A Permanent Living Library: An Innovative approach to sharing our Lived Experiences

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University Hospitals Dorset Knowledge and Library Services

University Hospitals Dorset NHS Foundation Trust
Knowledge and Library Services

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Background & Description

- A Living Library brings people together to share experiences, challenge stereotypes and raise awareness of the lived experience of others.
- We have developed a permanent Living Library at University Hospitals Dorset NHS Trust (UHD) and Dorset HealthCare NHS Trust.
- Our Living Library recruits volunteers to act as human 'books' to tell their personal stories. They share their lived experiences with staff that choose to 'borrow' them.
- It provides a safe space for conversations to support colleagues, share best practice and positively challenge prejudice or discrimination.

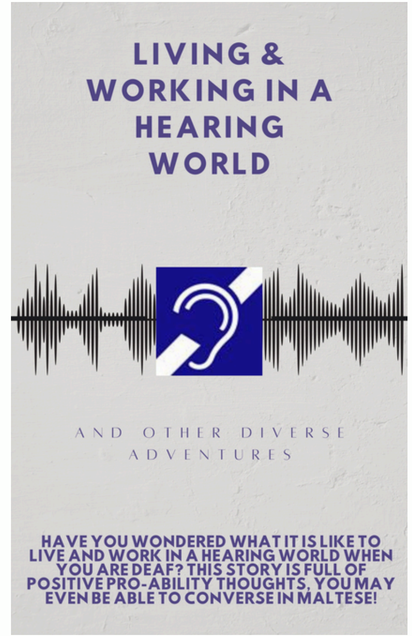
Challenges and Learnings

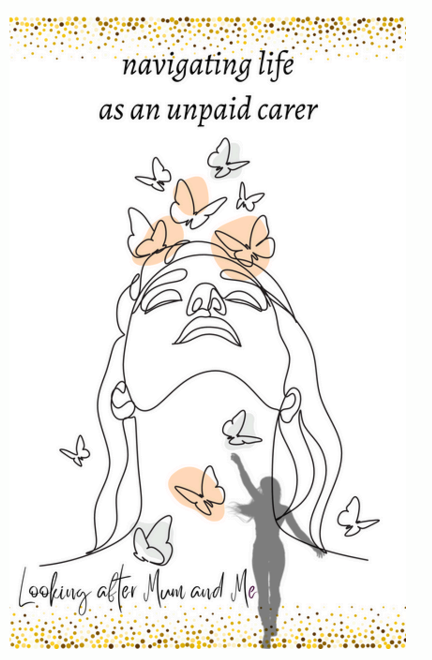
Challenges:

- Recruitment of 'books'.
- Marketing and promotion of the Living Library.
- Encouraging reading of the 'books' by other staff.
- Adapting existing library book cataloguing guidelines to accommodate human 'books'.

Learnings:

- Engaging with a wide range of organisational stakeholders improves project outcomes.
- Administrative and staffing burden needs to be factored in when commencing innovation projects.





What did we do?

- Facilitated focus groups, developed a guide and obtained UHD Executive sign off.
- Worked with UHD Communications team to develop a logo and marketing strategy.
- Created book cover designs, title and blub in collaboration with the 'books'.
- Added the 'books' to our regional library book catalogue.
- Developed a page on UHD KLS website.
- Held an in-person Launch Event.
- Developed an confidential, consent driven system to process requests to read the 'books'.

Next Steps

- Expansion to cover other Dorset based health and care organisations.
- Formal journal publication of outcomes.
- Continued recruitment of 'books' and 'readers'.

Impact and Outcomes

- 17 UHD or Dorset HealthCare 'books' are now available to borrow covering a range of topics.
- There have been 30 separate 'book' loans so far.
- UHD KLS staff have presented this work at national library conferences and we have provided advice and expertise to other NHS Library Services looking to develop a similar innovation.
- Impact data gathered indicates:
  - Books' value having the opportunity to share their story to others.
  - 'Readers' value being able to learn from an expert with lived experience.
  - 'Books' and 'readers' view the experience as a useful networking and knowledge sharing opportunity.
- Our Living Library demonstrates the value of developing a permanent knowledge mobilisation initiative.

Access and Inequalities Integrated Vaccination Service

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Dorset HealthCare University NHS Foundation Trust

Background

Dorset Healthcare initiated several projects to address low COVID-19 booster uptake for autumn/winter 23/24 among eligible residents. Focusing on communities with lower vaccination rates, particularly in deprived areas and minority groups, we used community insights and lessons from past campaigns to develop targeted proposals.

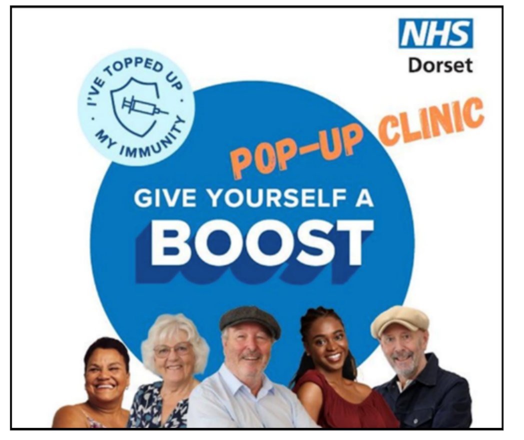
Rationale

Utilising a Task and Finish Group has facilitated an evidence-based approach to identify priority cohorts and foster multi-agency collaboration with VCS and Public Health partners. We plan to track vaccinations and health benefits, understand community perspectives, and gather evidence and feedback to inform recommendations for the upcoming COVID-19 spring campaign.

Building relationships with key community partners will improve vaccine confidence, and insights drawn on barriers to access. These will be shared across Dorset and for broader health services.

What went well

- We administered 421 COVID-19 vaccinations, including 128 for children with learning disabilities.
- Administered 44 flu vaccinations (42 co-administered with COVID-19 vaccines) to homeless individuals in BCP.
- Feedback indicates this co-administration and health checks were well received.
- Outreach efforts reached individuals who otherwise would not have been vaccinated. Feedback showed most patients at outreach clinics would not have been vaccinated without our presence.
- Multi-agency collaboration with VCS partners helped identify venues, improve communications, and provide access to wider health services using local channels like Facebook.
- DiiS data informed our priority settings.
- The Dorset HealthCare Vaccination Service quickly mobilised to deliver varied health inequality projects during a busy autumn/winter programme. Co-administration of COVID-19 and flu vaccinations reached homeless individuals unlikely to access services otherwise.



What we did

- Conducted three focus groups and three online vaccine confidence training sessions for community staff.
- Held nine outreach clinics in key geographical locations in BCP and Dorset leveraging other health events.
- Partnered with The Health Bus to deliver COVID-19 and flu vaccinations to the homeless in Bournemouth, Christchurch and Poole through six outreach clinics, providing individualised care.
- Delivered COVID-19 vaccinations at 22 schools for children with learning disabilities in BCP and Dorset.
- Conducted targeted case finding for COPD patients in Purbeck, scheduling those unvaccinated into a bespoke clinic at Wareham Community Hospital.
- Organised a Carers Celebration event at King's Park Vaccination Centre with partners, promoting health and wellbeing services.

What we could do better

- Focus earlier on specific cohorts (e.g. severe mental illness) and expand geographic coverage (e.g. carers, homeless).
- Engage stakeholders earlier and evolve strategies (training, focus groups) to improve training uptake.
- Enhance communications for patient accessibility, leading to health literacy training for vaccination staff.
- Collaborate across vaccination workstreams for co-administration and simplify online consent processes.
- Engage earlier and more structurally with primary care and PCNs for targeted case finding.

The way forward

- Start all projects earlier.
- Support the homeless community in the west.
- Prioritise health literacy in communications.
- Replicate carers' events in the north and west.
- Integrate with organised events and engage other clinical risk groups.
- Consult communities on best locations, advertise locally.

Access to Community Support & Services Project

Funded by: NHS Dorset

What are you searching for?

accurate local service information

Background

People with serious mental illness (SMI) are at risk of dying 15-20-years younger.

As part of the SMI programme, it is recognised that connection to local community services support people to live longer, happier and healthier lives.

This project aims to increase connection to community services and support by building a shared set of information (data set) which can be accessed by multiple organisations.

Innovation

Creating a **shareable resource** of community services, available for use by directories, websites and apps.

The Open Referral UK standard introduces a **common language** to guide how information is collated. This aligns with ICS directives and national goals for IT **interoperability**.

During this 18-month pilot, frontline workers in Dorset can access this information via a Service Finder.

Challenges

It requires time and resource to...

Achieve interoperability between different systems and data structures.

Maintain and update community information.

Impact & Outcomes

1080 services registered in shared data set
306 frontline workers registered with Service Finder.

"Great resource. We'll definitely use it to support clients to access services." "I've been trying to build something like this for carers, but this is well beyond that. Amazing."

Next steps

Highlight the benefits of adopting a data standard to Dorset ICS.

Support existing directories to utilise the shared data set.

Recommend ways for the VCS to **maintain the shared data set.**

Authors: Kelly Hewitt & Chris Small

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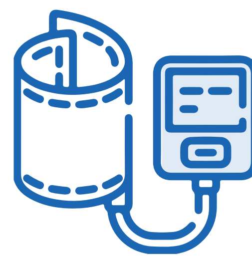
BP @ Home



BACKGROUND

Every day in the UK, 350 people have a stroke or heart attack that could have been prevented.

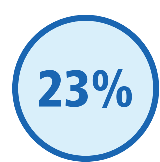
High blood pressure is one of the leading causes of cardiovascular disease, heart attack and stroke which account for a quarter of all premature deaths. Over 200,000 people in Dorset have high blood pressure. The BP@Home app, which launched three years ago in Dorset, has helped more than 2000 local people to manage their blood pressure from home, reducing the risk of heart failure and stroke by 23% after six months on the platform.

THE INNOVATION

"BP@Home is revolutionising blood pressure management and it's great to see Dorset leading the way, with general practice engaged and supporting patients to manage and control their blood pressure through the app. Not only have we seen a significant reduction in blood pressure from hypertensive people in Dorset since using the app, it also reduces the need for face-to-face appointments, saving time and costs for both patients and clinicians."

Dr Martin Longley, Cardiovascular Disease (CVD) Clinical Lead and Associate Clinical Director for Dorset County Hospital.

IMPACT AND OUTCOMES



23% reduction in risk of heart failure and stroke after six months

Av reduction in systolic BP: 6 months on the platform 8.3mmHg/12 months 13.3mmHg

Workforce saving equivalent to 55% from a GP to a different part of the workforce in the first year as well as a 45% reduction in the volume of appointments.

Drives productivity and efficiencies as workflow is automatic and medication changes made without the need for an appt, speeding up control of the hypertension.

See how BP@Home is helping people in Dorset with Hypertension.

What we have learned

"We know that this can make a real difference to people's lives and it has been positively received by patients. Patients have told us that using the app has made them take more notice and have a better understanding of their blood pressure and that they are seeing improvements."

Louise Bell, Advanced Nurse Practitioner at the Bridges Medical Practice in Weymouth who helped deliver BP@ Home.

Pharmacists and Advanced nurse practitioners, working alongside non-clinical roles - can manage our hypertensive population, escalating to a GP when appropriate.

Initially Primary Care focused on the highest risk patients, this proved to be overwhelming when combined with a new technology. The revised proposal of having them begin with the rising risk patients, who are easier to manage, was successful in building confidence prior to having the high-risk patients onboarded.

Next steps

The BP@home model is scalable to secondary care with the cardiology department in university hospital Dorset and Dorset County Hospital already looking at using this to manage their cohort of patients.

"Our hope for the future is for every GP practice in Dorset to offer this to their patients as standard care, which in turn will enable our colleagues in other care settings to confidently do the same. We aim to have at least 6,000 people using the app by April 2025"

Carly Ings, BP@Home Project Manager at NHS Dorset.

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Bridgit is an online self-help tool available 24/7. This supports Carers who are digitally enabled to connect to services, access information, advice, and guidance. Carers can develop a self-help plan and start a Carers Assessment when they want to.

Lead: Sarah Perrett

Carers are able to use the tool to:

- Share they are a Carer
- Start a Carers self-assessment
- Obtain a Dorset Carer Friendly ID Card
- Register with our lead Carer organisation and commissioned services
- Access NHS advice and learn more about health conditions
- Find out about services, peer support groups and community events

Identifying the Need, Carers told us they wanted:

- Clear bite sized information they could trust
- Information 24/7, when they wanted it
- Anonymity (access information without stigma and intervention)

Description of improvement (innovation), engagement and adoption journey

- Over 6 months, Dorset Council's version of Bridgit was developed in partnership with Bridgit and local stakeholders
- We engaged with carers early to test and refine the product
- Regular feedback loops enabled us to iterate
- In May 2023 Dorset Council went live

How was it scaled and what were the enablers?

- A further 2 years funding was secured from the Accelerated Reform Fund

Key challenges and learnings

- Building momentum with stakeholders
- GP Surgeries texting carers
- Integration with client database
- Governance of Artificial Intelligence
- Obtaining Carer feedback

Impact

We have reached 8250 carers, who have created 7814 self-help plans.

One carer said, "It is very intuitive, and it comes up with some excellent solution suggestions. You can personalise it and make lists according to your needs"

Brigit Care

Covid-19 Medicines Delivery Unit (CMDU)

A new Covid 19 treatment with intravenous neutralising monoclonal antibodies

Project Team: Laura Limm *Programme Manager, Transformation & Improvement,* **Nicola Lucey** *Project Lead Chief Nursing Officer/ Director of Infection Prevention & Control* **Cecila Priestley** *Medical Appraiser for Nmabs,* **Sonia Gamblen** *Divisional Head of Nursing*

BACKGROUND

In December 2021 NHS England and NHS Improvement asked NHS Trusts to contact high risk eligible patients (ie. pts with weakened immune system, organ transplant) for new COVID-19 treatments, intravenous neutralising monoclonal antibodies and oral antivirals. Working with local COVID-19 Medicine Delivery Units (CMDUs) the ask was to run a 7 day service to assess these patients and if relevant, offer treatment.

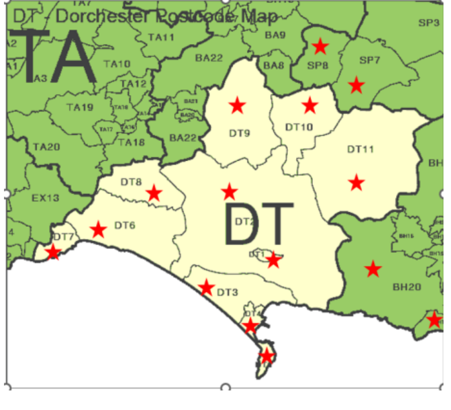
WHAT IS THE INNOVATION

DCH were required to set up and implement an on-site service within 7 days for C19 positive pts who met a high risk criteria.

ADOPTION JOURNEY

Were able to offer to a wide catchment area

Received total of 3,260 referrals with 1,118 pts receiving treatment



KEY CHALLENGES

- Commissioning and funding
- Equity of access
- Appropriate space for nMAB administration on site
- Managing peaks and troughs in demand vs capacity of service
- Workforce / role requirements
- Embedding into Business as usual

HOW HAS IT SCALED

Business as usual continues. Adhoc within DCH for iv Sotrovimab and primary care provide Paxlovid

WHAT WAS THE IMPACT

Gold standard service for patients

Patient and clinician feedback very positive.
No patient complaints received

happy privileged explaining looked_after phone lovely attentive very_well amazing caring impressive doctor reassuring reassure explain friendly quick team checks professional put_me_at_ease efficient kind brilliant very_good polite consultation organised outstanding confident great helpful excellent kindness service swift care good took_time prompt staff exemplary took_care treatment nurses thorough treated_very_well beneficial thank_you calm

Prepared by: Laura Limm, TIO
Date: May 2024

10 IMPLEMENTING GUIDANCE AND BEST PRACTICE ON THE USE COMPRESSION THERAPY FOR PERIPHERAL OEDEMA IN PATIENTS WITH HEART FAILURE

Background

◊ Heart failure is a clinical syndrome characterised by a number of clinical signs and symptoms that can vary in severity, including shortness of breath, fatigue and weakness, rapid or irregular heartbeat and oedema. The accumulation of excess fluid in the arms or lower legs is known as peripheral oedema. The prevalence of peripheral oedema in the lower legs is rising globally in the UK and, from a patient perspective, living with oedema can negatively affect the patient's quality of life and wellbeing. Lymphorrhea and ulceration are common complications of uncontrolled/ severe lower limb oedema, leading to high risk of chronic ulceration, patient suffering and financial burden

◊ Compression therapy typically involves the use of elastic stockings, bandages or compression wrap devices to reduce excess blood and fluid retention, aid venous hypertension and improve lymphatic insufficiency, helping to reduce oedema and inflammation (Montero et al, 2020).

◊ Compression therapy is the gold standard of care for treating lower limb oedema and ulceration; however, uncorrected knowledge gaps and misconceptions surrounding its use for patients with heart failure can deter healthcare professionals from applying it.

Innovation

Recognition of a lack of guidance and training.

Collaborative working between community heart failure and leg ulcer service to promote new guidance.

Opportunity to identify patients who may require specialist heart failure assessment or review of treatment.

Address training needs and develop training plan. Obtain copyright and permissions to reproduce training video.

Upload training to ehub and guidance pathway on intranet .

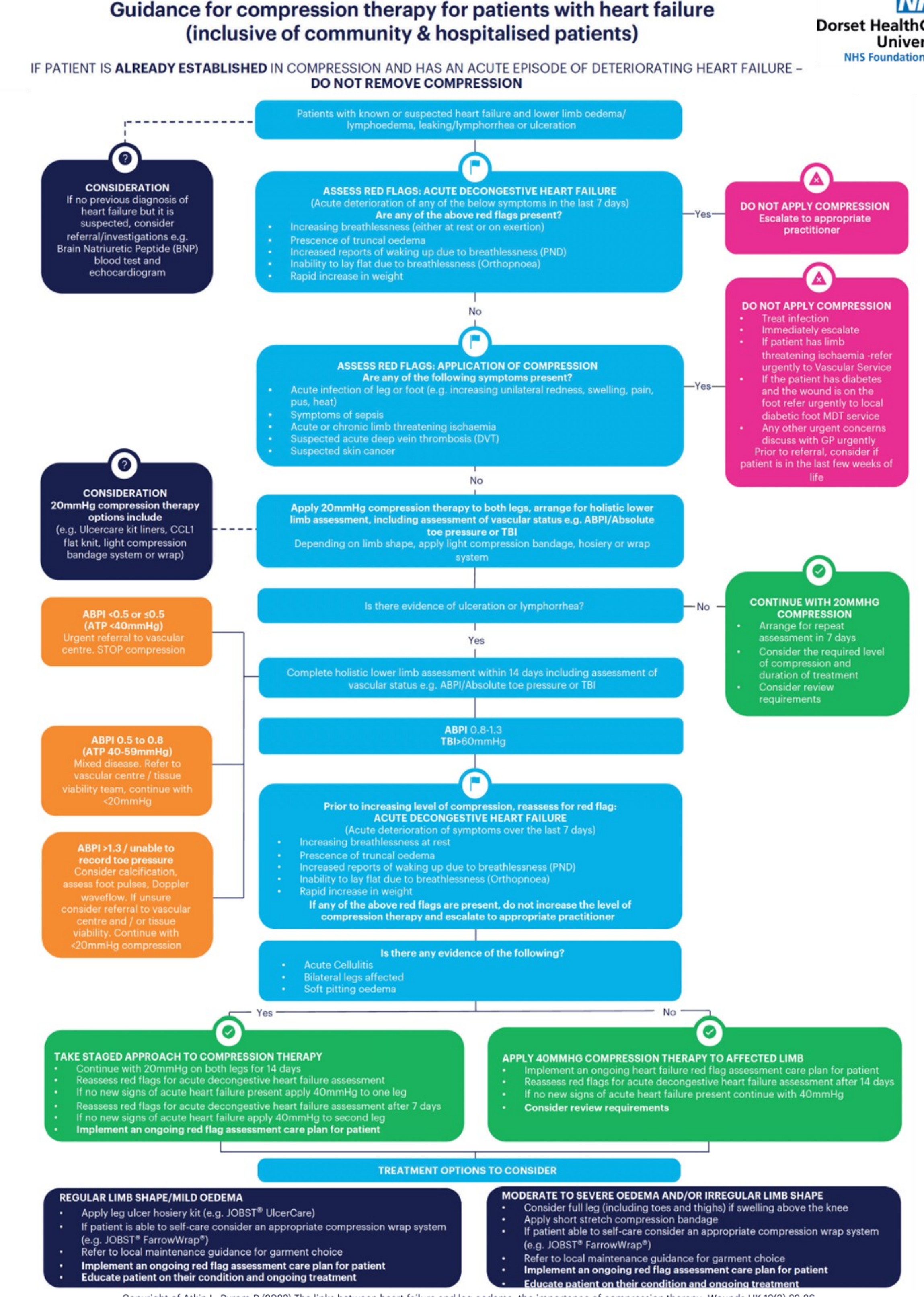
Raise awareness via communication teams and encourage leg ulcer and HF staff to undertake training

Baseline data collected.

Establish audit parameters and patient outcomes and set timelines for reviewing outcomes.

Identify 2 pilot sites within leg ulcer service to test out guidance pathway.

Audit direct referral from leg ulcer service into community heart failure service.



Adapted with permission of Atkin and Byrom

Key Challenges

Slow to start. The key staff found it a challenge to meet regularly due busy clinical roles and other demands.

Obtaining permissions to use pathway and training video then update to ehub took longer than anticipated.

Deciding on SMART objectives

Leg ulcer template on SystmOne lacked read codes to audit pilot- this is still outstanding

Learnings

The meetings were always very positive, and it felt like as a team we could really make a difference to patients quality of life.

Set small goals at each stage

Benchmark and learn from others doing similar projects

Work with Industry partners where available. They had lots of ideas and experience of implementing similar projects

Next Steps

Continue with monthly meetings to reflect on any changes made by using the Pathway

Work with clinical systems to identify appropriate Read Codes to allow more accurate audit of intervention

Evaluate data on the use of compression therapy in patients with heart failure.

Evaluate training and widen staff groups , i.e. community nurses and practice nurses

Consider joint heart failure and leg ulcer clinics

Produced by Ramona Willis Community Heart Failure Specialist Nurse and Jacky Collis Leg Ulcer Nurse, Dorset Health Care University NHS Foundation Trust

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Med Tech Funding Mandate

PROJECT Team: Lloyd Naerger, *Project Support Officer, Transformation and Improvement,* **Derek Kelly** *Innovation Programme Manager, DiH* **Sandra Courtiour** *Acting Innovation Programme Manager, Dorset ICS Innovation Hub*

BACKGROUND

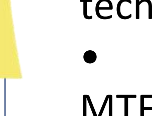
Of the 11 innovations introduced through the MTFM, Dorset County Hospital is currently either using, evaluating or considering 7 of these. Ranging from products used infrequently but for very specific instances to those used multiple times per-week, DCH has adopted a number of innovative technologies throughout the trust. These include Plasma Systems, Xpress and Thopaz+.

WHAT IS THE INNOVATION

In April '21 the MedTech Funding Mandate policy was launched by the NHSE to support adoption of MedTech and diagnostic technologies across almost 200 healthcare services.
This fulfilled a commitment in the NHS Long Term Plan to support commissioners and healthcare providers to bring life-changing innovations to patients quicker. Adoption support is also provided from Dorset Innovation Hub, Health Innovation Wessex and suppliers.

ADOPTION JOURNEY

- Effective (evidenced through NICE MedTech- or Diagnostics-Guidance)
- Deliver material savings to the NHS
- Cost-saving in 3 years
- Affordable to the NHS



HOW HAS IT SCALED

- Ring-fenced funding to implement MTFM technologies is available from NHS Dorset
- Funding can be used to implement new MTFM technologies or increase the use of one already in use
- DCH and NHS Dorset agree a timeline for when each funded technology to become BAU

KEY CHALLENGES & LEARNING

One of the most difficult obstacles to overcome for Dorset County Hospital is time. Engagement, input, feedback and support are already incredibly difficult to obtain from employees but through the collaboration between the Dorset Innovation Hub and Dorset County Hospital, communication channels are becoming clearer and relationships are continuing to build. This allows for more clear and efficient collaboration.

WHAT WAS THE IMPACT

Patients can expect a range of benefits from the products introduced to Dorset County Hospital. Improved quality of life, improved long term physical and mental health as well as sometimes ensuring patients do not require overnight stays. The knock on effect to the trust is significant, freeing up bed space, allowing for a more productive service and introducing innovative methods of treatment
Over 200 procedures for Benign Prostatic Hyperplasia (BPH) performed in 23/24 using Urolift or Plasma System, with the implementation of Rezum expected in 2024/25. Heartflow 3D modelling to be established in 24/25XprESS Sinus Dilation and Thopaz+ Chest Drains continue to be used in DCH.

Prepared by: Lloyd Naerger
Date: May 2024

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Embedding Youth Work in Diabetes Transition

University Hospital Dorset's (UHD) Young People's Diabetes Service (YPDS) supports young people aged 16-23. **2023 saw UHD introduce Youth Work to the YPDS, with aims to improve patient engagement and reduce health inequalities. Youth work is enhancing the service's person centred approach, empowering young people and giving them a voice to shape their care.**

"I got help to get my own fridge and ever since my insulin hasn't gone missing and don't have anxiety about it anymore"

"Thankyou so much for giving my daughter the confidence to come along...it gets her out of her comfort zone..."

Youth Work

Health Fund

Used to reduce health inequalities and support empowering YP living with Diabetes

Patient Engagement

- Escape Room
- Crazy Golf
- Paddleboarding
- Ringo's
- Quiz Night
- Bouldering

Empowerment

Support with education/employment, wellbeing and confidence, finance and housing, SEND advocacy

Health Inequalities

Removing barriers with one off purchases (Bike, Mini Fridge, Dance classes, Art supplies)

Benefits

- Peer Support
- Informal education
- Build Confidence
- Meet the Team
- Have FUN!

Person Centred Approach

- YP led activity ideas
- Moving engagement away from clinical settings

Impact

The informal nature of youth worker interactions may allow young people to open up about major concerns they believe clinicians will find trivial (Nakhla et al, 2017). **September '23, saw a YP self refer for YW support and attend 2 targeted support sessions, despite having a 80% DNA rate.** By **bridging the gap** between disengaged YP and the clinical team, UHD are monitoring how YW engagement can positively impact clinical attendance and diabetes control.

100% of patients who have completed a Health Fund Review say the purchase has helped their diabetes self-management "A lot"

YW has funded the attendance of 45 patients at social activities to date

Challenges

- Securing funding for Youth Work post
- Defining how YW can compliment work already done by clinicians.
- Engaging with high need, clinically disengaged patients

Learnings

- Poor clinical attendance does not translate to poor YW engagement
- Not assuming shared experience of Diabetes will make YP friends

Next Steps

- Secure funding for continued YW
- Measure if YW involvement correlates to positive clinical engagement with the MDT.
- Continue to explore innovative ways to engage with YP.

Kirsty Crook - YW, Coralie Loader - YW, Melanie Pritchard - DSN, Nicola Stacey - DSN, Irantzu Arregui-Fresneda - DSD
Contact ypdsyouthwork@uhd.nhs.uk for more information

(Nakhla M, Bell L, Wafa S et al (2017) Improving the transition from pediatric to adult diabetes care: the pediatric care provider's perspective in Quebec, Canada.)

Recommendations on Optimising Medicines Safety for EPMA Prescribing and Interaction Alerts

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NHS
et HealthCare
University
HS Foundation Trust

Background and Rationale

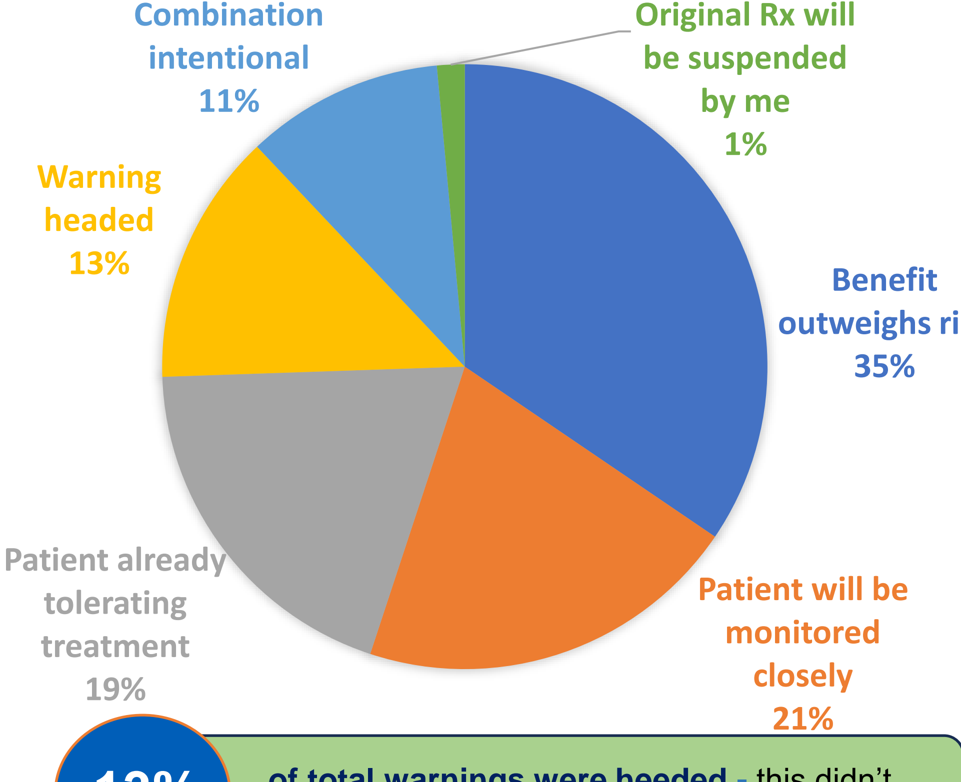
In Nov 2023, Dorset Healthcare configured EPMA to include only **level 3 and 4 severity alerts** (significant and high-risk interactions) to optimise efficacy and reduce alert fatigue [1]-[3], in line with recommendations [4].

This report analysed **how prescribers respond to interaction alerts** to recommend configuration changes within EPMA, with the aim to maximise the efficacy of these alerts.

Analysis – Method

1. Obtained dataset of all interaction conflict alerts in Trust between Nov 23- Jan 24.
2. Data was divided into subsets, with **quantitative and thematic analysis** conducted. The different alert types can be seen in figure 1.

Figure 1 – Proportion of override options chosen by prescribers



Positive takeaways

23% **of level 4 alerts were headed –** difference in how prescribers responded by perceived severity.

13% **of total warnings were heeded -** this didn't necessarily indicate unsafe practice.

Key Finding	Recommendation	Example	Feasibility
Some actions may be considered less appropriate at mitigating risks. E.g., 75% did not suspend the original prescription following a chelation interaction alert, after selecting this override option.	Define **"weaker override options"** and **monitor the frequency** in which these are selected by prescribers e.g., after appropriate 6–12-month periods.	"Patient will be **monitored**" for interactions **increasing arrythmia risk** – to what extent can this realistically be monitored in community settings?	Yes (allowing for appropriate time and resources to re-evaluate).
Mental health specialists suggest drug combinations generating some of the **most frequently occurring alert types** (CNS and antagonised anticonvulsant effects warnings) are in fact **regularly prescribed combinations.**	**Remove common mental health drug combination interactions,** agreed with mental health specialists as clinically unnecessary within the correct context.	Mirtazapine with venlafaxine, or clozapine with PRN lorazepam	**Accuracy to remove alerts** for users in mental health sectors specifically is uncertain. **Removing these alerts may be inappropriate to implement across the entire trust (**non-mental health settings)
94% of all level 4 alerts raised (N=128) within the dataset comprised of **three interaction alert types.**	Generate a **medicines safety dashboard tool** to highlight concerning drug interactions in combination with a particular prescriber override – requiring investigation if to occur.	Olanzapine IM injection + lorazepam IM injection where prescriber does not head warning, or 'benefit outweighs risk' for a level 4 interaction alert.	Yes (allowing for appropriate time and resources to re-evaluate).

Author: Emma Clarke and Medicines Management Team
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[1] Southampton Pharmacy Research Centre – ePrescribing tool kit (DISCUSS) [Online]. **[2]** Cresswell, K., et al. Investigating and Learning Lessons from Early Experiences of Implementing ePrescribing Systems into NHS Hospitals: A Questionnaire Study [Online]. PLOS ONE 8(9) 2013. [3] Bell. H., et al. Mixed methods study of medication-related decision support alerts experienced during electronic prescribing for inpatients at an English hospital. European Journal of Hospital Pharmacy 2019;26:318-322. [Online]. [4] Coleman, J., Slee, A. Guidelines for Hazard Review of ePrescribing Decision Support [Online].

Dorset County Hospital
NHS Foundation Trust

Gym Rehabilitation Service

A new approach to offering Physiotherapy Outpatient Rehabilitation Service to DCH patients

Henry Wathen *Senior Physiotherapist, Dorset County Hospital*

BACKGROUND

The Dorset County Hospital's Outpatient Physiotherapy Department (OPD) has seen a steady increase in demand with further increases expected due to growing waiting lists.

To be proactive, rather than reactive, the team decided to assess and pioneer different methods of expanding its musculoskeletal rehabilitation offering, aiming to optimising efficiencies whilst providing an evidence-based, high-level rehabilitation service for adult patients with musculoskeletal conditions.

Many patients in OPD require a progressive strengthening programme where resistance equipment is extremely beneficial or even required, but equipment is very expensive and not always available within the outpatient setting.

WHAT IS THE INNOVATION

The OPD team at DCH hypothesised that by introducing patients to exercising in a gym, rather than in the traditional hospital outpatient setting, patients would not only potentially have access to a bigger variety of equipment, but also gain more confidence in using gym equipment and be more inclined to continue resistance exercise beyond discharge from the rehabilitation service, long-term in the community.

Initial research showed that this different method of providing the hospital's rehabilitation service had not been done anywhere else at that point.

ADOPTION JOURNEY

To test the idea, a pilot was initiated, setting up an exercise rehabilitation service for adults with musculoskeletal conditions, operating from a leisure centre in the community rather than the 'usual' Physiotherapy outpatient service at DCH. Patient were first seen in the DCH outpatient physiotherapy department and then referred to the pilot service by a Physiotherapist if determined appropriate and agreed with the patient. Patients attended one hour-long gym sessions of individualised, progressive rehabilitation, led by a DCH Physiotherapist. Each session had a maximum of 4 patients at a time, with no more than two new patients per hour.

WHAT WAS THE IMPACT

Extremely positive **patient experience** and feedback with patients scoring the new service 4.9/5

Behaviour changes with patients scoring a 4.91/5 for likelihood to continue exercises after course and 1 in 4 signing up to gym membership

Time and cost-efficient care with physiotherapist able to see 3-4 times more patients in available clinic time

Potential to **accelerate patient pathway,** with patients attending weekly rehabilitation sessions the course is completed on average within 4 weeks rather than the 4-6 months in a standard outpatient setting

Prepared by:
Henry Wathen & Tina Hynch

Date: May 2024

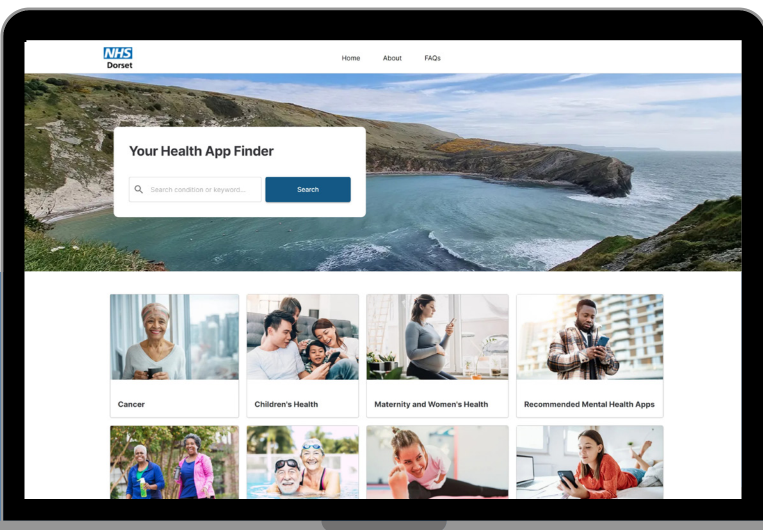
Our Dorset App Library

BACKGROUND

Working together, with Our Dorset partners and ORCHA, (The Organisation for the Review of Care and Health Apps) the Our Dorset Digital Health App Library gives Dorset's communities the power to manage their own physical and mental health, supporting them to stay healthy and well by recommending quality, safe and effective apps to suit their healthcare needs.

ADOPTION JOURNEY

The Integrated Care System has identified a clear plan, in which digital plays an enabling role. The App library helps health professionals in the awareness, accessibility, and trust to recommend the use of health apps. NHS Dorset were the first South West Integrated Care System (ICS) to launch their own Digital Health Library in April 2020. Following its success, this has now led to the launch of a series of Digital Healthcare Libraries across the southwest of England now available to a population of over 5M, to provide Apps that are safe and recommended, to support people with their health and wellbeing.



THE INNOVATION

The Our Dorset App Library helps in reducing waiting times for patients by offering trusted apps as an on-demand alternative to in person services, to help with a wide range of health conditions, from managing joint and muscular problems, to anxiety and how to improve mental wellbeing.

KEY CHALLENGES

The culture challenges in building a new capability has been around awareness/digital readiness of the workforce by providing onboarding/education which included:

- Why utilise digital health technologies as part of our supported self-management
- How to get the best out of the app library

There have been six App Library webinars on a range of topics to support the workforce, and these have been well received. The most recent was focused on apps to support children and young people's mental health and was attended by over 100 people.

People in Dorset are actively searching for apps to support their health and wellbeing needs. The analytics found the most popular public searches and downloads were for mental health apps and it is the top search each month.

Scan to visit the app library

Impact and outcomes

- Over 70k site visits & over 200k page views
- 6,000 apps recommended to date
- 33% of recommended apps downloaded
- Over 300 professionals/teams using the library across Dorset
- The App Library has been embedded into ICS websites such as Maternity Matters, Our Dorset care record, the Dorset mental health forum, Dorset Council and Live Well Dorset
- The Winter Wellness campaign, which was promoted by general practice between December 23 and February 24 drove 700 downloads of apps to help with topics including asthma, lifestyle and mental health.

We're proud partners of Our Dorset — Working better together

Specialist Healthcare for People Experiencing Homelessness

The HealthBus Trust is an award-winning charity offering mobile, specialist healthcare to people experiencing homelessness in Bournemouth and nearby areas. Collaborating with a multidisciplinary team, local authorities, and third-sector providers, the charity delivers GP-led care directly to rough sleepers and those in emergency accommodation, addressing significant healthcare inequalities.

WHO WE ARE

VISION: To reduce health inequalities and develop world class expertise in homeless health through multidisciplinary partnership working.

MISSION: We provide accessible, high quality, patient-centred healthcare for people experiencing homelessness.

VALUES: Every person has an equal right to effective and evidence-based healthcare. We deliver this in a safe and non-judgemental environment.

WHAT WE DO

SPECIALIST CARE:

- Basic Health Checks
- Wound Care
- Chronic Disease Management
- Practical Support to attend Appointments
- Physical & Mental Health Assessments
- Preventative Health including vaccinations
- Liaising with Primary & Secondary Care
- Smoking Cessation & Nutrition Advice
- Sexual Health Promotion and STI Checks.

Partnering with other allied services, we refer patients for; Liver Team Hepatitis Assessments, Drug & Alcohol Support, Optometrist, Podiatrist, and Dentist Support.

"I never thought care like this was possible when I was homeless"

OUR IMPACT

APRIL 2023 - MARCH 2024:

Patients we have seen are aged 18-75 years, some with very complex conditions. Operating part-time, our key achievements are:

- **3727** Total Clinical Interventions
- **1613** Outreach Nursing Engagements
- **1085** Social Prescriber Appointments.
- **692** Mental Health Appointments.
- **381** New Patient Registrations.
- **344** Patients treated via mobile clinic/drop-ins.
- **337** GP Sessions.

NEXT STEPS

SUPPORT: We require commissioning from the NHS to integrate and expand our model of delivery.

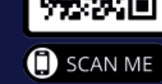
FUNDING: Statutory funding needed to develop and sustain this innovative service, through evidence based research and effective patient-centred care.

ACCESS: Access to primary care patient records via an NHS contract to deliver preventative, screening and opportunistic healthcare.

The MBE for volunteer groups

UK Charity Number: 1186790

healthbus.co.uk



SCAN ME

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"I AM MORE THAN …"

Research engagement with people who have experienced homelessness or being vulnerably housed.

September 2023 - March 2024

We're proud partners of Our Dorset Health, care & wellbeing

REN

Funded by ICS Research Engagement Network (REN) development programme

BACKGROUND

Dorset residents experience inequity to participating in research, leaving many unheard.

AIM

To include Dorset's marginalised in the Research Engagement Network to enhance participation equity.

ACHIEVEMENTS

- Involving people with lived experience of homelessness in research.
- Developing a flexible voluntary and community sector (VSC) involvement model.
- Increasing stakeholder awareness of the importance of having a voice in research

NEXT STEPS March -September 2024

(1) Develop and deliver practical tools to raise awareness of what having a voice in research means, among persons actively delivering research in Dorset. (2) Co-design with wider VCS partners how they would like to be involved. (3) Build VCS capacity to engage in research e.g. deliver training. (4) Inform the development of Our Dorset Insights Hub and supporting infrastructure to enable the sharing of learning and opportunities.

READ MORE HERE

in partnership NHS Dorset HealthCare University NHS Foundation Trust

Dorset Headache Service: Impact of gammaCore ™ on the Prevention and Treatment of Cluster Headaches

Sandra Courtiour *Acting Programme Manager (Dorset Innovation Hub),* **Dr Peter Grenholm** *Consultant Neurologist (UHD)*

What are Cluster Headaches?

Cluster headache is a highly debilitating primary headache disorder which is widely described as the most painful condition a person can experience and is reported to affect 0.1% of populations studied. Treatment often takes a trial-and-error approach with degree of effectiveness and side effects varying from person to person.

What is gammaCore ™ ?

gammaCore is a non-invasive vagus nerve stimulator which offers a non-pharmacological option for the treatment and prevention of cluster headaches. The Dorset Headache Service introduced gammaCore into clinical practice in 2021, with implementation supported by NHS England's Med Tech Funding Mandate policy.

Review of practice and impact

Over February to March 2024, a review was completed to assess the impact of gammaCore implementation. This review included a clinical audit and a patient experience questionnaire. At the time of completing the review, 10 patients had completed a trial of gammaCore.

Rate of effectiveness

4 (40%) of the 10 patients who trialled the device responded to gammaCore. Nationally reported expected rate of response being 25% to 50%.

Impact on key metrics

	No. of medications used		No. of cluster headaches (CH) a day during an attack		Frequency CH limit ability to do usual daily activities	
	Before using gammaCore	After using gammaCore	Before using gammaCore	After using gammaCore	Before using gammaCore	After using gammaCore
Patient 1	5	0	6+ a day	< 1 a day	Always	Never
Patient 2	2	2	6+ a day	< 1 a day	Always	Sometimes
Patient 3	4	1	6+ a day	< 1 a day	Always	Never
Patient 4	3	3	6+ a day	< 1 a day	Always	Sometimes

Use of sumatriptan

Cost modelling suggests a potential cost saving of £450 saving per patient over 1 year if gammaCore is used with standard treatment due to reduced sumatriptan use. Sumatriptan also being associated with significant side effects. In the cohort reviewed, 2 patients had a 100% and 1 patient had a 43% reduction in sumatriptan use. The remaining patient was not using sumatriptan pre gammaCore.

Next steps

Although the patient numbers are small, the impact, where patients respond to gammaCore, has been found to be enormous as the associated economic and societal burden of this condition is significant. This is best summed up by the patient quote below. Next steps include raising awareness within primary care of gammaCore as a treatment option for patients suffering with cluster headaches.

"I am now free to go to work, take holidays and participate in life again!"

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Improvements in Chlamydia and Gonorrhoea Molecular Testing in Dorset

Authors– Gareth Rees, Head of Microbiology Dorset County Hospital, Graham Marriott, Senior BMS, DCH, Samantha Turp, Associate Practitioner, DCH

Background

Polymerase Chain Reaction (PCR) testing is routinely carried out for detection and treatment of Chlamydia and Gonorrhoea in Dorset for customers, such as GPs and Sexual Health Dorset. Within the One Dorset Pathology (ODP) network Dorchester (Dorset County Hospital) and Poole (University Hospitals Dorset) laboratories each had a different testing platform for their respective catchment areas

Improvements

- **A single high throughput testing site located at one of the two ODP Hubs has been achieved using the existing platform at Dorchester. Urine and genital swab collection kits are standardised across the county for the Roche *cobas* chemistry to run on the 4800 platform**
- **Implementation of Inform Health electronic patient record (EPR) software for Sexual Health Dorset seamlessly linking the samples through the Laboratory Information Management System (LIMS) in One Dorset Pathology. This requires less hands on time in the labs and there are no manual transcription of patient information**

Key Challenges and Learning

Configuring and robust testing of LIMS and Inform Medical systems

Communication with stakeholders across Dorset throughout process

Modifying the lab sample receipt and data logging procedure for samples from outside of Dorchester catchment area and for samples received with the Inform Health single barcode sticker

Replacing the stocks of Urine and Swab collection kits in Eastern Dorset with Roche products instead of Becton Dickinson products. Building up buffer stocks of kits and reagents

Modelling sample volumes and testing for ODP. Providing the requisite level of staffing for laboratory activities and sample transport. Engage test platform manufacturer to ensure sample volume within capabilities

Existing Roche *cobas* x480 PCR Platform at Dorchester

Map identifying the future ODP Microbiology Hubs at Dorchester and Bournemouth for a Dorset wide solution

Impact and Outcome

Delivery of end to end solution of Inform Medical EPR. No manual transcription of patient data into LIMS eliminating a potential source of error and saving time. Result directly back to Sexual Health Dorset

Consolidation of high throughput PCR within ODP at Dorchester Hub laboratory

Single test price across Dorset

Fewer stock lines need to be held across Dorset, simplified procurement through an NHS Managed Service Contract

Longer sample stability for up to 12 months

Next steps

Leverage platform for other high demand molecular targets within ODP to reduce send away costs and reduce turnaround times

Imminent replacement with next generation Roche 5800 platforms from the Southern Counties Pathology Network procurement with onboard extraction increasing workflow automation with less hands on time. Common platforms provide service reliance to Dorset customers

Acknowledgements– RBH Poole and Bournemouth Microbiology Laboratories, DCH Pathology IT, One Dorset Pathology, Sexual Health Dorset

Outstanding care for people in ways which matter to them

Improving Dorset's community mental health services

What is Access Wellbeing?

Access Wellbeing is part of a national drive to improve access to mental health and wellbeing support. The NHS, councils, voluntary and community sector are working together to better meet the needs of the people who live in Dorset.

The new model of care recognises that sometimes, the challenges we face in our day-to-day life or experiences we have faced in the past can impact on our mental health, wellbeing and connections with others, and become overwhelming without the right support.

It aims to provide:

The right support – person-centred mental health and wellbeing support that can be accessed by anyone

At the right time – access to advice and help when it is most needed, recognising what matters most to an individual at any point in time

In the right way – a choice of different way ways to get help and support, including face to face and online, and a 'no wrong door' approach.

Access Wellbeing will offer different types of support depending on a person's need, including earlier access to help, which can prevent concerns from escalating, and empower people to support their future health and wellbeing.

New model of care

In Dorset, we worked with people who use services, alongside statutory partners and the local voluntary and community sector (VCS), to understand local need.

Phase 1: developed our values, philosophy and the overarching model, including a level of service that is accessible to everyone

Phase 2: worked with mixed groups to consider different needs and explore how teams can work together and connect services, to best meet those needs

Phase 3: now underway – pilot hubs in Poole and Weymouth have launched and will provide accessible support and allow us to understand more about the needs of the community.

Next steps

- asset mapping to support local design of model and it's mobilisation across Dorset
- Access Wellbeing partners to begin recruitment of further wellbeing coordinators
- identify a further hub space
- training and inductions across the system to support wellbeing coordinator role
- implementing Peer Open Dialogue – an innovative way to connect with families, networks and neighbourhoods in supporting a person with a mental health problem
- Developing a 'digital front door' website for online support.

Challenges and learning

- more time was needed to gather information about community assets and establish range of membership
- a comms and engagement group should have been established from the start
- there were too many meetings with similar membership. Keeping track of this via project email inbox helped to track them
- there was a need to support different partnerships priorities
- timescales needed to be more realistic
- project team needing to feel empowered.

Access Wellbeing hubs

Two pilot hubs are now open: Access Wellbeing Poole, which is located in the Dolphin Shopping Centre, and Access Wellbeing Weymouth & Portland, which is located in Hope House, close to the seafront in Weymouth. Trained wellbeing coordinators can help people to find the right support and advice. Teams can help people to access support from charities, community groups, NHS and councils.

Mental health and emotional wellbeing

Housing, benefits and finance

Social connections and activities

Support for carers

Education, training and work

Volunteering opportunities

Outcomes and success

1617 visitors to the hubs from Jan - April 2024. The team have given advice and guidance for drop-ins, 1:1 appointments, group offers and specialist services.

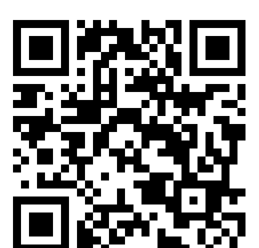
Feedback from visitors to the hubs

"Staff were calm and good listeners. They provided helpful advice and made me feel welcome to come back if I need more support."

"Helped to get me set off on the right track."

"Welcoming friendly open space."

"Felt listened and with no judgement."



Working in partnership with: NHS Dorset, Community Action Network, BCHA, Help & Care, Prama, The Lantern Trust and Dorset Mental Health Forum.

MHST PARTICIPATION 'VOICES MATTER 26

BACKGROUND

The Dorset Mental Health Support Teams (MHSTs) are based in educational settings across Dorset, providing early intervention and prevention support for children and young people with mild/moderate mental health difficulties, primarily anxiety and low mood.

It was important to us that we gave our stakeholders a chance to be heard, to shape future direction of the service and sense check our current offer.

Children's Mental Health Week focused on the theme of 'Your Voice Matters', so we launched our participation campaign during this time, as it shared in the core principle of participation; voices matter.

We aimed, to get feedback from young people, parents/carers and school staff on their knowledge of our service, and what support they would benefit from.

HOW

- We developed **online questionnaires** via Microsoft forms
- We set up **information stalls**, in person, at lunchtime, at various schools to gather qualitative feedback from students and parents
- We ran **webinars for Staff and Parent/Carers** to introduce our service and promote the questionnaires
- We provided **Introduction videos for young people**
- We used **QR codes** for accessibility
- We promoted the campaign via our **social media**

CHALLENGES

- Relying on Schools to promote and to share resources with stakeholders.
  - We overcame this by being present in school and built on our existing trusted relationships with young people, parents/carers and staff.
- Staff engagement in completing questionaries' was low. Potentially due to workload
  - How can we improve engagement?

PARTICIPANTS

In total, we had a fantastic response to our questionairres

Young People	School staff	Parent/ Carer
2349	28	196

INITIAL INSIGHTS

- **Anxiety was the key identified need across all three 'groups'.**
- Parent/carers and staff requested more **information leaflets** and **pre-recorded content** from our service so we are more accessible.
- Children and young people highlighted **the importance of knowing who they would be talking to about their mental health** as being a key factor in making it easier for them to access support services.

NEXT STEPS

- Launching the **'You said - We did'** Campaign to feedback service developments to stakeholders, and promote existing resources.
- **Focus in increasing MHST visibility** in education settings with all stakeholders
- Develop **Parent Forums & Young Peoples Voice groups** for future service development
- Developing **mailing lists**, to assist in sharing information

FREE RESOURCES

E: dhc.mhsteam.bcp@nhs.net

Project leads:
Clare McCartan & Emma Hopkins

@DORSETMHST

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NOURISHING FUTURES

SUPPORTING HEALTHIER FOOD CHOICES FOR CHILDREN ON FREE SCHOOL MEALS THROUGH WORK WITH PROVIDERS OF THE HOLIDAY ACTIVITY FOOD PROGRAMME

BACKGROUND

Health inequality:
Obesity rates in children are highest in the most deprived 10% of the population, more than twice that of the least deprived 10% (2)

The Holiday Activity Food (HAF) programme is a Government funded scheme for children on Free School Meals (FSM). It focuses on food provision and activity during holiday times. Activity providers have to incorporate, "helping children to understand more about the benefits of healthy eating and nutrition" into their programme. (1).

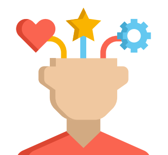
Most providers have limited knowledge in this field. To support them Public Health Dorset with the Friendly Food Club have developed and piloted the following:

- A training programme - now made mandatory to attend
- A set of relevant resources

In addition support to was given to the food providers to ensure the Food School Standards were met.

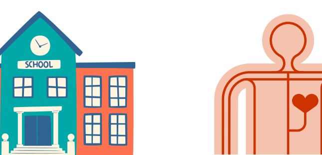
RATIONALE

Obesity harms children and young people



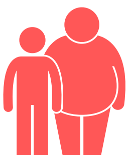
Emotional & behavioural

- stigmatisation
- bullying
- low self-esteem



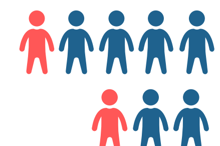
School absence

- high cholesterol
- high blood pressure
- pre-diabetes
- bone & joint problems
- breathing dificulties



increased risk of becoming overweight adults

risk of ill-health and premature mortality in adult life



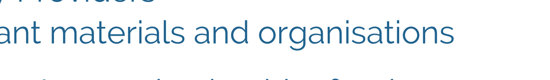
Year R - 1 in 5 children overweight or obese

Year 6 - 1 in 3 children overweight or obese

WHAT WE DID

The Friendly Food Club and Public Health Dorset worked in partnership to:

- Develop a set of relevant activity based resources to support activity providers
- Pilot the material and adapt as necessary
- Design and run 3 mandatory training sessions across Dorset for Activity Providers
- Signpost to relevant materials and organisations



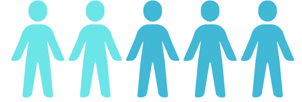
Training sessions for providers included:

- Background on healthy eating
- Alternatives to food as a reward
- Modelling behaviour
- Integrating healthy food messages
- Food safety
- Oral health
- Where to signpost to
- How to use the resources with practical applications

The material was piloted with 3 providers and the material subsequently adjusted from the feedback. During June 2023 we then ran 3 sessions. Uptake improved when it was made mandatory.

CHILDREN IMPACTED

- 5299 children attended a Summer in Dorset HAF programme of these
- 2050 of these were on FSM (there were 9452 children on FSM)



- over the summer 19360 visits were made by children on FSM
- The activities were be provided by 56 different organisations across multiple venues in Dorset

HOW DID IT GO?

HAF Providers Questionnaire (n= 24)

50 providers (90%) attended the training.
24 replied to the questionnaire. The material was used in the following ways:

Use	Count
Use the Eat the Rainbow Activity...	13
Use the Eat the Rainbow place ...	8
Give out Oral Hygiene kits	13
Give out Recipe Cards	10
Host a Friendly Food Club cooki...	4
Host a Friendly Food Club one h...	2
I didn't use any of the resources	0
I used my own resources	8
Other	4

At the training attendees were asked to describe 2 surprising or interesting facts they learnt from the session. This is the slido response:

Ways to engage children with healthy eating
Statistics on obesity
bc
days
Stats on obesity
58%
Eat the rainbow was excellent
Food banks
Really good information and fun training
teeth
children
responsibility
Signposting info
disrupted
Stats on obeisity
Obesity stats
Work book/activities
The aims of the haf programme and Educating kids

THE WAY FORWARD

We cannot measure the change in diets as it is beyond the scope of the project, however research shows that preparing food increases liking and consumption (3). There are associations with nutrition and emotional wellbeing (4) as well as a sense of achievement (5). Previous findings suggest that cooking programs may positively influence children's food-related preferences, attitudes, and behaviours (6).

REFERENCES

Numbers in brackets: Scan here

Public Health Dorset
Part of BCP and Dorset Councils

Naomi Mason: Naomi.mason@dorsetcouncil.gov.uk

Parkinson's Time-critical Medication:

Improving timely administration for community hospital inpa

NHS Dorset HealthCare

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WHY ?

Parkinson's medication

- Improves symptoms
- Reduces disease progression

Timely administration

- Often 5-times daily, ideally taken within 30-minutes of planned time
- Timeliness impacts symptoms & slows disease progression
- Poor disease management prolongs patient stays in hospital

Parkinson's UK challenge[1]

- Estimates only 42% medicines timely in secondary care (hospitals)[2]
- Asks NHS Trusts to audit and improve timely administration

Motor skill symptoms

Bradykinesia (slow movement, loss of facial expression, decreased blinking)

Soft / monotone voice

Rigidity / unstable posture

Tremors

Difficulty walking

Dystonia (involuntary muscle movements, can be painful)

Non-motor skill symptoms

Mental issues (depression, anxiety, sleep, fatigue, cognitive problems)

Reduced sense of smell

Excessive sweating

GI problems (urinary issues, weight loss)

Skeletal / joint pain

OPPORTUNITIES

Data gathered and staff survey indicated:

- 71% doses inside target of ±30 minutes window (6-months data)
- Staff awareness variable
- Medication system not ideally configured
- "Passive" patient engagement

1st ACTIONS

Medication system configuration changes:

- Prescribing and administration prompts
- Staff survey follow-up

IMMEDIATE IMPROVEMENT +11%

- 82% doses now timely

NEXT STEPS

1. Monitor data for longer-term impact & sustainability
2. On-ward visible prompts
3. Highlight in regular staff communications
4. Patient self-monitoring tool

CONCLUSIONS

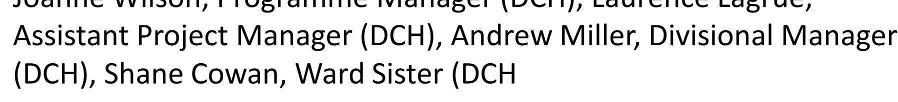
- **Appears possible to achieve 90%+ timely administration for inpatients**
- **Patient engagement key when inpatients and on hospital discharge**

Authors:
Robin Mitchell, Medication Safety Officer, Dorset Healthcare University NHS Foundation Trust
Hatim Aessa & **Elhassan Fatehelbab**, Department of Life Sciences, University of Bath
May 2024

Selected resources:
1. *Time critical medication – ten recommendations for your hospital* & *UK Parkinson's audit – transforming care* (Parkinson's UK, Apr 2023, see www.parkinsons.org.uk)
2. *Get Parkinson's medications on time: the Leeds QI project* (Corrado J. *et al*, Age Ageing, Aug 2020, see https://academic.oup.com/ageing/article/49/5/865/5869603)

Pathway Home Hub

Developing an innovative space to reduce avoidable admissions, enhance flow and enable better patient outcomes for people over the age of 75



PROJECT TEAM:
Joanne Wilson, Programme Manager (DCH), Laurence Lagrue, Assistant Project Manager (DCH), Andrew Miller, Divisional Manager (DCH), Shane Cowan, Ward Sister (DCH

BACKGROUND

This project began with an initial mandate to create a 'No Criteria to Reside' Ward, on the hospital site, to support flow. Feedback from key stakeholders advised the option to explore avoidable admissions, earlier in the patient journey.

Flow had been identified as a key priority for the Trust. It is well documented that keeping patients in hospital when they are medically fit for discharge leads to worse outcomes. This is even more pertinent when a person, could have avoided the admission all together.

Issue map: orange highlighting areas where the Pathway Home Hub is anticipated to support

WHAT IS THE INNOVATION

Working with stakeholders to identify a completely new way of working, across organisational boundaries, to develop a solution which fits the need of our local community

What makes the Hub different?

- Focus on prevention and early intervention to reduce or avoid acute care needs and help people to stay well
- Booked appointments and same day care
- Homely welcoming environment
- No beds
- Partnerships with DCH and local Community and Voluntary Services (one stop shop)
- Opportunities for staff skill development and rotations

ADOPTION JOURNEY & ENABLERS

- Establishing a project leadership triumvirate including Management Lead, Clinical Lead and Project Lead
- Engagement and ongoing management of broad range of stakeholders, including ED, Estates, Elderly Care, Pharmacy, discharge lounge, primary care, virtual wards, Therapies, Care Homes and VCSE organisations
- Workshops using tools such as brainstorming and dot voting enabled effective and interactive idea generation
- Staffing workshops to map available resources, gaps, and opportunities for collaboration
- Name for the hub developed with stakeholders and agreed with patient forum
- Operating model developed with stakeholders
- Identification of space on site and engagement to ensure utilisation

KEY CHALLENGES & LEARNING

- Be ready for change, an ambitious scope can lend itself to refinement
- Stakeholders will evolve as the project evolves - new stakeholders will be identified, and others will vary their engagement. Maintaining communication with them is vital
- Be aware of the wider work going on that may compliment or even complicate the ambition
- Challenges include projects competing for funding
- Successes include the consistent enthusiasm for this project from members inside and outside of it

WHAT IS THE EXPECTED IMPACT

- The key areas for measurement are:
- Reduction in admissions of patients 75 + with a frailty score of 6 or above
- Reduction in re-admission of patients 75+ within 30 days of discharge
- Reduced length of stay for patients 75 +
- Improved patient experience

Prepared by: Ciara Darley, TIO

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Patient Action Tracker

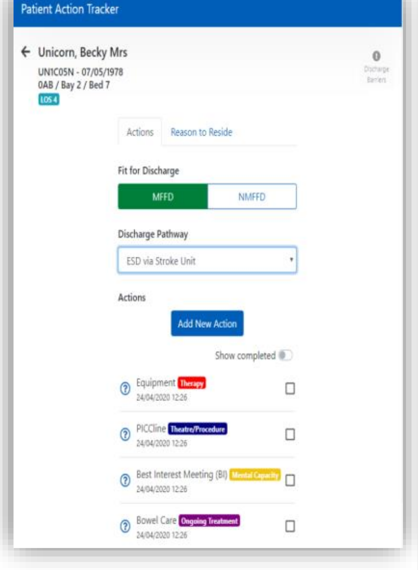
A bespoke app, co-designed with operational and clinical colleagues, to improve patient flow management

Project Team:
Christina Hynch *Project Manager, Transformation & Improvement,* **Becky Vass** *Divisional Support Officer,* **Laura Pearson** *Deputy Head of Business Intelligence ,* **John Collinson** *Head of Digital Development*
Andy Miller Divisional Manager of Operations *(not in photo)*

BACKGROUND

Effective patient flow management is critical to the smooth running of hospital inpatient services. Achieving this requires the combination of robust discharge planning and the early identification of any impediments in the treatment pathway.

In the years preceding this project, multiple attempts had been made to improve the process, including interventions using Excel spreadsheets. This was resource intensive, did not support any centralised reports or business intelligence analysis, and was not user-friendly.



WHAT IS THE INNOVATION

To improve the patient flow management process at Dorset County Hospital, a multidisciplinary project group was established. After fully understanding the need and challenges colleagues were facing, the small project team developed a bespoke app, the Patient Action Tracker (PAT), which was co-design with end-users such as ward sisters, discharge team members, operational managers, and administrators.

The developed app draws known patient information from clinical systems, including demographic information and inpatient location details, to improve data quality and reduce data entry. It enables teams to record 'next steps' in patient's care pathway and provides business intelligence. To support patient flow management.

ADOPTION JOURNEY & KEY CHALLENGES

The original plan was to pilot the PAT on one ward during April 2020 however, the Covid-19 pandemic disrupted this plan. Instead of allowing this to delay the project, the team responded by pivoting to meet the emerging need. This included adding functionality to record the 'Criteria to Reside' data set. Furthermore, the project and senior management teams agreed to accelerate the implementation plan from six months to three weeks and from one ward to 13 wards, due to the challenges being faced. During the short implementation period, the team trained more than 170 staff members and held multiple engagement events to ensure end-users continued to be fully involved and empowered to contribute.

HOW HAS IT SCALED

Additional functions have since been added to the app such as ability to escalate to senior managers, order patient medication directly from the app, automated alerts to discharge lounge when patients are ready to leave and many more. The app has been fully embedded, and engagement continues to be high.

WHAT WAS THE IMPACT

The PAT app has completely transformed patient flow and discharge planning at DCH. Live PAT dashboards are now integral part of Trust's bed management settings, data collection via the app is used to inform system-wide tactical and strategic discussions and for the first time, DCH has a truly transparent picture of internal and external causes of delays to discharge and meaningful business intelligence.

Prepared by: Christina Hynch, TIO

Date: May 2024

The Oral Health Collaborative

BACKGROUND

Access to dental care in Dorset has become increasingly challenging, with a rise in population and limited availability of NHS dentists.

Currently, only 35% of adults in Dorset have access to an NHS dentist.

The situation is similarly challenging for children, pregnant women, and those on low-income benefits.

Geographical barriers, particularly in rural areas, further exacerbate the problem. Eleven areas in Dorset are within the top 20% most deprived nationally.

The percentage of children and adults accessing NHS dentistry in Dorset in the last 12 months (as of Feb 2024) is lower than the national and regional averages.

Adults:

41%

Dorset National

Children:

51% VS 53%

Dorset National

THE SOLUTION

We have proposed the creation of an oral health collaborative.

The objective of this collaborative is to integrate training and development of oral healthcare professionals, tailoring service provision to workforce requirements.

We will:

increase the number of dentists and dental health practitioners providing NHS Care. This will reduce waiting times and improve overall oral health.

establish an oral health training hub. This will provide hands-on training routes and skill development for oral health programmes.

conduct community outreach. This will raise awareness of oral health and promote preventative measures.

promote and develop oral health reasearch. This will address specific oral health challenges faced by the local community.

Impact and outcomes

The oral health collaborative is expected to have a significant impact on oral health provision in Dorset.

Key outcomes include:

- enhanced access to dental care in Dorset and the South West
- increased number of dentists and dental health practitioners providing NHS care
- establishment of an oral health training hub to facilitate the training and development of oral healthcare professionals
- improved oral health provision in clinical pathways
- creation of a provider collaborative to sustain the oral health ecosystem.

What we have learned

In addressing Dorset's significant dental care challenges we have learned that collaboration and innovative solutions are essential.

Comprehensive approaches are necessary to ensure equitable access to dental care for all residents, regardless of their location or socio-economic status.

Next steps

For more information or to get involved contact:

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Virtual Hub

I have a lady living in BH11 area that needs ....

Community Action Network

Professionals spend countless hours searching for support options for their clients. This limits collaboration and hinders efficient service delivery. We wanted to find a solution.

We created the Virtual Hub as a secure online real-time information-sharing platform. It's a place where professionals can ask questions, find resources and connect with colleagues, across the system, in a user-friendly space.

Moving from traditional email enquiries to a system wide digital platform, creates user engagement, ongoing support, increased integration and a space to share knowledge.

We have a challenge in relation to 'net.uk' email addresses. Some colleagues are unable to join the Virtual Hub due to system permissions, We would love to solve this issue - Is anyone at UHD or DHC able to help us?

"It saves me HOURS per week, improves access to information and fosters collaboration! That means better support for residents and improved well-being in Dorset."

"This service is radically changing adult social care and healthcare for people, reducing decline in mental and physical health - and you can quote me on that!"

bit.ly/CANVirtualHub

WEYMOUTH RESEARCH HUB

Collaboration across four organisational boundaries to create and run a clinical trials facility in Weymouth

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In 2023 four R&D teams came together to open Weymouth's first ever clinical trials facility. This provides local people the chance to be involved in health research on their doorstep. The hub runs major commercial studies to develop new vaccines and drugs. We have one aim: to **save** and **improve lives**. Our pipeline includes flu, respiratory, Mpox and norovirus studies and maternal and paediatric vaccines.

Challenges

- Dividing work equitably
- Management of budgets across organisations
- Aligning visions and ambitions

Impacts and Outcomes

- Complex collaboration is possible
- Increase in research delivery workforce capacity & capability

Learnings

- Keep communication open
- Diary regular catch ups
- Try to meet face to face

FUTURE

We want to align our research with local health needs. If we can offer innovative treatments and interventions to local communities, we will really benefit patients living with long term diseases and conditions.

Poster by Comms and Engagement Lead, Chrissy.Sturt@nihr.ac.uk

Young Person's Diabetes Service

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Young person said:
"after seeing the dietitian I had the best gym sesh I've had in a while, nice to have my energy back, enjoy my work out and my blood sugars stayed in check."

Redesigning Transition Services in Diabetes A Person Centred Approach

Young people told us:
"just being able to keep in contact via a simple text message between appointments is greatly appreciated"

Our Purpose:

To provide a service that builds on teamwork, shared goals and overall holistic care in order to encourage autonomy and independence and ensures a seamless transfer of care.

Service Aims & Objectives:

- A higher percentage of young people achieving their target blood glucose levels.
- A higher percentage of young people engaging in specialist clinics and improving access.
- Reduction in admission with diabetic ketoacidosis (DKA).
- Co-design of education structure and delivery.
- Establishing local peer support to aid in-patient empowerment and self-management.
- Better access to technology to support management of diabetes.

The journey so far - our service currently provides:

Young Person's Diabetes Service (YPDS) clinics running once weekly for 18-24 yrs. Multi Disciplinary Team (MDT) approach which includes Consultant, Diabetes Specialist Nurse (DSN), Dietitian (DSD), Clinical Psychologist and Youth worker (YW).

Psychology clinic running alongside offering psychological assessment and therapy to young people who want to better understand their relationship with their health and address patterns which are causing difficulties.

YPDS offers 4x MDT clinic appointments per year, 8 additional contacts from the team in between clinics, and an annual dietitian review.

Once a month transition clinic for 16-18yrs – held jointly with members of the paediatric team at the Diabetes Centre.

Once monthly MDT high HbA1c meetings using a case formulation risk tool designed by the Clinical Psychologist to support the team to consider wider psychological and social factors impacting on a young person's ability to manage their diabetes.

Patient database spreadsheet is used to measure outcomes and target achievement rates for the NICE recommended 8 care processes, specifically in the young adult cohort.

Flexible drop in sessions, ad hoc appointments, text and telephone support with DSN, DSD and YW in between appointments. Non-judgemental, open door approach that supports and builds trusting relationships with young people.

Pre and post clinic MDT – joint working, raising concerns, problem solving and agreeing action plans.

7 day 8-5 pm DSN advice line service.

Design and publication of Transition in Diabetes and YPDS booklets - available in both digital and paper formats.

Patient Voice:

- Assessing expectation and satisfaction through questionnaires.
- Focus group meetings to obtain feedback and reflection of positive and negative aspects of the service.
- Working together to continue service improvement.

Education:

- Bite size virtual education sessions co-designed focusing on topics of interest following feedback from YP. Flexible timings.
- First session - Gaining muscle with diabetes running successfully with good attendance and positive feedback.
- YPDS social evening – opportunity to meet others living with diabetes and to get to know the team. Informal education delivery and discuss innovations in diabetes care.

Adopted Tech:

- Digibete
- Follow our instagram page – dorset.ypds
- Quarterly newsletter
- Donate IT - helping to support access to phones and laptops.
- Virtual appointments

YPDS Team: Laura Brokenshire - DSN, Jo Hanna - DSD, Sarah Cook - Clinical Psychologist, Kate Parish -Youth Worker, Dr Adam Nicholls - Consultant
For more information contact YPDS@dchft.nhs.uk

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Major Incident Simulation

As part of the paramedic science and nursing curricula, students take part in a mass casualty simulation: Zombie Attack. On Day 1 paramedic students from all years are involved in triaging and treating multiple high-fidelity patients with multi-system traumatic injuries in a disused underground car park. On Day 2 this car park in transformed into a simulated field hospital where the final year adult and mental health nursing students put their skills to the test. In total over 450 BU students take part in this interprofessional simulation event.

This multi-faculty, interprofessional event had humble beginnings. Four years ago "aliens attacked" the same underground car park and 34 first year paramedic students took part in a low-fidelity trauma simulation. Building upon the feedback from students, this then evolved into "Godzilla" wreaking havoc causing a major incident high-fidelity simulation the following year, with the moulage being created by AUB students.

In 2023 the Adult Nursing team joined the fray and 300+ nursing students manned the simulated field hospital treating Godzilla's victims.

Changes led by student feedback and staff innovation have evolved this small-scale simulation into the interprofessional, multi-faculty two-day event it is today, with student engagement and learning at it's heart.

This event would not be possible without the help and good will of clinicians from many organisations who act as directing staff:

- Dorset and Somerset Air Ambulance
- Wiltshire Air Ambulance
- University Hospitals Dorset
- Southwestern Ambulance Service Trust
- South Central Ambulance Service Trust
- South East Coast Ambulance Service
- London Ambulance Service
- Hazardous Area Response Team SWAST
- National Ambulance Resilience Unit

Further innovation is being planned to extend the reach of this event to include the BU Children's and Young People Nursing cohort along with Physician Associate and Operating Department Practice students. There is ongoing research in collaboration with UHD simulation team regarding peer-led student debriefing and wellbeing.

BU Major Incident Simulation Event Video link

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