60th anniversary of the founding of the NHS.
The Commission draws its board of expert members (*Commissioners*) from Wales, the UK and internationally.

OUR COMMISSIONERS:

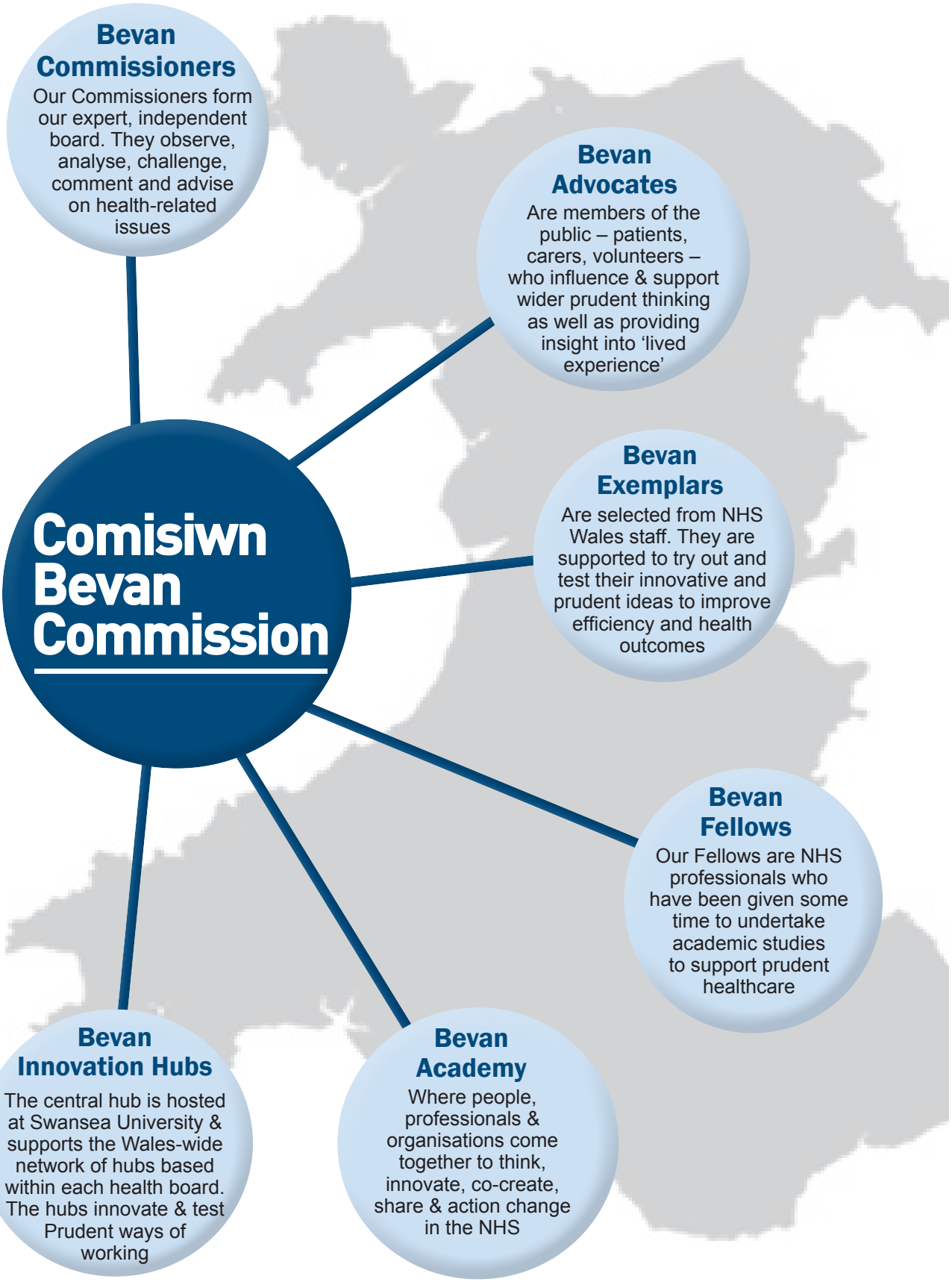
Prof Sir Mansel Aylward CB (*Chair*); Nygaire Bevan; Prof Bim Bhowmick OBE DL; Prof Dame Carol Black DBE; Dr Tony Calland MBE; Sir Ian Carruthers OBE; Mary Cowern; Ruth Dineen; Dr Clare Gerada MBE; Prof Trevor Jones CBE; Lt Gen Louis Lillywhite CB MBE OStJ; Ann Lloyd CBE; Juliet Luporini; Prof Ewan Macdonald OBE; Chris Martin; Prof Sir Michael Marmot; Prof Sir Anthony Newman Taylor CBE; Dr Helen Paterson; Prof Elizabeth Robb OBE; Prof Phillip Routledge OBE; Fran Targett OBE; Sir Paul Williams OBE CStJ DL; Prof Hywel Thomas; Baroness Ilora Finlay and, Prof John Wyn Owen CB.

INTERNATIONAL COMMISSIONERS:
Prof Donald Berwick (USA);
Prof Gregor Coster (New Zealand);
Dr David Bratt (New Zealand).

SPECIAL ADVISORS:
Prof Marc Clement, Prof Marcus Longley; Prof Ceri Phillips; Prof Donna Mead OBE.

THINK	INNOVATE	CO-CREATE	SHARE	CHANGE
The Commission encourages radical thinking within the NHS to find new ways of working and to challenge current practices	Through our Academy, Exemplars & Innovation Hubs we are working to stimulate, nurture & embed innovation	We are working in partnership with everyone as equal partners - to help make services more effective & sustainable	To action real change we encourage a sharing of knowledge, learning and experience to aid adoption	We are committed to developing leaders fit for the future who can deliver meaningful change

What is the Bevan Commission?



Bevan Academy & Exemplars

With Bevan Commission & Academy Deputy Director Siôn Charles

The Bevan Academy for Leadership and Innovation in Health is a pro-active response to turn the theory and principles of ***Prudent Healthcare*** into action and meaningful change within the NHS.

The Bevan Commission identified the need for an Academy to strengthen leadership and innovation in health across Wales. The Academy has three primary roles:

- ►To inform Bevan Commission thinking;
- ►To bridge theory and practice; and,
- ►Translate thinking into action - at pace.

The Academy provides a dynamic learning and development environment to support inspirational leadership, innovative ideas, new ways of working and action research.

We are proud that it is a place where people, professionals and organisations come together to ***think, innovate, co-create, share and action change***.

The Academy brings together NHS professionals, academics, third sector, industry and the public to work together to find better solutions for more sustainable prudent health and care service in Wales.

The Bevan Academy has also established the Bevan Exemplar programme. Our Exemplars are selected from NHS Wales staff of all grades and staff groups. The Commission's ambition is to ensure the principles of Prudent Healthcare are considered to help create a social movement for change. ***The Exemplars are our agents of change within the NHS.***

Exemplars identify, drive and spread innovation through their innovation projects which aim to improve NHS Wales resource efficiency, health outcomes or patient

experience and drive the application of ***Prudent Healthcare*** in practice by making the very most of all the skills and resources we have available to us.

Due to the success of the Exemplar programme we have now also created the Bevan Health Technology Exemplar programme which has been co-designed with Welsh Government. The programme provides funding and support for NHS Wales staff to collaborate with an industry partner to implement innovative health tech in their clinical area, with the aim of improving ways of working, solving health problems and improving health outcomes.

Over the following pages you will get a snapshot of the projects which have been undertaken by our second cohort of 2016/17 Exemplars. We are proud that all of NHS Wales's health boards are represented by Bevan Exemplars as well as the three NHS Wales Trusts.

The projects range from structuring preventative education for diabetes patients, offering new roles to support GPs, reducing medicines waste in care homes to innovating a new diet to transform the lives of people suffering with Irritable Bowel Syndrome (IBS) which is being piloted in five GP surgeries in South Wales.

►See pages 8-35 for our Exemplar project posters

Taking a STANCE on Patient Education

Angela Jones, Specialist Podiatrist
Cardiff & Vale University Health Board

AIM:

To provide foot health education and healthier lifestyle support to all patients with diabetes who are referred to podiatry.
The project was developed in partnership with patients and healthcare professionals: ***"My Healthy Feet"*** concentrates on diabetic foot health and foot pathology prevention. ***"Healthy Me"*** enables the patient to have the right knowledge and support to control their diabetes.

CONTEXT:

►No structured delivery of foot health education or healthier lifestyle messages;
►Informal education delivered at clinician's discretion;
►Increasing numbers of patients with diabetes challenging NHS constraints;
►Increasing complex caseload of patients with diabetes who are at risk of developing foot ulceration; and,
►Strategic Drivers: NICE (NG19) 2015, All Wales Diabetes Delivery Plan.

GOALS:

►Provide structured education to people with diabetes; and,
►Provide structured access to support networks that enable healthier lifestyle choices.

TARGETS:

►Increase patient knowledge and engagement in foot health;
►Increase confidence to self-care; and,
►Reduce dependency on podiatry for basic foot care.

DEVELOPMENT:

➔STANCE education for ***"My Healthy Feet"***
➔Support directory of local services and training for staff to support ***"Healthy Me"***
➔Collaboration with Diabetes UK and Pocket Medic - bespoke diabetes education;
➔Delivery of one-hour diabetes education 2 weeks prior to 1-to-1 consultation;
➔Consultation to identify ***"My Healthy Feet"*** and/or ***"Healthy Me"*** concerns; and,
➔Provision of additional support/empowerment to self-care and access to help when needed.

DIABETES UK

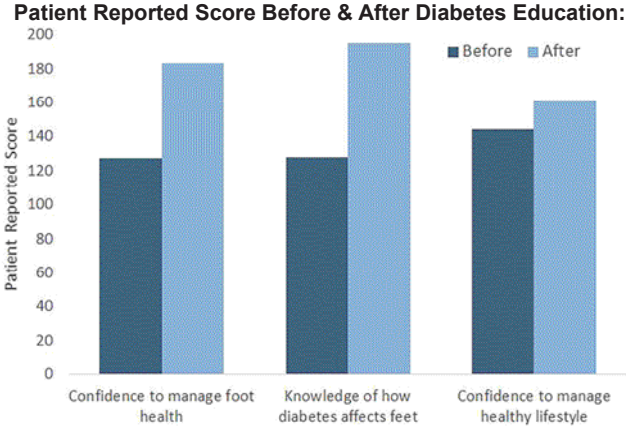
POCKET MEDIC®

PLANNING:

►**Patient Focus Group:** Co-development of group education session. *What would patients like to know?*
►**Swim Lane Method:**To identify risk and inefficiencies for the care of patients with diabetes.
►***Plan, Do, Study, Act:*** To review methods, procedures, progress and outcomes.
►**Patient Reported Outcome Measures:** Are we meeting the patient's needs and expectations?

RESULTS:

Patient Reported Score Before & After Diabetes Education:



FIT WITH PRUDENT HEALTH:

Principle 1: Co-produced Education session and collaboration with Diabetes UK and Pocket Medic;
Principle 2: Increased efficiencies through informative care for those with lower risk of foot disease. Increased capacity for those with foot disease;
Principle 3: Supporting the patients to have confidence to look after themselves, but have easy access to help when they need it; and,
Principle 4: Structured consistent education messages for all in accordance with NG19, 2015.

Bevan mentor: Rhys Howell **Contact:** angela.jones34@wales.nhs.uk

A New Model With a New Hope: Key Teams

Darryn Thomas, Senior Key Team Co-ordinator
Betsi Cadwaladr University Health Board

AIM:

A new model of Primary Care means a new approach to the services available. The introduction of an enhanced non-clinical Key Team co-ordinator within a Primary Care setting, focusing on a more consistent point of contact for patients and professionals and changing the way an administrator works.

CONTEXT:

A new model of care means a new approach to patient care. The introduction of a ***Key Team*** means an MDT approach can offer a better service. The personal approach has been lost throughout the years. Evaluating the needs of the patients, it is vital to build up the consistency of care.

BENEFITS & OUTCOMES:

The Key Team Co-ordinator is the pinnacle point of contact between patient and professional. This role is an administrative role with a difference. Enhanced training means the Co-ordinators can get involved in the clinical care of patients, dealing with more complex requests and providing a more streamlined service.

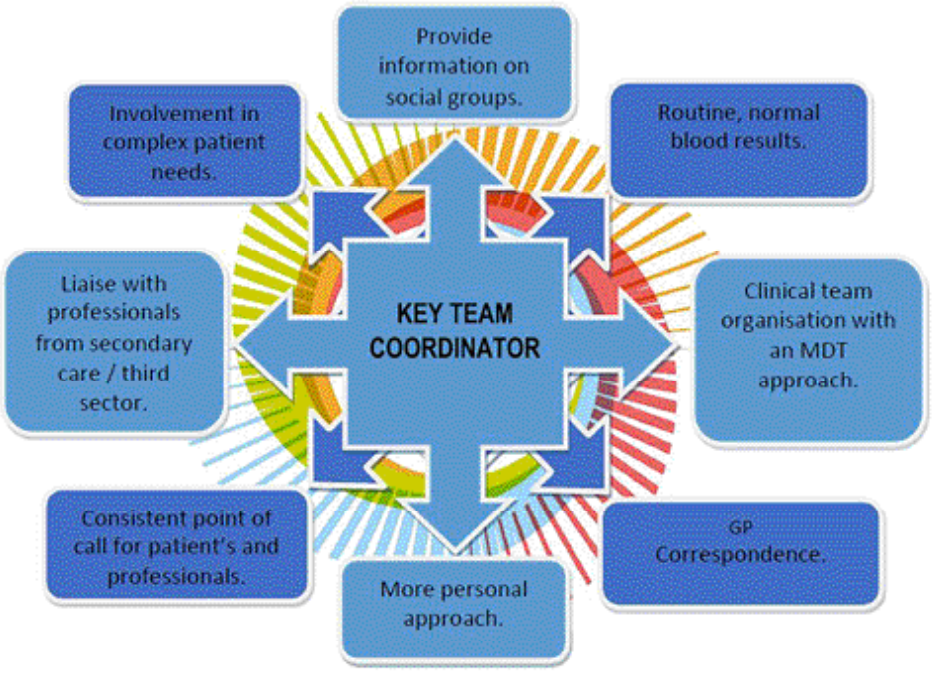
Since the role has commenced, there have been many changes to the role as it matures. These changes are made to ensure that patients receive the best care. At present, the role is proving to be very popular with patients and professionals alike.

FIT WITH PRUDENT HEALTH:

Having a Key Team Co-ordinator means less time needed to get to the right professional and increasing the number of ways to get in touch.
It has given a more personal MDT approach, proving popular to many patients who struggle to access the Primary Care service. With each team focusing on **5-6,000** patients rather than **22,000** as a whole, patients have seen the advantage of a team of people working for their needs,
Educating the patients will still take time and in the first year alone, the different made to the service and care of patients has been proven to be a success so far.

In the first year of the role, there have been over 10,000 patients in which the co-ordinators have helped, without the need for an appointment with a GP. Figure 1 (below left) shows the diversity of the co-ordinator.

The Key Team Co-ordinator also deals with the team diaries and clinical time. As patients are able to be signposted to the relevant professional. The co-ordinators have been able to allow 15-minute appointments for GP's so they are able to deal with more complex cases. This has proven to make the patient feel more at ease and allow them to discuss problems without feeling rushed. These appointment times are standard throughout the new model.



Enhanced training means more administrative work that would previously be done by a GP is now undertaken by the co-ordinator with close supervision to ensure patient safety. This had provided a faster, more efficient and prudent service with patients getting treatment sooner than they previously would have.

Bevan mentor: Helen Howson **Contact:** darryn.thomas@wales.nhs.uk

Reducing Medicines Waste in Care Homes

David Minton, Anne Sprackling, John Dicomidis
Anuerin Bevan University Health Board

AIM:

To reduce medicines waste in care homes through improving the efficiency of medicines ordering.

CONTEXT:

▼Perceived waste of medicines through: over ordering by care home staff; over prescribing by GPs; overly complicated ordering process via community pharmacy; and,
▼Historical work on practice prescribing not altered probable over-prescribing.

PLANNING:

➔Introduce alternative way of homes ordering 'as required' medications; make routine medication ordering more efficient to give confidence to care home staff that when medication is ordered it will be delivered expediently; and,
➔Use MHOL to improve ordering process, speeds ordering up, removes initial step of MAR chart going to pharmacy before prescription request arriving at GP practice. Reduces risk of practice issuing script not required.

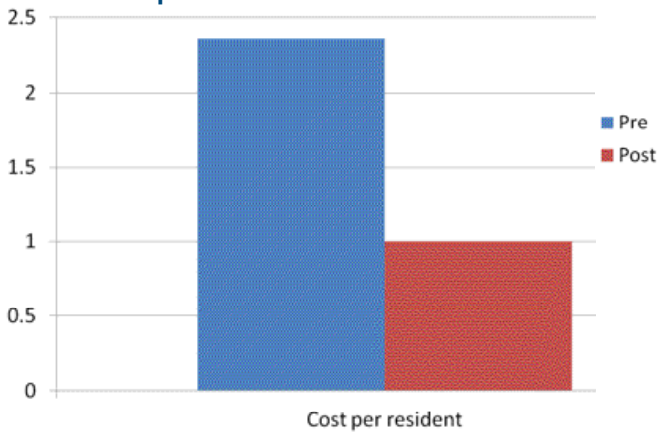
MEASUREMENT:

△Measure level of waste;
△Homes record waste – nursing homes with reason for wast;
△Measure change in wastage;
△Measure 'urgent' script requests if possible;
△Time to order prescription;
△Time to process prescriptions.

IMPACT & BENEFITS:

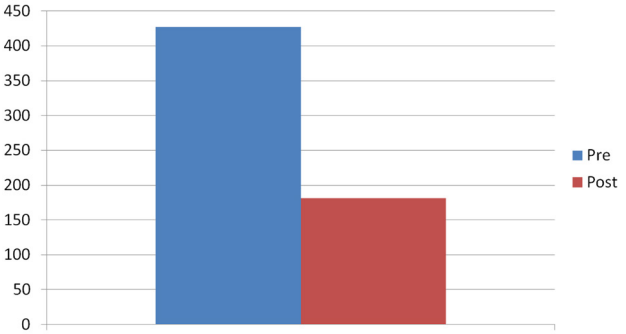
➔Reduce waste = reduce cost
➔Reduce over ordering = reduction in workload for both practices and pharmacies

Waste cost per resident before & after:



➔Increase ownership and understanding of medicines amongst staff = reduction in potential harm to residents
➔Less time at every step in process
➔Feedback from homes to influence future uptake
➔Measure after 6 months to prove waste reduction. If confirms then approach other homes within BGW NCN and other NCNs, further afield as feasible.#

Average monthly waste, before & after:



NEXT STEPS:

↗Proof of concept;
↗Roll out to more homes;
↗Measure time to prove anecdotal time saving;
↗Influence MHOL development – e.g home can log on once rather than for each patient;
↗GP practice views first line of patient address and can view by address; and,
↗Further measurement of waste.

FIT WITH PRUDENT HEALTH:

►By improving the efficiency of repeat prescribing ordering in care homes there is a lesser chance of residents receiving medications unnecessarily and thus reducing harm;
►Potential reduction in costs;
►Greater ownership of the patient's medication by the carers in the home and through education of staff a greater understanding of the residents' medications and further reduction of harm risk;
►Reduced inefficiencies in pharmacies and practices allowing staff to focus on patient care by not being diverted to 'unnecessary' work;
►There is only one step in the ordering process, making identification of any issues possible at an earlier stage.

Contact: david.minton@wales.nhs.uk

Low FODMAP Diet: A New Direction for IBS

Debbie Thomas, Prescribing Support Dietitian
Abertawe Bro Morgannwg University Health Board

CONTEXT:

Irritable bowel syndrome (IBS) has a prevalence in the UK of ~15% and is thought to affect the lives of 1 in 5 people. Symptoms are individual, but are characterised by bloating, abdominal cramps and pain, excessive wind, diarrhoea with 'urgency' and constipation.

Traditional dietary management has limited benefits, but the low **FODMAP** diet is a one-off dietary intervention focusing on the reduction of fermentable carbohydrates and provides better clinical outcomes and improved quality of life.

The low FODMAP Diet:

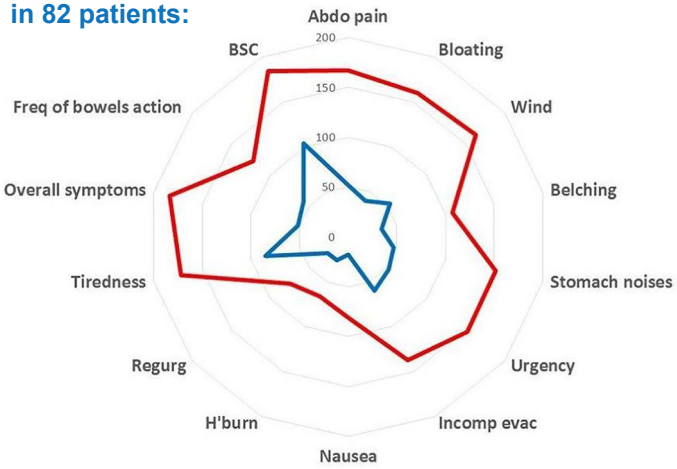
Fermentable carbohydrates known as **FODMAPs** (**F**ermentable **O**ligo-saccharides, **D**i-saccharides, **M**ono-saccharides **A**nd **P**olyols) are fermented by bacteria in the gut resulting in the common symptoms of IBS. Reducing FODMAPs in the diet has been shown to improve gut symptoms in ~75% of people with IBS. FODMAPs are then reintroduced into the diet to identify trigger foods.

BENEFITS:

185 patients from 5 Bridgend Practices were advised on the low **FODMAP** diet locally in their GP Practice. Many of the 82 patients who completed their treatment, describe it as 'life changing' and some even declare they no longer have IBS. The dietary changes are only temporary and usually only 2 consultations are necessary.

Results of a Symptom Questionnaire completed at each session are shown below:

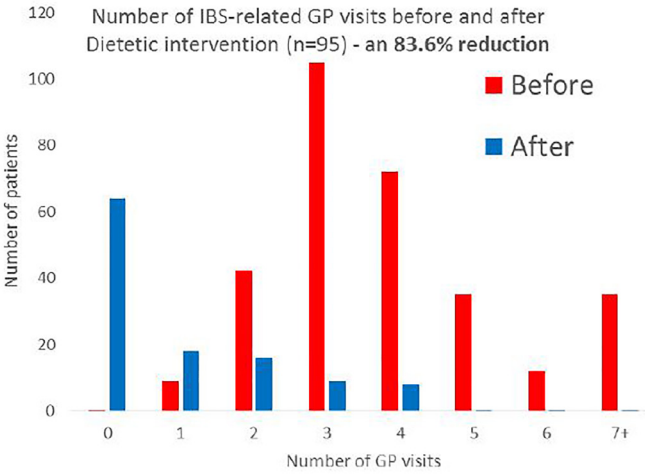
Total symptom reduction in 82 patients:



Additional benefits of the low **FODMAP** diet Intervention with the low **FODMAP** diet has also shown benefits with a reduction of 83.6% in IBS-related GP visits as shown in the graph (below).

A reduction of 6.25% in prescribing of antispasmodic drugs has also been shown as many patients are able to stop/reduce their IBS medication.

Reduction in GP IBS-related visits:



FIT WITH PRUDENT HEALTH:

Principle 1: IBS patients being offered the opportunity to work in partnership to improve their condition and quality of life using an evidence-based treatment plan
Principle 2: Timely referral of those with IBS whose symptoms impact on their life for priority assessment and treatment in their GP Practice
Principle 3: Ensuring that appropriate tests are undertaken to avoid unnecessary delays in treatment. Offering tailor-made advice and support to ensure that unnecessary dietary restriction can be avoided
Principle 4: Positive clinical outcomes from this evidence-based approach should enable adoption across the Health Board and ultimately across Wales, providing equity of treatment for IBS patients

Acknowledgement: PHW Improvement Advisor Andy Ware (1000 Lives)

Bevan mentor: Howard Rowe **Contact:** debbie.thomas7@wales.nhs.uk

Transforming Ward-based Dementia Care

Amy Uren, Senior Nurse
Cwm Taf University Health Board

AIM:

We must make sure that people living with dementia feel safe and listened to, valued and respected, can get the help that they need, can do the things that matter to them and live in a place that suits them and their lives.

CONTEXT:

As the population ages, the demographic nature of general ward populations is changing. A recent survey revealed that almost 3 in 4 general hospital beds in Cwm Taf were occupied by patients over 65 and 1 in 4 beds were occupied by someone identified as suffering from dementia. People living with a form of dementia and their carers are some of our most vulnerable patients, and we should aspire to deliver the very best for those who are potentially at risk of being excluded from so much that matters to them.

DEVELOPMENT:

Traditionally, institutional care for older people with dementia has been arranged according to the medical model which is focused on the physical and biological aspects of specific diseases and conditions. Enhancing the support for people with long-term conditions is critical. If we aspire to deliver world class quality care we need to do things differently and remove barriers to ensure that people are getting the right care, in the right place at the right time.

Our plan is centred on a more effective focus on safety, quality and improved outcomes. The approach involves dementia friendly changes to the routine on the ward with a focus on individualised care.

Patients wake up naturally in their own time, can do activities that are meaningful for the person. Often, meaning is tied to past occupation or hobbies, so what's meaningful for one person might not be so for another, dressing as they would at home, spending time socialising with other patients in a dementia friendly homelike dayroom environment and normalisation of daily life.

Changes to the physical environment including comfortable seating, a change in colour scheme evidenced to help people with dementia recognise key areas were also required to support changes to routine, and ensure care is patient-centred, safe and that the environment is dementia friendly.

IMPACT:

Relatives have given the following feedback:

"My mother has had a lovely experience this time, the day room has had a positive effect on my mother's recovery. It's been so nice to see my mother interacting with other patients."

"Mrs V, has been attending the day room. The carers have been involved. A lot of attention provided for patients needs of simulation."

"What a fabulous surprise to visit my dad today in the day room."

"Thank you for this facility and all who work here as it brightens my mothers day."

FIT WITH PRUDENT HEALTH:

►Collaboration between patients and all connected with them is crucial to their health and their wellbeing. This initiative aspires to enhance long-term outcomes and quality of life for patients with dementia;
►Adopting the principles of John's Campaign within community hospitals means we are supporting and encouraging the continued connection between carers and those who need their care regardless of the environment that they are in;
►Families are recognised as more than "visitors" to a person with dementia; they are an integral part of that person's life and identity and often their last and best means of connection with the world.

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Facing the Future as One Service

Margaret Devonald-Morris, Service Delivery Manager
Hywel Dda University Health Board

SCOPE:

Hywel Dda's Children's Community Integrated Nursing Service has been a pilot project bringing together two small nursing workforces, generic and continuing care into one community team. It has also allowed a separated assessment capability which focuses on needs assessment & care provision recommendations from care package management.

CONTEXT:

Hywel Dda University Health Board is the second sparsely populated Local Health Board in Wales serving a 0-18 years population of 71,058 across the counties of Carmarthenshire, Ceredigion and Pembrokeshire.

Starting Position – February 2016:

Children's Continuing Care Nurses x 3:

►1 based in Ceredigion
►1 based in Pembrokeshire
►1 based in Carmarthenshire
= managed by 1 team leader.

The nurses undertook the continuing care assessment process and managed a total of 16 packages averaging 800 care hours/week delivered by the third sector. Seven packages located in Carmarthenshire, six packages in Pembrokeshire and three in Ceredigion resulting in the Ceredigion nurse having to travel from North Ceredigion to manage a package in both Pembrokeshire and Carmarthenshire. In addition there was one WellChild Transitional Care Nurse based in Carmarthenshire working across both services.

Generic Children's Community Nurses x 6.5

►3 based in Pembrokeshire of which 0.8 was the Team Leader
►3 based in Carmarthenshire of which 0.2 is the Practice Teacher
►0.5 based in Ceredigion

A caseload of 270 children and young people (CYP) across the three counties with varying health needs including long term, life limiting and complex health needs. A number of the CYP were defined as being inactive i.e. no nurse contact for 4 weeks. In Pembrokeshire there is an additional 0.48 nursing post funded by education-based in specialist school. Due to the Children's Continuing Care Team Leader securing another post led to a review of how the workforce continues to meet its service demand. It provided the opportunity to pilot the integration of the two small nursing workforces and funding to recruit 1.26 WTE Band 5 nurses and additional 5 hours for the Team Leader post. Agreement from the nursing workforce and planning for the pilot began in February 2016 with the start of a six-month pilot from March 1, 2017. Participatory action research approach was applied as a reflective process of progressive problem solving.

PLANNING & DEVELOPMENT:

The planning process involved the team undertaking an analysis of the strengths, weaknesses, opportunities and threats, barriers and counter measures leading to the development of pilot objectives, education programmes, a review and development to the teaching library resource and the implementation of a single nurse assessor role for the continuing care process. Nurse bases were reviewed with two sites in Ceredigion-north and south, two sites in Carmarthenshire-east and west, and two sites in Pembrokeshire-mid and south.

The development of a traffic light system provided a risk framework to support the delivery of an equitable, safe and sustainable children's community nursing service.

BENEFITS:

➔The risk framework facilitated implementation of the centralised referral system;
➔Initiated the pilot of a nurse led clinic service for CYP requiring overnight oxygen saturation monitoring Instead of receiving home visit by a nurse, the CYP attends the clinic to collect and return saturation monitor the next day for the nurse to download their recordings for review by the prescribing doctor.

At the end of the six months, there was agreement that we cannot return to being two teams, maintain the nurse assessor role and review in 3 months.

FIT WITH PRUDENT HEALTH:

►The pilot facilitated the development of an in-house education programme, mentoring/buddy system to support the development/updating of nursing knowledge and skills;
►The integration of two small nursing workforces maximises clinical capacity by having nurses based across six sites;
►The risk framework promotes the identification for the right practitioner, providing the right care at the right time and right place, acknowledging the need for further service mapping.

Contact: margaret.devonald-morris@wales.nhs.uk

Pharmacy + Admissions Unit = >Safety?

Kieron Power, Lead Pharmacist for Elderly Care
Abertawe Bro Morgannwg University Health Board

CONTEXT:

Medicines reconciliation (MR) is defined by NICE as *"the process of identifying the most accurate list of a patient's current medication and comparing it with the list currently in use, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications accurately communicated".* **The absence of this process when patients are transferred between care settings can lead to medication errors and omissions, and potential harm.**

While MR is the responsibility of all healthcare professionals involved in medicines management, in practice it is pharmacists who generally undertake this role in a hospital setting; collecting a medication history from a variety of sources, checking this against the drug chart written by a doctor on admission and communicating any discrepancies to the prescriber for action. MR has always been a retrospective process, undertaken after the prescriber has completed the clerking. NICE recommend that medicines reconciliation must be completed within 24 hours of a patient being admitted. Baseline data from the Singleton Admission Unit (SAU) identified a 45% error rate and 15 hours mean time to reconciliation (Table 1). During the window from admission to reconciliation, a patient is at a higher risk of potential harm due to medication error or omission.
Our challenge was to re-engineer pharmacy services on an admissions unit to reduce these risks.

PLANNING & DEVELOPMENT:

We have:
➔Trained more pharmacy technician staff in drug history taking and medicines reconciliation;
➔Repositioned the pharmacy team (a pharmacist and technician) to the start of the admissions process, to undertake prospective medicines reconciliation;
➔Extended the time the pharmacy team spend in the admissions unit from 9am to 11am to 9am to 8pm; and,
➔Had agreement that pharmacist write drug charts prior to doctor seeing patient, which the doctors sign after clerking the patient.

KEY FINDINGS:

↗For almost 70% of admissions via SAU, the pharmacy team are first healthcare professionals to have contact with the patient. Prospective MR is performed for these patients;
↗Compared to baseline data;
↗The mean time for MR for all patients admitted via SAU fallen from 15 hours to 3.5 hours (see the table below):

	Baseline data	Following Intervention	
	Dr (In hours)	*Dr (Out of hours)*	*Pharmacist*
Total Items	100	342	267
Total Errors	45 (45.0%)	144 (42.1%)	7 (2.6%)
Type of errors			
Omission	38	120	1
Dose error	7	22	2
Other	0	2	4
Average Time to first pharmacy contact	15 hours	3hr 31 min	

↗There has been a considerable reduction in patients who leave the admission ward without MR performed (33% to 6%); and,
↗Pharmacist transcribing onto drug charts following prospective reconciliation has reduced prescribing error rate from above 40% to 2.6% (See the table above).

FIT WITH PRUDENT HEALTH:

► There is no recommendation as to where MR should be performed in an acute care setting, only that it should be performed within 24 hours of admission, at the point where patients' *healthcare needs are at their greatest.*

This project demonstrates that prospective MR at the point of admission reduces risk with regard to medicines error or omission, *improving patient safety, and reduces harm*. Through an effective training programme and standardised process, there is a reduction in inappropriate variation. Patients are given the opportunity to discuss their medication, allowing them to *feel engaged* with their medication.

Bevan mentor: Chris Martin
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App to support Community Dementia Triage

Clive Thomas, Primary Mental Health Link Practitioner
Abertawe Bro Morgannwg University Health Board

SCOPE:

The Community Dementia Support Teams in ABMU are using an electronic app called *CANTAB* Mobile to help triage for clinically significant memory impairment.

The team are using this to expedite appropriate referrals to the Memory Assessment Service by 'screening in' only those with a clinically significant memory impairment. This is helping to tackle the issue of poor dementia diagnostic rates by encouraging GPs to identify those patients who are at risk and who they think would benefit from more in-depth cognitive assessment. This represents a significant saving and more efficient use of current resources.

PLANNING & DEVELOPMENT:

The project is delivered through The Bevan Commission's Health Technology Exemplar Programme and its partners in industry, Cambridge Cognition. This collaboration has enabled the purchase of multiple use licenses for use by Dementia Support Workers who can now deliver a robust method of triage for clinically significant memory impairment in the patient's own home. This ensures faster signposting to the appropriate pathway and further supports the Welsh Government initiative to employ Dementia Support Workers within Primary Care to help improve dementia diagnosis.

The ***CANTAB*** Mobile is an effective test of cognition and is 100% sensitive and 92% specific in detecting Alzheimer's disease (AD). It uses Paired Associates learning to detect changes to memory and uses a touch-screen i-Pad to show a sequence of abstract shapes.

Unlike other paper-based cognitive tests there is no reliance on fine motor skills to draw or write. Although not diagnostic, the results are easy to interpret and using a traffic light system (in which RED means clinically significant impairment) it is useful in helping to broach the subject of dementia with both the family and GP alike.

The test highlights the need for further in-depth cognitive testing and is suitable for administering by both qualified and unqualified staff.

The voiceover instructions are available in multiple languages, including Welsh, making it highly accessible to all patients.

BENEFIT & IMPACT:

Access to a robust method of triage is essential and the ***CANTAB*** Mobile test means that GPs can now action referrals to Specialist Memory Services with confidence. Not only does this screen out unnecessary referrals and reduce burden on existing resources but has also helped to explore new pathways to diagnosis.

By foremost raising awareness of the need to diagnose dementia, patients can then be signposted for appropriate help. In ABMU, the ***CANTAB*** has been very successful in triaging for clinically significant memory impairment and is recommended as a suitable precursor for all referrals to Memory Assessment Services throughout Wales.

FIT WITH PRUDENT HEALTH:

The CANTAB rapidly establishes whether memory impairment is clinically significant or not and highlights the need to diagnose dementia. It identifies early those patients who need referral for more in-depth cognitive testing whilst also identifying those patients that don't. Included within the test is the Geriatric Depression Scale and Activities of Daily Living, which can also help signpost patients for treatment other than dementia where indicated. This represents significant progress in terms of more efficient use of resources in line with the principles of Prudent Healthcare

Bevan mentor: Theresa Richards **Contact:** clive.thomas@wales.nhs.uk

Catching Children's Continence

Jennifer Walsh, Community Children's Nurse
Powys Teaching Health Board

CONTEXT:

NICE estimate 900,000 children and young people suffer with continence problems, that is bladder and bowel dysfunction. Put simply, one in every 12 children will have wetting and soiling problems, but only one in three families will seek help. The impact of having continence issues will have a profound effect on their self esteem, education, family and social relationships. This can affect them into adulthood, and has the ability to prevent them from reaching their full potential.

THE PROJECT:

1. Scoping current service provision for child and family with continence issues in Powys: Findings indicate lack of absence of service provision;
2. Exploration of current governance that establishing an integrated community-based paediatric continence service has the potential to reduce emergency admissions by 80%, and a significant reduction in consultant led OPD (constipation/ bedwetting are now the most common reasons for referral); and,
3. Introduction of a new service pathway for paediatric continence.

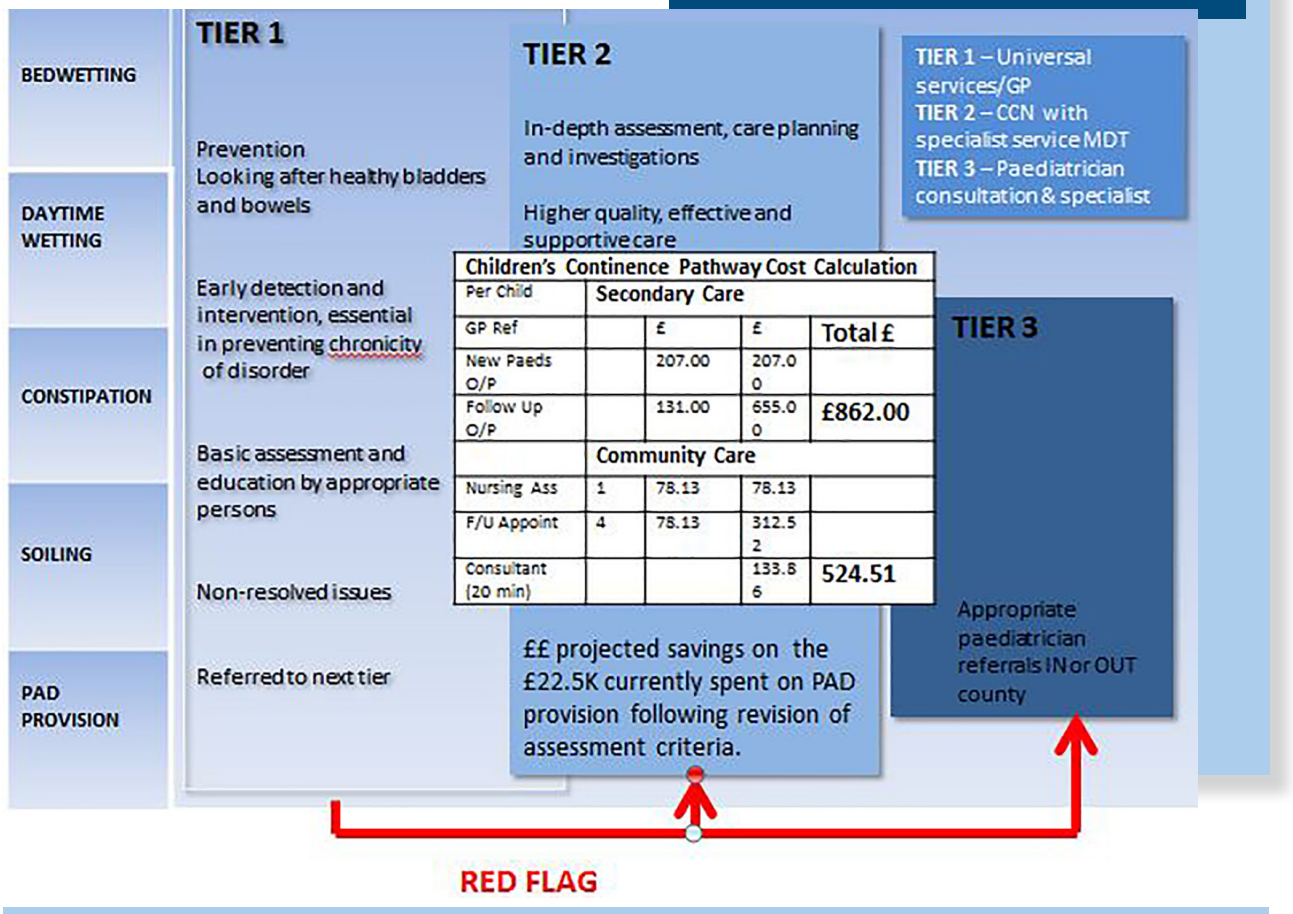
FIT WITH PRUDENT HEALTH:

► Governance call for all areas to have a single integrated paediatric continence service for all bedwetting, constipation and soiling issues;

►Supporting self care through equal partnership. ERIC unites children, families and professionals to co-produce outcomes based on best practice;

► Motivate and empower children and their families to gain greater control over their own continence health, decreasing emotional distress; and,

►Shifting services to community based care, and access to timely and effective treatment will reduce complications, and result in acute problems not becoming chronic, thus reducing subsequent future resource demand.



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Good News 4 Home

Chris Peter Subbe, Acute Medicine Consultant
Betsi Cadwaladr University Health Board

CONTEXT:

Can I go home? Will I be ok?
We finally have an answer using routine NHS data that is available today at every bed side in Welsh hospitals

Discharge decisions are complex but involve the diagnosis of 'stability' prior to transfer from an acute hospital to the community, be it the patients' own home or a rehabilitation facility.

Defining in-stability:
The National Early Warning Score (***NEWS***) is generated from vital signs that are being collected by nurses in hospitalised patients. ***NEWS*** is being used throughout all hospitals in Wales as a tool to identify patients at risk of catastrophic deterioration on general wards. Patients with higher scores have a higher risk to die, to suffer cardiac arrests, to be admitted to Critical Care or to require a prolonged hospital stay

How about the reverse?
If high scores identify patients who require high levels of care in hospital, can low scores identify patients who are likely to be able to leave hospital safely? After what period of time with a low value of NEWS is the risk to suffer adverse events so low that allowing patients to return to their own home or in other community settings would represent a more patient centred and cost-effective way to care?

The National Early Warning Score (NEWS):

Physiological Parameters		3	2	1	0	1	2	3
A	Respiratory rate (bpm)	≤8		9-11	12-20		21-24	≥25
B	O2 Saturations (%)	≤91	92-93	94-95	≥96			
	Any supplemental Oxygen		Yes		None			
C	Systolic BP (mmHg)	≤90	91-100	101-110	111-219			≥220
	Pulse (bpm)	≤40		41-50	51-90	91-110	111-130	≥131
D	AVPU score				Alert			VPU
E	Temperature (°C)	≤35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥39.1	

Concern about a patient should lead to escalation, regardless of the score.

PLANNING & DEVELOPMENT:

Good NEWS 4 Home: Machine learning at bedside:
As part of a collaboration with Philips Healthcare Betsi Cadwaladr University Health Board has got clinical areas which record electronically all ***NEWS*** scores and basic patient characteristics. These provide the setting for a high-impact low-cost intervention:
We used Random Forest Analysis, a form of machine learning, to review data from a sub-group of 1,451 patients to generate a stability indicator that takes values from -1 (very unstable) to +1 (very stable). Mean age of patients was 69 years (+/- 18).
866 patients achieved a stability indicator value of +1. Of these 473 patients had a stability indicator of +1 for more than 24 hours, 318 achieved the value for 24-48 hours, 273 to 72 hours and 257 for 92 hours or more.
No patient had a period of deterioration with a ***NEWS*** score of 6 or more after a value of +1 of the indicator.

Together with a team from Philips Healthcare we have:
➔Analysed routine data from patients admitted to hospital to generate a novel 'stability index' that takes value from -1 (very unstable) to +1 (very stable);
➔Tested the algorithm in simulation in a sample of patients admitted to the Ysbyty Gwynedd in Bangor;
➔Confirmed acceptability of the algorithm to nursing and medical team members in two focus groups; and,
➔Planned prospective implementation as part of a digital healthcare solution.

FIT WITH PRUDENT HEALTH:

Prudent Principle 1: Good NEWS 4 Home was co-designed with an award winning team of clinicians from secondary care;
Prudent Principle 2: Good NEWS 4 Home allows to make the most effective use of the limited bed-base in secondary care;
Prudent Principle 3: Good NEWS 4 Home permits the limiting of hospital stay to a time when it is needed for safety of patients; and,
Prudent Principle 4: Good NEWS 4 Home uses the universally available National Early Warning Score to introduce objective criteria for transfer of patients from acute hospitals.

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Supporting Cancer Services in Primary Care

Elise Lang, Macmillan GP Cancer Lead
Velindre NHS Trust

CONTEXT:

1 in 2 people are expected to develop cancer in their lifetime, by 2020 150,000 people in Wales will be living after a cancer diagnosis (5% of the population). For those who have completed their treatment cancer must be managed in collaboration with primary care as a chronic condition - this is often more appropriate for patients and supports prudent use of limited health resources. To facilitate this there needs to be increased support for primary care.

AIM:

We are helping a cohort of interested GPs to develop a special interest in oncology to become local specialists in their communities. We are also delivering training across the board to primary care clinicians to increase knowledge in all areas of cancer, from referral criteria to long-term consequences of treatment.

The aim is to be a leading UK educational centre for oncology supporting, medical students, GP trainees and primary care teams to deliver excellent holistic patient care locally and to help support recruitment and retention of clinicians to primary care in Wales.

PLANNING & DEVELOPMENT:

As part of the Macmillan framework for cancer, I have been working in Velindre Cancer Centre alongside clinical staff and their '*Transforming Cancer Services*' team. We have been reviewing their relationships with primary care and forging new approaches. We have reviewed the content and timeliness of information shared with primary care and are improving communication in both directions.

We have adapted the content of the primary care letter to a more standardised format with salient points and information highlighted. We have surveyed the general practitioners in South Wales to identify their appetite for further learning and the format that that should take. We are changing ways of working and adapting to The current and future population's non-surgical cancer needs.

A total of 198 GPs responded to our engagement survey and provided feedback on current service and requirements of potential learning opportunities. The data identified learning needs, 40 GPs provided their contact details to be contacted directly about educational opportunities. Further meetings involving Macmillan and Velindre have proposed a direction of travel and we will be hosting an educational event in September.

Moving forward we will be looking towards universities to consider developing a postgraduate level qualification in primary care oncology.

We will be developing roles for some of these GPs To work with the cancer centre in out-patient departments and learning from each other to provide excellent patient care.

FIT WITH PRUDENT HEALTH:

Prudent Principle 1: Empowering primary care to manage oncology follow up and survivors, utilising the resources already available in primary care. mproving well being of patients through access to local services and availability of local GP champions. It will reduce travel time to attend specialist clinics, when they can see a GP locally;
Prudent Principle 2: This allows staff to be focused on acute, priority patients and allows cancer survivors care to be handed back to empowered GPs. It will reduce follow up appointments in the specialist setting, therefore freeing specialist time to focus on acute/new patients;
Prudent Principle 3: General practice is perfectly positioned to manage cancer survivors and request appropriate investigations as they have been advised to do through educational events. Including investigation and referral onwards, or management locally, avoid repetition of tests, eg through better communicaton/info sharing; and,
Prudent Principle 4: Standardised training for GP champions should remove variation in management and close liaison with oncology leads should support clinicians through more difficult cases.

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Making Sense of Food

Rhianon Urquhart, Principal Health Promotion Specialist
Public Health Wales

CONTEXT:

Trying to understand how people choose the food they eat and the impact it has on their health is really complex - see (the figure below), which visualises how complex the issue we face. Trying to force change on people and their food choices is even harder. Research shows that those who need the healthiest food the most find it hardest to access – for this project, we've called this the Inverse Food Law.

AIM:

We have been trying to find a way to change people's food choices for the better where there's little agreement on what needs to be done and a lack of certainty about the best way forward. To start with, we have brought together a number of stakeholders from different agencies and interests to help them understand each other in order that they can work together more effectively.

Secondly, we have been working with residents to better understand how different determinants impact on their food choices - with the support of our partner agencies.

We will collect this information using the ***SenseMaker*** system, and then use those insights to guide the actions and interventions of the newly established Food Vale partnership as a whole.

PLANNING:

Getting the different stakeholders interested, involved and sharing resources has taken a lot of effort but has laid the foundations for the long-term impact of this project.

FIT WITH PRUDENT HEALTH:

The time taken to *co-produce* the Food Vale approach has been challenging but rewarding
We are targeting those in *greatest need* in the more deprived areas within the Vale. We aim to *do only what's needed* using the insights from Sensemaker and Network members. We aim to *reduce variation in access* and affordability of healthy foods.

There's an old African Proverb which says *'if you want to go fast, go alone. If you want to go far, go together.'* We want Food Vale to go far, which has meant putting a great deal of effort into this part of the process.

It's also very easy to be busy, but harder to achieve and make long-term change. The Bevan Commission has provided the opportunity to reflect on how to approach and develop this work and the time to talk and share ideas has been invaluable.

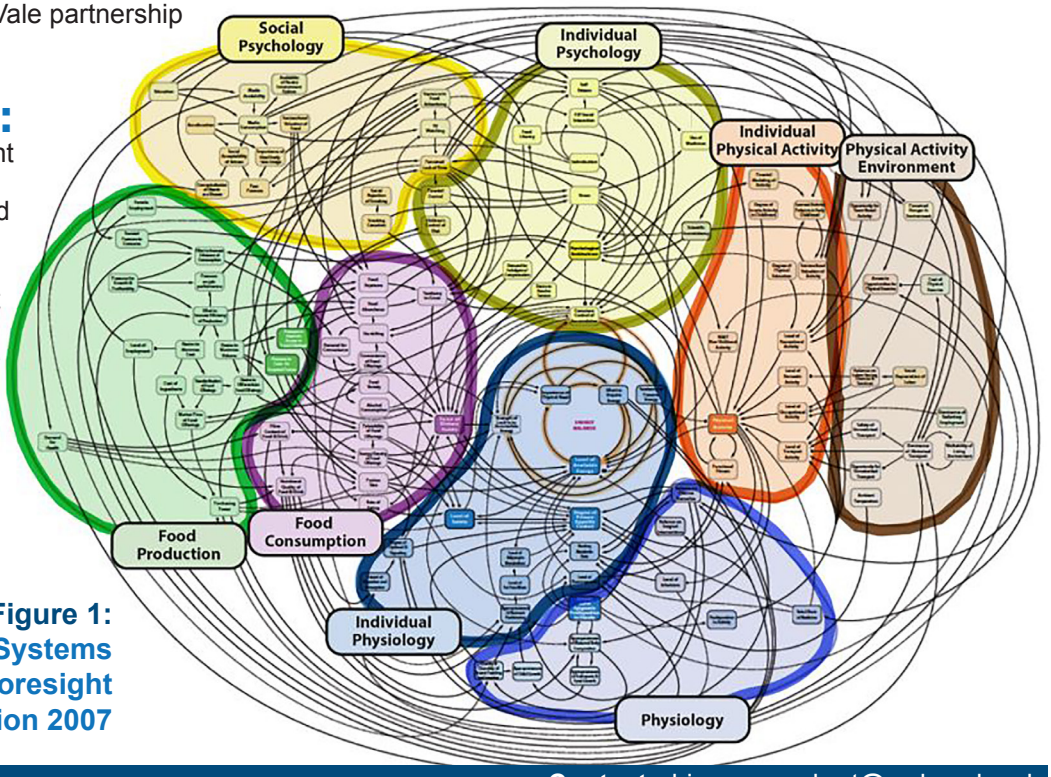

Figure 1: The Obesity Systems Map, Foresight Commission 2007

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Electrifying the Handheld Maternity Record

Marie Lewis, Practice Development Midwife
Powys Teaching Health Board

CONTEXT:

Imagine: You are pregnant, you are receiving care from several people in different locations, you have complex needs and are required to tell your story to every clinician that provides your care, over and over and over again.

Imagine: You are a midwife, you are passionate about providing good clinical care to pregnant women but you spend most of your time completing paperwork by hand, you spend several hours with a woman completing her handheld record and then you give it to her to keep. You now have to repeat the information onto separate sheets and transcribe it to different information systems.

The current hand held paper document used in Wales is reliant on a woman to remember to take it with her, reliant on colleagues in different organisations to update it and there is no back up copy should the record be lost or damaged. Powys is a large rural county which does not have its own district general hospital, pregnancy care is shared across a wide geographical area and feeds into 11 different district general hospitals across both England and Wales. Communication and sharing information relevant to the client pathway is problematic and time consuming.

AIM:

The overall aim is to reduce risk from loss of information, improve communication with all data available at the time and place that a woman is seen, to have a system that will work across both community and hospital settings but complies with the All Wales pregnancy record format and to develop the system so that it has connectivity to other data systems, such as Myrddin to allow for automatic data transfer when required. The initial project will be to provide a proof of concept for development with NWIS to enable an across Wales approach and to evaluate acceptability for use with both women using the service and the midwives.

PLANNING & DEVELOPMENT:

We have partnered with Symlconnect to develop a proof of concept prototype for a smart electronic maternity record that women can have as an app on their own device. We are using PDSA cycles to develop the technology and to input smart guidelines to make the record more effective.

Methods include:

➔Mapping the current process and pathways;
➔Collecting data from time assessments;
➔Missing information mapping;
➔Identifying the risks and mitigating them;
➔Privacy impact assessments.

GOALS:

Our ultimate goal is to produce an interactive electronic pregnancy record with the capability to connect to other healthcare electronic systems. And also to:

➔Develop the backdrop for the All Wales pregnancy hand held record electronic format;
➔To develop links and smart technology to include alerts for midwives;
➔To develop an app for women that they can download to their own IT as a read only copy;
➔Test usability from both the midwives and the woman's perspective;
➔Develop a prototype ready for demonstration to NWIS and ready for a further project to explore connectivity with other health care systems.

So far we have:

➔Formed a project group with Powys midwives, Symlconnect and Powys LHB managers;
➔We have reviewed the current hand held record and made suggestions for how this could be transferred into the electronic format, basic data entry, drop down menus etc;
➔We have reviewed local and national guidelines and begun to identify key aspects that could form part of the smart alerts for the midwives;

SymlConnect are building the basic electronic platform for us to test. We have made good progress but we are not finished and the work will continue over the next six months to develop the prototype. The pilot project to test with live data is likely to take 1-2 years.

FIT WITH PRUDENT HEALTH:

► Estimated clinical efficiency with information access on-demand, right time, right place.;
► Reduction of errors and duplications; and,
► Potential time saving by midwives, reduction in waste.

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Community Paramedic Pilot: A Safe, Sustainable & Shared Alternative to A&E; A Partnership Approach *(interim report June 2017)*

Roger John, Adv Paramedic Practitioner & Gwen Kohler, Financial Planning Manager
Welsh Ambulance Service NHS Trust

SCOPE:

A joint initiative instigated by the Welsh Ambulance Service NHS Trust (WAST) in partnership with St Johns General Practice and Cwm Taf University Health Board (CTUHB). Exploring the potential to reduce conveyance, accident and emergency attendances, hospital admissions and to increase GP capacity. This is a 12-month pilot where paramedics are supporting the Multi-Disciplinary Team model.

CONTEXT:

We know that:
▼Capacity is stretched within General Practice particularly home visits;
▼There is pressure of increasing demand within accident and emergency departments;
▼In line with national trends there is a high percentage and increasing number of elderly patients on the practice register, plus the patient demand from 8+ care homes; and,
▼We need to work across organisational boundaries to deliver patient focused care, which is founded by the principles of prudent healthcare.

PLANNING & DEVELOPMENT:

Patients are referred to a 'Virtual Ward' with reference to their frailty, multiple complex health and social care needs. Individual care plans are developed and agreed through a multi-disciplinary team approach which include allied healthcare professionals, paramedics, social care and GPs.

FEEDBACK:

"The paramedics have been a great help and support to the GPs in managing a large percentage of home visits"
Practice Manager St Johns Medical Practice

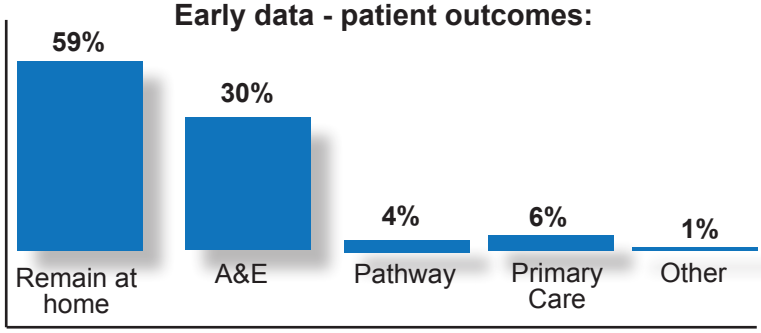
"It was nicer to be treated at home rather than the hustle and bustle of hours at A&E"
Extract from patient feedback

"Being Involved in this trial allows me to take multiple high quality health care skills to a patients front door, and if safe to do so treat them at home"
Community Paramedic

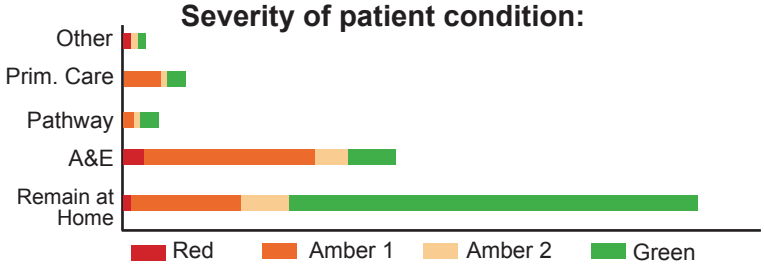
Paramedics undertake home visits to deliver care packages on behalf of the practice. There is a focus on providing care which will enable patients wherever possible to remain at home safely. Clinical Supervision is in place, with regular case reviews with both WAST, GP and CTUHB. This is a new way of working together to ensure patients see the "right clinician at the right time".

Initial results indicate *(February to July 2017)

Early data - patient outcomes:



Severity of patient condition:



OUTCOMES:

Initial outcomes suggest:

➔Facilitation of advanced care planning and raised standards of care resulting in increased patient satisfaction and improved outcomes *(through partnership & co-production)*;

➔Reduction in the number of A&E attendances/unplanned admissions, for a number of individuals *(do only what is needed)*;

➔Increased GP capacity and improved access as a result of the reduction in disruption of home visits *(most effective use of skills)*;

➔Potential to improve response times for non-life threatening calls (amber) *(reduce inappropriate variation).*

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Waiting in Pain? Access to Palliative Radiotherapy

Steve Hill, Palliative Radiographer
Velindre NHS Trust

CONTEXT:

Imagine: You have been diagnosed with cancer, and then you have been told it is not curable and treatment is now palliative. Imagine one day that you are suffering with a multitude of symptoms, and the medication does not help.

You need radiotherapy (RT), and your treatment is scheduled sometime within the next two weeks. How would this affect your quality of life? Could you do the things you want to do? With time being short.

Any solution needed to have a patient centred approach, involving everyone as equally as possible without demanding too much of the patients precious time.

In Velindre Cancer Centre (VCC), approximately 1621 patients per year are receiving palliative radiotherapy, (1341 palliatives and 280 emergency patients), which is approx 39.7% of total radiotherapy patients in VCC and 7355 fractions (sessions) of RT. A recent telephone palliative patient experience survey carried out at VCC asked what symptoms they experienced and found 45% of patients have had symptoms for over 3 months, while 69% having had their symptoms over one month.

PLANNING & DEVELOPMENT:

Identifying what problems the patients were facing and why they were delayed helped the team identify where the greatest need was first four months worth of data was then collected and analysed along with swimlane mapping and calculating Opportunity Costs for past, present and future developments.

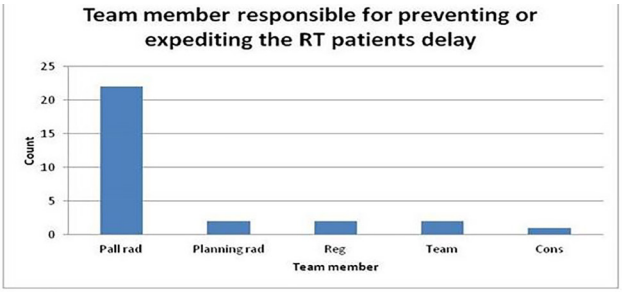
KEY FINDINGS:

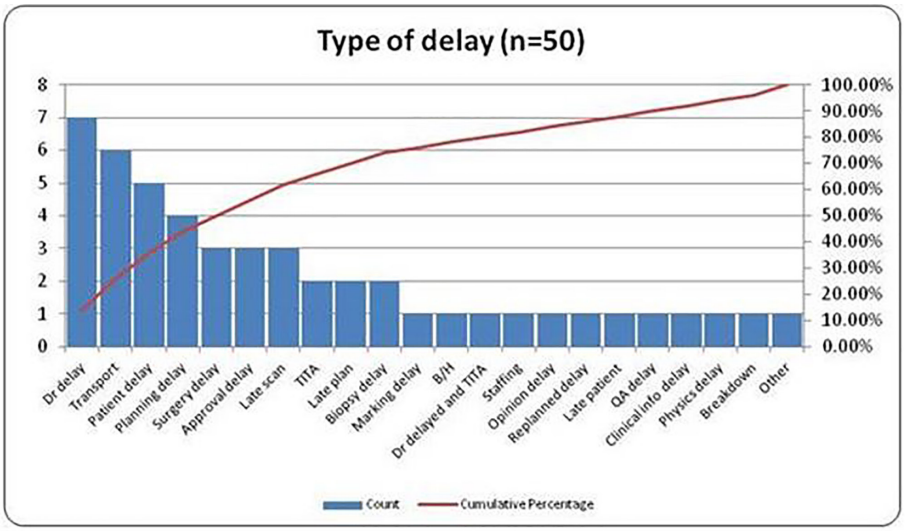
The Royal College of Radiologists (RCR) recommend the gold standard from referral to starting RT for all emergencies is 24 hours (acceptable is 48 hours) and palliatives is 2 days (accepted is 14 days) (RCR, 2005).

The service at VCC before May 2016 delivered an average referral to starting RT time for emergencies of 1.14 days and 5.45 days for palliative patients. Although acceptable, it was found this causes a disruption 51 % of the time to a busy Outpatient department. The palliative radiographer and team at VCC identified a need to develop a rapid-access service onto Palliative Radiotherapy, to reduce the wait from referral to treatment time (RTT) with little or no disruption to outpatients and deliver the expected quality of care. This was piloted from May 2017.

Data analysis showed that days the palliative radiographer undertook tasks on behalf of the medic had significantly shorter cycle times and expedited delays.

Figure shows palliative radiographer expediting or preventing delays for palliative patients:





FUTURE:

By adopting more of the roles traditionally performed by the medical staff could further reduce RTT. This scenario has been swimlane mapped and an opportunity cost analysed.

Further development of an advanced palliative radiographer role across Wales to further improve patient experience and reduce disruption to outpatients could save £211,224 per year at least.

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Co-producing Solutions to Hip & Knee Problems

Naomi Stanton, GP
Cwm Taf University Health Board

CONTEXT:

Collectively, musculoskeletal conditions are the greatest cause of disability in the UK accounting for a third of years lived with disability. Between 1990 and 2010 the disability due to OA has increased by 16%.

Cwm Taf University Health Board has among the highest rate of referrals to orthopaedics and the highest rate of conversions to surgery in Wales. GP referrals to orthopaedics in Cwm Taf are above the Welsh average, with an average of around 800 referrals per month.

The World Health Organisation (WHO) defines Health Literacy as: "… personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health."

Health Literacy is a key determinant of health. There is a strong correlation between low literacy and low numeracy skills and poor health literacy. Poor Health Literacy in turn is associated with poorer health and poorer health outcomes. Poor health literacy is associated with increased hospital admissions and readmissions, less participation in preventive activities, higher prevalence of health risk factors, poorer self-management of chronic conditions and poorer disease outcomes, lower functional status and increased mortality. Improving Health Literacy is a key priority for WHO and Royal College of General Practitioners and the Welsh Government because of the link between poor Health Literacy and poor health outcomes, and is also an enabler to reduce health inequalities.

AIM:

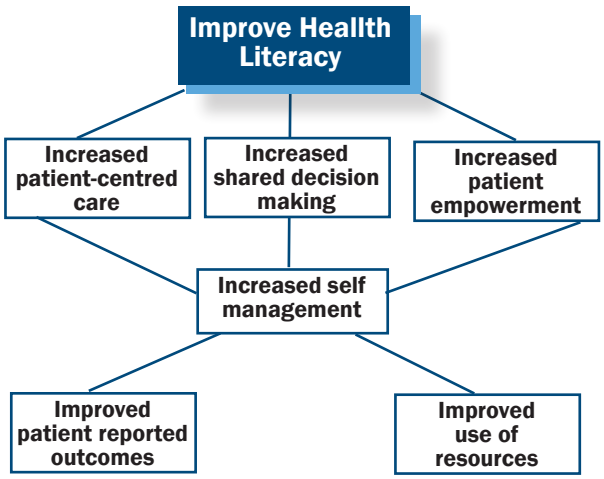
The overall project aim is to tailor interventions based on Health Literacy baseline levels to improve this asset in order to allow patients to choose alternative strategies for management and to ensure more appropriate selection of patients for surgery through working with citizens and local communities to co-design solutions to their health needs.

PLANNING & DEVELOPMENT:

Phases 1 and 2 are currently underway.

Phase 1:

➔Establish baseline Health Literacy levels for patients with hip or knee joint pain who have been referred by their GP to secondary care; and,



➔Conduct a narrative review of co-production use in healthcare.

Phase 2:

➔Three workshops:

Workshop 1 Citizens:
To co-design interventions to improve self-management of their condition and develop tools to help informed, shared decisions about management options;

Workshop 2 Healthcare Professionals:
Healthcare professionals such as orthopaedic surgeon and physiotherapists to discuss their understanding of the challenges and solutions;

Workshop 3 Citizens & Healthcare Professionals:
Workshop to allow citizens and healthcare professionals to co-design interventions. Evaluate the co-production sessions.

Phase 3:

➔Implement the interventions co-designed on a new cohort of 100 patients referred in by their GP.

Phase 4:

➔Evaluate interventions regarding impact on patient decisions about management options including a cost-effectiveness analysis. Evaluate Health Literacy following co-design events and implementation of interventions.

FIT WITH PRUDENT HEALTH:

►Co-designing solutions locally improves uptake and use of tools through ownership;
►Improving health literacy empowers patients to work with healthcare professionals to derive a more patient-centred decision on management.

Bevan mentor: Helen Howson **Contact:** stanton@cf.ac.uk

Tackling Inequalities Together: BCUHB Leading from Front

Glynne Roberts, Programme Director of Well North Wales
Betsi Cadwaladr University Health Board

Gogledd Cymru WellNorth Wales

CONTEXT:

In North Wales, over 80,000 people live in areas that are amongst the most deprived in Wales.

In working towards improving the health of the North Wales population, Betsi Cadwaladr UHB has taken positive steps in the establishing ***Well North Wales*** to work collaboratively with relevant organisations to address health inequalities, and to improve the health of the poorest fastest.

AIM:

The initial intention of the project was to introduce a small scale project in designated areas, but the appetite to develop robust multi-agency partnerships has seen the ***Well North Wales*** initiative take off dramatically.

Well North Wales provides a framework for local communities and organisations to work together to improve health and wellbeing, with the aim of reducing inequalities through creating independent individuals, resilient families and stronger communities.

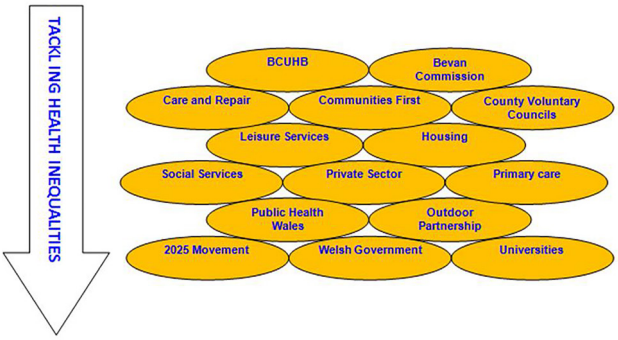
PLANNING & DEVELOPPMENT:

The past 12 months have seen innovative approaches to partnership working, drawing together themes around homelessness, employability, community resilience, as well as more traditional health and wellbeing centres.

Some examples of this are:
➔Developing a health and wellbeing centre on the site of the old social club at Shotton - supporting a broad regeneration, social enterprise and employability programme;
➔Adding to the health precinct at Eirias Park (below) in Colwyn Bay;

➔Developing a health and wellbeing centre in Bangor, *"putting health and wellbeing on the High Street"* through linking in with economic, housing and business regeneration plans;
➔Developing an NHS strategic and operational response to food poverty; and,
➔Developing an innovative social prescribing programme.

PARTNERS:



OUTCOMES:

The programme is still at an early stage, but has set the strategic scene for tackling poverty and health inequalities:
➔Focus on the most deprived communities of North Wales, aiming to improve the health of the poorest fastest;
➔Community priorities established;
➔Creating new ways of partnership working through co-production; and,
➔Needs identification to feed into the strategic planning cycles.

FIT WITH PRUDENT HEALTH:

►Establishing specific programmes to achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
►Targets communities with the greatest health need first;
►Aiming to reduce inappropriate variation using evidence-based practices consistently & transparently.

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A Rubbish Project: Recycling Innovation

Peter White & Chris Davies, Waste & Energy Environmental Managers
Aneurin Bevan University Health Board

AIM:

We aim to divert a waste - currently being classified as clinical waste and heat-treated using a very carbon intensive process at high cost - into a commodity that has revenue value.

PLANNING & DEVELOPMENT:

The project is a "world-first" as it is the first time that polypropylene sterilisation wrap has been processed at a hospital site using a Sterimelt machine.

The Sterimelt machine was designed and developed by Thermal Compaction Group (TCG) and is used to melt sterilisation wrap material and converts it into a liquid that flows into a mould cavity to create a block of material that is dense and sterile. The machine produces one 12 - 15Kg block of sterilised polypropylene during each cycle with a volumetric reduction of 85%.

OUTCOMES:

The Health Board can demonstrate a number of benefits in relation to the diversion of material from the clinical waste stream, while producing a commercial polymer with a commodity value. The St Woolos/Royal Gwent hospital is the first in the world to experience this type of technology and will lead to future projects to look at other plastic wastes produced in the healthcare environment. These will enhance savings within the healthcare waste sector while creating a worthwhile e-saleable plastic.

FUTURE PLANS:

Further plans are in process for collaboration with a major established Healthcare Supplier to look at creating the use of 3D printing technology directly from the hospitals own “plastic waste”.

The Bevan Commission funding has enabled a member of the waste team to work on the project for a period of four months to optimise the Sterimelt process and scale up the concept throughout the Health Board’s other hospitals.

Trials have also been run on processing disposal polypropylene curtains and other plastic healthcare consumable products. It is envisaged that the technology will be adopted throughout Wales and across the NHS in the UK with interest from across the world.

The Aneurin Bevan University Health Board Sterimelt team.

The other future plans relate to the use of the recycled polypropylene block as a feedstock for 3D printing. The block would be granulated and processed into a filament for 3D printing.

The longer term goal would be for each hospital to have their own Sterimelt machine and 3D printer creating a close loop on site for the manufacture of plastic healthcare consumables.

FIT WITH PRUDENT HEALTH:

The project has reduced cost and carbon and introduced a truly sustainable approach which demonstrates closed loop recycling and the principles of the circular economy.
It showcases a ‘best in class’ innovative world-first technology which has turned a waste product and revenue cost into a recyclate with a commodity value.

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Closing Information Loop for Home Dialysis

Dafydd James, Senior Pharmacy Technician, Renal Services
Abertawe Bro Morgannwg University Health Board

SCOPE:

The South West Wales home nocturnal dialysis programme is an award-winning service recognised as a UK beacon centre for treatment innovation.

Here the application of the Prudent Healthcare principles has created a new treatment option that is achieving more for less – more for patients' wellbeing, longevity and quality-of-life with less use of NHS resources.

PLANNING & DEVELOPMENT:

Through co-production we developed an efficient, gentle and regular form of dialysis that is performed by the patient in their own home as they sleep.

This treatment innovation has been possible by service modernisation tailored towards supportive self care enabled by digital innovation. Crucially, the use of technology consolidated our clinical notes to a single eRecord which also allows patients access their blood results and prescribed treatments enabling them as active partners in their own care.

Clinical data previously recorded by a healthcare professional is now recorded by the patient at home. This vast quantity of data is needed to oversee the safety and efficiency of the home therapy. This data is paper recorded; a final element to our home dialysis service awaiting digitisation.

FIT WITH PRUDENT HEALTH:

► Aligning an innovative project such as this with a Prudent approach ensures a robustness and will likely be a success. The benefits are:

Efficiency & quality improvement:

1. Real time return of patient data (enabling rapid intervention);
2. Eliminates staff time spent on data entry (1 WTE per 100 patients);
3. Standardisation of data return with automated checks ;
4. Reduced replication and transcription errors;
5. Patient empowerment/accountability;
6. Closed loop for digital communication (two way data sharing)

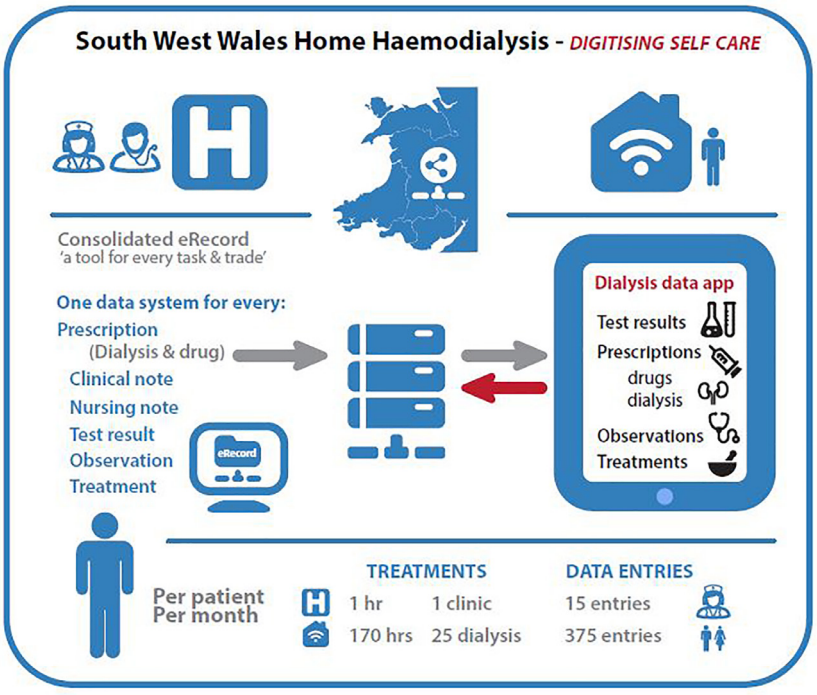
Enhanced service delivery:

1. Virtual clinics: centralised monitoring in real time;
2. Improved preparation for actual clinics – improving patient flow;
3. Reduced inappropriate variation; and,
4. Treatment decision made on sound evidence in controlled environments with full real time access to the patient's clinical information.

KEY FINDINGS:

The health technology exemplar process has enabled development of a 'digital dialysis data tool'. Patients are now able to enter their own daily treatment details and observations onto a digital platform that links directly into our consolidated eRecord to fully digitalise the service (See figure 1, right).

This development has enabled real time capturing of home dialysis treatment observations which has allowed enhanced service delivery in terms of rapid intervention enabled by continuous monitoring and improved compliance for recording treatment observations. By practically eliminating unnecessary replication and transcribing, this time can now be better spent providing training and support.



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Challenges of finding time to prioritise service change

Chris Stockport, Clinical Lead Directly Managed Primary Care
Betsi Cadwaladr University Health Board

CONTEXT:

My Bevan Exemplar project was about finding ways of including substantial patient representation within the local decision making process of our innovative, health board-run primary care service.

AIM:

It is so much more than a group of patients telling us whether they like ideas that we've come up with. The real reward for everyone is a council that can successfully share the ideas generation, the pain when making tough resource decisions and that can help our community explore the obligations that we all have as patients to make good lifestyle choices and use healthcare services prudently.

I think it's really important. Yet I haven't managed to get very far, despite working hard. I'm further along than I was 12 months ago, but it's been slow progress - although I will get there.

CHALLENGES:

Successfully delivering change within complex systems, is much tougher than you think, even with the great support of organisations such as the Bevan Commission.

The challenges will be different for others, but here are a few of mine…

General Workload:
It's been hard to find things to shift to allow time to undertake service change activity;

Priorities:
This piece of work competed with several other changes relating to managed practices. Mid-way through the year I then unexpectedly inherited an additional managed practice, requiring lots of time. And clinical events through the year ended up taking priority too - "patient safety today" took priority over "patient safety tomorrow".

Politics:
A couple of existing groups felt they should already be considered "the Council". It's taken more time than I expected to work this through to satisfy them that they aren't able to fulfil this role.

Personal pressures:
Three children undertaking combinations of GCSE's and A/S-level exams. Enough said!

I don't get it:
Never underestimate the power of other teams within large organisations to obstruct your work, particularly when you are innovating!

TARGETS:

Never give up! I'm still moving the project forward, and we'll get there, although with a longer timescale.

I've learned a lot in the last year about introducing change. And I will be continuing to share that learning within my own organisation, and in particular the absolute need to protect time and resource for those trying to innovate and spread change to improve services for our patients.

"Success is stumbling from failure to failure with no loss of enthusiasm"

Winston Churchill

Bevan mentor: Helen Howson **Contact:** christopher.stockport@wales.nhs.uk

Growing Our Own Wellbeing Champions

Paul Dunning, Head of Staff Health & Wellbeing, Bethan Lavercombe, Workforce Manager, & Victoria Williams, In-Work Support Manager
Abertawe Bro Morgannwg University Health Board

AIM:

Our Wellbeing Champions encourage colleagues to seek early intervention for their health issues so that they feel supported and valued and able to remain in work.

PLANNING & DEVELOPMENT:

We have empowered and encouraged our Champions to feel valued in their role of supporting colleagues to manage their own health and wellbeing.

We began with 40 ABMU staff who volunteered to become Wellbeing Champions, this has now grown to more than 150 in less than 12 months and continues to flourish, with more staff volunteering to help and support their colleagues.

FEEDBACK:

What our Champions have told us:
"I feel very proud and excited about being a Wellbeing Champion"

"When we feel well at work we flourish and are able to reach our full potential. This has a positive impact for everyone. I feel strongly that everyone should be given the support to blossom and believe my role in that is an important one"

Feedback from ABMU staff:
"My Champion took the time to listen to me and what I was struggling with. She was empathetic and took the initiative to support me in accessing the correct services"

"The role of the Champions is greatly valued in our team. It is so reassuring to know there is support available"

Wellbeing services available to NHS staff in ABMU Health Board:

Counselling; Stress-busting sessions; Discounted Lesiure Facilities; Physiotherapy; Occupational Health; Emotional Support; Wellbeing Courses; Emotional Support;Cycle for Health; and, Fast-track MSK Appointments.

FIT WITH PRUDENT HEALTH:

►Caring for Each Other is one of the ABMU's core values. Providing a supportive environment and opportunities which positively impact the lives of employees, will demonstrate that we value the health and wellbeing of our staff and want to work together to create a workplace that supports and nurtures this;
►Our staff play a vital role in the delivery of NHS provisions - without them it would not be possible to provide high-quality and effective services. Improving staff experience will have a positive impact not only on employee health and wellbeing, but also on the experience and outcomes of the patients we serve.

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The Gold Standard Approach to Medicines Homecare

Reuben Morgan, Medicines Homecare Manager
Abertawe Bro Morgannwg University Health Board

AIM:

Medicines HomeCare is a service of medication delivery, prescribed and managed in secondary care, delivered directly to a patient's home at a time that convenient.

If you required high cost specialist medication prescribed in a secondary care setting, delivered to your door, wouldn't you want the service governed by the leaders in the field within the NHS in Wales?

That is exactly what the latest Welsh Audit office findings, of the gold standard service provided by the Medicines HomeCare Team in ABMU Health Board.

CONTEXT:

The quality and standard of medicines homecare services across the NHS in Wales is disjointed, under-resourced and lacking leadership.

PLANNING & DEVELOPMENT:

Detailed procedures have been written and changes to existing practices implemented to ensure clinical, corporate and financial governance targets are achieved, and addresses the standardisation issues.

BENEFITS:

Ownership and responsibility of prescriptions has achieved an opportunity cost of £39,544 (*see table 1 below):*

Opportunity cost-saving of prescription management by admin, not consultant:

Est. hours p/w in ABMU on prescription management	18.75
Difference in hourly rate of a consultant over Band 3	£40
Cost-saving if PM by Band 3 instead of consultant p/a	£39,544

A once for Wales approach reduces the variation of procedure and policies across the National Health Service, standardises the practice of Medicines Homecare and ensures value for money.

The potential VAT savings accrued by this delivery method can be reinvested into patient care.

ABMU Health Board has maximised these potential savings by investing in staff to safely manage the medicines provided via HomeCare, and if ABMU were responsible for medicines homecare for Wales the National savings would amount to £101,054 per annum.

Missed revenue opportunities due to team capacity issues, based on latest demography data, amounts to an estimated £1,367,642 per annum (see table 2 below):

What are potential VAT savings of increasing no. of patients serviced by HomeCare?

Healthboard	Current # Homecare Patients	Population		Per Patient 15-16 £		CT up to 0.3% # Homecare Patients	
Betsi Cadwalader	2,262	695,822	0.33%	4703		2,262	0.33%
Velindre	125			12655		125	
Aneurin Bevan	969	584,133	0.17%	8382		1,752	0.30%
Cardiff & Vale	1,673	489,931	0.34%	9004		1,673	0.34%
Cwm Taf	550	298,116	0.18%	8813		894	0.30%
Hywel Dda	1,396	383,710	0.36%	3837		1,396	0.36%
ABMU	2,500	529,278	0.47%	6550		2,500	0.47%
Powys		132,160				-	
Total	9,475	########	0.30%	6345		10,603	0.34%

Bevan mentor: Sion Charles **Contact:** reuben.morgan@wales.nhs.uk

Your Next Eye Test on an iPad. . .

Stephanie Campbell, NCN Lead Optometrist
Aneurin Bevan University Health Board

CONTEXT:

Eye departments are experiencing unprecedented demand due to increasing drug treatments available for elderly and diabetic populations. Stable patients must be monitored regularly yet there is simply not enough capacity in the current eye care system to meet this requirement.

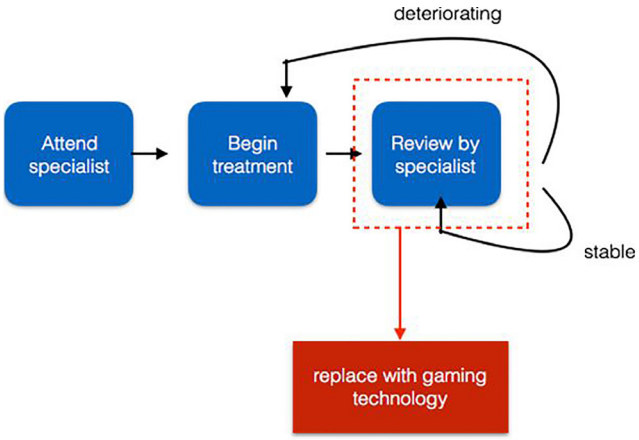
The traditional eye chart remains largely unchanged over the last 150 years. While very useful for checking glasses, the eye chart in (its current form) is now known to be a poor indicator of disease. Incorporating measurements of vision, such as sensitivity to low contrast, is scientifically known to monitor cataract more effectively. However, convention is such that the uptake into eye clinics is very limited.

SCOPE:

The advent of devices such as tablets and smartphones provides a platform for the measurement of vision in a more comprehensive way. Not only can small detail (like on the traditional eye chart) be measured, but many other scientific principles previously confined to the laboratory.

Gaming technology is used to maintain interest of the patient, providing much more accurate responses, collecting data based on what the patient does and does not respond to.

Of course, further development of the technology will mean that patients can safely monitor their vision from home, and away from hospital clinics.



The above model demonstrates how specialist review is a time-consuming aspect of the treatment cycle.

With the developing tech, stable patients may be monitored regularly from home, freeing up capacity for patients with worsening vision who need close specialist monitoring, in hospital clinics, in person.

FIT WITH PRUDENT HEALTH:

►**Public and professionals as equal partners -** This technology will allow a patient to measure their own vision when they wish, and access their own vision data, from home;

►**Care for those with greatest health need first -** When fully developed, this technology will identify and prioritise those with largest drops in vision for automatic e-booking to specialist clinic;

►**Do only what is needed, and no harm -** This tech is designed to measure vision more accurately than ever before, and to provide an individual's own data reliability index, preventing false positives and unnecessary treatment;

►**Reduce inappropriate variation -** Currently, patients with eye care problems living far from hospitals must travel many miles to establish if their vision is stable or not. This tech will allow them to access quality eye care assessment from home.

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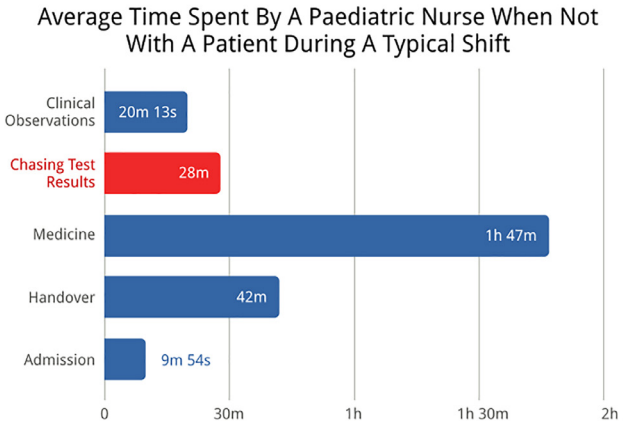
Know When Patients' Results Are Ready With a Ping!

Lynda Jones & Jane Brady
Betsi Cadwaladr University Health Board

CONTEXT:

If nurses wish to check if their patients' laboratory test results are available, current practice is to repeatedly log onto the Welsh Clinical Portal (WCP) to view the status of their request or to telephone the pathology department.

A 2014 Betsi Cadwaladr UHB study at Wrexham Maelor Hospital found nurses in a typical paediatric ward spend an average of 28 minutes per shift doing this activity, for adult wards this figure is expected to be higher.



THE PROJECT:

CHAI™ Ping is a notification service for use in clinical environments integrating with PAS (Patient Administration System) and Clinical Portals.

A permanently connected interface lists patients on the ward and alerts when results are ready for collection, in real time.

OUTCOMES:

Following extensive testing with simulated PAS and WCP systems, CHAI™ Ping is ready for integration with real patient data for benchmark testing, final evaluation and roll-out.

FUTURE PLANS:

Future development plans will extend functionality to single-user registered apps on mobile devices; facilitating c linician-customised patient lists and auditing.

AIM:

Our aim was to produce a tool for healthcare professionals that allows them to provide safe, quality care in a timely manner. Our guiding principles ensure that we can reach this goal in a prudent manner:

User-Centred Design

The healthcare practitioners who will use the system are placed at the centre of design and development. Our work is progressively revised in an iterative design process with frequent consultation, requirements capture and qualitative usability testing.

Easy to Implement:

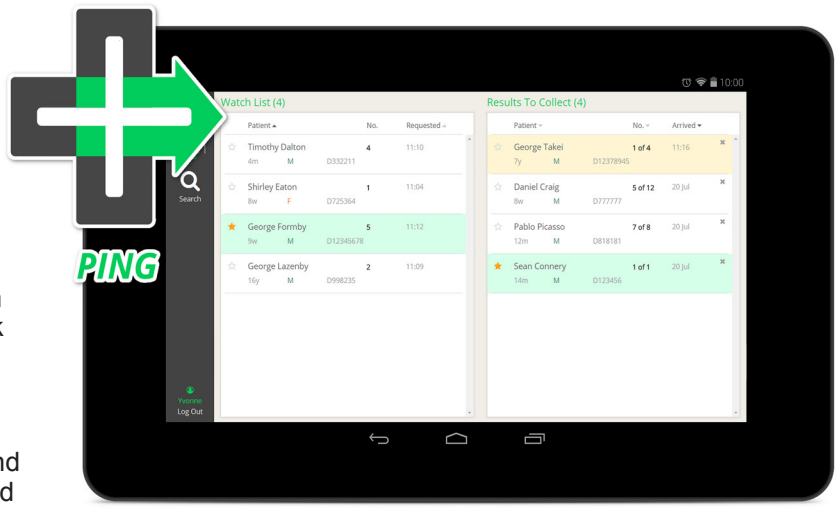
Ping aids and augments practice works alongside existing IT systems with no disruption to current infrastructure.

SAFETY & PRIVACY:

Ping assists with ensuring patient safety by maintaining logs on notifications, dismissal and resulting action.

The contents of test results themselves are not released, thereby safeguarding patient privacy; users must complete a further verification step by logging into WCP to retrieve results. Users retrieve actual results by verifiably logging in to WCP as normal.

Ping ensures effective use of the clinical portal.



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Bridging the Gap: A Place Called Home

Marianne Walmsley, Head of Quality, & Jane Roberts, Primary Strategy Lead Nurse
Betsi Cadwaladr University Health Board

CONTEXT:

To ensure a safer, equitable and sustainable care delivery for the needs of residents in care homes. We have identified the need for a new Multi-Disciplinary (MDT) model of support, monitoring and development within care homes across North Wales.

Over the past two years there has been a consistent increase in the number of nursing homes being put under formal escalating concerns, closing due to financial or quality issues as well as a number of homes having increasing quality and safeguarding issues. A recent audit has also shown a high level of admissions form nursing homes that could have been potentially prevented.

A solution to this is for the MDT to support the health and wellbeing of patients by proactively reviewing and initiating new treatment regimes. To enhance the competencies and skills of clinical staff working in the homes by providing training, education and clinical skills. To ensure implementation of evidence based practice delivery by undertaking quality monitoring and structured leadership.

PLANNING & DEVELOPMENT:

The MDT consisted of ANP, pharmacist, physiotherapist, speech & language, dietetics, practice development nurses and occupational therapists. To influence key health board senior managers data has been collected regarding, admissions, quality concerns, WAST data and district nursing visits, POVA and safeguarding. This data was then used to inform the selection of homes requiring further support and to test the model.

A pilot within four care homes across North Wales is currently being implemented. Funding has been secured from intermediate care funds across two areas.

BENEFITS:

Patient & Safety experience:
➔Ensure patients are treated with dignity and respect and are properly consulted regarding their care and changes to their treatment plan;
➔Development and promotion of patient-centred care delivered within the patients home; and,
➔Prevention of patient deterioration and improvement of quality of life and increase in

delivery of evidence-based safe and effective care.

Staff:
➔Increased competencies of staff;
➔Access to education and education; and,
➔Access to specialist support, advice and leadership.

Efficiency benefits:
➔Contribute to reduction in A/E attendance, hospital admissions and enable earlier discharge to the home;
➔Provide appropriate information, knowledge and support for care home staff in order to enable them to identify early need for intervention; and,
➔Cost savings in medication and consumables.

Regulatory benefits:
➔Reduction in escalation concerns, safeguarding incidents and complaints;
➔Reduction of loss of beds from placements; and
➔Reduction in home closures.

FIT WITH PRUDENT HEALTH:

►The project supports Prudent Healthcare by encouraging collaboration and co -production within care homes , primary, community and secondary care. By sharing the skills and resource of health board staff

►With the care homes it ensures equitable and consistent practice. The model will ensure the patient is seen by the most appropriate MDT professional rather than requiring an acute admission or GP visit.

Bevan Mentor: Morag Olsen **Contact:** Marianne.walmsley@wales.nhs.uk/Jane.Roberts5@wales.nhs.uk

A New Approach to Frequent Attenders

Naomi Stanton, Adarsh Shetty & Paul Davies
Cwm Taf University Health Board

AIM:

Patients who attend the GP repeatedly (*Frequent Attenders*) place a significant and disproportionate burden on GP services. We aim to audit factors associated with persistent Frequent Attendance, before designing and piloting a multidisciplinary approach incorporating cognitive behavioural therapy and community assets to improve management within a primary care setting.

CONTEXT:

Frequent Attender (FA) describes a patient who presents to healthcare services repeatedly, and more often than the general population. Chronic physical illness, especially hypertension, musculoskeletal pain and gastrointestinal upset is correlated with frequent attendance. Psychological morbidity (depression, anxiety and somatisation) is strongly associated. Social factors - being elderly, female, having lower education and socioeconomic background and having a high body mass index (BMI) are all associated.

A recent feasibility study of CBT in primary care targeting FAs concluded that joint working between a GP and therapist could create greater capacity in primary care (halving consultation rates at one year with no increase in secondary care consultations) and support GPs in managing FAs. Patient satisfaction was good.

PLANNING & DEVELOPMENT:

A literature review was conducted of:
1. Factors associated with FAs;
2. Interventions to improve quality of life outcomes.

An audit within a pilot practice of factors associated with FA was conducted including co-morbidities, reasons for presentation, repeat medications used, etc and compared to the literature. A multidisciplinary intervention to devise a novel approach to managing FAs involving CBT and linking into community assets via a community care co-ordinator is currently in development.

RESULTS:

During audit, 101 adults were defined as FAs:
➔*Number of consultations:* The median number was 17. The overall range was 15-34 over one year.
➔*Ages:*The median age was 63 years. The overall range was 19-94 years old;
➔*Gender:* 64 (63%) of the study sample were female;

➔*BMI:* The median BMI was 29.9. The overall range was 18.8-51.6;
➔*Co-morbidities and medications:* 58 (57%) of patients had a past medical history of psychiatric conditions including depression and anxiety or were under secondary care with psychiatric conditions. The mean number of medications per patient was 6. The most common repeat medications were Proton Pump Inhibitors (PPIs), antidepressants/anxiolytics (excluding benzodiazipines) and analgesics including opioids.
There was a mean of 3 co-morbidities per patient (the most common co-morbidities were depression/anxiety, then hypertension arthritis/chronic pain and asthma/COPD).
There was a familial component, with family members exhibiting similar presentation patterns. There was also an association with high use of services such as the GP Out of Hours service and the Accident & Emergency departments.

NEXT STEPS:

Patients have been identified and will be invited shortly. The intervention is currently being refined.

Acknowledgment: *Medical student Bradley Dawes, who assisted with data collection of audit and literature search*

FIT WITH PRUDENT HEALTH:

►The British Journal of General Practice (BJGP) study estimates that if the reduction in service use demonstrated in its study was replicated and maintained, engaging only a small proportion of long-term FAs would lead to cost-effective capacity generation within primary care;
►The intervention aims to improve quality of life, rationalise medication use and use community assets and social prescribing as an alternative to the current pattern of contact / support.

Bevan mentor: Helen Howson **Contact:** stanton@cf.ac.uk

Frailty Support Workers: Transforming Care

Aysha Thomas, Integrated Community Care Co-ordinator
Hywel Dda University Health Board

AIM:

To highlight the benefits of introducing Frailty Support Workers in the acute hospital setting and how their interventions bridge the gaps between different healthcare disciplines and lead to improved outcomes and cost savings.

The role allows for individualised patient care in a busy acute environment and has demonstrated to have a positive impact on patient experience and demonstrated a reduction in length of stay.

CONTEXT:

Senior nursing staff and ward clinicians recognised that there were difficulties in maintaining existing good clinical practice for frail elderly patients as well as supporting other interventions (mobilising, rehabilitation and group activities).

The complexity of patient needs in a cohort of dependent patients attributed to an increased workload in relation to fundamental patient care, reducing the amount of time available for staff to focus on all patient's holistic needs.

It has been recognised that for every day a patient spends in bed it takes a further week to rehabilitate them thus increasing patients length of stay, risk of pressure damage and hospital acquired infections. As a result, the Frailty Support Workers (FSW) role was introduced.

PLANNING & DEVELOPMENT:

The role of the Frailty Support Worker (FSW) is to work in conjunction with other members of the multi disciplinary team in assessing patients for frailty.

Through an assessment based on Comprehensive Geriatric Assessment (CGA) FSW can determine a frail older person's medical conditions, mental health, functional capacity and social circumstances.

Whilst working closely with patients, their families and carers they aim to establish an individual's previous functional ability which allows them to identify areas contributing to the patients decline and to bring about improvements and interventions to aid return of independence and their previous level of function.

The FSW role has improved patient outcomes and experience, as well as reducing length of stay.

Through frequent mobilisation and improved nutritional input, patients are able to maintain and improve their previous level of function and independence.

A reduction in hospital length of stay by 1 day for the whole ward was recorded following introduction of the FSW for 24 beds which equated to an annual saving of £198,000.

Following introduction of the milkshake rounds by the FSW the nutritional status of patients evidenced improvement with improved nutritional scores and a mean patient weight gain of 1.5kg, with £18,000 saved through reduction in nutritional supplement prescribing.

During April 2016 – February 2017 a total of 147 patients were identified as being suitable for frailty intervention:
-112 patients gained weight - **76%**
-118 patients Nutritional Screening Score improved or maintained – **80%**
-146 patients frailty scores improved or maintained – **99**

FIT WITH PRUDENT HEALTH:

► By working in conjunction with other members of the multidisciplinary team and by adopting a prudent view and frailty model that best suits the health needs of a significant frail older population will aid in preventing, preserving and supporting their wellbeing in order to maximise a more positive outcome for those individuals

Bevan Mentor: Sion Charles **Contact:** aysha.taylor@wales.nhs.uk

Clever Referrals – Building an Artificial Expert

Dafydd Loughran, ABCi Clinical Leadership Fellow
Aneurin Bevan University Health Board

CONTEXT:

Currently all GP referrals are 'vetted' in secondary care and a priority assigned. This process accounts for between 0.5% - 1% of all Welsh NHS Consultant time. These decisions are usually made from only a few lines of information from the referring GP.

AIM:

We hypothesised that we could train an algorithm to predict the prioritisation decisions of our consultants, thereby allowing us to release this time, as well as providing instant information to referring GP's and patients of the likely timescale to be seen in secondary care.

PLANNING & DEVELOPMENT:

With the aid of several senior clinicians, ABCi's mathematical modelling capability, and NWIS, decision-tree algorithms were developed, initially for secondary care breast services referrals, to be incorporated within the national electronic WCCG referral architecture.

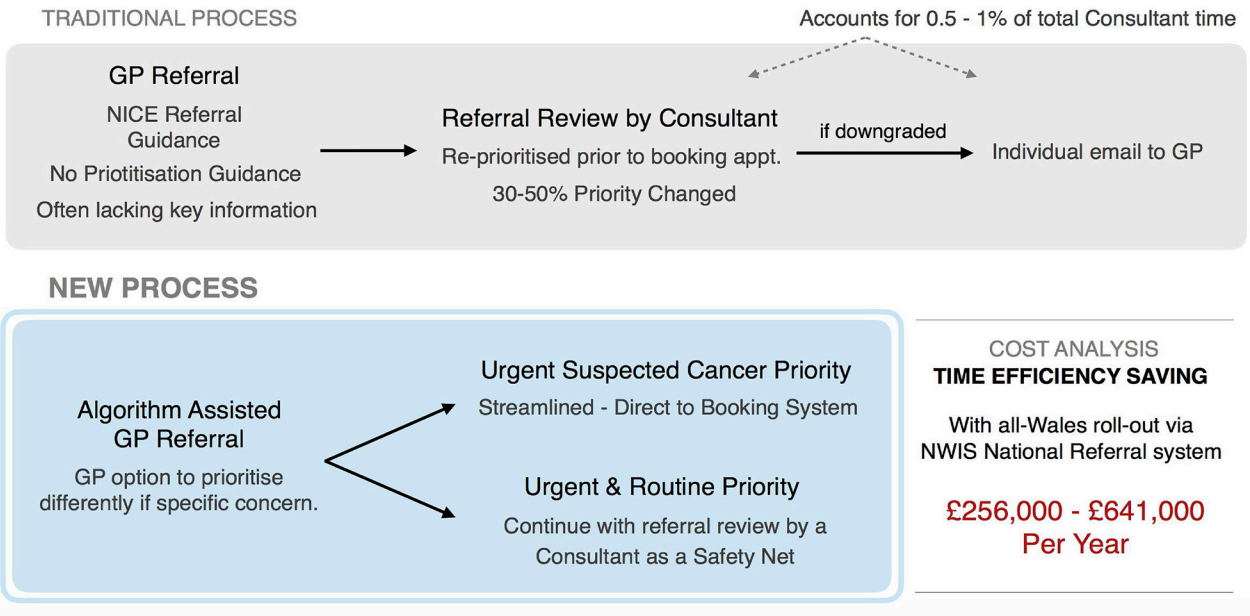
GP assessment of case priority, either routine, urgent, or Urgent Suspected Cancer (USC), was equivalent to Consultant assessment in only 50% of cases, significantly surpassed by algorithm equivalence in 75-90% of cases.
Despite minimal algorithm under-prioritisation rates, patient safety was of paramount importance to the team. Any cases which the algorithm classed to be a 'USC' priority could be deemed as such, requiring no further human prioritisation, but all others – routine and urgent - would continue to be reviewed by a consultant as a safety net.

OUTCOMES:

This approach delivers a potential time efficiency saving to the Welsh NHS of £256-641k per year once scaled nationally, releasing consultants to deliver direct patient care, whilst also providing GP's and patients with instant information regarding referral timeframes.

FIT WITH PRUDENT HEALTH:

► In an age of increasing hype around Artificial Intelligence, Clever Referrals is the Welsh NHS's first steps in this regard to support the interface between primary and secondary care.
► Clever Referrals demonstrates a key area where consultant time can be released to deliver better value, whilst reducing inappropriate variation by aligning national practice, and through this, ensuring consistent prioritisation so that those with the greatest health need are cared for first.



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Bevan Exemplars:

Our Bevan Exemplar Programme has delivered two cohorts. Every health board and trust in Wales has been represented on the programme. We will be welcoming our third cohort in October 2017. We wish to take this opportunity to thank each of our Bevan Exemplars for their hard work, creativity, forward-thinking and enthusiasm.

Cohort 1 (2015/16):

Michelle Key.....Aneurin Bevan HB
Helen Crosbie.....Aneurin Bevan HB
Nicola Quarry.....Aneurin Bevan HB
Annie Llewellyn Davies..Aneurin Bevan HB
Rhys Howell.....ABM UHB
Stephen Bassett.....ABM UHB
Mike Rowlands.....ABM UHB
Janet Thomas.....Betsi Cadwaladr UHB
Theresa Richards.....Betsi Cadwaladr UHB
Cathy Wynne.....Betsi Cadwaladr UHB
Robert Caine.....Betsi Cadwaladr UHB
Jeremy Jones.....Betsi Cadwaladr UHB
Siobhan Jones.....Betsi Cadwaladr UHB
Moyra Barnes.....Betsi Cadwaladr UHB
Helen Fitzpatrick.....Betsi Cadwaladr UHB
Caroline Evans.....Cardiff & Vale UHB
Lisa Jenkins.....Cardiff & Vale UHB
Ceri-Ann Hughes.....Cardiff & Vale UHB
Mike Simmons.....Hywel Dda UHB
Sharon Daniel.....Hywel Dda UHB
Anna Tee.....Hywel Dda UHB
Rhian Dawson.....Hywel Dda UHB
Paul Gimson.....Public Health Wales
Anne Hinchliffe.....Public Health Wales
Martin Davies.....Public Health Wales
Mark Taub.....Velindre NHS Trust
Lynn Turner.....Powys Teaching HB
Brian Makusha.....Powys Teaching HB
Catrin Hawthorn.....Powys Teaching HB
Susan Stavrides.....Powys Teaching HB
Dr Dave Smith.....ABM UHB
Alex Chase.....ABM UHB
Anwen Jenkins.....ABM UHB
Iona Collins.....ABM UHB
Mr Vinod Kumar.....ABM UHB
Samantha Murray.....Aneurin Bevan UHB
Richard Westwood....Betsi Cadwaladr UHB
Dr Gurudutt Naik.....Cardiff & Vale UHB
Sian Morgan.....Cardiff & Vale UHB
Matthew Lyon.....Cardiff & Vale UHB
Helen Roberts.....Cardiff & Vale UHB
Dr Richard Hughes.....Cardiff & Vale UHB
Hazel Ingram.....Cardiff & Vale UHB
Patrick Fielding.....Cardiff & Vale UHB
Chris Marshall.....Cardiff & Vale UHB
Andrew Hermon.....Cwm Taf UHB
Owen Hughes.....Powys Teaching HB
Martin Rees-Milton.....Velindre NHS Trust

Cohort 2 (2016/17):

Kieron Power.....ABM UHB
Debbie Thomas.....ABM UHB
Clive Thomas.....ABM UHB
Dafydd James.....ABM UHB
Paul Dunning.....ABM UHB
Beth Lavercombe.....ABM UHB
Victoria Williams.....ABM UHB
Reuben Morgan.....ABM UHB
Stephanie Campbell....Aneurin Bevan UHB
Dafydd Loughran.....Aneurin Bevan UHB
Peter White.....Aneurin Bevan UHB
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Anne Sprackling.....Aneurin Bevan UHB
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Marianne Walmsley...Betsi Cadwaladr UHB
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Steve Hill.....Velindre NHS Trust
Roger John.....WAST

Get in Touch:

If you would like to find out more about The Bevan Commission and its work, then visit our new-look website today at: *www.bevancommission.org*

You can also follow us on Twitter *@BevanCommission*

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If you would like to find out more about becoming a *Bevan Exemplar, Fellow or Advocate* and be part of the movement for change in health and care , get in touch with the team. . .

You can email us at bevan-commission@swansea.ac.uk or call us on 01792 604629

Swansea University
Prifysgol Abertawe

School of Management
Yr Ysgol Reolaeth

The School of Management is the proud partner and host of the Bevan Commission Academy.

The partnership demonstrates the strong alliance of academic and applied work to improve the performance of the healthcare systems globally.

Our world leading research into quality improvement and patient safety ranges from initial designs of healthcare processes and buildings (including new hospitals), to improving the safety and quality of established service delivery.

One of the most recent research collaboration projects has proven the savings of over £3million for the Welsh National Health Service (NHS) through the Bevan Commission Academy's Exemplar Programme.

The School of Management offers bespoke short courses in subjects such as lean healthcare systems, improvement processes, human factors and safety management as well as more general management processes.

We also offer the very popular SoM 'Clinic' for healthcare professionals. The purpose of the clinic is to support healthcare staff as they engage or review improvement and transformation programmes. The clinic offers a direct access to academic 'critical friends' who will help you to build your intervention programme using the latest knowledge and proven methods.

The School offers consultancy services independently, and through the Bevan Commission Academy for longer-term support and change transformation and leadership/mentoring.

We look forward to welcoming you to our school and supporting your next improvement activity. For further details about the school and its services please contact Mrs Rebekah Mannion or Professor Nick Rich.

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