TRFT Library & Knowledge Service

A library & knowledge service for all NHS staff in Rotherham

11/04/2014 Innovation and Improvement Bulletin

This bulletin includes research which focuses on improving and developing services to improve the patient journey and make services more effective and efficient. It also includes information on service evaluations and future challenges for services that need to be considered in planning.

Contents

Urgent care

An alternative guide to the urgent and emergency care system in England
A&E is often seen as a service in crisis and is the focus of much media and political interest. But A&E is just the tip of the iceberg – the whole urgent and emergency care system is complex, and surrounded by myth and confusion. Our brand new animation gives a whistle-stop tour of how the system fits together and busts some myths about what's really going on – explaining that the underlying causes go much deeper than just A&E and demand a joined-up response across all services.

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Medicines management

NHS Trust heatmaps for spend on innovative medicines (April-Sep 2013)
Heatmaps at NHS Trust Level on spend for 64 medicines purchased between April and September 2013, based upon Innovation Scorecard Table 3.1 March 2014, are available from NHS England. Data can be used to compare organisations for a particular medicine.

Identification of an updated set of prescribing-safety indicators for GPs
BJGP April 1, 2014 vol. 64 no. 621 e181-e190
Medication error is an important contributor to patient morbidity and mortality and is associated with inadequate patient safety measures. However, prescribing-safety tools specifically designed for use in general practice are lacking.
Aim To identify and update a set of prescribing-safety indicators for assessing the safety of prescribing in general practice, and to estimate the risk of harm to patients associated with each indicator.

Design and setting RAND/UCLA consensus development of indicators in UK general practice.
Method Prescribing indicators were identified from a systematic review and previous consensus exercise. The RAND Appropriateness Method was used to further identify and develop the indicators with an electronic-Delphi method used to rate the risk associated with them. Twelve GPs from all the countries of the UK participated in the RAND exercise, with 11 GPs rating risk using the electronic-Delphi approach.
Results Fifty-six prescribing-safety indicators were considered appropriate for inclusion (overall panel median rating of 7–9, with agreement). These indicators cover hazardous prescribing across a range of therapeutic indications, hazardous drug–drug combinations and inadequate laboratory test monitoring. Twenty-three (41%) of these indicators were considered high risk or extreme risk by 80% or more of the participants.
Conclusion This study identified a set of 56 indicators that were considered, by a panel of GPs, to be appropriate for assessing the safety of GP prescribing. Twenty-three of these indicators were considered to be associated with high or extreme risk to patients and should be the focus of efforts to improve patient safety.

Oral penicillin prescribing for children in the UK: a comparison with BNF for Children age-band recommendations
Br J Gen Pract April 2014 64:e217-e222;
Background The British National Formulary for Children (BNFC) recommends dosing oral penicillins according to age-bands, weight-bands, or weight-based calculations. Because of the rising prevalence of childhood obesity, age-band-based prescribing could lead to subtherapeutic dosing.
Aim To investigate actual oral penicillin prescribing by GPs in the UK with reference to the current BNFC age-band recommendations.
Design and setting Descriptive analysis of UK prescriptions in the 2010 IMS Disease-Analyzer database (IMS-DA).
Method A detailed database analysis was undertaken of oral penicillin prescriptions for 0–18 year olds from the 2010 IMS-DA. The prescription analysis included all available data on formulation, strength (mg), prescription quantity unit, package size, prescribed quantity, and volume.
Results Considering amoxicillin alone, no infants (aged <1 year) were prescribed the BNFC 2011 edition recommended unit dose (62.5 mg), while the majority received double the dose (125 mg); among children aged 1–5 years, 96% were prescribed the recommended unit dose (125 mg), but 40% of 6–12 year olds and 70% of 12–18 year olds were prescribed unit doses below the BNFC recommendations. For otitis media, only those children aged <1 year received the recommended dose of amoxicillin (40–90 mg/kg/day). Similar variations in dosing across age-bands were observed for phenoxymethylpenicillin and flucloxacillin.
Conclusion There is wide variation in the dosing of penicillins for children in UK primary care, with very few children being prescribed the current national recommended doses. There is an urgent need to review dosing guidelines, in relation to the weights of children today.

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Clinical commissioning

Clinical commissioning groups – one year on

The King's Fund and the Nuffield Trust have published an audio slide-show and a document containing headline results from a survey of GPs in six clinical commissioning groups. The survey explored member engagement and primary care development one year after CCGs were introduced. The survey is part of a three year project, looking to understand how the clinical commissioning groups are at the heart of the NHS reforms and how they are developing.

Primary medical care functions delegated to clinical commissioning groups: Guidance
NHS England has updated its guidance on CCGs' responsibilities for commissioning GP IT services and out-of-hours primary medical care services. It includes new arrangements to ensure publication and benchmarking of information about the quality of out-of-hours services.

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Innovation and improvement policy

Putting patients first

NHS England has published a refreshed business plan, describing its role in delivering high quality care for all, now and for future generations. Putting Patients First: the NHS England business plan for 2014/15 – 2016/17 describes everything NHS England does as an organisation, both as a direct commissioner and as a leader, partner and enabler of the NHS commissioning system.

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Innovation and Improvement Tools and Techniques

Making sense of evidence in management decisions: the role of research-based knowledge on innovation adoption and implementation in health care

Authors: Kyratsis Y, Ahmad R, Hatzaras K, Iwami M, Holmes A.
Journal: Health Services and Delivery Research Volume: 2 Issue: 6; Publication date: March 2014
Although innovation can improve patient care, implementing new ideas is often challenging. Previous research found that professional attitudes, shaped in part by health policies and organisational cultures, contribute to differing perceptions of innovation 'evidence'. However, we still know little about how evidence is empirically accessed and used by organisational decision-makers when innovations are introduced. We aimed to investigate the use of different sources and types of evidence in innovation decisions to answer the following questions: how do managers make sense of evidence? What role does evidence play in management decision-making when adopting and implementing innovations in health care? How do wider contextual conditions and intraorganisational capacity influence research use and application by health-care managers?
An evidence-based management approach that inflexibly applies the principles of evidence-based medicine, our findings suggest, neglects how evidence is actioned in practice and how codified research knowledge inter-relates with other 'evidence' also valued by decision-makers. Local processes and professional and microsystem considerations played a significant role in adoption and implementation. This has substantial implications for the effectiveness of large-scale projects and systems-wide policy.

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Patient and community involvement

NHS Choice framework

The Department of Health has published 2014/15 Choice Framework. The framework brings together information about patients' rights to choice about their health care, where to get more information to help make a choice, and how they can complain if they have not been offered choice. The 2014 to 2015 version reflects changes to expansions of patients' rights to choice in the areas of general practice, mental health and personal health budgets.

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Patient Safety

Reducing harm to patients

The Health Foundation has published a briefing entitled Reducing harm to patients. The briefing follows a March 2014 speech by the Secretary of State for Health at Virginia Mason Medical Centre in Seattle. In recent years, the centre has had considerable success in delivering safe care and financial sustainability. This briefing outlines the factors that have contributed to their success, and how a similar approach has been used in the UK. It aims to help those working to improve patient safety in the NHS.

BMJ Quality & Safety: a collection of key articles

BMJ Qual Saf 2014;23:196-205 doi:10.1136/bmjqs-2013-001812

BMJ Quality & Safety: a collection of key articles contains a selection of articles featured in the journal BMJ Quality & Safety during 2013. The journal aims to encourage innovation and creative thinking to improve the quality of health care and the science of improvement. The articles featured in this collection are:

- Identification of doctors at risk of recurrent complaints
- The global burden of unsafe medical care
- Systematic review of the application of the plan–do–study–act method to improve quality in healthcare
- Assessing adverse events among home care clients in three Canadian provinces using chart review
- 'Care left undone' during nursing shifts
- Allocating scarce resources in real-time to reduce heart failure admissions
- Culture and behaviour in the English National Health Service

Human factors and ergonomics as a patient safety practice

BMJ Qual Saf 2014;23:196-205

Background Human factors and ergonomics (HFE) approaches to patient safety have addressed five different domains: usability of technology; human error and its role in patient safety; the role of healthcare worker performance in patient safety; system resilience; and HFE systems approaches to patient safety.

Methods A review of various HFE approaches to patient safety and studies on HFE interventions was conducted.

Results This paper describes specific examples of HFE-based interventions for patient safety. Studies show that HFE can be used in a variety of domains.

Conclusions HFE is a core element of patient safety improvement. Therefore, every effort should be made to support HFE applications in patient safety.

Patient safety and general practice: traversing the tightrope

BJGP April 1, 2014 vol. 64 no. 621 164-165

INTRODUCING PATIENT SAFETY

The emerging field of patient safety already has some very apt metaphors. Reason's 'Swiss Cheese' model suggests patients suffer preventable harm when a number of holes (system weaknesses) temporarily align; high profile media reports of serious patient safety incidents (PSIs) are the 'tip of the iceberg'; while the Indian fable of the blind men interacting with different parts of an elephant illustrates how perceptions of safe care varies between patients, clinicians, researchers, and policymakers. We can add another parallel: delivering safe care in general practice is like balancing on tightropes. Increasing numbers of patients scamper willingly into our wheelbarrows every day, with the full expectation that we will deliver them safely (and quickly) to the other side. And for the most part we do, even if it increasingly requires running back and forth or hanging on precariously by one arm from the rope.

Unfortunately, slips and accidents do happen on tightropes, as they do in health care. While patient harm in general practice is yet to be reliably quantified, there is compelling evidence that it does occur, and not infrequently.

Clinical handover within the emergency care pathway and the potential risks of clinical handover failure (ECHO): primary research

Handover and communication failures are a recognised threat to patient safety. Handover in emergency care is a particularly vulnerable activity owing to the high-risk context and overcrowded conditions. In addition, handover frequently takes place across the boundaries of organisations that have different goals and motivations, and that exhibit different local cultures and behaviours. This study aimed to explore the risks associated with handover failure in the emergency care pathway, and to identify organisational factors that impact on the quality of handover.

The research findings suggest that handover should be understood as a sociotechnical activity embedded in clinical and organisational practice. Capacity, patient flow and national targets, and the quality of handover are intricately related, and should be addressed together. Improvement efforts should focus on providing practitioners with flexibility to make trade-offs in order to resolve tensions inherent in handover. Collaborative holistic system analysis and greater cultural awareness and collaboration across organisations should be pursued.

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Public health

Bowel cancer screening

Public Health England has reported that the roll out target of screening centres offering the latest bowel cancer screening test has been exceeded. The new figure released shows that nearly 37% (36.6%) of bowel scope screening centres in England are operational, exceeding the 30% roll out target, set by the Department of Health in their 'Improving Outcomes: A Strategy for Cancer' document (2011).

Rotavirus vaccination programme

Public Health England has reported that the rotavirus vaccine, introduced in July 2013, is having a significant impact on the number of cases according to new interim figures. Preliminary data published covering the period from July 2013 to March 2014, shows 93% of children in the survey had received the first dose and 88% had completed the second dose course. In addition, laboratory reports of rotavirus showed 70% fewer cases during the same period when compared to the average over the last 10 seasons.

PHE bulletin: 28 March 2014

School nursing: public health services guidance

This guidance supports effective commissioning of school nursing services to provide public health for school aged children. It also explains how local school nursing services can be used and improved to meet local needs.

- Maximising the school nursing team contribution to the public health of school-aged children
- Promoting emotional wellbeing and positive mental health of children and young people
- Developing strong relationships and supporting positive sexual health
- Supporting the health and wellbeing of young carers

NICE Public Health Guidance: needle and syringe programmes

NICE has published guidance which makes recommendations on needle and syringe programmes, including those provided by pharmacies and drugs services for adults and young people (including those under 16) who inject drugs, including image- and performance-enhancing drugs. Needle and Syringe Programmes (PH52) is for directors of public health, commissioners, providers of needle and syringe programmes and related services, and those with a remit for infectious disease prevention.

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Older people

Focus on: social care for older people - reductions in adult social services for older people in England

This report examines the scale and scope of cuts to social services for older people in England from 2009/10 to 2012/13. It reveals that most local authorities are tightly rationing social care for the over-65s in response to cuts, resulting in significant drops in the number of people receiving services.

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Mental health

Mental health provision in women's community services

The British Association for Counselling and Physiotherapy in collaboration with the Centre for Mental Health and Women's Breakout has published Mental Health Provision in Women's Community Services: Findings from a survey

conducted in England and Wales. The report highlights the breadth and depth in the mental health interventions available at women's community centres in the UK. It demonstrates that women's community centres have established good working partnerships with other organisations such as local authorities, NHS trusts and probation services in order to meet the mental health needs of their clients. The findings back up existing evidence suggesting that in many cases referral to women's community centres is a more effective cost-effective solution than imposing a custodial sentence.

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Learning disabilities

Implementing the 0 to 25 special needs system

The Department for Education and Department of Health have updated the document Implementing a new 0 to 25 special needs system: LAs and partners - Further Government advice for local authorities and health partners. The document provides departmental advice for local authorities and health partners about implementing the 0 to 25 special needs system from September 2014.

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Other

NHS procurement transparency

The Department of Health has published details of actions required by NHS provider organisations relating to procurement transparency from April 2014. Procurement Transparency provides guidance to all NHS Foundation and Non-Foundation trusts on the actions to be taken to increase openness and clarity about NHS procurement. Although this document is not applicable to independent sector providers of NHS healthcare, such providers may wish to consider the benefits of adopting the guidance.

Improving wheelchair services

Wheelchairs enable many people to live fuller lives, yet the wheelchairs services provided by the NHS often fall short of meeting the needs of wheelchair users. In an attempt to redress that, NHS England is working with others to improve the way in which they can support all wheelchair users.

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