CLAHRC Wessex

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WELCOME TO CLAHRC WESSEX FORMAL LAUNCH AND FIRST ENGAGEMENT EVENT

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Professor Jessica Corner

Dean for the Faculty of Health Sciences
(University of Southampton)
Director of CLAHRC Wessex

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Fiona Dalton

CHIEF EXECUTIVE

University Hospital Southampton NHS Foundation Trust

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NIHR Centres for Leadership in Applied Health Research and Care (CLAHRCs)

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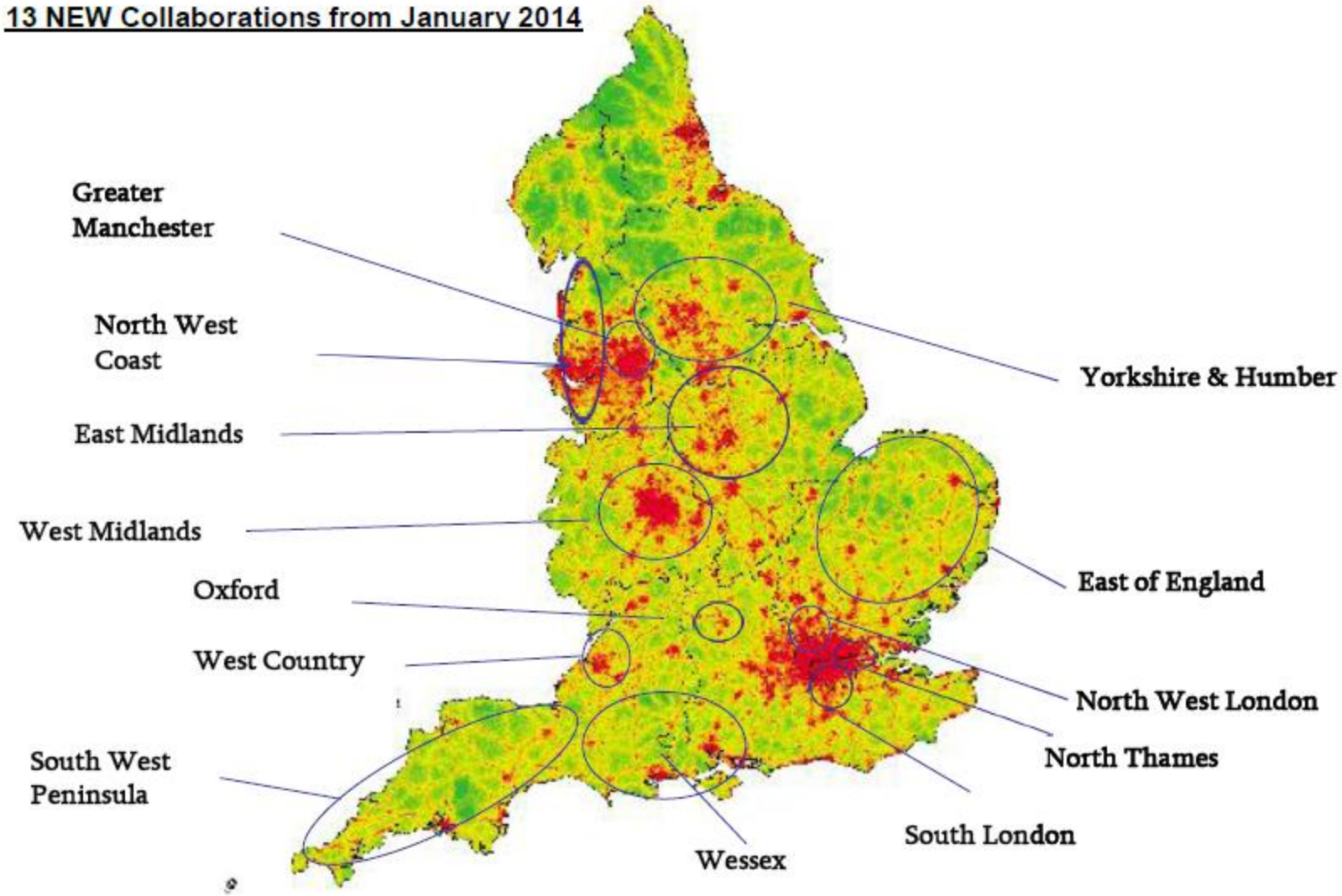
13 NEW Collaborations from January 2014



NIHR Clinical Research Infrastructure

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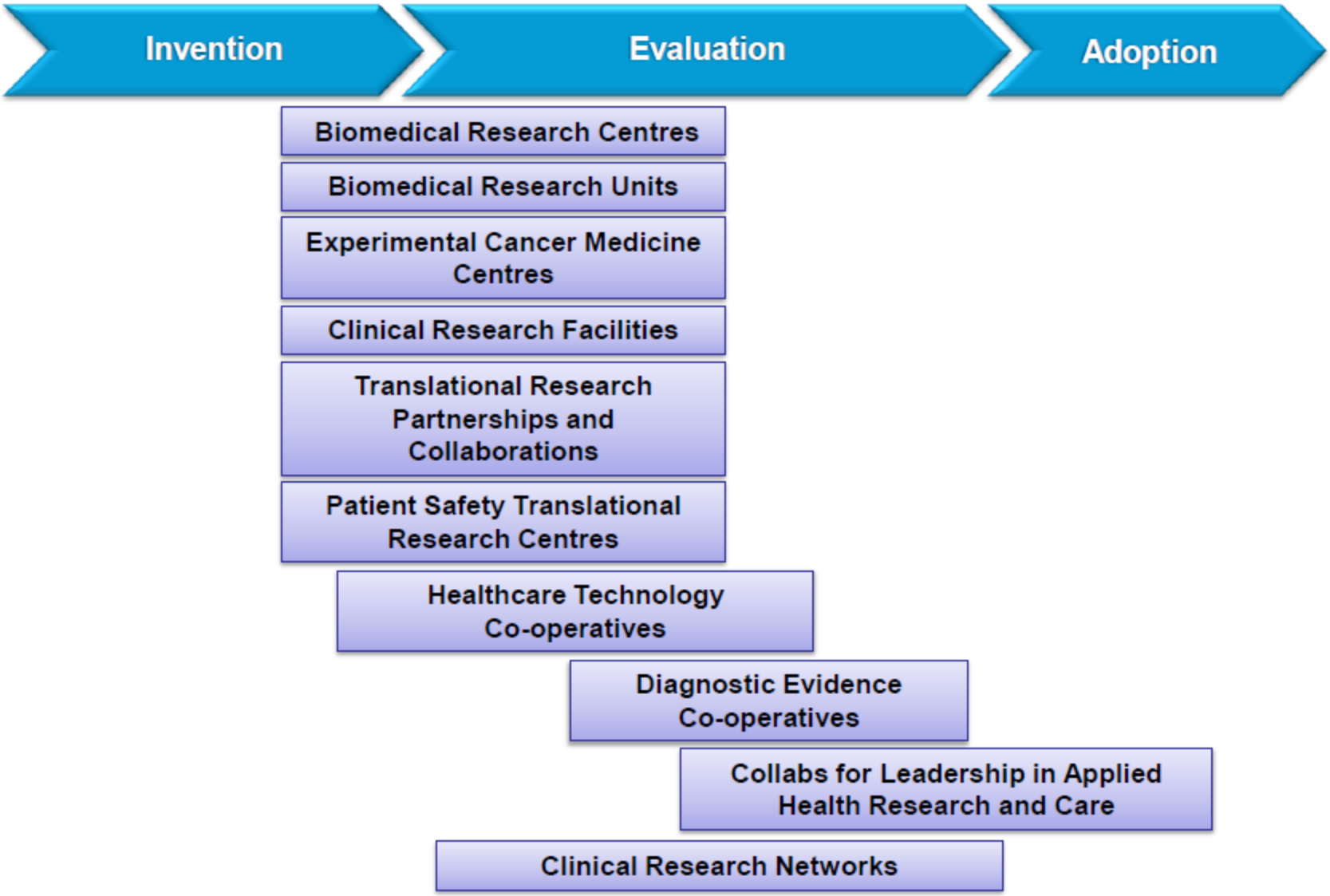

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CLAHRC Impacts – First Round

- CLAHRCs are **patient-focused** and **service-led**: NHS and social care partners identify the key areas to be addressed by the collaboration.
- The nine CLAHRCs adopted a **range of approaches but have developed a common understanding** of both challenges and solutions to achieving these goals.
- All have demonstrated **successes in encouraging academics to respond to NHS needs** and for the NHS to develop its research and implementation capacity.
- All have **formed and sustained strong partnerships** between the health service, academia and industry that are vital to success.
- The CLAHRC's have **adapted to the changing financial landscape** and shown evidence of new ways of working.

– Taken from NHS Confederation Briefing

Aims of renewed and refreshed CLAHRCs

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- **develop and conduct applied health research** relevant across the NHS, and to translate research findings into improved outcomes for patients;
- create a **distributed model** for the conduct and application of applied health research that links those who conduct applied health research with all those who use it in practice **across the health community**;
- create and embed approaches to research and its dissemination that are specifically designed to take account of the way that health care is delivered **across the local AHSN**;
- increase the country's **capacity** to conduct high quality **applied health research** focused on the needs of patients, and particularly research targeted at **chronic disease and public health interventions**;
- **improve patient outcomes** locally and across the wider NHS; and
- **contribute to the country's growth** by working with the life sciences industry.

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Vision

Improve the health of the people of Wessex and quality and cost-effectiveness of health care

- **Step change in integration/pathways of care for people with long-term conditions**
- **Reduce hospital admissions/re-admissions – more appropriate health care utilisation**

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Our Partners and People

University Hospital Southampton	University of Southampton	World-leading Implementation Scientists and Nursing and Allied Health Research	Wessex AHSN Quality Improvement Programme and Centre for Implementation Science
Wessex Inclusion in Service Research and Design (WISeRD)	NHS England Local Area Team and 10 Wessex Clinical Commissioning Groups	10 Wessex NHS Trusts	Health Education Wessex

What are the CLAHRC Partnerships?

- Academic – Practice
- Clinical – Social Scientists
- Professionals/academics – Patients, Carers and Public
- Traditional NHS orgs – New and other orgs/agencies (Commissioners)

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Patient and Public Involvement

- By PPI, we mean carrying out research (and implementation) ***with*** or ***by*** the public, rather than ***to***, ***about*** or ***for*** them.
- We are embedding PPI within each theme, through our 'theme champions'.
- Our public contributor group, WISeRD, will promote PPI throughout the CLAHRC.
- Our mission is to create a resource for meaningful public involvement to enhance healthcare for the people of Wessex.

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Approach to Implementation

Direct knowledge transfer – building and exploiting things we know work

Mutual knowledge exchange through social interaction

Multi-level implementation encouraging environmental and organisational readiness

Facilitate knowledge translation heuristic tools

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Outcomes

5%
reduction in antibiotic prescribing across Wessex and corresponding reduction in respiratory admissions

30%
improvement in Patient Experience in hospital for Wessex

100
Wessex staff trained in essential care and compassionate relationships

Implementation capacity –
50
Wessex Implementation Associates

Networks of
300
volunteers across **4 NHS Trusts** in Wessex improving care in hospital for older people

Participatory research led by
30
user -researchers

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Match Funding

Richard Trowbridge

Chief Operating Officer – NIHR CLAHRC Wessex

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Our Partners and People

NHS Isle of Wight Clinical Commissioning Group

University Hospital Southampton NHS Foundation Trust

NHS Dorset Clinical Commissioning Group

WISeRD

Wessex Inclusion in Service Research and Design

Salisbury NHS Foundation Trust

NHS West Hampshire Clinical Commissioning Group

Dorset County Hospital NHS Foundation Trust

NHS North East Hampshire and Farnham Clinical Commissioning Group

Hampshire Hospitals NHS Foundation Trust

NHS Fareham and Gosport Clinical Commissioning Group

Poole Hospital NHS Foundation Trust

NHS Portsmouth Clinical Commissioning Group

Isle of Wight NHS Trust

NHS Southampton City Clinical Commissioning Group

WESSEX ACADEMIC HEALTH SCIENCE NETWORK

NHS Health Education Wessex

Portsmouth Hospitals NHS Trust

NHS South Eastern Hampshire Clinical Commissioning Group

UNIVERSITY OF Southampton

Southern Health NHS Foundation Trust

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

NHS North Hampshire Clinical Commissioning Group

NHS Wessex Local Area Team

Solent NHS Trust

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There are six types to match:

- Cash
- In kind / People time
- In kind / NHS desk space/ meeting space
- Fee waivers
- Research project costs not funded by the NIHR grant (e.g. NHS excess treatment costs)
- Industry

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Highlights

The draw down of funds from NIHR is dependent on the level of “match funding”. The match needs to be **at least** to the level of the NIHR award. Per the bid we have to achieve a level of £10 million match over the 5 year period.

Match is a requirement of the NIHR contract and is more evident than in the previous contract. We need to be prepared to have this reviewed by the NIHR because of its high profile in the contract.

The Theme Leads, Theme Managers and Core Team should negotiate match with partners based on shared objectives of partner organisations, and make visible for auditing purposes. **This will be an on-going and flexible activity based on the needs of the NHS, and responsiveness to opportunities.**

We aim to have an auditable trail of match funding based within the financial spread sheets for each theme and the core team.

The source of match will also be identified in the spread sheets so our Partner organisations will have annual feedback on what they have worked on with us.

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Example Central Recording Template

Theme	Funder	Type	Status	Comment	Name	Grade if Known	Start Date	Post End Date	FTE	Grade	Aug-15 Point	August Basic	August Cost	Aug-14	Sep-14	Oct-14	Nov-14
1	University of Southampton	Co-Investigator	Confirmed		Prof Anne Jones		01/01/2014	31/12/2018	0.03	acp2	20	2,073	2,405	200	200	200	200
1	University of Southampton	Co-Investigator	Confirmed		Dr Rob Smith	sen lecturer	01/01/2014	31/12/2018	0.03	acp2	20	2,073	2,405	200	200	200	200
1	University of Southampton	Principle Investigator	Confirmed		Prof Roger mallet		01/01/2014	31/12/2018	0.05	acp2	20	4,147	4,810	401	401	401	401
1	University Hospital Southampton NHS Foundation Trust	Research Nurse	Proposed		Research Nurse	**Band 6**	01/01/2014	31/12/2014	0.50	NHS6	29	17,610	21,413	1,784	1,784	1,784	1,784
1	University Hospital Southampton NHS Foundation Trust	Research Nurse	Proposed		Speech and Language Therapist	**Band 6**	01/01/2014	31/12/2015	1.00	NHS6	29	35,221	43,673	3,639	3,639	3,639	3,639
2	University Hospital Southampton NHS Foundation Trust	Trainer	Proposed		Dietician	**Band 7**	01/01/2014	31/12/2015	0.50	NHS7	34	20,685	25,299	2,108	2,108	2,108	2,108
2	University Hospital Southampton NHS Foundation Trust	Trainer	Proposed		Therapist	**Band 6**	01/01/2014	31/12/2015	0.50	NHS6	29	17,610	21,413	1,784	1,784	1,784	1,784
2	University Hospital Southampton NHS Foundation Trust	competency assessment	Proposed		Senior Nurse	**Band 5**	01/01/2014	31/12/2015	0.50	NHS5	23	14,230	17,140	1,428	1,428	1,428	1,428
4	University Hospital Southampton NHS Foundation Trust	Project Manager	Proposed		Research Nurse	**Band 8**	01/01/2014	31/12/2015	0.50	NHS8a	38	24,015	29,509	2,459	2,459	2,459	2,459
5	Portsmouth Hospitals NHS Trust	Research Nurse	Proposed		Dr Moss	**Band 6**	01/01/2014	31/12/2015	1.00	NHS6	29	35,221	43,673	3,639	3,639	3,639	3,639
6	Southern Health NHS Foundation Trust	Co-Investigator	Proposed	Implementation HD care guidelines	Research Nurse	**Neurology**	01/01/2016	31/12/2018	0.03	NHS9	54	2,511	2,912	n/a	n/a	n/a	n/a
2	Southern Health NHS Foundation Trust	**Research Nurse**	Proposed	startify memory clinic risk profile study	PI seconded to study		01/06/2014	31/12/2018	0.50	NHS6	29	17,610	21,413	1,784	1,784	1,784	1,784
1	Southern Health NHS Foundation Trust	**Psychiatrist**	Proposed	stratify memory clinic risk profile study	Dr B Geldof		01/01/2014	31/12/2015	0.10	NHS9	54	10,042	11,847	987	987	987	987
5	Southern Health NHS Foundation Trust	**Co-investigator**	Proposed	routine use of CGA and trained volunteers studies	Nurse champion		01/01/2014	31/12/2017	0.03	NHS9	54	2,511	2,912	243	243	243	243
1	The Royal Bournemouth & Christchurch Hospitals Foundation Trust	**Co-Investigator**	Proposed	Implement trained volunteers	Dr R Tims		01/01/2014	31/12/2015	0.40	NHS8a	38	19,212	23,438	1,953	1,953	1,953	1,953
2	The Royal Bournemouth & Christchurch Hospitals Foundation Trust	**Co-Investigator**	Proposed	Falls in PD - toolkit evaluation and implementation	Dr L Carter	**Geriatrics**	01/01/2014	31/12/2015	0.03	NHS9	54	2,511	2,912	243	243	243	243
1		**Co-investigator**	Proposed	Implement trained volunteer mealtime assistants		**geriatrics**	01/01/2014	31/12/2015	0.03	NHS9	54	2,511	2,912	243	243	243	243

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THEME PRESENTATIONS

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THEME ONE

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Achieving Sustainable Improvements in Respiratory Health through Integrated Care Update

Dr Tom Wilkinson
Professor Mike Thomas

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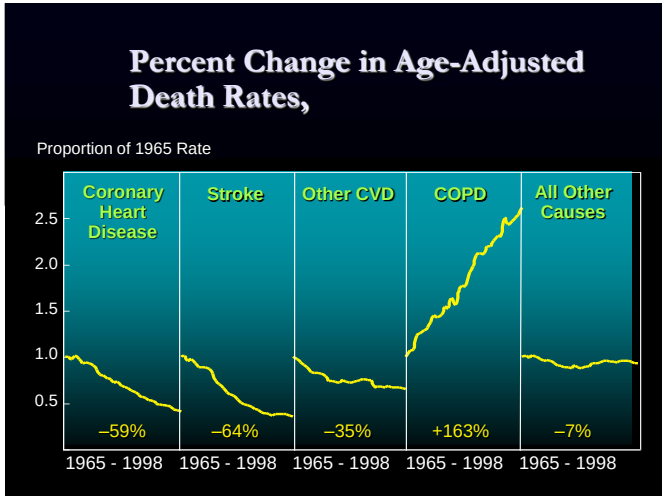
Respiratory Disease in Wessex

High prevalence of disease
Variation of outcomes across region
Hospital admission rates high
Rising Prevalence
High cost of medication & poor adherence
Training needs identified
Patient Input- poor access to services

Wessex HIEC Partnership



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Respiratory Theme

1. Quantification of variations in outcomes of respiratory care in Wessex
2. Improving COPD diagnosis (1-3 Years)
3. Improving respiratory skills in primary care in Wessex (2-3 years)
4. Improved ‘complex case’ management. (1-3 years)
5. Improved supported self-management in asthma and COPD
6. Improved recognition and management of psychological distress in asthma and COPD.
7. Improved access to Pulmonary Rehabilitation
8. Repeated Quantification of Health Outcomes across Wessex to establish impact of integrated service improvement

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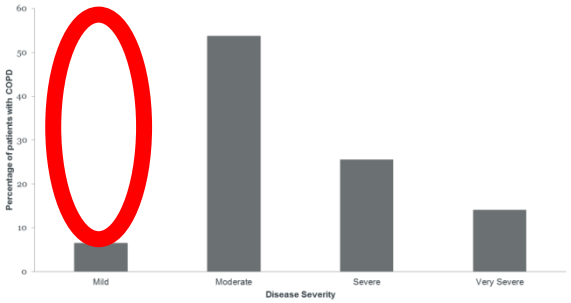
Project 1: Case Finding

- GP Partnership process
- Partnership with West Hants CCG
- Case Finding Strategy meeting – 5th March
- Public Health, Smoking Cessation, Patients
- 3 Pilot practices in Totton
- Linked local pharmacies
- PM and Band 6 Nurse appointed
- Evidence Synthesis
- Public Engagement events – Q3 2014



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Next Steps

- Joint Governance and Project Planning with Wessex AHSN
- Evidence synthesis
- Begin joint working in Primary care Develop Complex Care and End of Life working group
- Links to industry support
  - Nutricia
  - Boehringer Ingelheim
- Discussion across region regarding Wessex wide working

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THEME TWO

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Ageing and Dementia

Improving Routine Clinical Care

Theme Leads: Helen Roberts and Chris Kipps

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Ageing: Identification of patients at risk of hospital admission and long stay

- Implement & evaluate routine measurement of grip strength to allow focussed clinical review of inpatients at risk of long stay
- Implement & evaluate comprehensive geriatric assessment (CGA) in geriatric clinics
- Evaluate the wider application of CGA to other clinics and wards to improve frailty assessment & guide treatment

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Ageing: Improving routine clinical care

- Trained volunteers can improve the quality of mealtime care
- Implement and evaluate the volunteer mealtime assistant programme across other wards and sites
- Extend programme to research whether volunteers can help mobilise older inpatients to promote independence

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Dementia: Improving the diagnosis

- Management of mild cognitive impairment
- Identification of working age dementia
- Evidence synthesis of risk factors predicting decline
- Develop tools to capture & identify risk factors for progression, carer burden
- Standardise imaging protocols & dementia scan reporting
- Trial diagnostic tools in memory and neurology clinics
- Develop clinical guidelines for diagnosis and monitoring

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Dementia: Improving routine clinical care

- Research evidence on falls in patients with Parkinson's dementia
- Evaluate feasibility of using falls toolkits for dementia in Parkinson's disease
- Implement toolkits in practice
- Evaluate implementation of evidence –based therapy guidelines for patients with dementia in Huntington's disease

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Theme Strengths

- World class researchers
- Extensive clinical and research networks
- Extensive research networks
- Links to Wessex HIEC and AHSN
- Established voluntary sector involvement

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THEME THREE

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Fundamental Care in Hospital

Theme Lead
Professor Peter Griffiths

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- …aims to improve the quality of fundamental care delivered by nurses and care assistants to adult patients in general wards of acute hospitals.
    - basic physical needs (e.g. eating, drinking, hygiene and mobility)
    - dignity and positive relationships
    - patient safety (including avoiding harm and identifying deterioration).

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Patricia Balsom: Diary of my final days How one cancer patient suffered at the hands of the NHS

'I was shocked by the lack of care' A report by a committee of MPs and peers warns that many hospitals and care homes are not protecting the human rights of older patients.

BBC News 2007

The Independent. Thursday, 16 November 2006

Confessions of a Nurse I have often seen patients left in their own excrement for a number of hours and patients left on wet sheets/in wet clothes for hours.

Channel 4 Dispatches

Is caring a lost art in nursing?

International Journal of Nursing Studies 2008;42(2):163

'Grubby' nurses slammed by peer A Conservative peer has launched an attack against nurses at Bath's Royal United Hospital.

BBC News 2008

Confessions of a Nurse I've seen a drink put on the table out of the reach of a patient who cannot now take a drink themselves… But on a busy ward, there are bound to be omissions, aren't there?

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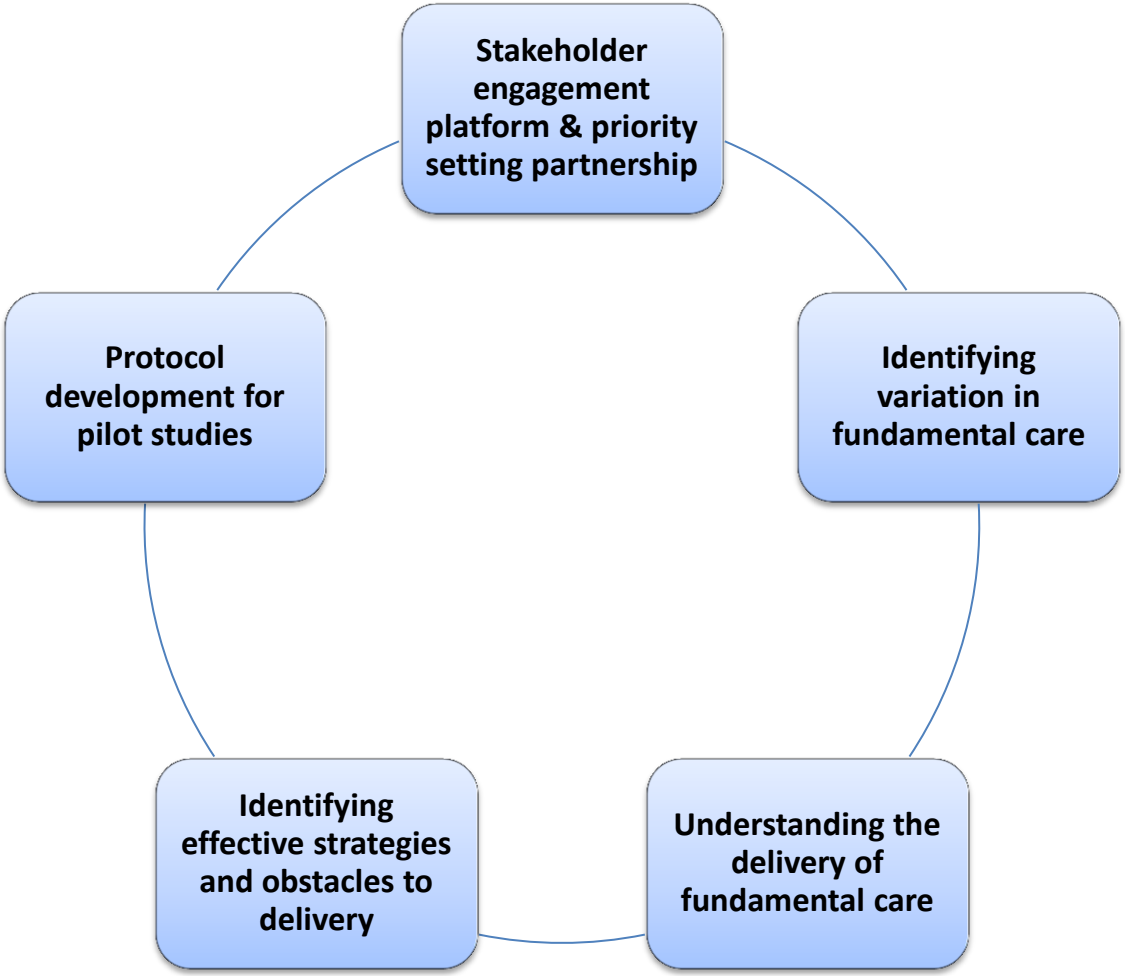
Fundamental Care (early years)



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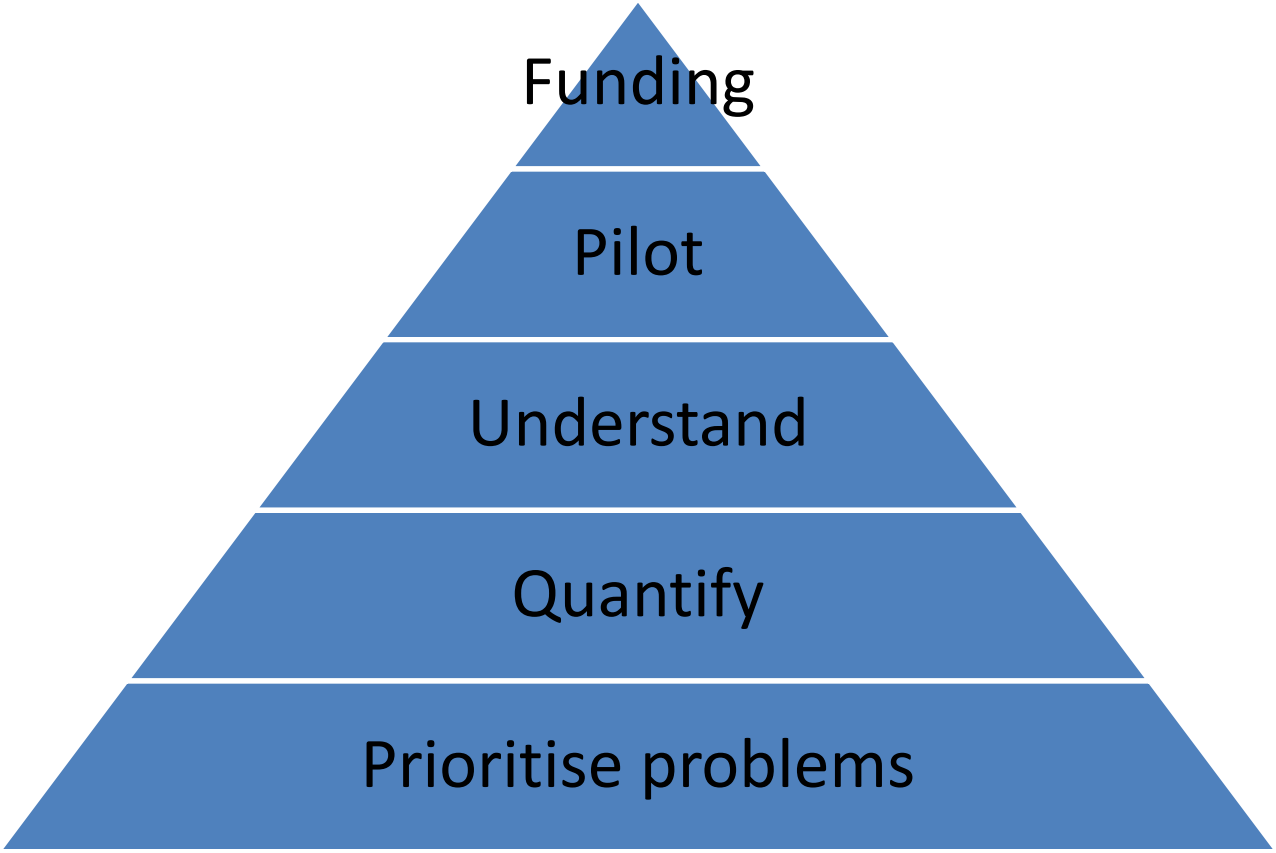

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Research goals

- Based on the results of WP 1-5 we aim to develop and pilot through a cluster (ward) randomised controlled trial a *multifactorial* intervention that addresses multiple priorities in fundamental care.
  - *e.g.*
  - *changes in working practices (e.g. intentional rounding)*
  - *point of care monitoring technology, workforce development*
  - *structural workforce reform (e.g. changes in skill mix and use of lay volunteers)*

Example projects

- *Developing and evaluating a workforce development intervention to improve compassionate care*
- *Modelling the associations between nurse staffing and missed vital signs observations*
- *Developing and piloting a programme of interventions to improve management of toileting and avoid use of indwelling urinary catheters*

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THEME FOUR

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Public Health and Primary Care

Theme Leads
Dr Michael Moore
Dr Julie Parkes

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Antimicrobial stewardship in primary care

"Antimicrobial resistance is a **ticking time-bomb** not only for the UK but also for the world."
"We need to work with everyone to ensure the **apocalyptic scenario** of widespread antimicrobial resistance does not become a reality."

"This threat is arguably as important as **climate change** for the world."

"Antimicrobial resistance poses **a catastrophic threat**. If we don't act now, any one of us could go into hospital in 20 years for minor surgery and die because of an ordinary infection that can't be treated by antibiotics."

Primary care is responsible for 80% of prescribed antibiotics

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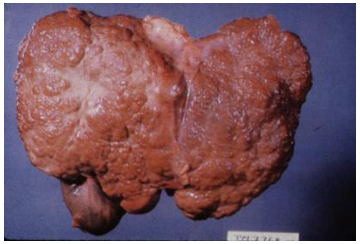
Vulnerable groups & Health Inequalities

- **Chronic liver disease**
  - Chronic Hepatitis C - accessing the “unknown unknowns”
  - Epidemiology
  - Care pathways
  - Missed referral opportunities



- **Acute kidney injury**
  - Initial focus analysis HHR data .
  - Working with Manchester CLAHRC on potential intervention in primary care

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Alcohol

- Priority of Wessex AHSN, Public Health England, Wessex Directors of Public health and the CLAHRC
- Develop conceptual framework of alcohol use across life course
- Stock take on scale of misuse, impact, commissioning, ongoing research and innovation.
- Initial projects:
  - » Detoxification services
  - » Work in alcohol in sexual health settings
  - » “know your number” acute hospital evaluation

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THEME FIVE

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Theme 5 - A cross-cutting theme

Patient engagement with self-directed support for long-term condition management

Theme lead: Anne Kennedy

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Our Aims

- Reach, engage and support people in managing their long-term conditions
- Develop and adapt resources and tools and implement a strategy for deployment
- Work with people's social networks and links to local resources
- Adapt and use e-health and mobile apps for use with the health service and informal settings

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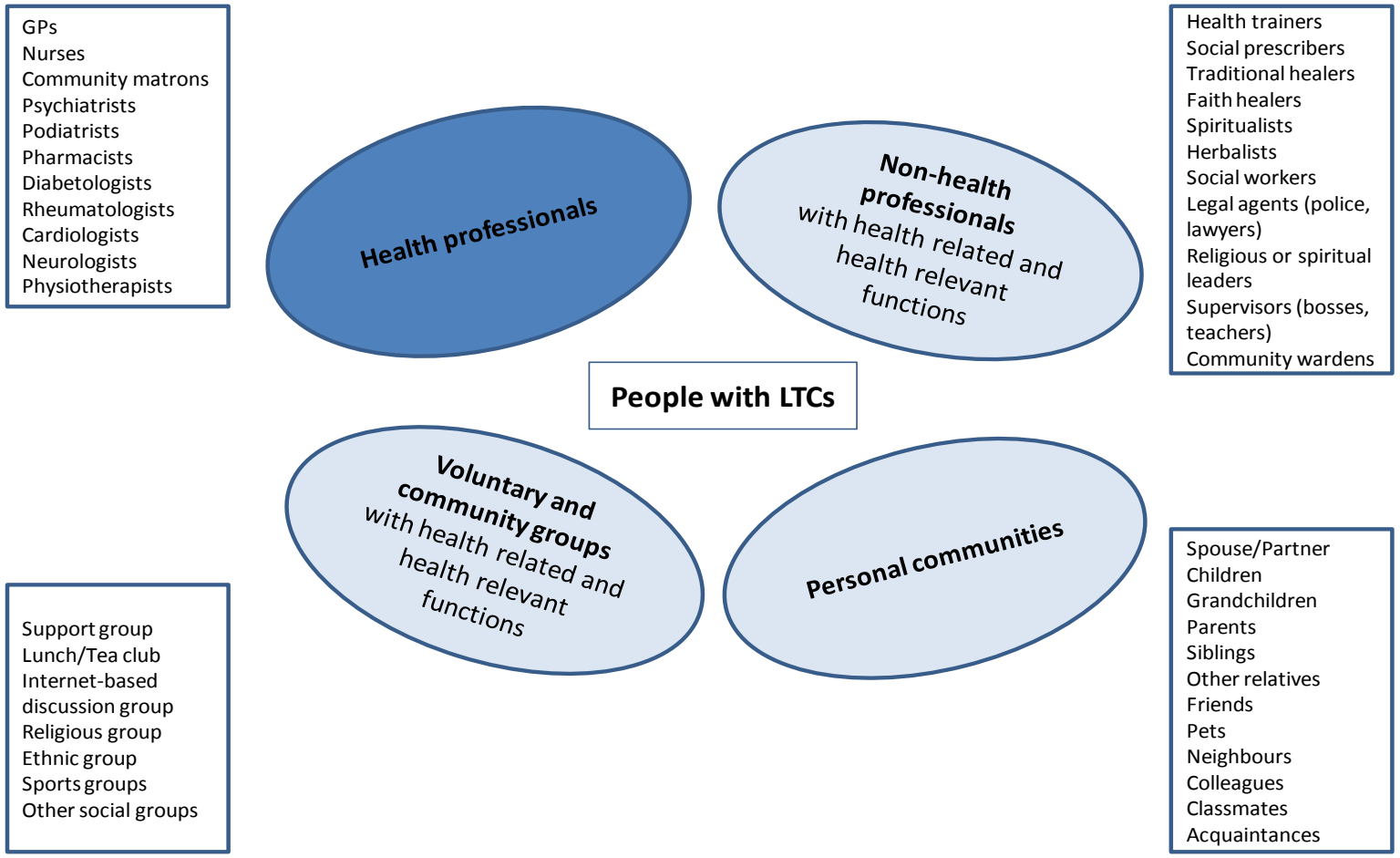
Systems of support



What we are doing first

- Working with My Life A Full Life programme on Isle of Wight to implement a social networks approach to self-management support: GENIE
- Reviewing tele-health interventions to find out what works best and for who
- Exploring how self-management support is commissioned and what commissioners want
- Using health modelling to help understand where self-management support resources can best be used

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THEME SIX

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Minimally Disruptive Healthcare:

Complexity, Patient Experience and Organizational Behaviour

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For many people with complex long-term and life-limiting conditions, approaching end of life is characterized by:

- complex careers: hospital admissions and readmissions, interactions with multiple generalist and specialist health providers,

- increasing demands: on professionals, family members and wider social networks as symptom burdens and treatment burdens grow.

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- Focus: people with complex life-limiting conditions (non-malignant disease), and their families, at end of life.
- Aim: to identify, describe, and explain sources of disruption and complexity in interactions between patients, professionals, and healthcare services.
- Outcome: tools and toolkits to support patients, families, and professionals on complex journeys through multiple healthcare providers.

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Improving patient experience:

- by improving navigation and co-ordination of patient journeys
- Co-production and co-design of tools and toolkits to assess and minimize burdens of illness and treatment
- Low cost, simple interventions to improve patient and family capacity to respond to complex experiences at end of life.

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END OF FORMAL THEME PRESENTATIONS

QUESTIONS?

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SESSION TWO: NETWORKING

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