AN INTERNATIONAL LEADER IN ACCELERATING INNOVATION THAT TRANSFORMS CITIZENS HEALTH AND WELLBEING
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INTRODUCTION

As an academic health science and innovation system, Health Innovation Manchester (HInM) is at the forefront of transforming the health and wellbeing of Greater Manchester’s 2.8 million citizens.

Health Innovation Manchester was formed in October 2017 by bringing together the former Academic Health Science Network and Academic Health Science Centre under one single umbrella, which also represents Greater Manchester’s wider research and innovation system.

In Greater Manchester, we have the unique ability to deliver innovation into front-line care at pace and scale thanks to our £6bn devolved health and social care system, unrivalled digital assets and ambitions, exceptional academic and research capability and thriving industry partnerships.

Despite having one of the fastest growing economies in the country, people here die younger than those in other parts of England. Cardiovascular and respiratory illnesses mean people become ill at a younger age and live with their illness longer than in other parts of the country. Our growing number of older people often have many long-term health issues to manage.

Therefore, Health Innovation Manchester has a pivotal role in bringing forward a constant flow of targeted innovations and putting them through an effective but streamlined evaluation process so they are adopted at pace and scale across our 10 localities.

Our collective ambition is to make Greater Manchester one of the best places in the world to grow up, get on and grow old.

Health Innovation Manchester is currently delivering in excess of 75 innovation programmes and projects locally in partnership with industry, academia, and commissioners and providers across Greater Manchester. This is in addition to fulfilling a national role working as part of a collaborative with the wider Academic Health Science Network.

This project portfolio provides a snapshot of some of key programmes and projects within the Health Innovation Manchester portfolio which will undoubtedly change in line with Local and National priorities.

If you would like more information about any of the programmes and projects featured please email info@healthinnovationmanchester.com.

Amanda Risino
Managing Director
Health Innovation Manchester

UPDATED SEPTEMBER 2018
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COPD is the 5th biggest killer in the UK

23,000 deaths in England each year.

67,000 patients diagnosed with COPD living in Greater Manchester.

Someone in the UK dies as a result of COPD.

Cost of managing COPD hospital admissions and medications for Greater Manchester:

£73m

£57.5m prescribing cost per annum

£16.4m hospital admissions

**COPD Patients’ Inappropriate Medicines Reduction**

**Innovation Programme Overview**

We are bringing together resources from the NHS, social care and pharmaceutical industry to ensure that every person with COPD has access to equitable, high quality care.

Our innovation programme involves working closely with GPs and in the community to develop personalised treatment plans that are based on up-to-date research and the most effective medications.

Our holistic approach has a greater emphasis on self-management, smoking cessation, physical activity, mental health and reducing social isolation.

We help localities to implement the COPD programme approach by providing increased clinical leadership from a respiratory consultant, education and training for primary care and access to additional help and resources, such as digital apps.

**Programme Objectives**

- Deliver changes across the whole system with expert support deployed across the whole pathway and ensure shared decision-making is at the centre of all interventions and changes.
- Up-skill and enhance the knowledge of the existing community and primary care team so that teams work more efficiently in partnership.
- Utilise support from existing workforce as well as externally validated providers. There is a need to up-skill the entire workforce across the Care Pathway “so effective COPD care is everyone’s business.”
- Develop sustainable legacy of learning leading to cultural changes in how COPD is managed in the future.
- Increased focus on the patient experience and quality through the gathering of insight. This approach is key to the personalised care approach.
- Evaluate effectiveness of models such as the virtual clinic and adherence to the new Greater Manchester Medicines Management Group (GMMMG) guidelines. This will allow key benefits to the system and patients to be realised. Further change promoting holistic care can be accelerated from this foundation.

**Potential Impacts and Outcomes**

- Reduced exacerbations.
- Reduced hospital admissions.
- Reduced side effects from inappropriate therapy.
- Increase in cost effective therapies (pharmacological and non-pharmacological).
- Reduced smoking rates.
- Increased physical activity.
- Increased self-management.
- Better outcomes for patients.

**Clinical and Policy Priorities**

This initiative follows the guidelines for treating and managing COPD patients as advocated in the Greater Manchester Medicines Management Group (GMMMG) COPD guidance. This guidance reflects the current COPD guidelines from the Global Initiative for Chronic Obstructive Lung Disease (GOLD).

The GMMMG COPD guidelines also consider the locally derived findings emerging from the Salford Lung Study.

**Contacts**

**Programme Leads:**

Dai Roberts (Senior Programme Development Lead)

Jay Hamilton (Associate Director - Health & Implementation)

**Clinical Leads:**

Consultant Dr Binita Kane

(Manchester University NHS Foundation Trust)

Prof. Jorgan Vestbo (The University of Manchester & Honorary Consultant, Manchester University NHS FT)
Patients undergoing surgery at six Greater Manchester hospitals will be prepared for the experience in the best possible way using the Enhanced Recovery After Surgery (ERAS+) programme. The surgical pathway builds on the success of the in-hospital programme but expands it to include six weeks of pre-surgery patient preparation and post-hospital recovery six weeks after, with patients and their family supported through a Surgery School.

There are around 250,000 high-risk elective major surgeries a year in England and Wales and there is a post-operative pulmonary complication risk of up to 30%. Complications, such as respiratory failure or pneumonia, can increase the length of stay in hospital and reduce life expectancy after surgery.

The ERAS+ programme places the patient at the centre of their own recovery and supports them to be dynamic in their own care. It encourages increased activity, better nutrition, oral healthcare and the practice of chest exercises to help reduce chest problems. It aims to reduce complications post-surgery, with evidence suggesting a reduction in pulmonary complications by 50%, reduced length of stay in hospital by around three days and improved quality of life for patients for six to 12 months after major surgery.

### PROGRAMME OBJECTIVES

The aim of ERAS+ is to replicate the benefits achieved from the pilot at the University of Manchester NHS Foundation Trust across Greater Manchester and beyond with a national scale implementation in the future. The programme is being implemented in two phases with three NHS Trusts in each phase which include:

- Manchester University NHS Foundation Trust.
- Stockport NHS Foundation Trust.
- Bolton NHS Foundation Trust.

### POTENTIAL IMPACTS AND OUTCOMES

- Reduced length of stay in hospital by approximately three days.
- Reduced perioperative morbidity.
- Reduced complications in patients post major surgery – evidence suggests a reduction in pulmonary complications by 50%.
- Improved quality of life 6–12 months after major surgery.
- Increased life expectancy of approximately three years dependent upon the type of illness.
- Patients enabled to return to work quicker, or get into work or stay in work, more easily.

### CLINICAL AND POLICY PRIORITIES

ERAS+ has been recognised by NHS England and NICE with a National Innovation Accelerator fellowship. It has also been recognised locally by the Healthier Together programme as a surgical pathway which now falls under Theme 3, Standardising Acute and Specialised Care, of the Greater Manchester Health and Social Care Partnership Sustainability and Transformation Plan.

### CONTACTS:

- **PROGRAMME LEAD:** Cara Afzal (Senior Programme Development Lead)
- **CLINICAL LEAD:** Consultant Dr John Moore (Manchester University NHS FT)

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**ERAS +
SARAH LOWE’S STORY**

Sarah Lowe says the ERAS+ programme helped her feel “empowered” before undergoing surgery.

Sarah, aged 51, who lives in Whalley Range with her husband and three children, was diagnosed with ampullary cancer after being admitted to Manchester Royal Infirmary with jaundice.

She said: “I was given two to three weeks’ advanced notice of the surgery to remove the cancer and what helped me most was the support I received through the ERAS+ programme.

“It helped me feel mentally and physically prepared for surgery.”

She added that she was introduced to a team of people who helped with nutrition and fitness and attended “surgery school” where she had an extensive talk, visited the unit and was able ask any questions she may have.

Sarah continued: “I felt empowered. I was part of the team preparing me for my surgery, not just a person this was all happening to.

“The programme let me take charge of my own care and feel that I was able to influence the outcome of my treatment with little things that I could do while in the hospital bed.

“I was told that something as simple as brushing our teeth and using mouthwash could help reduce the chances of a contracting pneumonia.

“Working with a dietitian I put back on some of the weight I’d lost and I was also able to build up my fitness so I was as physically ready for the operation as possible.”

Sarah added that she believes other patients should consider the ERAS+ programme.

“I would really encourage other patients to embrace the programme and know that they can make a difference.

“The fitter they are going into the operation the better their outlook afterwards.”

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**ERAS + ENHANCED RECOVERY AFTER SURGERY**

**PROJECT START: JAN 2018 | PROJECT END: MAY 2019**

- The Pennine Acute Hospitals NHS Trust.
- Salford Royal NHS Foundation Trust.
- The Christie NHS Foundation Trust.

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**CONTACTS:**

- **PROGRAMME LEAD:** Cara Afzal (Senior Programme Development Lead)
- **CLINICAL LEAD:** Consultant Dr John Moore (Manchester University NHS FT)
Becoming pregnant after a stillbirth is a daunting prospect characterised by the terror of potentially repeating the experience. However, Victoria Ashcroft says she can’t thank Manchester’s Rainbow Clinic enough for helping her have the family she had always wanted.

Victoria attended the Rainbow Clinic at Saint Mary’s in 2016 when she became pregnant again 12 weeks after her son Archie was tragically born still.

When I found out that I was pregnant for the second time I was absolutely elated and absolutely petrified at the same time.

“I lost my first baby at 37 weeks and initially we weren’t sure why. My pregnancy had been very low risk and he had grown well but we later discovered that I had a very small placenta and it had ruptured.”

Anxious about her second pregnancy, Victoria heard about the clinic and the specialist support they offer and knew that she wanted to attend as part of her care plan.

Victoria travelled to Manchester’s Rainbow Clinic where she was offered specialist placenta scans, currently not available at her local hospital in Macclesfield, as well as emotional support for her and the rest of her family during her pregnancy.

“The Rainbow Clinic was amazing as they were able to offer a specialist placenta scan and could tell me, at 24 weeks in my second pregnancy, that my placenta was the same size as it had been at 37 weeks in my first pregnancy,” Victoria continued.

“It was fantastic to know that my placenta was growing much more normally as the pregnancy progressed.”

The staff at the Rainbow Clinic were also fantastic in offering emotional support during the second pregnancy.

“The anxiety never left me during my pregnancy but having an expert in placentas and stillbirths telling me that everything is OK is the best anyone can hope for. It doesn’t take that risk away, because every pregnancy has risk, but it reassures you that you’re going to get to take a healthy baby home.”

Victoria and her partner James were delighted when they welcomed a baby daughter, Ella, on 1 August 2017 following a healthy pregnancy.

“Ella was born at Macclesfield hospital by a very calm and planned C-section. We had amazing care from the team at the hospital and I want to credit them for how they supported us.”

“We have now just celebrated Ella’s first birthday. She is the most chilled-out, happy little soul, although she isn’t a fan of sleeping.”

I can’t thank the Rainbow Clinic enough for helping us have the family we wanted.

Since then Victoria has shared her story to support the work of the Rainbow Clinic, including presenting at the GMEC PSC Maternity and Neonatal Learning System Launch.

INNOVATION PROGRAMME OVERVIEW

Women who have had a stillbirth are at increased risk of complications in subsequent pregnancies, including stillbirth, pre-eclampsia, placental abruption and low birthweight. It is also associated with increased psychological, emotional and social challenges.

The Rainbow Clinic, at Saint Mary’s Hospital, is a specialist service for women and their families during a subsequent pregnancy following a stillbirth or perinatal death. It cares for families from the time of the postnatal appointment onwards and into a subsequent pregnancy. It engages with women early, ensuring they are on the right treatment, making any necessary referrals and providing more detailed ultrasound scanning.

The additional tests and continuity of care, provided by a small team of specialist doctors and midwives, result in improved outcomes for the baby as well as improved psychological wellbeing for parents and better use of NHS resources.

PROGRAMME OBJECTIVES

For Women and their families:

- Raise awareness of the clinic service, and its benefits, to provide reassurance and reduce anxiety.
- Increase confidence in the maternity service.
- Provide opportunities for families to co-design the service.

For Rainbow Clinic staff:

- Generate pride in the clinic and the service provided.
- Ensure staff have the information they need to support women and their families.
- Support staff to act as ambassadors for the clinic and its achievements.
- Provide opportunities for co-design of the service.

Provide opportunities to contact colleagues from other Rainbow Clinics to share experiences and learning.

CLINICAL AND POLICY PRIORITIES

There are approximately 2.6 million stillbirths (the death of a baby at 24 week’s gestation or more) globally each year. In the UK, this equates to 9 stillborn babies a day. In 2016, the Office for National Statistics reported 363 stillbirths within GM.
INNOVATION PROGRAMME OVERVIEW

For older people living with frailty, a fall or fracture can result in a rapid deterioration in health and significant loss of independence. There are approximately 65,000 hip fractures taking place in the UK each year, costing the health and social care system around £2 billion. It is imperative that systems are in place to help identify people who are at risk of falls and fractures to ensure there are appropriate treatment and services that meet their needs.

The Health Innovation Manchester project aims to reduce falls and fractures related to frailty across Greater Manchester through early intervention, treatment and management of at-risk patients. The project will support primary care by finding at-risk patients so that they can be treated with appropriate bone-sparing therapies, including medication to strengthen bones, and supported with services in the community to help manage their condition.

Through early and increased identification of osteoporosis and other high-risk patients, the established use of fracture risk assessment tools in primary care and patient behavioural and lifestyle changes through education programmes, it is hoped there will be a reduction in fractures and associations costs.

PROGRAMME OBJECTIVES

The main objective of this programme is to support primary care with the case finding of patients at risk of falls and fractures, so that they can be treated with the appropriate bone-sparing therapies and supported with services in the community to help them manage their condition.

POTENTIAL IMPACTS AND OUTCOMES

- Reduction in hip fractures.
- Reduction in fragility fractures.
- Decrease in mortality rates due to hip fractures.

- Early and increased identification of osteoporosis and other high-risk patients.
- Reduction in non-elective admissions related to falls and fractures.
- Better outcomes for patients who have fractures or are at risk of fractures, with a reduced risk of disability, malnutrition, loss of independence, etc.
- Optimisation of electronic frailty index resulting in additional income for GPs.
- Establish the use of fracture and falls risk assessment tools in primary care.
- Reduction in costs related to hip fractures and fragility fractures across the health and social care systems.
- Patient behavioural and lifestyle changes through patient education programmes leading to better outcomes for the patient and NHS.

CLINICAL AND POLICY PRIORITIES

This programme aligns to NICE clinical guideline CG146 which identifies cohorts of patients that should be assessed for risk of a fragility fracture.

Additionally, the five-year vision for Greater Manchester, ‘Taking Charge of our Health and Social Care in Greater Manchester’, which was endorsed by the Health and Social Care Strategic Partnership Board in 2015, sets out an ambition to reduce falls-related injuries admissions.

CONTACTS:

PROGRAMME LEAD:
Dai Roberts (Senior Programme Development Lead)

CLINICAL LEAD:
Dr Saif Ahmed (Clinical Director, Tameside and Glossop NHS Foundation Trust)
Sue Clarke (Operations Manager, Alzheimer’s Society)

Sue Clarke, Operations Manager Greater Manchester at Alzheimer’s Society, believes dementia “cuts across society” and it is vital that organisations work together to deliver transformations in outcomes and help people to live well with dementia.

Sue, who is co-chair of the public involvement and engagement workstream of the Dementia Early Detection & Diagnostic Framework, believes Greater Manchester is well placed to make a difference in dementia awareness, support and research, working towards a goal of making it “the best place to live with dementia in the world.”

“Dementia is cross-cutting; it is not just about health and social care – it involves everyone in the community,” she said. “Industry, retail, businesses, local authorities, research, leisure services and charities all have a role to play in supporting people to live with dementia.

“It is fantastic that Health Innovation Manchester have managed to cut across traditional boundaries to bring so many organisations together for the framework.

“It will enable a variety of voices to be heard and make a real difference to those who are living with or caring for someone with dementia.”

Dementia is one of the greatest health challenges facing the country and Greater Manchester at the moment. In Greater Manchester alone, it’s estimated there are currently over 30,000 people living with dementia and numbers are predicted to rise over the next 20 years.

She added that a vital part of the framework will be awareness raising of dementia.

“People with dementia are at greater risk of social isolation and loneliness and part of our Dementia Friendly Communities work focuses on everyone in the community sharing responsibility for ensuring people with dementia feel understood, valued and able to contribute to their community,” she said. “Health Innovation Manchester have been amazing at understanding this and bringing together organisations and innovative ideas which will make a difference.

“I’d encourage others to get involved with the Dementia project – the more representation, knowledge and experiences we have, the broader our impact can be.”

Dementia Consortium:
Maximising Research, Early Diagnosis & Intervention

Phases:
Phase 1 Start: Mar 2018
Phase 1 End: Dec 2018

Innovation Programme Overview

There are currently more than 30,000 people living with dementia in Greater Manchester and the city region spends £270 million a year treating and caring for people with the disease.

One million people in the UK will have dementia by 2025 and this will increase to two million by 2050 according to Alzheimer’s Research. In the UK there are approximately 850,000 people living with a diagnosis of dementia.

If the prevalence of dementia remains the same, the number of people with dementia in the UK is forecast to increase to 1,142,677 by 2025 and 2,092,945 by 2051, an increase of 40% over the next 12 years and of 157% over the next 38 years.

Health Innovation Manchester is working with academia, the healthcare system, commissioners and providers within Greater Manchester to consider the future possibilities of prevention, via the development of an Early Dementia Diagnostic framework for Greater Manchester working with the Dementia Industry Group, which is a life sciences industry collaborative group supporting the UK to lead in the field of dementia treatment and research.

In parallel we are also working with Dementia United (DU) and the established research community to support a more coherent strategy for dementia research/trials.

The vision is to improve outcomes in dementia by ensuring optimal access and uptake of innovative technologies and treatments for eligible patients as well as ensuring the health and care system is geared to provide the best support for people living with dementia.

Programme Objectives

The overall aim of this group is to work towards improving outcomes in dementia by ensuring optimal access and uptake of innovative technologies and treatments for eligible patients as well as ensuring the health and care system is geared to provide the best support for people living with dementia by establishing an early detection and diagnostic framework for Greater Manchester.

Potential Impacts and Outcomes

• Support social values and the economic development of GM through collaborative arrangements to benefit patient care.
• Drive inward investment from the biopharmaceutical industry to the region.
• Understand and enhance the value that health and social care in GM derives from investment in medicines and technologies.
• Support personalised self-care and reduce health inequalities and achieve the best outcomes for people in the most cost effective, safe way.
• Innovative use of high quality international evidence and proven best practice to shape services.
• Sustainable increase of the adoption of medicines innovation across the GM footprint, where patient and population benefits are accrued safely.
• Accelerated discovery, development and deployment of innovative medicines solutions.
• Enhanced contribution of GM to the UK’s life sciences industrial strategy and development of the Northern Powerhouse and Connected Health Cities programmes.
• Innovative use of high quality international evidence and proven best practice to shape services.

Clinical and Policy Priorities

• The GM Dementia United Strategy (2017).
• Greater Manchester Dementia Standards UK (2016).
• National Dementia Strategy (2009).
• The Dementia Challenge (2012).

Contacts:

Programme Lead:
Cara Afzal (Senior Programme Development Lead)

Clinical Lead:
Professor Alistair Burns
(Professor in Old Age Psychiatry, University of Manchester)
INNOVATION PROGRAMME OVERVIEW

Early detection and monitoring can pave the way for better treatment for people with AF (avoidance of the illness, disability and premature death associated with AF-related strokes), and major healthcare savings. Conservatively, an AF-related stroke is estimated to cost the NHS £12,228 in the first year (NICE CG 180).

AF is more common in older populations and in patients with particular comorbidities [Diabetes, CVD, P/H Stroke or TIA], for which there is also a prevalence correlation with ethnicity (South Asian) and socio-economic status. Consequently, these groups of people will benefit over others.

As part of our Cardiovascular Programme, Health Innovation Manchester is working to reduce the number of people dying or disabled by AF-related stroke, by optimising the use of anticoagulants in line with the National Institute for Heath and Care Excellence (NICE) CG180 guidelines.

The programme encompasses three categories ‘Detect. Review. Protect’ and includes a variety of interventions including improving the detection of patients with AF using screening devices, performing timely anticoagulation reviews and ensuring patients are receiving appropriate care.

As part of the programme of work, ‘Detect’, we are working to provide healthcare professionals across GM with mobile ECG devices. These devices will help increase the detection of people with AF, in clinical and/or community settings.

PROGRAMME OBJECTIVES

The primary aim of Health Innovation Manchester’s work is to foster the adoption and use of AliveCor devices [340 devices deployed] within a variety of settings.

POTENTIAL IMPACTS AND OUTCOMES

- Increase QoF AF001 - number of people with AF as a percentage of the registered population
- Increase QoF AF007 percentage of patients with AF, with a CHA₂DS₂-VASc score of 2 or more, who are currently treated with anti-coagulation drug therapy
- Reduce the percentage of patients with AF admitted to hospital for stroke – measured through HES data

CLINICAL AND POLICY PRIORITIES

- National Institute for Heath and Care Excellence (NICE) CG180.
- National Cardiovascular Health Intelligence Network (NCVIN, 2016).

This is part of a national programme of rolling out these devices to all Academic Health Science Network geographies.

SUPPORTING NHS ENGLAND ROLL OUT OF ALIVECOR KARDIA MOBILE ECG DEVICES

PROJECT START: OCT 2017  PROJECT END: MAR 2019

Contacts:

PROGRAMME LEAD:
Cara Afzal (Senior Programme Development Lead)

CLINICAL LEAD:
Dr Jaydeep Sarma
(Consultant Cardiologist) Manchester University NHS FT
T-MACS: Troponin Only Manchester Acute Coronary Syndromes Decision Aid

Project Start: Oct 2017 | Project End: Dec 2018

Innovation Programme Overview

Patients presenting with chest pain at the emergency department are the group most commonly requiring hospital admission. Troponins are a family of proteins found in heart muscles that produce a muscle contraction, with serial troponin testing remaining the standard of care to rule out heart problems.

Troponin only Manchester Acute Coronary Syndromes (T-MACS) is a decision-aid, in the form of a computerised clinical prediction model which calculates each individual patient’s probability of acute coronary syndromes following a single blood test at the time of arrival. This probability is used to assign each patient to the relevant risk group and suggest a course of action for the clinicians to follow.

Since implementation at Manchester Royal Infirmary, over 3,500 patients have been treated using T-MACS, with the algorithm superior to NICE guidelines. More than two-thirds of patients can be treated in an ambulatory care setting, such as outpatient clinics or emergency departments, with the vast majority discharged on the same day, compared to a two-day average stay with routine care.

T-MACS won Manchester University NHS Foundation Trust’s Transformation Prize in 2016 and Health Innovation Manchester now aim to implement it across Greater Manchester to increase the quality and efficiency of healthcare provided to patients.

Programme Objectives

Health Innovation Manchester aim to support the implementation T-MACS across Greater Manchester.

Potential Impacts and Outcomes

The project will result in improved quality of life for patients, due to quicker and more effective diagnosis and treatment and more appropriate triaging of patients. It is projected to save £100 million per year if rolled out across Greater Manchester.

As all the data is automatically collected, implementation will lead to formation of a world-leading registry for patients with acute chest pain. Linking with outcome data this will create an unrivalled infrastructure for ongoing audit, for introducing artificial intelligence and for enabling future pragmatic/point of care trials and a more collaborative approach between patients and consultants – sharing real time data and analysis of risk.

Clinical and Policy Priorities

Cardio A&E Pathways in acute settings Clinical Guidelines (CG95) quality Standards for treating acute chest pain GM HSCP Theme 3 CVD Programme

Contacts:

Programme Lead: Cara Afzal (Senior Programme Development Lead)

Clinical Lead: Dr Richard Body (Consultant in Emergency Medicine, Manchester University NHS FT)
INNOVATION PROGRAMME OVERVIEW
Healthy Hearts is an innovative programme aiming to reduce deaths from Cardiovascular Disease (CVD) through better identification of those at risk of heart attack or stroke in Greater Manchester.

The project will work closely with Clinical Commissioning Groups to find those at highest risk of CVD, including those with high blood pressure and high cholesterol in a systematic and targeted approach. The programme will also link with targeted health checks and lifestyle interventions. Data shows that if each CCG in the area reached the level of the five best similar CCGs, there would be 356 fewer deaths for under 75-year-olds each year.

It is estimated that ideal control of diagnosed hypertensives – those patients with high blood pressure – could save 470 heart attacks and 700 strokes over three years in Greater Manchester, a financial saving of over £13.2 million. The project aims to reduce deaths from CVD by at least 600 by 2021 and identify those at highest risk of CVD to enable treatment, lifestyle interventions and self-management opportunities.

Health Innovation Manchester have also provided practices in Greater Manchester with access to the AliveCor Kardia hand-held Atrial Fibrillation (AF) detection device (See page 11)

POTENTIAL IMPACTS AND OUTCOMES
- Reduce deaths from CVD in Manchester by at least 600 by 2021.
- Identify those at highest risk of heart attack or stroke and optimise treatment at scale.
- Reduce the number of CVD events and associated morbidity.
- Reduce the equity gap for deaths from premature CVD across GM.
- Identify and share best practice in GM and elsewhere systematically.
- Increase in target population on optimal treatment and with optimal control.
- Reduce the observed/expected prevalence gap for hypertension, CVD and Atrial Fibrillation.
- Identify those at highest risk of CVD to enable other lifestyle interventions and support self-management.
- Overall reduction in strokes and heart attacks across GM.

CLINICAL AND POLICY PRIORITIES
Emergency Laparotomy is a surgical operation that is used for people with severe abdominal pain to find the cause of the problem and in many cases to treat it. Emergency laparotomy is a major surgical procedure with 30,000 – 50,000 performed annually in the UK. However, 14.9% of patients are reported to die within 30 days of surgery, rising to 24.4% for those over the age of 80 years. It is a costly procedure, with over 25% of patients remaining in hospital for more than 20 days after surgery, costing the NHS over £200 million a year in ward care.

The Emergency Laparotomy Collaborative (ELC) is a Kent Surrey and Sussex (KSS) Academic Health Science Network-led programme that involves the spread and adoption of the evidence-based Emergency Laparotomy Pathway Quality Improvement Care (ELPQuiC).

Programme Objectives
Royal Surrey County Hospital NHS Foundation Trust have developed an evidence-based laparotomy care bundle that aims to:

- Improve standards of care for patients undergoing emergency laparotomy surgery.
- Reduce mortality rates, complications and hospital length of stay.
- Encourage a culture of collaboration across the regions.
- Embed quality improvement skills to ensure sustainability of change.

The Collaborative aims to deliver 6 key themes using a care bundle approach, including the involvement of consultant surgeons, anaesthetists and intensivists from time of the patient presenting to hospital, throughout the patient’s time in the operating theatre and beyond. The bundle elements are:

- Use of Early Warning Score to identify patients most at risk for deterioration and the delivery of prompt resuscitation for these patients.
- Use of sepsis screening tool to identify septic patients and treatment with Sepsis Six.
- Definitive surgery within 6 hours of decision to operate for patients categorised as Level 1 and 2a in urgency.
- Appropriate dynamic fluid resuscitation and optimisation using goal-directed fluid therapy.
- Postoperative critical care (level 2 or 3) for all patients. Consultant delivered care throughout the perioperative journey.

Potential Impacts and Outcomes
- National reduction in crude mortality.
- National reduction in length of stay.
- Scaling up delivery care bundles.
- Improvement in Consultant-led care nationally.

A social return on investment modelling has estimated for every £1 invested, there will be a return of £4.50 to the wider health and social care economy.

And Policy Priorities
- Five Year Forward View.
- DH Musculoskeletal Framework.
- Public Health England’s ‘Everybody Active Everyday’.
- Towards an Active Nation – Sport England.

Contacts:
Programme Lead:
Jay Hamilton (Associate Director - Health & Implementation)

Clinical Lead:
Eva Bedford (GMEC PSC Lead deteriorating patient workstream)
INNOVATION PROGRAMME OVERVIEW
Across the United Kingdom, osteoarthritis (OA) affects nearly 10 million people, causing pain, reduced mobility, impaired physical, mental and emotional well-being, and reduced independence and quality of life. It also increases the risk of co-morbidity and mortality. 90% of people with OA are managed by GPs. It accounts for 2 million GP consultations and approximately 150,000 knee/hip replacements, making it the third largest NHS expenditure. It causes 36 million lost working days and accounts for approximately £480 per person per year out-of-pocket expenses. The total health and social welfare and societal costs is £3.2 billion, which equates to approximately 1% of GDP.

ESCAPE-pain (Enabling self-management and coping of arthritic pain through exercise) is a rehabilitation programme for people with chronic joint pain that integrates core recommendations around self-management, coping strategies as well as undertaking exercise. Designed for people over 45 years, who have chronic knee and/or hip pain, ESCAPE-pain runs over 12 sessions, with each session comprising of:

- An education component – group themed discussions (led by a supervisor) that covers possible causes of pain, and advice about simple pain management and coping strategies.
- An exercise component – group participate in personalised progressive exercise regimen to increase strength, endurance and function.
- Behavioural change component – techniques that subtly challenge erroneous beliefs that physical activity causes and/or exacerbates joint pain.

PROGRAMME OBJECTIVES
The aim of the ESCAPE-pain is to increase access of the programme across the UK so that as many people as possible can benefit.

POTENTIAL IMPACTS AND OUTCOMES
The economic evaluation suggests that for every 1,000 participants who undertake ESCAPE-pain there are potential savings of:
- £20,280/annum in medication
- £59,560/annum in community-based care (GP consultations, district nurse, social care contacts)
- £2.8 million/annum in total health and social care (medication, community care, acute hospital care–mainly elective surgical procedures)
- Independent research shows participants on programmes like ESCAPE-pain are more likely to decline or delay surgery. It is estimated that £1 million could be saved nationally, for every 1,000 participants completing the programme.

Public Health England has calculated that ESCAPE-pain would bring a positive return on investment of £5.20 for every £1 spent on the intervention.

CLINICAL AND POLICY PRIORITIES
- Five Year Forward View.
- Department of Health Musculoskeletal Framework.
- Public Health England’s ‘Everybody Active Everyday.’
- Towards an Active Nation – Sport England.

CONTACTS:
PROGRAMME LEAD:
Dai Roberts (Senior Programme Development Lead)

CLINICAL LEAD:
Currently in recruitment
Psoriasis is a long-term autoimmune disease characterised by red, flaky, crusty patches of skin covered with silvery scales. The World Health Organisation Global Report on Psoriasis recognises this condition as a 'painful, disfiguring and disabling disease, which causes great physical, emotional and social burden' for patients. This report highlighted the need for early diagnosis and improved access to appropriate care to reduce 'needless suffering' [World Health Organisation Global Report on Psoriasis. 2016].

At present, patients receive very little ongoing support so become despondent and disengaged from the healthcare system. The consequences are poorly managed psoriasis and multiple contacts with health and social care providers. In addition, there are several comorbidities linked with psoriasis which carry a significant burden on the health economy and patients' wider economic contribution.

PROGRAMME OBJECTIVES

The psoriasis rapid access clinic (P-RAC) will be based within a community practice. The clinic will initially run in Salford, using a pool of patients who are known to have been suffering with psoriasis over the last two years (but not referred to secondary care dermatology services) as well as new cases of the disease. The clinic will provide patients with a complete assessment of their psoriasis, cardiovascular disease risk screening, education about the disease and how to manage it.

The aim is to assess the feasibility, practicality and benefits of setting up a Rapid Access Clinic for newly diagnosed patients with psoriasis.

Specifically the programme will:

- Determine the characteristics of patients who are most likely to benefit from the P-RAC.
- Identify the perceived barriers and facilitators to wider implementation of the P-RAC across NHS organisations.

- Determine if the service leads to an improvement in psoriasis severity measures.
- Establish the prevalence of CVD risk factors and unhealthy lifestyle behaviours amongst this group.
- Determine whether a patient’s attitude towards and understanding of psoriasis improves with the P-RAC intervention and whether this influences care/ self-care.
- Describe the costs of this service and determine if it is cost-effective.

POTENTIAL IMPACTS AND OUTCOMES

- Viable product for roll-out across Greater Manchester and a model for early-intervention and management of other long-term conditions.
- Increased self-care.
- Increased adherence to medication.
- Early referral to hospital services for those most at risk.
- Increased understanding of cardiovascular risk factors in this population.
- Prevention of serious co-morbidity.
- Reduced absenteeism and presenteeism.

CLINICAL AND POLICY PRIORITIES

- Transforming community-based care and support is one of the transformation themes of the Greater Manchester Health and Social Care Partnership.
- The Salford Locality Plan has committed to “achieve a more personalised and patient centred approach to caring for people with long term conditions.”

CONTACTS:

PROGRAMME LEAD:
Cath Barrow (Senior Programme Manager)

CLINICAL LEAD:
Professor Christopher Griffiths (Salford Royal Foundation Trust)
INNOVATION PROGRAMME OVERVIEW

The prevalence of pre-term birth is increasing. Although the survival of infants born pre-term has improved, the prevalence of cerebral palsy has risen; this is because the incidence of cerebral palsy decreases significantly with increasing gestational age.

It is evidenced that antenatal magnesium sulphate given to mothers who are likely to deliver a pre-term baby reduces the risk that the baby will later develop cerebral palsy.

Around 11,000 women a year deliver pre-term babies and 36% (4,000) of these babies will incur a brain injury which could be prevented by prescribing magnesium sulphate to pregnant women that are likely to deliver a pre-term baby.

According to the National Neonatal Audit Programme (2016) 60% of women with pre-term pregnancy in the UK are not receiving magnesium sulphate.

PROGRAMME OBJECTIVES

This project aims to reduce cerebral palsy in very pre-term babies (less than 30 weeks gestation) by providing antenatal magnesium sulphate to women; increasing the uptake of magnesium sulphate from the current national average of 40% to 85% (equivalent to international benchmarks).

The costs associated with the administration of magnesium sulphate are insignificant. However in addition to the improved quality of life, the savings associated with the prevention of cerebral palsy amongst per-term babies is momentous.

The total lifetime cost across the health and social care system per baby born with cerebral palsy is in the range of £850,000 to £1m.

POTENTIAL IMPACTS AND OUTCOMES

- Reduction in pre-term babies born with cerebral palsy.
- Increased uptake of magnesium sulphate.
- Savings across the health and social care system associated with the care of cerebral palsy patients / individuals.
- Improved quality of life for the new baby and family.
- Better prospects for the new baby with regards to living a more independent life, ability to work, obtain mainstream education, etc.

CLINICAL AND POLICY PRIORITIES

COCHRANE Database Systematic Review 2009: CD004661 and NICE Guidelines on pre-term labour and birth NG25 2015 both recommend the administration of antenatal magnesium sulphate amongst mothers who are likely to deliver a pre-term baby to reduce the risk of the unborn child being born with cerebral palsy.

CONTACTS:

PROGRAMME LEAD:
Debby Gould (PSC Lead for Maternity/Neonatal Workstream)

CLINICAL LEAD:
Currently in recruitment
INNOVATION PROGRAMME OVERVIEW

Inflammatory bowel disease (IBD) is a broad term that refers to chronic swelling (inflammation) of the intestines and is often confused with the non-inflammatory condition irritable bowel syndrome (IBS). Although the two disorders share similar names and some of the same symptoms, they have distinct differences.

Faecal Calprotectin is a Biomarker that is used to help differentiate between Irritable Bowel Syndrome (IBS) and Inflammatory Bowel Disease (IBD).

IBS affects between 10-20% of the population with 95% of patients being referred unnecessarily for secondary care.

Current processes are causing unnecessary treatment for those patients with IBS, impacting on resources, cost and outcomes on patient experience.

The new pathway supports CCGs and GPs in decision-making to refer or treat. Resources have been produced to provide CCGs, GPs and Trusts to ensure the pathway is utilised and implemented.

Evaluations in Yorkshire to understand the benefits of the new pathway concluded that for every 1000 patients who go through this new pathway, we could potentially save £152,000 and prevent 271 unnecessary procedures, saving a further 300 outpatient appointments.

PROGRAMME OBJECTIVES

The primary aim of this project is to improve pathway of treatment for IBS and IBD patients through faecal calprotectin testing by:

- Developing an implementation plan for roll-out of the pathway into the local areas.
- Utilising and adopting resources for CCG and GPs to use.

POTENTIAL IMPACTS AND OUTCOMES

- Reduced waiting times in endoscopy and gastroenterology.
- Reduction in hospital admissions for secondary care.
- Cost saving to the NHS from reduction of unnecessary treatment.
- Better patient experience.

CLINICAL AND POLICY PRIORITIES

This initiative has been adopted from NHS England which created the algorithm for faecal calprotectin testing and is undergoing NICE endorsement.

NHS Business Authority have developed a business case outlining the use of the pathway in Yorkshire, which can be used to promote in local areas.

CONTACTS:

PROGRAMME LEAD:
Cara Afzal (Senior Programme Development Lead)

CLINICAL LEAD:
Dr Simon Smale
(Consultant Gastroenterologist Manchester University NHS FT)
INNOVATION PROGRAMME OVERVIEW

Atrial Fibrillation (AF) is a heart condition that causes an irregular and often abnormally fast heart rate. AF is the most common cardiac arrhythmia and is a major cause of ischaemic stroke, with the risk of stroke being five times higher than in a person with a normal heart rhythm.

Anticoagulation to reduce the risk of stroke is an essential part of AF management, however according to the Department of Health, patients are not always appropriately anticoagulated and they suggest that 7,000 strokes could be avoided and 2,100 lives saved each year in England with appropriate AF management.

Health Innovation Manchester are delivering an innovative care pathway, supported by digital solutions to utilise Community Pharmacists in stroke pathway redesign: a shared team approach that empowers Community Pharmacists to work jointly with General Practice (GPs) to undertake a Medicines Review (MR) with AF patients.

PROGRAMME OBJECTIVES

To deliver an innovative care pathway, supported by innovative digital solutions, for the management of known, sub-optimally managed AF patients. The project is novel in engaging the community pharmacy services, primary care based GP practices and the patient, in delivering a ‘shared team approach’ to managing these patients more effectively.

POTENTIAL IMPACTS AND OUTCOMES

- Medicines review by a community pharmacist will reduce pressures on GP appointment time.
- Enhanced information sharing between community pharmacy and primary care patients referred for AF.
- Warfarin patients are better managed and, potentially, reduce the number of times they are seen by a GP or at an Anticoagulation Clinic.
- AF patients, not currently medicated, are managed with more effective treatment, reducing the risk of stroke.

CLINICAL AND POLICY PRIORITIES

- NICE CG180: AF – anti-platelets no longer an option, anticoagulants recommended to reduce stroke risk
- NICE QS 93: AF
- DH Cardiovascular outcomes strategy (2013)
- NICE Implementation Collaborative – Supporting local implementation of NICE guidance on use of the novel (non-Vitamin K antagonist) oral anticoagulants in non-valvular atrial fibrillation

CONTACTS:

PROGRAMME LEAD:
Dai Roberts (Senior Programme Development Lead)

CLINICAL LEAD:
Dipesh Raghvani, Clinical Lead Greater Manchester Local Pharmaceutical Committee
INNOVATION PROGRAMME OVERVIEW
Health Innovation Manchester aims to demonstrate innovation in the field of mental health through the testing of an outcomes based pricing model for schizophrenia treatments.

Pharmaceutical Industry partner Janssen-Cilag has offered Mental Health Trusts in Greater Manchester a rebate scheme which reimburses the provider if the treatment doesn’t work as planned.

Newer, second-generation antipsychotics represent an advance in the long-term management of schizophrenia and the project provides an evaluation of those who have been clinically approved and initiated on the medications within mental health trust.

As relapse in schizophrenia can cost between £12,000 and £25,000, Janssen-Cilag has developed an outcomes payment scheme and rebate to demonstrate their belief that their medicines can play a role in preventing relapse and the key cost that goes with it.

The scheme aims to provide real-world data as to whether the second-generation antipsychotic injections prevent relapse and admission as well as potential financial savings and better patient care with improved outcomes.

PROGRAMME OBJECTIVES
◆ To track the patient journeys of those prescribed paliperidone (Xeplion and Trevicta), including discontinuation
◆ Investigation into the cost implications of intervention required as a result of failure of the medication: costing model/pharmaceutical industry partnership.

POTENTIAL IMPACTS AND OUTCOMES
◆ Real-world data as to whether these depot injections are preventing admission.
◆ Potential for financial savings via the rebate scheme.
◆ Potential for better patient care with improved outcomes.

CLINICAL AND POLICY PRIORITIES
The prevalence of schizophrenia is 1 in 100 of the population, with a reduction in lifespan by 14.6 years. Those with schizophrenia are admitted for double the number of bed days than other MH diagnoses. There is a need to ensure the right medication for the right patient, through medicines optimisation, and participation in this scheme provided the opportunity to track the patient’s journey following initiation, to evaluate the medication’s effectiveness in preventing relapse.

CONTACTS:
PROGRAMME LEAD: Cara Afzal (Senior Programme Development Lead)
CLINICAL LEAD: Petra Brown (Greater Manchester Medicines Optimisation Strategic Lead Pharmacist)
INNOVATION PROGRAMME OVERVIEW
Greater Manchester has the ambitious aim to become the first UK city region to eliminate Hepatitis C by 2025. The virus, which affects the liver, can sometimes cause serious and potentially life-threatening damage if left untreated.

There are estimated to be around 17,450 people in Greater Manchester living with the infection, including around 7,000 who are undiagnosed. Of those diagnosed, only 28% are engaged with specialist services.

The Health Innovation Manchester project aims to eliminate Hepatitis C by using a networked and phased approach. Working across settings and services such as community pharmacy, prisons, drug and alcohol services. Initially, community pharmacies will deliver point of care testing and dry blood spot testing to maximise the number of people tested and identify high risk patients as well as providing treatment in a more convenient location for the individual. Pharmacies will be targeted in terms of methadone dispensing and opiate replacement therapy as well as those operating a safe needle exchange.

Following an initial pilot, the project will look to test and treat the wider population groups at high-risk of infection and a rapid testing and treatment regime will also be implemented for those in or entering prison.

The project aims to bring specialist services to the patient at the point of need and develop a new, more cost-effective testing and treatment infrastructure. It would also result in a reduction in associated healthcare costs and a better quality of life for patients.

PROGRAMME OBJECTIVES
The objective of this programme is to eliminate Hepatitis C Virus (HCV) in Greater Manchester; this will be achieved by:

- Diagnosing individuals in Greater Manchester who have HCV but are not aware they have the disease
- Engaging those individuals who are aware they have the disease but are not currently engaging with specialist care, and providing them with curative treatment.
- Increasing accountability and responsibility across the partnership to reduce the risk of relapse.

- Putting in place a credible delivery model which is realistic in terms of costs and return.
- Recognising the need and continuing to monitor the impact of the intervention and providing live assurance on progress.
- Bringing specialist services to the patient and provide comprehensive integrated services to patients at the point of need.

POTENTIAL IMPACTS AND OUTCOMES
- Reduction in exacerbations.
- Curing patients of Hepatitis C.
- Longer term decrease in testing and treatment costs.
- Reduction in associated healthcare costs.
- Increased contribution in terms of employment and tax payments in terms of those cured.
- Reducing chance of reinfection.
- Reduction in hospital admissions.
- Better quality of life for patients.
- Cost benefits from switching patients to more cost effective drugs which are clinically effective at the same time.
- Development of a new and more cost-effective testing and treatment infrastructure.

CLINICAL AND POLICY PRIORITIES
This initiative aligns to World Health Organisation goals of eliminating Hepatitis C by 2030, the UK’s commitment to adopt the Global Health Sector Strategy on Viral Hepatitis 2016-2021, and; Greater Manchester Health and Social Care Partnership ambition to see the greatest and fastest possible improvement to the health, wealth and wellbeing of the 2.8 million people in GM

CONTACTS:
PROGRAMME LEAD:
Dai Roberts, Senior Programme Development Lead

CLINICAL LEAD:
Dr Andrew Ustianowski (Consultant, infectious diseases, North Manchester General)
INNOVATION PROGRAMME OVERVIEW

Health Innovation Manchester supports a system-wide approach to driving quality and improvement and offers a free tool to health and social care organisations across Greater Manchester.

Life QI is a web-based platform designed to assist frontline staff running quality and safety improvement projects and connect with a community across the country to share best practice.

The tool, developed as part of the Patient Safety Collaborative in partnership with SeeData, supports frontline NHS and social care teams to plan, monitor and report progress of their improvement projects.

The flexible LifeQI application contains tools to help improvement work and makes it easy to see progress. It allows teams to create driver diagrams, conduct “Plan, Do, Study, Act” (PSDA) cycles and visualise results through charts, as well as creating a bank of QI projects which can be shared.

Users can also connect to a QI community of practice across the country, encouraging collaboration with teams working on similar challenges, avoiding duplication and sharing learning and success while building a network of people committed to improving care.

More than 140 people and organisations working on service improvement projects have already signed up to the Life QI tool through Health Innovation Manchester and free licences are still available.

Health Innovation Manchester has also partnered with Advancing Quality Alliance (AQuA) and The Health Foundation’s Q Community for the Q Book Club.

The Q Community is an initiative connecting people who have health and care improvement expertise across the UK with opportunities to share ideas, enhance skills and collaborate.

PROGRAMME OBJECTIVES

The system aims to achieve an online community of QI projects and people, and a place for health and social care professionals to share, learn and collaborate with each other.

POTENTIAL IMPACTS AND OUTCOMES

- Enable novice users to manipulate charts and statistics.
- Enable sharing of best practice and lessons learned amongst users engaging on quality improvement projects.
- Create a platform for users to collaborate on quality improvement projects.
- Familiarise and educate users on the underlying QI methodology.
- Enable users to capitalise on the system and self-serve via an accompanying learning centre, that will provide a wealth of information on both how to use the system, and the underlying QI methodology.

CLINICAL AND POLICY PRIORITIES

- Quality and service improvement.

The Q Community Book Club will feature five sessions which will examine key quality improvement literature, hear from local and national improvement leaders and explore online tools to help Q community members share discussion and apply learning.

CONTACTS:

PROGRAMME LEAD:
Jay Hamilton (Associate Director - Health & Implementation)

SERVICE PROVIDER:
SeeData (www.seedata.co.uk)
When Gillian Bardsley had a poor experience giving birth to her daughter Jessie in February 2017 following an induction at the Royal Oldham Hospital, she was inspired to bring about change for other women. Gillian was left with PTSD symptoms and wrote a letter of complaint which resulted in a meeting the hospital’s Head of Midwifery at the time where she shared her experience.

Gillian said: “She managed to answer the questions that I had, gave me a sense that I was heard and gave me the closure I needed following the experience.”

Gillian was then put in touch with Patient Experience Midwife Sam Whelan, learned about the plans to improve the department and quickly became engrossed in the drive for change, appearing in a patient experience video which was used for training with the maternity department.

She then began to share her story on a wider stage, including speaking at NHS Improvement Conferences in Manchester where she met Debby Gould, GMEC PSC Clinical Lead, and supporting the set-up of the Royal Oldham Hospital.

Gillian has also worked with Sam to set up and chair a Maternity Voices Partnership for Rochdale and Oldham. The group, which is supported by Health Innovation Manchester, aims to give women the opportunity to help co-design and improve local maternity services.

“I am happy to report that more and more women are getting involved with the group and we are going to carry out the 15 Steps for Maternity initiative which is aimed at reporting on first impressions and delivering ideas for how we could improve things from a woman’s point of view,” Gillian said.

“The PSC have been great supporters of the group, attending our launch event, helping with materials to display at the hospital and encourage women to get involved.

“The impact of this on me has been a healing one, I feel that being heard, and having the opportunity to give back is part of the reason why I have been able to recover from the effects of the birth.

“As a service user, I would like to see the PSC is bringing together professionals and women together to share best practice and learn from ideas from across the network.”

Gillian and I forged a way to launch the group in May and I am looking forward to the group taking part in the ‘15 Steps’ initiative on the maternity unit at The Royal Oldham Hospital.

“I would encourage others to seek support from Health Innovation Manchester for their wealth of knowledge and support that they can offer for your project.”

The PSC has been set up to support, connect and provide initiatives and activities to drive improvement and ensure patient safety is embedded throughout the Greater Manchester health and social care community.

The PSC have held several interactive days with speakers, activities and information sharing across its workstreams.

INNOVATION PROGRAMME OVERVIEW
Safety and ensuring patients are not harmed within a health and social care setting is everyone’s responsibility and Greater Manchester is in a unique position to be able to support and create a smooth pathway to improvement.

Through the Patient Safety Collaborative, a joint initiative funded and coordinated by NHS Improvement and delivered by Health Innovation Manchester, we can work directly with local teams, supporting them to make sure they have the right skills and resources to implement improvements.

We can also share good practice across the health system, focus on people-centred care and build relationships with NHS staff, business and academia to stimulate innovation and improvement.

The PSC will focus on three national areas of work:

- Maternity and Neonatal: To improve maternity and neonatal care, specifically reducing the rate of stillbirth, neonatal death and brain injuries occurring during or soon after birth by 20% by 2020.

- Deteriorating Patient: To reduce harm and enhance the outcomes and experience of patients who are deteriorating.

- Culture and Leadership: To help create the conditions that will enable healthcare organisations to nurture and develop a culture of safety.

POSSIBLE IMPACTS AND OUTCOMES
- The PSC has been created to support, connect and potentiate initiatives, activities and people.

- The PSC will develop sustainable PSC models so that quality improvement in patient safety is embedded throughout the Greater Manchester and Eastern Cheshire health and social care community.

- A more joined up approach across GM across all health and social care sectors sharing good practice.

CLINICAL AND POLICY PRIORITIES
This programme is part of the national NHS Improvement’s Patient Safety Collaborative (PSC) programme which is the largest safety initiative in the history of the NHS, supporting and encouraging a culture of safety, continuous learning and improvement, across the health and care system.

The PSC is funded and coordinated by NHS Improvement, with the 15 regional PSCs organized and delivered locally by the Academic Health Science Networks (AHSNs).

CONTACTS:
- PROGRAMME LEAD:
  - Jay Hamilton, (Associate Director – Patient Safety and Improvement)
  - Dai Roberts (Senior Programme Development Lead)

- CLINICAL LEAD:
  - Debby Gould (Lead for Maternity/Neonatal Workstream)
  - Eva Bedford (Lead for Deteriorating Patient Workstream)
INNOVATION PROGRAMME OVERVIEW

We are improving medicines safety in partnership with NHS England, by rolling out electronic systems to support transfer of care. The systems enable discharge information about medicines to be instantly transferred by a hospital to a patient’s chosen community pharmacy.

When patients are discharged from hospital, the transfer of care process is associated with an increased risk of adverse effects. 30-70% of patients experience unintentional changes to their treatment or an error is made because of a miscommunication. This is what the Transfers of Care Around Medicine (TCAM) project aims to address.

Particularly patients who are assessed in hospital as needing additional support with their medicines, they are referred to their community pharmacist on discharge.

PROGRAMME OBJECTIVES

Through the national implementation of TCAM across the 15 AHSNs in 2018-2020, each AHSN will support their local trusts to establish a TCAM pathway. This will enable all suitable patients to be referred to their community pharmacy or GP pharmacist where appropriate.

In Greater Manchester, Salford Royal is the first hospital and locality to be implementing a TCAM software platform (based on the PharmOutcomes system). Several more hospital Trusts will follow throughout 2018/19.

The main objective is to implement TCAM across all Greater Manchester Trust sites.

POTENTIAL IMPACTS AND OUTCOMES

- Reduction in emergency bed days.
- Reduction in length of stay.
- Across the 9 hospital sites a potential saving of £2.5m in financial savings to the local health economy
- Integrating working arrangements.
- Improved patient experience.
- Improved monitoring and reporting of adverse drug reactions.
- Improved medication adherence.
- Reduction in hospital readmissions.
- Early identification and intervention.
- Delivery of care in alternative settings.
- Optimisation of direct patient care through forming links with community pharmacy.
- Reduction in drug waste and impact on primary care medicines spend.

CLINICAL AND POLICY PRIORITIES

Aligns to GM Health & Social Care Partnership Transformation themes:
- Transforming community-based care & support
- Standardising acute and specialist services to the best evidence
- Standardising clinical support and corporate functions
- Enabling better care

CONTACTS:

PROGRAMME LEAD:
Dai Roberts (Senior Programme Development Lead)

CLINICAL LEAD:
Currently in recruitment
In a recent large-scale study in English general practices, prescribing errors were identified in 5% of prescription items, with one in 550 items containing a severe (potentially life-threatening) error. This equates to approximately 1.8 million serious prescribing errors in English general practices each year.

Further studies have shown hazardous prescribing in general practices to contribute to around 1 in 25 hospital admissions, with annual hospital admission costs in England for adverse drug events of £650 million (at 2013 prices).

The World Health Organisation has set a ‘Medication Without Harm’ (2017) Global Patient Safety Challenge aiming to reduce severe avoidable medication-related harm. The Francis Report stated that, ‘It is crucial that the patient is protected from avoidable harm’, and the Secretary of State for Health has set a goal of saving 6,000 lives in the NHS by reducing avoidable harm.

PINCER is a pharmacist-led intervention for reducing clinically important errors in general practice prescribing.

PINCER requires a community pharmacist to work with GP practices to run a search of 11 prescribing safety indicators on their clinical system. The search and results are generated and viewed in PRIMIS software (CHART and CHART Online) and Pharmacists review patient notes using clinical judgement to assess risk and appropriate actions needed to address issues identified. Pharmacists apply root cause analysis to identify the circumstances that led to the potential risk and feedback to the practice.

Together they build an action plan to protect patients at risk and work on any system issues resulting in those risks occurring.

PINCER has been shown (in a trial published in the Lancet) to be an effective method for reducing a range of clinically important and commonly made primary care errors.

**STUDIES HAVE SHOWN HAZARDOUS PRESCRIBING IN GENERAL PRACTICES CONTRIBUTE TO AROUND 1 IN 25 HOSPITAL ADMISSIONS, WITH ANNUAL HOSPITAL ADMISSION COSTS IN ENGLAND FOR ADVERSE DRUG EVENTS OF £650 MILLION**

**INNOVATION PROGRAMME OVERVIEW**

Programme objectives:

- Reduction in hazardous prescribing and avoidance of patient harm, including medication related hospital admissions and deaths.
- Improvements in prescribing safety in NHS general practice.
- Cost savings to the NHS.

Programme objectives:

- Medicines Optimisation.

Potential impacts and outcomes:

Using evidence-based indicators (of harm) to run database searches across 12 CCGs and 361 practices in the East Midlands on 2.9 million patients, it revealed 22,000 patients with potentially hazardous prescribing.

The evaluation of the PINCER trial demonstrated that the intervention is effective at substantially reducing the prevalence of specific prescribing errors in general practice. For example, six months after the intervention the following changes were noted in two of the main outcome measures:

- 44% reduction in the proportion of patients with at least one medication monitoring error, e.g., failure to undertake essential blood tests.
- 29% reduction in the proportion of patients with at least one prescribing error, e.g., prescribing contraindicated medicines to patients.

**CLINICAL AND POLICY PRIORITIES**

- Medicines Optimisation.

**CONTACTS:**

Programme Lead: Dai Roberts (Senior Programme Development Lead)

Clinical Lead: Currently in recruitment