Poster Examples

Establishing PROMs/PREMs* in Head and Neck Skin Cancer management

Jonathan Hulbert

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Maxillofacial Outpatient procedure Patient Feedback

Background

- PROMs are standardised, validated questionnaires completed by patients to measure their perceptions of their own functional status and wellbeing
- Facilitate quality improvement, audit, and research

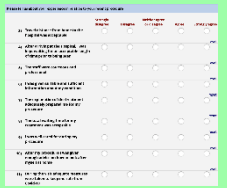
*Patient Reported Outcome Measures / Patient Reported Experience Measures

Aims

- Integrate PROMs/PREMs collection into the care pathway in the Maxillofacial OPDs
- Provide a more rounded and patient centred approach to care and outcomes assessment

Outcome

- PREM administered via web link provided to patients at treatment appointment to measure experience of surgical treatment and gather quantitative data on patient experience
- RedCap database



Method

- Evaluation of published evidence – selection of validated PROM: FACE-Q
- Collect data in electronic format
- Consultation with Value-Based Healthcare teams, Nationally and at Health Board level
- Involving colleagues in design and delivery of the questionnaire

Challenges

- Finding the right people to help instigate change
- Complexity of PROM design/validation
- IT infrastructure / implementation
- Long-term goal to improve Outcomes and patient satisfaction
- Moving to a National PROM for facial skin cancer

What I have learned

- Think big, start small
- The importance of networking – especially for an introvert
- Change is slow and requires persistence
- Adapting default influencing style to be more effective

Integration of a clinical Pharmacist into the Heart Failure (HF) service at the Princess of Wales (PoW) Hospital, CTMUHB

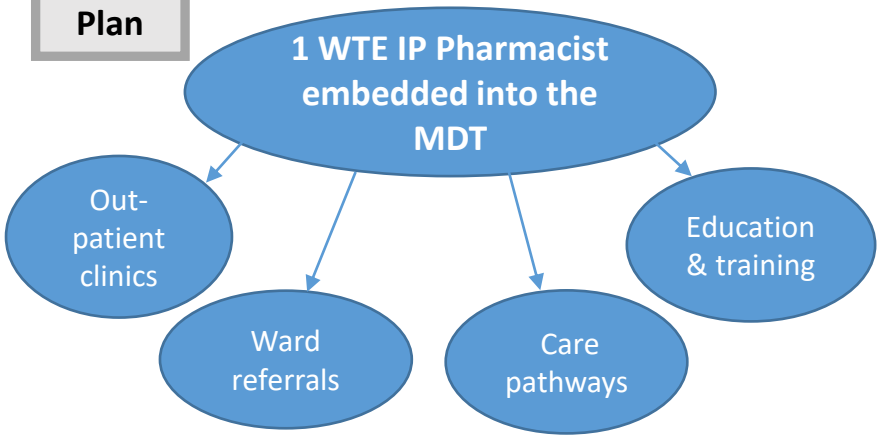
Eleri Schiavone

Background

- 1-2% of the adult UK population affected with heart failure (HF), increasing to 10% in those aged 70 years or over
- High prevalence of acute hospital admissions
- Significant inpatient mortality (8.9%)
- Up to a 30% mortality one year after discharge
- Polypharmacy – 5 or more medications

Aim - To improve patient safety and access to expert medicines advice through integration of a clinical independent prescribing (IP) pharmacist into the HF team

Plan

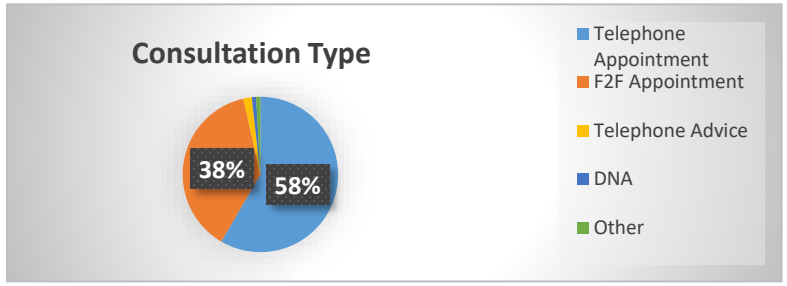


Outcomes

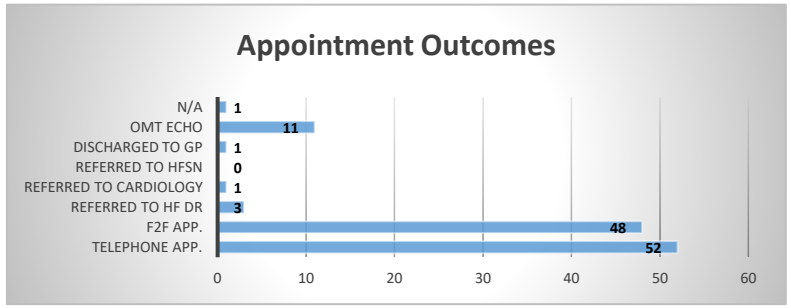
- Funding gained through winter pressure bid (Nov – April 2021)
- 2 X IP Pharmacists trained & embedded into HF team (=1 WTE)
- Data Collection (Dec – April 2021)

Data evaluation

- 112 patient consultations conducted



- 97 items prescribed / 17 items de-prescribed
- 141 Biochemical test requests made
- 24 additional test requests made (e.g. TTE, ECG, sleep study)



Challenges

- COVID
- Obtaining substantive funding
- Workforce recruitment & retention
- Training burden
- MDT / Patient acceptance of new service

Next Steps

- Apply for three month extension on funding
- Review Patient & MDT feedback
- Bid for substantive funds to continue service
- Apply model to other chronic disease areas

Key learning from 3D course

- How to influence positive change
- Chairing meetings
- Business case writing
- Networking & sharing good practice
- Understanding organisational cultures
- Be passionate about your work

Acknowledgement: Pharmacy Department: David Hughes, Rhys Williams & Rhian Donald for supporting & delivering the service. Dr Wong & the HF team for the training provision & the on-going support. Katie Innes & the directorate management team for supporting the business case.

Establishing Virtual Consultations for Patients with Kidney Stones and Benign Urological Disorders.

Mr Hrishi Joshi, Consultant Urological Surgeon
and Honorary Lecturer, UHW.

Introduction

- Traditional patient follow-up in the clinic involves:
- multi step approach; face to face contact; resource implications
- The Covid 19 pandemic: challenged the traditional model
- New model required: integration of technology with key stakeholder involvement
- Should be generalisable, feasible and reliable with no harm

Proposed solution

To integrate three parts of a face to face consultation, into single digital platform (with equal clinical and cost efficacy while minimising COVID risks)

1) Patient completing e-PROM, viewed by the consultant, prior to the consultation
2) Patient has up to date imaging prior to the consultation
3) Patient have audio-video consultation with all the information

Plan of management arranged

Platform phases

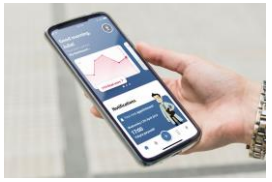
Feasibility study & pilot

New application deployment for pilot:
Deployment of ePROMS application

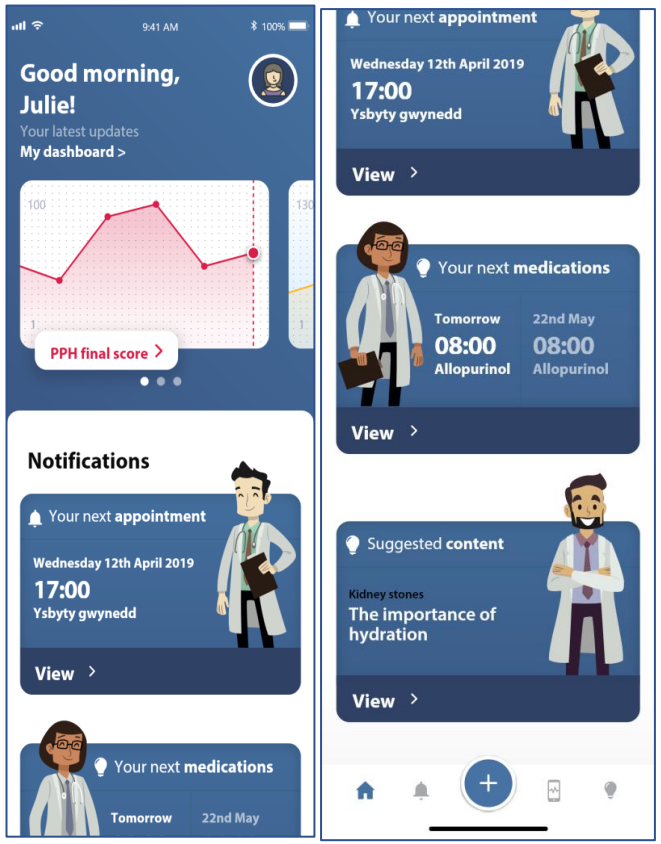
- ePROMS tracking and visualisation
- Appointment and reminder functionality
- Educational content

Roadmap

- Portal for remote viewing of ePROM data
- Integration with existing X-Ray systems
- Live consultation integration with existing appointment system



Project Aim: How to convert traditional face-to-face consultations for patients with kidney stones in to virtual ones without missing key signs?



Progress so far and stakeholders involved

- Have presented the draft proposal to the national VBHC lead and the UHW trust patient channel board – project on the top agenda
- Key leads and the team members involved – necessary contacts obtained from the 3D team!
- Trust team already working on the necessary platform
- None of the existing platforms provide all the functions
- Integration of different platforms on its way

Obstacles

- Integration challenging
- Trust run out of the contract with one key platform (PKB)
- Platform contracts and IT - High level decisions

Benefits of 3D

- Better understanding of organisational cultures, especially within the NHS
- Understanding the importance of developing a sound business case and its effective application – platforms for e-consultations
- Recognising the skills necessary for influencing and adaptation of own default style
- How to establish key contacts that help develop the project and the team – Helped the project become part of the Welsh Value Based Health Care (VBHC) agenda, integration into patient information channel at the UHB trust
- Understanding importance of multidisciplinary team and project drivers for effective project management – IT, management, different specialties (urology, radiology), VBHC staff
- All of the skills useful for my future management role in the department

Project benefits and future prospects

- Avoid face to face consultation and minimise COVID 19 risks (50-60 patients/month/dept.)
- Help select patients who do need to come to the hospital, for effective management
- Achieve cost effectiveness, patient convenience -> prudent healthcare
- Potential for the model to be used for other urological conditions (e.g. BPH) (200 - 250 patients/month/dept.)
- Facilitate nurse led clinics
- Easy to set up and ready for implementation immediately

GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Trawsnewid y gweithlu ar gyfer Cymru iachach
Transforming the workforce for a healthier Wales

3D Discovering Developing Delivering in healthcare

Developing GP-led Same Day Emergency Care (SDEC) at Prince Philip Hospital

Dr Louisa Morris – General Practitioner and Clinical Lead for Quality Improvement Prince Philip Hospital Llanelli louisa.morris@wales.nhs.uk

Background:

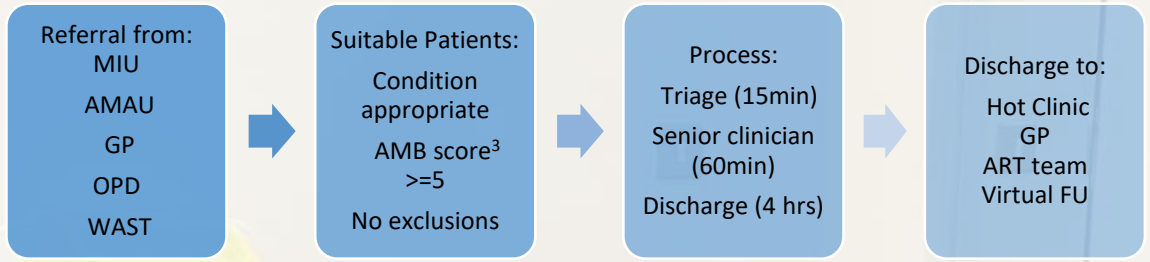
- Prince Philip Hospital (PPH) Llanelli is a 223 bed DGH within Hywel Dda University Health Board (HDUHB).
- PPH 'Front of House' consists of Acute Medical Assessment Unit (AMAU) and GP-led Minor Injuries Unit (MIU).
- Pressures on existing services analysed using retrospective data collection from Feb 19-Feb20 (pre COVID-19)[1]
- New challenges Mar 20 onwards resulting from COVID-19 and social distancing requirements.

MIU	Medical patients Seen (n)	Admitted n (%)
	3119	1078 (35)
AMAU	**Medical LOS < 72hrs (n)**	**SDEC suitable n(%)**
	3250	1129 (35)

Table 1[1]

Objectives:

- Schedule unscheduled care where possible
- Reduce overcrowding in hospitals – 'SDEC first'
- Community management where possible
- Reduce admissions to Acute Medical Assessment Unit (AMAU) by 30%
- Stream acute medical patients away from MIU
- Provide rapid access to investigations and senior doctor decision (aim 4hr turnaround)
- Health Board wide project– each site developing SDEC as part of wider unscheduled care (USC) plan[2]



Method:

- Core working group established – two Clinicians and one QI Practitioner
- Initial SDEC business case (Oct20) secured pilot funding until 31st March 2021
- Phase 1 pilot 1: 16-19 Nov 20
- Phase 2 pilot 2: 7 Dec 20 – ongoing (10hrs/day Mon-Fri)
- Initial location plus staffing model agreed and equipment secured
- Engagement exercise with all relevant parties undertaken
- Clinical Pathways developed for acute medical conditions (inc. Chest Pain /Palpitations /Shortness of Breath/ Headache/ Hypertension/ Cellulitis/ Pyelonephritis/ Metabolic disturbance).
- Defined exclusions to SDEC (inc. Sepsis / STMI / Stroke / DKA)
- Initial pathway based model to prove concept – now moved towards a process based model
- Business case submitted for ongoing funding 12 hr / 7 day service (Apr21)

Results:

National evaluation framework metrics for SDEC[4]	Week 31 data % (10/5/21)	Average % (7/12/21-10/5/21)
% of acute medical take managed on AEC pathway (aim 30%)	23 % (during opening hrs) 14 % (over 24 hrs)	29% 16%
% patients on AEC pathway not admitted (aim >90%)	100 %	90%
% patients on AEC pathway continuing care outside hospital (aim 100%) *includes in hospital f/u e.g. hot-clinic	89%	56%
Average time in department	147 min	157 min

Table 2[5]

3D Course Influence:

- Influence of organisational culture and personality types on how to 'pitch' your project
- Application of project management and QI methodology
- Peer support and 'sounding board' for ideas
- Collective group experience & advice invaluable

Discussion:

Strengths:
- Initial patient feedback overwhelmingly positive
- Short time to see senior clinician and discharge
- GP letter received within 4 hrs of discharge
- Aligns with wider HB USC plans
- GP led model working well

Weaknesses:
- No full time project lead
- Limitations of existing IT systems for data analysis
- Reliance on locum staff
- Location not purpose built / pressure on space
- No acute physician at 'front door'

Opportunities:
- Develop further hot-clinics based on current cardiology model
- Links with WAST / ART team
- Support DVT pathway outside core hrs
- Potential for frailty specific SDEC

Threats:
- Patient numbers during pilot extremely labile
- Lack of engagement from both primary and secondary care.
- Workforce and recruitment crisis
- Finance short term funding only

References:

1. 2020101_SBAR PPH SDEC_V2
2. HDUHB Contact First / Urgent Care Model
3. Royal College of Physicians. Acute care toolkit 10: ambulatory emergency care. London: RCP 2014.
4. Developing Ambulatory Emergence Care in Wales – Advice to Health Boards 2018
5. 202110510_PPH_SDEC Project Plan

From GP Directory to *HealthPathways* Dr Rebecca Thomas

Background

I had long felt the need for a system within primary care where all the important information required for the referral process be easily accessible in one place. After a few months of 'toing and froing' and not really making any progress, during a project clinic, Phil Coles one of the programme directors told me about *HealthPathways*. It was an initiative that had recently been taken on by Cardiff and Vale Health Board to improve primary care.

Immediately on seeing *HealthPathways*, I could see this was exactly what I had envisaged but on a far larger scale than I could ever have achieved. Benefitting all primary care clinicians, it includes guidelines and referral pathways for all specialities that are SPECIFIC to your LOCAL area and UP TO DATE, helping to prevent unnecessary referrals thus leading to a better overall patient experience and care. Equally as positive is the ability to improve relationships between primary and secondary care, something which is particularly pertinent post Covid-19.

What is *HealthPathways*?

- A digital platform offering locally agreed referral pathway information written by clinicians for clinicians, aiding in decision making with patients at the point of care.
- Initially developed by Canterbury District Health Board in New Zealand, 2008.
- > 40 instances of *HealthPathways* throughout New Zealand, Australia and the UK.
- They are all part of the *HealthPathways* community which enables them to share knowledge, processes, pathways and infrastructure.

Project Aim

To produce a resource collating all information useful to primary care clinicians from secondary care specialities that can be utilised to improve referrals and ultimately patient care.

Benefits of *HealthPathways*…

References

Communityhealthpathways.org

http://cardiffandvale.communityhealthpathways.org

Progress to date

After initial stumbling blocks I made contact with the team involved in setting up the Cardiff and Vale *HealthPathways* and I was put in touch with Mark Girvan the Programme Manager and Community Success Manager for South Tyneside, who joined *HealthPathways* in 2016.

The Future…

This is just the beginning and things are still very much in progress. The next step is to present *HealthPathways* to my local cluster before taking it to Powys Health Board to consider accessing transformation funding.

Challenges

Covid-19 provided many challenges to us all as we were busy in our day to day jobs.
Projects were not seen as a priority and I often found my e mails were unanswered.

My 3D Journey

The 3D course has equipped me with the tools and confidence to take a project on. As a new GP partner it has also helped me develop my leadership skills that will be transferable to my role as staffing lead.

The Myers-Briggs report for Healthcare Professionals and recognising different organisational cultures made me reflect on who I am as a doctor and how I can implement this to influence change.

Project clinics have enabled me to move my project forwards through discussions and networking with other group members and the Programme Directors

DEVELOPING AN ONCO-GERIATRIC SERVICE FOR SOUTH WEST WALES CANCER CENTRE

INTRODUCTION:

Over two-thirds of all patients diagnosed with cancer in the UK are aged 65 and over, and this number is expected to triple by 2040. Older people are a heterogeneous group, and often have biopsychosocial factors that will impact on their access to healthcare, on the time taken to diagnosis, and on their treatment options and prognosis. This project sought to establish unmet need and identify reversible factors that could improve fitness for cancer treatment in older people. The project resulted in combining experience and data into a business case and report of recommendations to improve care for older cancer patients.

Learning from the 3D Course

Organisation cultures	Stakeholder mapping	Understanding barriers to communication
Personal Development	My personality, strengths, and weaknesses	My influencing style
Business Case	Why, How, and for Whom?	Finance and Terminology
Peer Support	Sharing experiences	Sharing knowledge and contacts

What are the measurable outcomes of an onco-geriatric service?

1) **Reduced unscheduled care among cancer patients**
2) **Improve patient experience**
3) **Empower patients to self-manage their medications, well-being, and co-morbidities**
4) **Pro-actively address psychological and physical health needs**
5) **Reduce toxicity, and improve tolerance of anti-cancer treatments**
6) **Improve survival in older people with cancer**

I have learned…

How to write a business case – and have submitted one!

How cultures within organisations shape how I need to work

How to present concisely and keep people interested – and have presented to medical director, and cancer leads, with brilliant feedback.

To map stakeholders according to their power and influence

To play to my strengths

Dr Anita Parbhoo
Spr Geriatric Medicine
Welsh Clinical Leadership Fellow

GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Trawsnewid y gweithlu ar gyfer Cymru iachach
Transforming the workforce for a healthier Wales

3D Discovering Developing Delivering in healthcare

Developing a Healthy Weight Service for Children in North Wales.

Naomi Simmons, Consultant Paediatrician, Ysbyty Glan Clwyd.

The Challenge:

- Childhood obesity is higher in Wales compared with any region of England or Scotland.[1]
- 12% of 4-5 year olds are obese. BCUHB is 1 of 3 health boards with obesity prevalence significantly higher than the Wales average.
- A further 14% are overweight.[1]
- Children are developing 'adult' illnesses eg. type 2 diabetes, fatty liver disease.[2]
- High BMI is the leading contributor for increased years lived with disability.[3]
- The pandemic has worsened the lives of children and young people who struggle with their weight.[4]

Where we were:

- No dedicated support for children in BCUHB.
- Adult Tier 3 service in place.

Benefits of 3D- Empowerment in service development through learning about:

- **QI theory – Leadership styles**
- **Writing a business case - A mutually supportive 'safe space' to discuss challenges and learn from one another.**

As a new consultant I strove to develop services due to the large number of patients needing support. Throughout my time on 3D:

- ✓ Attended BCUHB Healthy Weight Group meetings to develop a business case for tier 3 support for severely obese children.
- ✓ The team's business case was approved.
- ✓ Launched Glan Clwyd weight management clinic
- ✓ Interviewed by BBC about the new Tier 3 service
- ✓ Joined Liverpool Obesity Research Network
- ✓ Appointed to new role within the Tier 3 service, currently in the 'set up' phase.

Now:

- Establishing referral criteria.
- Developing pathway.
- Aiming to start MDT clinics end of 2021.
- Will use patient feedback & data to continually refine.
- Anticipate significant value to patients & health board – obesity associated Illnesses projected to cost NHS Wales > £465 mil. p.a. by 2050.[5]

1 Public Health Wales 2019 .2 Diabetes UK 2018.
3 Obesity in Wales 2019. 4 Diabetes UK 2020.
5 Welsh Government 2019

GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Trawsnewid y gweithlu ar gyfer Cymru iachach
Transforming the workforce for a healthier Wales

3D Discovering Developing Delivering in healthcare

Introducing Consultant Connect in Betsi Cadwaladr University Health Board

Dr Nicky Davies, GP and Assistant Medical Director, Central

3Discovering Developing Delivering in healthcare

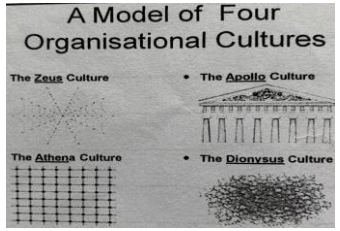
Consultant Connect is a rapid Advice and Guidance via phone or App for GPs, supported by National and local teams . Telephone advice or messaging for Dermatology, Cardiology, MaxFax, Diabetic Podiatry, ENT, Ophthalmology, Trauma and Ortho

A fantastic course!
Highlights for me: Influencing skills, Model of Organisation Culture, Myers Briggs, Driver diagram

Introduced in May 2020: I have been working to raise profile amongst GPs and to encourage local team commitment

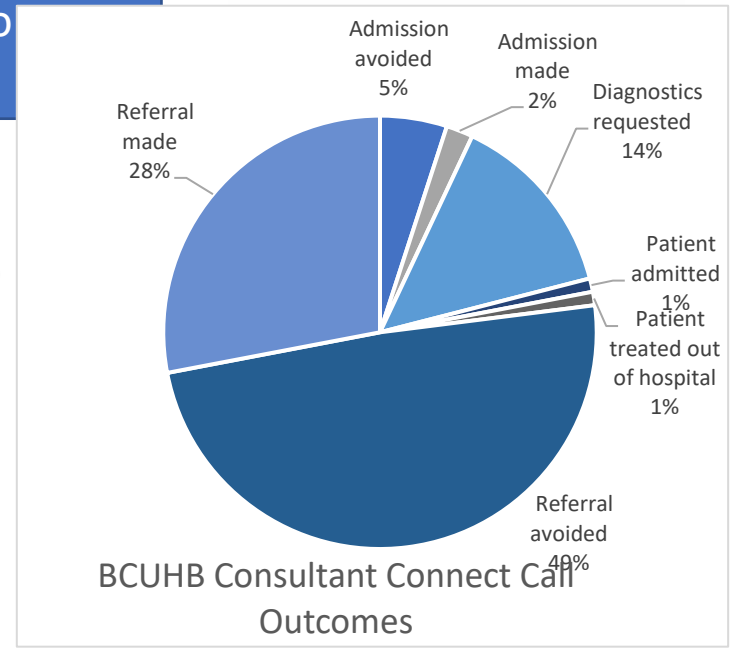
3D- helped with:
*Problem solving
*Enhance ability to work in and lead teams
* apply aspects of organisational theory to work place and project
*QI
* Networking
*Communication
* Presentation skills

THANK YOU!



A fascinating insight and an understanding of organisational structure - helps with working in NHS

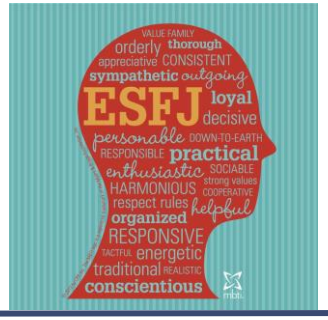
287 GPs have downloaded the App.
Calls have been placed by 81 Practices to 38 different specialities. Connection rate 86%. Total calls answered 1,052.



BCUHB Consultant Connect Call Outcomes

Messages have been sent from 53 Surgeries to 8 specialities

Average call connection speed 34 seconds.
Average call duration 4 mins 17 seconds



Myers-Briggs: an insight and understanding into our pyshcology, strengths and weaknesses

Dermi messaging: a favourite with GPs, excellent feedback: 1006 photo messages sent
Average response time 3:44 hours.
Referral avoided 70%