Oxford Academic Health Science Network

Medicines Optimisation Clinical Network

Launch Event – 28th April 2014

16.00	Welcome and introductions	Mr Bhulesh Vadher Clinical Director of Pharmacy and Medicines Management Oxford University Hospitals NHS Trust
16.10	Introduction to Oxford AHSN	Prof Gary Ford CBE Chief Executive Officer, Oxford AHSN
16.25	The Best Care Programme	Mr Chandi Ratnatunga FRCS SRO Best Care Programme, Oxford AHSN
16.40	The importance of Medicines Optimisation	Mr Steve Fairman, Director of Business, Improvement & Research, NHS England
17.00	• Project 1 – reduction in unwarranted variation • Project 2 – QIPP and waste reduction • Project 3 – provision of medicines information knowledge on discharge • Project 4 – develop strategic relationship with pharmaceutical industry partners	Ms Kate Masters, Specialist Clinical Pharmacist Berkshire Healthcare NHS Foundation Trust Mr Michael Marven, Chief Pharmacist, Oxford Health NHS Foundation Trust Ms Gita Vaidya, Deputy Clinical Services Pharmacist Buckinghamshire Healthcare NHS Trust Mr Bhulesh Vadher Clinical Director of Pharmacy and Medicines Management
17.30	Patient and Public Involvement, Engagement and Experience	Mr Steve Candler Network Manager & PPI Lead Thames Valley Strategic Clinical Network, NHS England
17.40	Sustainable Healthcare	Ms Rachel Stancliffe, Director, The Centre for Sustainable Healthcare
17.50	Questions to the panel	
18.00	Summary and close	Mr Bhulesh Vadher

Oxford Academic Health Science Network

Introduction to Oxford Academic Health Science Network

Professor Gary Ford, CBE
Chief Executive Officer, Oxford AHSN

Oxford Academic Health Science Network

Introducing the Oxford AHSN

Professor Gary Ford, CBE
Chief Executive Officer
Consultant Physician

Recent NHS Focus on Innovation

- An **Invention** is a unique or novel device, method, composition or process. Some inventions can be patented.
- **Innovation** is the application of new solutions that meet new requirements, inarticulate needs, or existing market needs.
  Something original, new and important that breaks in to (or obtains a foothold in) a market or society.
- **Improvement** is doing the same think better.

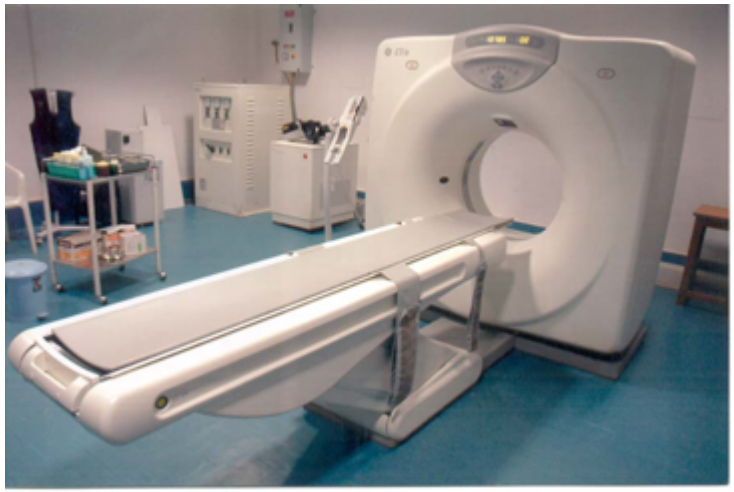
Barriers to Uptake and Development of Innovation in the NHS

- Cost
- National strategies and plans – absent in many
- Financial incentives - lacking
- Training
- Procurement
- Culture of healthcare professionals and organisations
- Clinical engagement
- NICE 'blight'
- Failure to evaluate impact of new innovations when implemented
- Failure of the NHS to stop doing things that do not deliver promised benefits

NHS Slow to adopt Innovation

- CT and MR imaging invented in the UK
- Poor access and utilisation in UK stroke services
- Australian Professor Stroke Medicine 2005

  "You guys invented CT but your use of it in acute stroke is pathetic"

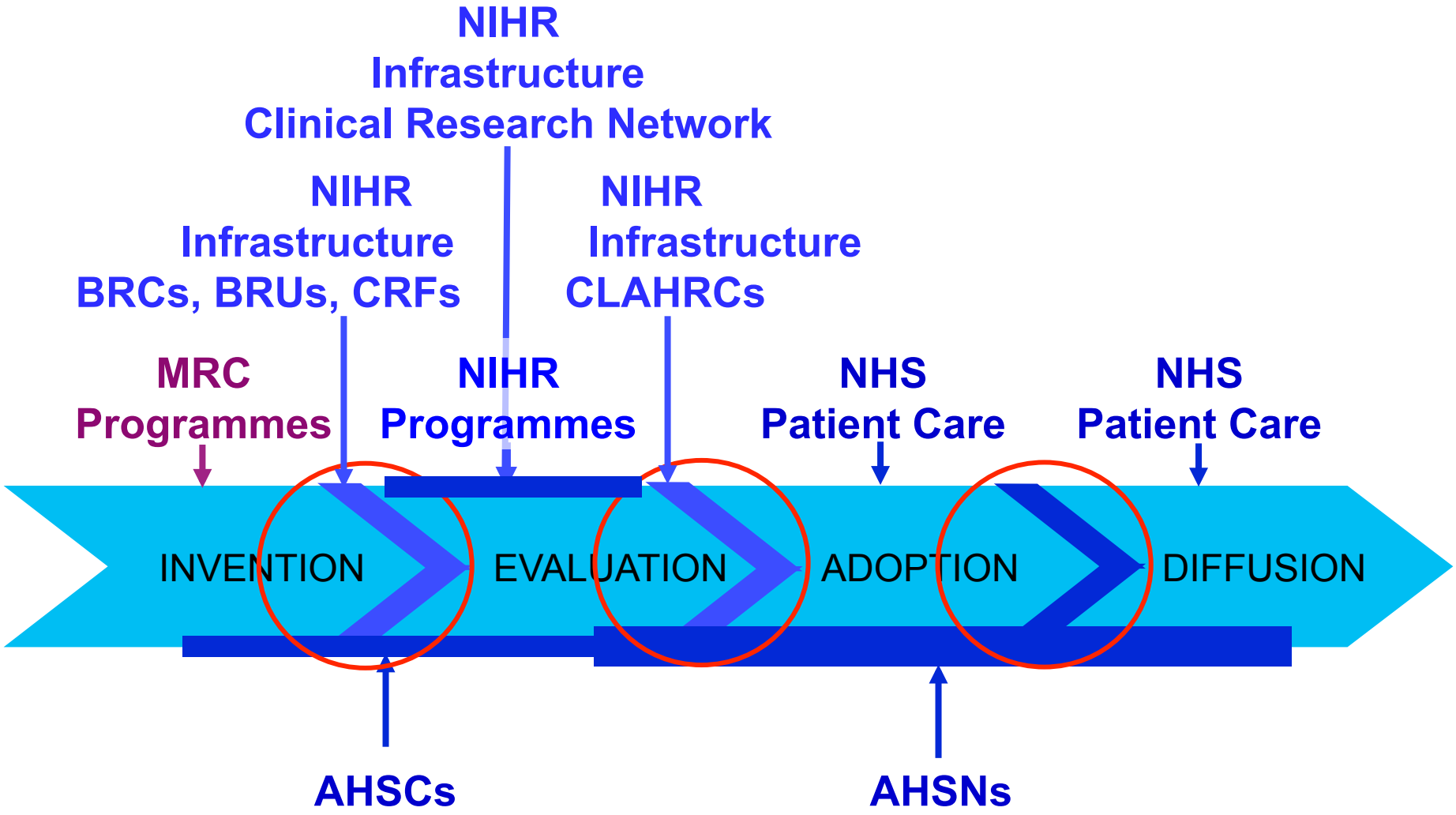


NHS Response: Academic Health Science Networks and Academic Health Science Centres

- 15 AHSNs licensed by NHS England for 5 years to:
- focus on the needs of patients and local populations.
- speed up adoption of innovation into
- build a culture of partnership and collaboration
- create wealth

- 6 AHSCs represent partnerships between “world-class” universities and leading NHS organisations:
- research new treatments
- improve health education and patient care
- bring scientific discoveries "from the lab to the ward“
- drive economic growth through partnerships with industry.

AHSNs, AHSCs and the Research and Innovation Landscape



The Oxford AHSC

- Designated from 1 April 2014 – one of six in England
- Partnership to build on world class basic medical research, translational research, education and patient care
- Partners are Oxford Brookes University, Oxford Health NHS Foundation Trust, Oxford University Hospitals NHS Trust, University of Oxford
- Nested within the Oxford Academic Health Science Network
- Six themes:
  - Big Data: delivering the digital medicine revolution
  - Building novel NHS, university and industry relationships
  - Modulating the immune response for patient benefit
  - Managing the epidemic of chronic disease
  - Emerging infections and antimicrobial resistance
  - Cognitive health: maintaining cognitive function in health and disease

AHSN core purpose – health and wealth

- Licensed by NHS England for 5 years to deliver four objectives:
- **Focus on the needs of patients and local populations:** support and work in partnership with commissioners and public health bodies to identify and address unmet health and social care needs, whilst promoting health equality and best practice.
- **Speed up adoption of innovation into practice** to improve clinical outcomes and patient experience - support the identification and more rapid uptake and spread of research evidence and innovation at pace and scale to improve patient care and local population health.
- **Build a culture of partnership and collaboration**: promote inclusivity, partnership and collaboration to consider and address local, regional and national priorities.
- **Create wealth** through co-development, testing, evaluation and early adoption and spread of new products and services.

The Oxford AHSN

- **Our Vision.** Best health for our population and prosperity for our region
- **Our Mission.** We will support collaboration, research and innovation across the NHS, universities and business, building on our strengths to deliver exemplary care and create the strongest life science cluster

What and where

Oxford AHSN – 1 of 15 in England
3.3M population
Annual NHS spend circa £5bn
NHS employees 65,000
12 Clinical Commissioning Groups
4 Local Enterprise Partnerships
12 Councils
Major international companies
300 Life Sciences businesses

Complex landscape with many providers and agencies

Our Healthcare, Academic and LEP partners

NHS in the Network

1 Berkshire Healthcare NHS Foundation Trust
2 Buckinghamshire Healthcare NHS Trust
3 Central and North West London NHS Foundation Trust (community and mental health services)
4 Heatherwood and Wexham Park NHS Foundation Trust
5 Milton Keynes NHS Foundation Trust
6 Oxford Health NHS Foundation Trust
7 Oxford University Hospitals NHS Trust
8 Royal Berkshire NHS Foundation Trust
9 South Central Ambulance Service NHS Foundation Trust
10 Southern Health NHS Foundation Trust (Learning Disabilities)

(Locations of HQs except for 3 and 10)

Aylesbury Vale CCG
Bedfordshire CCGs
East Berkshire CCGs
West Berkshire CCGs
Chiltern CCG
Milton Keynes CCG
Oxfordshire CCG

Universities in the Network

1 Buckingham University
2 Buckinghamshire New University
3 Cranfield University
4 Oxford Brookes University
5 The Open University
6 University of Bedfordshire
7 University of Oxford
8 University of Reading
9 University of West London (Reading Hub)

Local Enterprise Partnerships

Buckinghamshire LEP
Oxfordshire LEP
South East Midlands LEP
Thames Valley Berkshire LEP

Thames Valley Berkshire

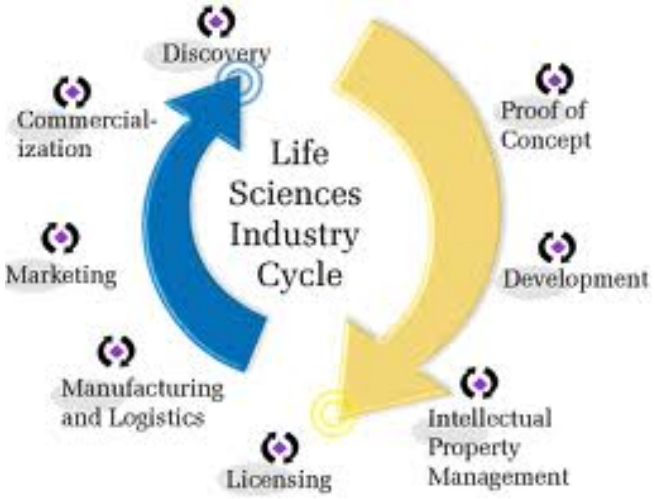
Oxfordshire Local Enterprise Partnership

SEMLEP
South East Midlands
Local Enterprise Partnership

Buckinghamshire Thames Valley | LOCAL ENTERPRISE PARTNERSHIP
THE ENTREPRENEURIAL HEART OF BRITAIN

The Oxford AHSN – facilitating partnerships

NHS



Cranfield UNIVERSITY

UNIVERSITY OF OXFORD

The Open University

bucks new university

UNIVERSITY OF WEST LONDON

THE UNIVERSITY OF BUCKINGHAM

OXFORD BROOKES UNIVERSITY

University of Reading

University of Bedfordshire

The Oxford AHSN
5 Programmes and 2 Themes

- **Best Care programme** 10 AHSN funded clinical networks
- **Continuous learning** Patient Safety and 8 Evidenced Based Medicine MScs
- **Innovation Adoption** Clinically led, working with the NHS providers and industry to accelerate adoption of medical innovations
- **Research and Development programme** work with Local CRN NIHR, CLAHRC, life science industry and other research infrastructure
- **Wealth creation programme** help the region become the favoured location for inward life science investment, life science business creation and growth
- **Informatics** provide strategic leadership to the Oxford AHSN and Oxford AHSC partners' strategies
- **PPIEE** embed partnership with patients and the public across programmes

Oxford AHSN – Best Care Programme

- **Ten Clinical networks**
  - Diabetes – Prof Stephen Gough
  - Dementia – Dr Rupert McShane
  - Depression and anxiety – Prof David Clark
  - Mental and physical co-morbidity – Prof Mike Sharpe
  - Early intervention in mental health – Dr Belinda Lennox
  - Imaging - Prof Fergus Gleeson
  - Medicines optimisation – Boo Vadher
  - Maternity – Prof Stephen Kennedy / Mr Lawrence Impey
  - Children – Prof Andrew Pollard
  - Out of Hospital – Dr Dan Lasserson
- **Continuous Learning** in collaboration with Health Education Thames Valley
  - 8 Fellowships (MScs) in Evidence Based Medicine
  - Patient Safety Academy
- **Innovation Adoption** – clinically lead adoption of 10 innovations at scale per annum; 5 NICE TAs and 5 other innovations in 2014/15

What is Innovation Adoption?

Oxford AHSN has defined innovation as:

"..... an idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care, and delivers value for money, wherever it is applied."

NHS Innovation Adoption in tertiary care, secondary care, community care, mental health care, primary care and **self-care**

Facilitating rapid adoption of innovation with demonstrated value

- **Identify the innovations**

  NICE technology appraisals previous year

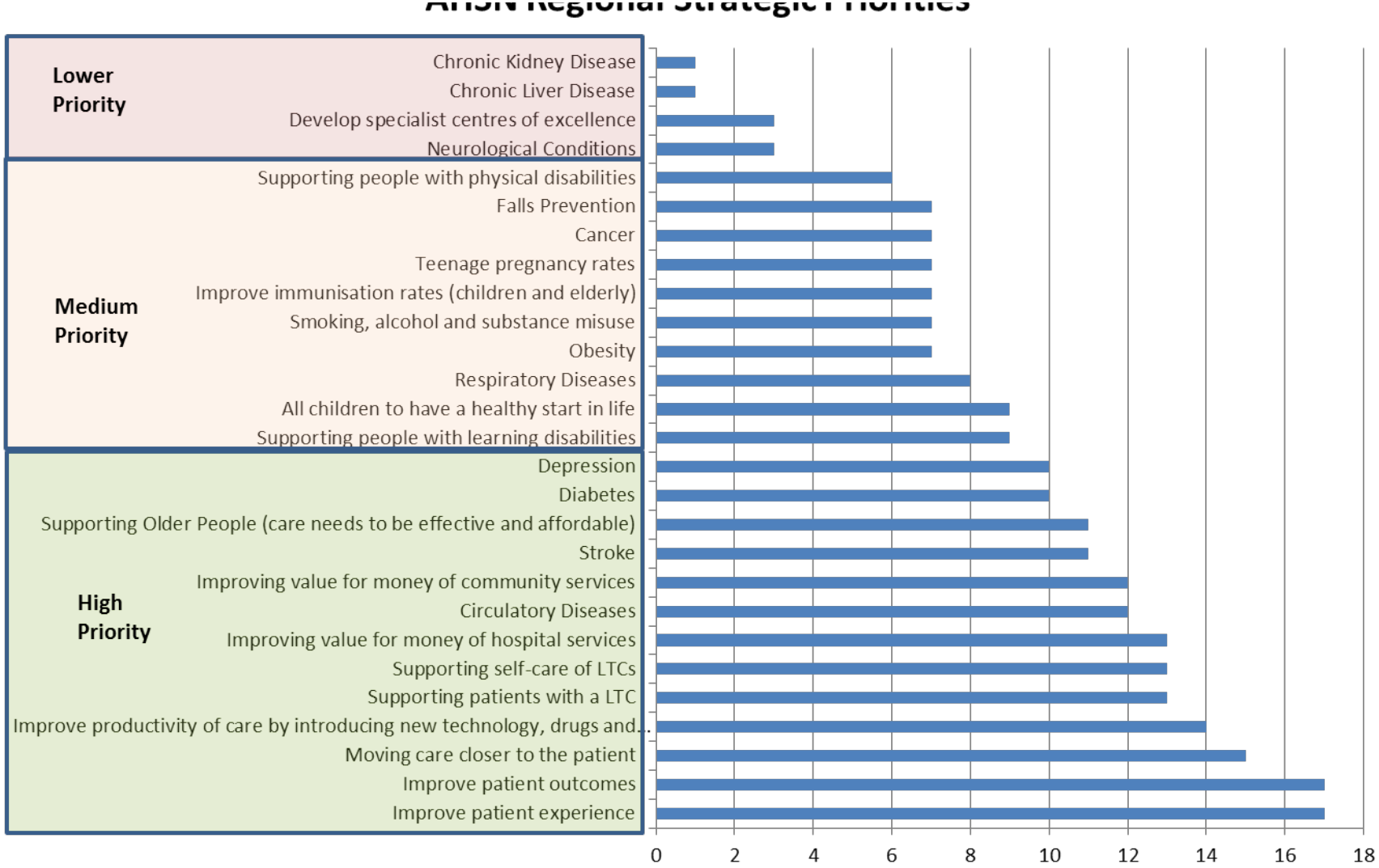
  Other interventions proposed by clinical networks where value is clear
- **Prioritisation by NHS providers, clinical networks, commissioners and patients**
- **Develop an implementation plan for top 10 innovations across AHSN partners**

  Identify potential barriers, appoint clinical champion, finance and procurement plan, training issues, process to record utilisation
- **Review impact at 12 months**

  If failure of adoption identify reasons

  Compare uptake of interventions not supported by an implementation plan

Oxford AHSN Strategic Priorities of Providers and Commissioners

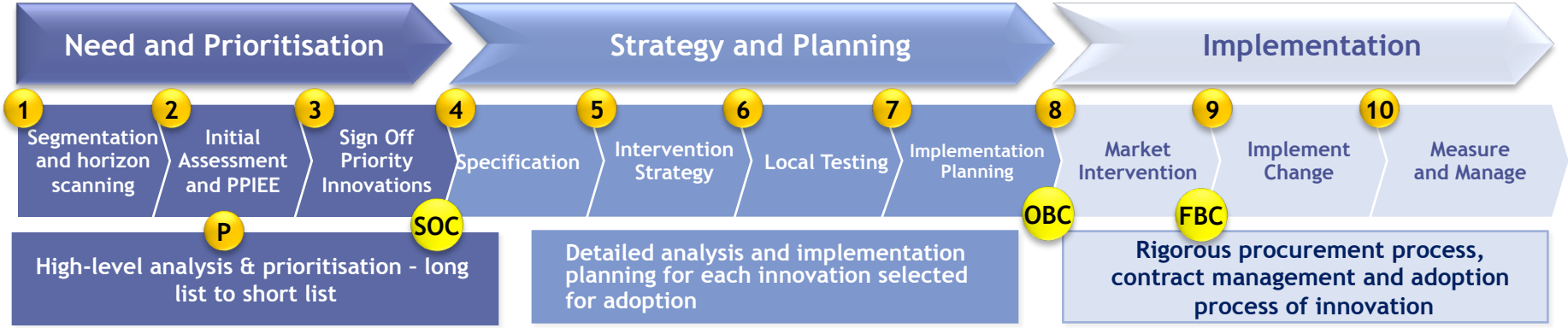


Source: NHS Providers Strategic Plans, NHS CCGs Strategic Plans, Joint Strategic Needs Assessments for Oxfordshire, Buckinghamshire, Berkshire and Bedfordshire

'Top 10' Innovation Candidates

- NICE Technology Appraisals
  - Alzheimer Drugs - Acetylcholinesterase inhibitors
  - New Oral Anticoagulants
  - Monoclonal antibodies for rheumatoid arthritis
  - Renal cancer drugs
- Others
  - Intermittent pneumatic compression stockings for stroke
  - Electronic blood transfusion
  - Ambulatory ECG monitoring
  - Bladder scanner to reduce catheter UTIs
  - Intra-operative fluid management
  - SHaRON social network support for eating disorders
  - Gestation diabetes

Clinical Innovation Adoption process steps 1–10



1. Segmentation and horizon scanning of innovations by clinical specialism- establish long list of available innovations through horizon scanning by clinical networks supported by Innovation Adoption Managers (IAMs). Clinical Innovation Adoption Oversight Group (CIA) agree long list

2. Initial assessment and PPIEE. Engagement with patients establish the need and the case for change, High level benefits analysis of the long list. Common approach to prioritisation balancing clinical impact, value for money and ease of implementation with a realistic view of barriers to change - eg change costs, training needs. IAM coordinate - identify 5-10 innovations per annum.

3. Sign off priority innovations. Early engagement of procurement and finance; process and budget. Coordinated by IAM who prepares Strategic Outline Case (SOC) for the priority innovations. CIA Oversight Group sign off priority 5-10 innovations). OJEU to parallel track PQQ processed (if necessary for new supplier not on framework or existing contract

P. For new technologies an initial pilot will be required - this needs to be planned and monitored by the clinical networks with agreed measures of success - results would be built into the case for change

4. Specification. IAM working with procurement and Clinical Networks and Trusts to gather detailed information about the supply market and draft specification including potential demand (volume) required, maintenance if applicable, local requirements, timescales to implementation. Clinical Champion to draft specification with Procurement and IAM. Clinical Networks or Medical Directors identify Clinical Champion to take innovation forward

5. Intervention strategy - (1) understanding of procurement options. (2) understanding detail of implementation, change costs, training needs, identify clinical champions, project management requirements, information sources. (3) Clarification with commissioners if contract changes required. Consensus on the strategic approach to implementation lead by the Clinical Networks. For Best Practice, obtain agreement with Innovators that they will support implementation Actionable implementation plan

6. Local testing of the intervention plan with local Clinical Champions- end users, patients, suppliers if applicable and finalise procurement route with procurement specialists

7. CIA B (IAM) finalise implementation plans and get implementers/buyers (ie Trusts) to sign off clinical and financial business cases Outline Business Case or OBC including costs/benefits and delivery timescales) prepared by IAM. OBCs required to secure funds for implementation at local level

8. Market intervention - if applicable commercially robust procurement process to source innovation OR secure services of the innovators to support implementation of best practice. IAM update OBC with final numbers (eg prices) to create FBC

9. Implement change - install equipment, train end users (clinicians and/or patients). Or disseminate best practice. IAM to project manage and Best Care Programme Board to oversee.

10. Measure and manage - IAM monitor uptake and report on quality and value impact with feedback loop of benefits from adopters to potential adopters

Clinical leadership, effective PPIEE and data analysis results in systematic approach to innovation adoption and procurement strategy

Facilitating evaluation of innovation with promising potential

- **Identify the innovations**

  Clinical networks, industry proposals, University/NHS partners

- **Prioritisation by NHS providers, clinical networks, commissioners and patients**

- **Develop an implementation plan for provisional adoption of 5-10 innovations – some / all AHSN**

  Identify potential patient population, appoint clinical champion, finance and procurement plan, training issues, process to record utilisation, costs and patient outcomes

- **Review impact**

  Effectiveness, cost and cost effectiveness
  Potential barriers to adoption in clinical practice

What will success look like?

Oxford Academic Health Science Network

The Best Care Programme

Chandi Ratnatunga FRCS
SRO Best Care Programme

Oxford Academic Health Science Network

Medicines Optimisation Clinical Network Launch

Chandi Ratnatunga FRCS
SRO Best Care Programme

History

- First approach: Summer 2012

- South Central Networks
- Track record
- Healthcare professionals
- ABPI & pharmaceutical industry
- Innovation adoption NICE TAs
- Individuals

- Iterative process to sign off

Best Care Programme

- Clinical Networks
- Themes: crosscutting
- Patient Safety Academy
- Evidence-based Healthcare Fellowships
- Collaborative for Innovation Adoption

Best Care Programme Board

- SRO: Chair
- COO (CEO)
- Clinical Network/Theme Leads
- Leads for PSA and Fellowship programme

- Senior Project Manager – Clinical Networks (SRO deputy)

- Lead for Collaborative for Innovation Adoption

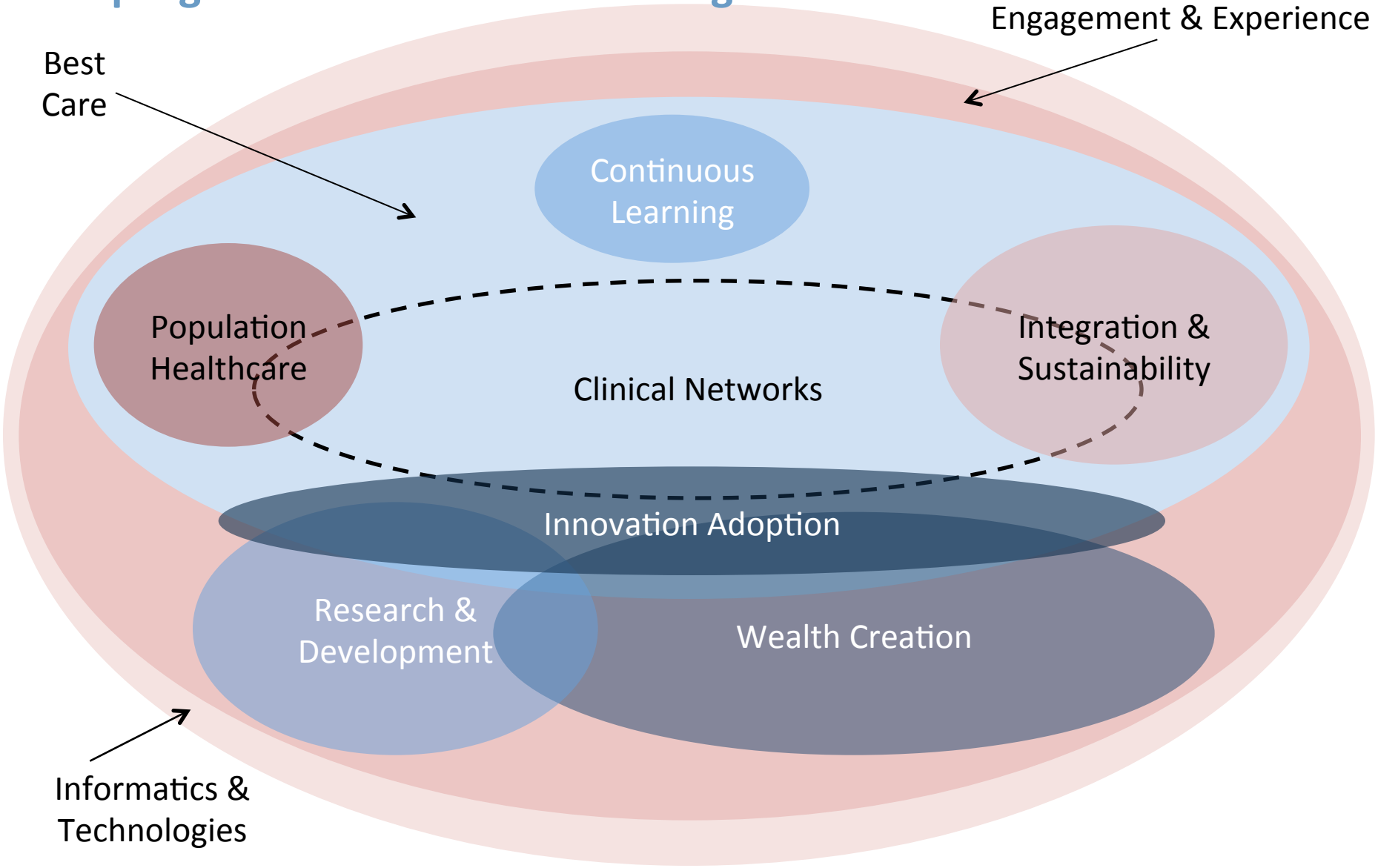
Best Care Programme Board: Key roles

- Ensure the Programme delivers within its agreed boundaries
- Manage the interfaces / inter-dependencies between Clinical Networks / Programmes
- Define and manage risks and issues
- Resolve strategic issues escalated by the Projects
- Shape future strategy for sign off by the Oxford AHSN Board including contribution to Annual Report, Business Plan and Investment/Disinvestment Plans

Clinical Networks *(Objective 1 & 2)*

- Oxford AHSN's unique delivery mechanism
- *"Clinical networks are a NHS success story"*
- NHS challenges today: 'wicked' problem
- Mobilise clinician frontline knowledge and commitment
- Work in a new way with core values such as sharing of information, support and integration ***(Objective 3)***
- Multi-professional
- Disease, service or population group specific
- Integrate vertically and horizontally (and more) across our geography

How programmes and themes fit together



Clinical Networks: Ten

- Anxiety & Depression: Prof David Clark
- Children: Prof Andrew Pollard
- Dementia: Dr Rupert McShane
- Diabetes: Prof Stephen Gough
- Early Intervention in Mental Health: Drs Belinda Lennox/ Mark Allsopp
- Imaging: Prof Fergus Gleeson
- Maternity: Mr Lawrence Impey
- **Medicines Optimisation: Boo Vadher**
- Mental and Physical Co-morbidity – Prof Mike Sharpe
- Out of Hospital: Dr Dan Lasserson

Strategic Clinical Networks (Commissioner: Thames Valley)

- Cancer
- Cardiovascular

Clinical Networks: Role

- Documentation of metrics of care (activity, outcomes, costs) across the geography (Atlas) ***(Objective 1)***
- Identification of unwarranted variation and its reduction

- Raise the baseline of care and improve care by adopting healthcare innovations rapidly ***(Objective 2)***

- In doing this, stimulate, support and grow a market for the life sciences industry ***(Objective 4)***

Themes: Two Crosscutting

Sustainability: Dr Rachel Stancliffe *(Objective 4)*

- New ways of providing healthcare so that the NHS is sustainable. Triple Bottom Line (nephrology: £7m, 470mL of water, 11,000tonnes CO_2e)
- Reductions in wastage; reduction in carbon emission and release of funding resources to be spent elsewhere

Population Healthcare: Prof Muir Gray: (*Objective 1*)

- Difficult choices that centre around the value derived from services; their allocative efficiency
- Consider and debate, how a programme budget is best spent
- Involves addressing prevention, increasing responsibility of the patient and the public for their own health including the principle of shared decision making

Patient Safety Academy: (Peter McCulloch)

- Supported by **Health Education England Thames Valley**
- Francis, Berwick, Keogh
- We are still nibbling at it through small uncoordinated efforts, rarely learning within or between organisations
- Culture change both at Board level and on the shop floor
- Use of Human Factors and Ergonomics
- Across all aspects (mental and physical) and across all sectors (acute and primary care sectors)

- Patient Safety Collaborative (footprint of the AHSN) to implement safety initiatives: April 2014

Evidence-Based Health Care (EBHC) Fellowships (Prof Carl Heneghan)

- Absence of evidence permeates healthcare
- Clinical, policy and financial decisions

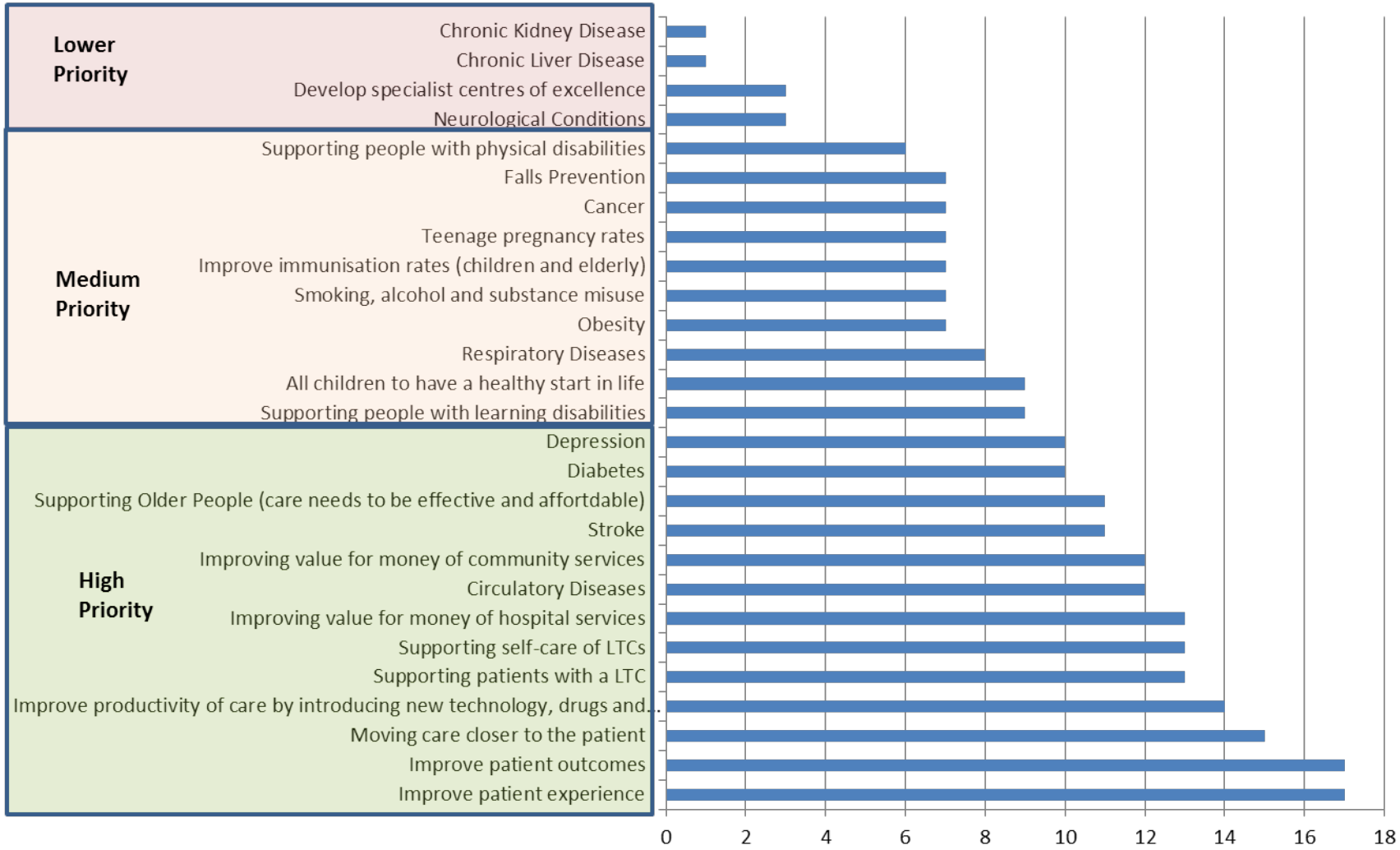
- 7 Fellowships to produce champions (CEBM and Kellogg College)
- MSc and support to implement a project with a Clinical Network in third year

- Pharmacist (Mental Health): Unified approach to adopting new drugs in a trust

Collaborative for Innovation Adoption (Tracy Marriot) *(Objectives 2 and 4)*

- *In this country the mean time for implementation of a healthcare innovation from its introduction is 17 years*
- Collaborative of clinicians, academics, industry, NHS finance and procurement and the public
- Implement 5 to 10 innovations in 2014/15 across the geography
- Innovation pipeline

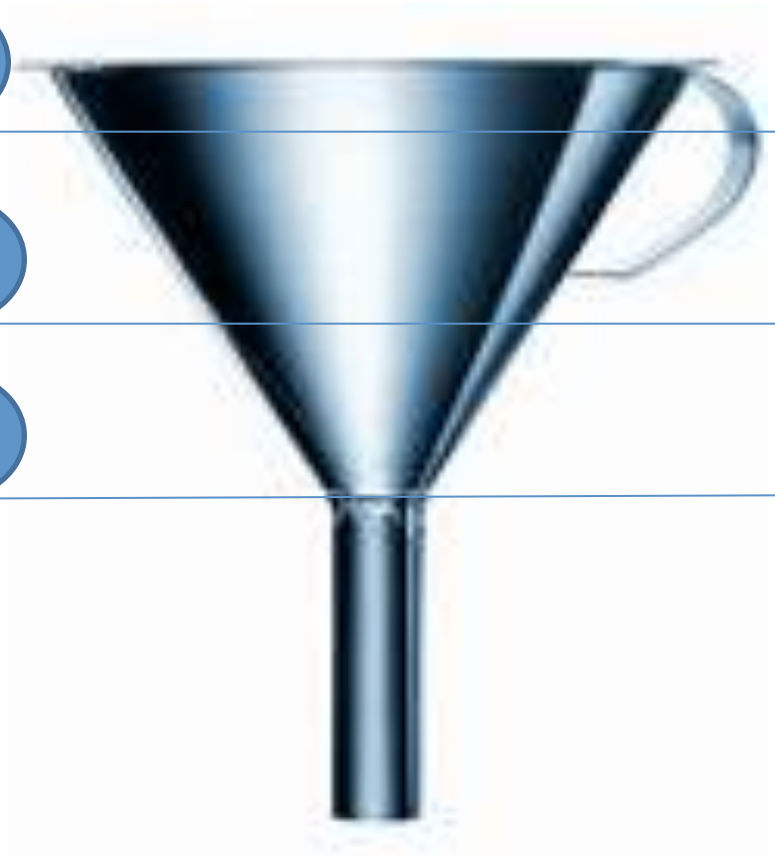
AHSN Regional Strategic Priorities



NICE TA Recommendation?

Supports a regional priority

Supports achieving a national priority



Top 30 Innovation Candidates

Priority Innovations for 2014/15

- Long list: Over 200 innovations
- Short list: 30 innovations
- Prioritised by the core team and the Clinical Networks for the Interim CIA Board
- Ratified by AHSN Board

- Final List: 5-10 innovations
- Further market assessment and engagement of providers with sign up with provider Boards and sign off by CIA/AHSN Board

Innovations for 2014/15

- IOFM, Sharon, Gestational diabetes, Blood transfusion, Bladder Scanner and Intermittent pneumatic compression

- Warfarin and NOACs
- Monoclonal antibodies and rheumatoid arthritis
- Alzheimer's
- Renal cancer

Oxford Academic Health Science Network

The importance of Medicines Optimisation

Mr Steve Fairman,

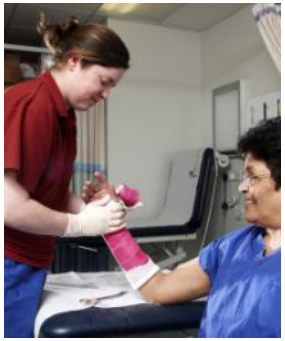
Director of Business, Improvement & Research, NHS England

The importance of Medicines Optimisation

Steve Fairman
Director of Business, Improvement & Research
NHS England

27 April 2014

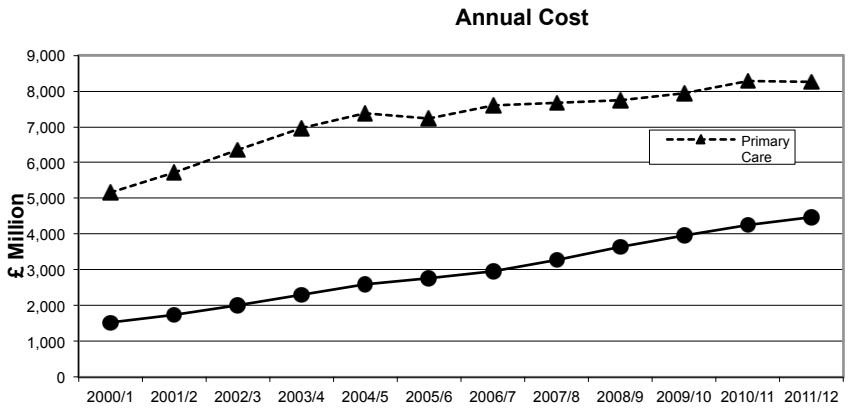
Oxford AHSN event April 2014

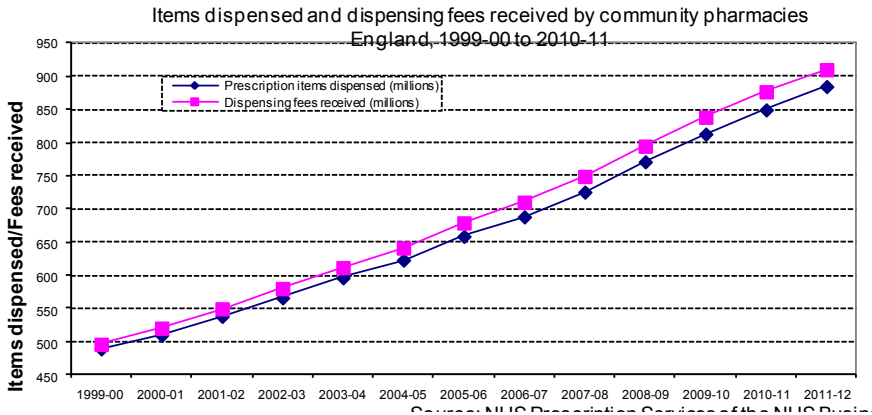


Medicines Optimisation

- NHS England
- Progress Update
- What next?
- Role of AHSNs

Medicines Utilisation in Practice





- Medicines still most common therapeutic intervention and biggest cost after staff, but, for example:
- -30 to 50% not taken as intended
- - Patients have insufficient supporting information
- UK Literature suggests 5 to 8% of hospital admissions due to *preventable* adverse effects of medicines
- Medication errors across all sectors and age groups at unacceptable levels
- Medicines wastage in primary care: £300M pa with £150M pa avoidable
- NHS Atlas of Variation
- Relatively little effort towards understanding clinical effectiveness of medicines in real practice
- The threat of antimicrobial resistance
- Appropriate vs inappropriate polypharmacy

Medicines Optimisation

- So we need a step change in the way we support patients to use their medicines well.
- Medicines optimisation offers us the opportunity to collaborate with patients, the public and Pharma to get better outcomes.
- We must move the focus from cost to value
- Its **not** “NHS jargon for improving prescribing and reducing waste”!!!!!


BURYING MY HEAD IN THE SAND OVER CLIMATE CHANGE IS MUCH EASIER NOW THAT HALF THE WORLD'S TURNED TO DESERT!
IF THIS MESSAGE IS PRESENT THIS IMAGE IS BEING USED WITHOUT PERMISSION ©
CHRIS MADDEN.
www.chrismadden.co.uk

NHS England

We need to make this vision a reality, translating it into how patient care looks and feels

NHS Outcomes Framework 2013/14

at a glance

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
i Adults ii *Children and young people*
1b Life expectancy at 75
i Males ii Females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4)
1.2 Under 75 mortality rate from respiratory disease* (PHOF 4.7)
1.3 Under 75 mortality rate from liver disease* (PHOF 4.6)
1.4 Under 75 mortality rate from cancer* (PHOF 4.5)
i *One- and* ii *Five-year survival from all cancers*
iii *One- and* iv *Five-year survival from breast, lung and colorectal cancer*

Reducing premature death in people with serious mental illness
1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)

Reducing deaths in babies and young children
1.6 i Infant mortality* (PHOF 4.1)
ii Neonatal mortality and stillbirths
iii *Five year survival from all cancers in children*

Reducing premature death in people with a learning disability
1.7 *Excess under 60 mortality rate in adults with a learning disability*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions** (ASCOF 1A)

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions** * (ASCOF 1E PHOF 1.8)

Reducing time spent in hospital by people with long-term conditions
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers** (ASCOF 1D)

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **** (ASCOF 1F & PHOF 1.8)

Enhancing quality of life for people with dementia
2.6 i Estimated diagnosis rate for people with dementia* (PHOF 4.16)
ii *A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life*** (ASCOF 2F)

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11)

Improvement areas

Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins
v *Psychological therapies*

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 Proportion of people who recover from major trauma

Improving recovery from stroke
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures
3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation service*** (ASCOF 2B)
ii Proportion offered rehabilitation following discharge from acute or community hospital

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services
ii GP Out of Hours services
iii NHS Dental Services
4b Patient experience of hospital care
4c *Friends and family test*

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator is under development*

Improving people's experience of integrated care
4.9 *An indicator is under development* *** (ASCOF 3E)

5 Treating and caring for people in a safe environment and protect them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b Safety incidents involving severe harm or death
5c *Hospital deaths attributable to problems in care*

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI)
i MRSA
ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

Alignment across the Health and Social Care System

* Indicator shared with Public Health Outcomes Framework (PHOF)
** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)
*** Indicator shared with Adult Social Care Outcomes Framework
**** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework

Indicators in italics are placeholders, pending development or identification

NHS Outcomes Framework 2013/14

at a glance

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
i Adults ii *Children and young people*
1b Life expectancy at 75
i Males ii Females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4)
1.2 Under 75 mortality rate from respiratory disease* (P
1.3 Under 75 mortality rate from liver disease* (PHOF 4.6)
1.4 Under 75 mortality rate from cancer* (PHOF 4.5)
i *One- and* ii *Five-year survival from all cancers*
iii *One- and* iv *Five-year survival from breast, lung and colorectal cancer*

Reducing premature death in people with serious mental illness
1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF

Reducing deaths in babies and young children
1.6 i Infant mortality* (PHOF 4.1)
ii Neonatal mortality and stillbirths
iii *Five year survival from all cancers in children*

Reducing premature death in people with a learning disability
1.7 *Excess under 60 mortality rate in adults with a learning disability*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions** (ASCOF 1A)

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition*

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions** * (ASCOF 1E PHOF

Reducing time spent in hospital by people with long-term conditions
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers** (ASCOF 1D)

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **** (ASCOF 1F & PHOF 1.8)

Enhancing quality of life for people with dementia
2.6 i Estimated diagnosis rate for people with dementia* (PHOF 4.16)
ii *A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life**** (ASCOF 2F)

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospi

Improvement areas

Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins
v *Psychological therapies*

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
roportion of people who recover from major trauma

Improving recovery from stroke
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures
3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation service*** (ASCOF 2B)
ii Proportion offered rehabilitation following discharge from acute or community hospital

Alignment across the Health and Social Care System

* Indicator shared with Public Health Outcomes Framework (PHOF)
** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)
*** Indicator shared with Adult Social Care Outcomes Framework
**** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework

s in italics are placeholders, pending development or identification

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services
ii GP Out of Hours services
iii NHS Dental Services
4b Patient experience of hospital care
4c *Friends and family test*

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator is under development*

Improving people's experience of integrated care
4.9 *An indicator is under development* *** (ASCOF 3E)

5 Treating and caring for people in a safe environment and protect them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b Safety incidents involving severe harm or death
5c *Hospital deaths attributable to problems in care*

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI)
i MRSA
ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

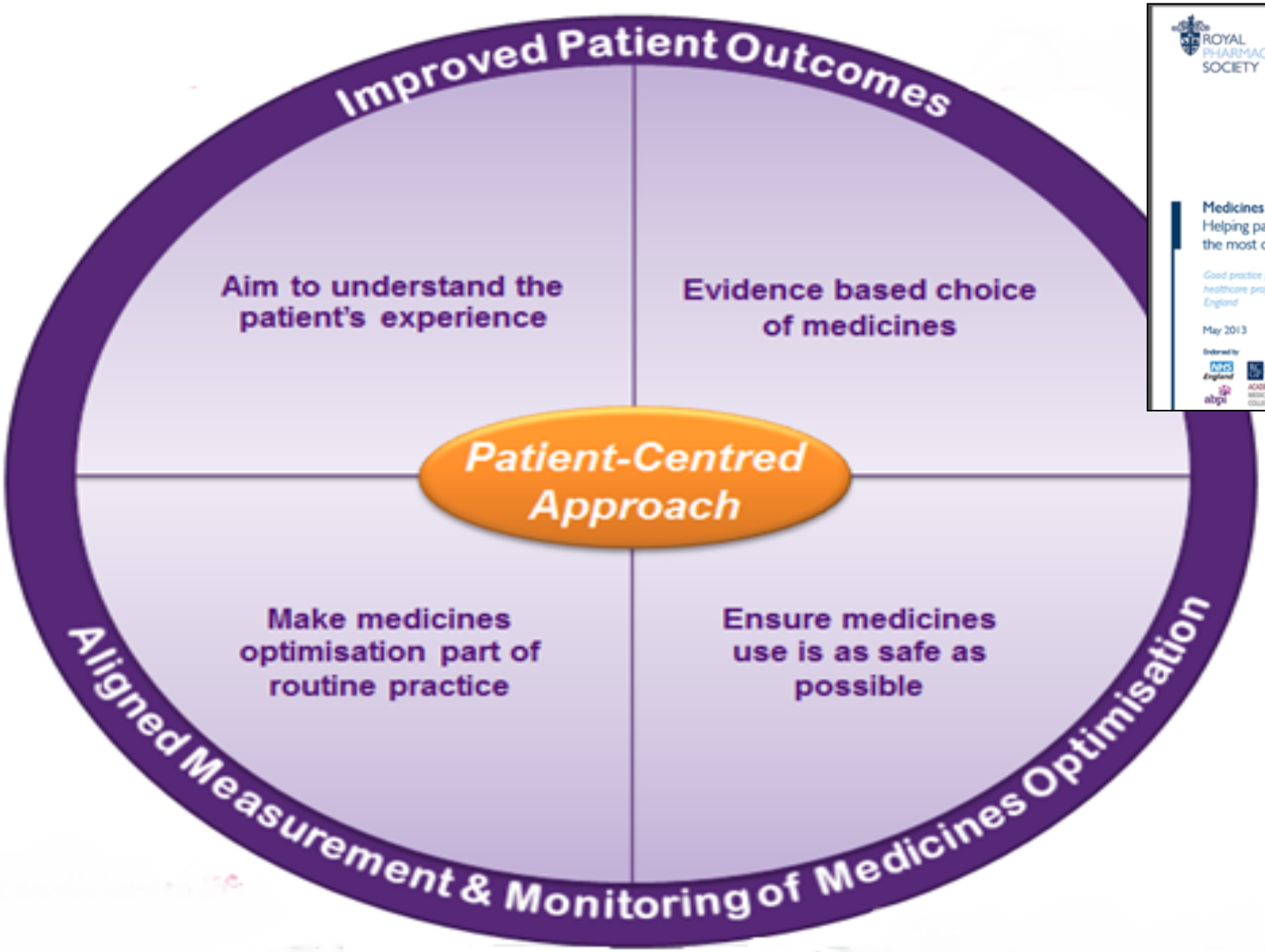
Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

Key outcomes where MO contributes

Outcome indicator	Description
5.4 (Main contribution)	**Incidence of medication errors causing serious harm**
1.1	Under-75 mortality rate from cardiovascular disease
1.2	Under-75 mortality rate from respiratory disease
1.5	Excess under-75 mortality rate in adults with serious mental illness
2.1	Proportion of people feeling supported to manage their condition
2.2	Employment of people with long-term conditions
2.6ii	A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life
3a	Emergency admissions for acute conditions that should not usually require hospital admissions
3b	Emergency readmissions within 30 days of discharge from hospital
3.6ii	Proportion offered rehabilitation following discharge from acute or community hospital
4.1	Patient experience of primary care
4.2	Patient experience of outpatient care

Medicines Optimisation Principles



MO - High level Indicators

- Reduction in medicines related admissions
- Increase in patients who take their medicines as intended.
- Increase in reporting of medication incidents from primary care.
- Proportion of Trusts compliant with the Home Care recommendations. (select key recommendations)
- Increase in the proportion of Trusts reporting medicines reconciliation rates monthly
- Increase in the medicines reconciliation rate to 80%
- Demonstrable reduction in wasted medicines
- Increase in community based support for patients taking medicines
- A measure of patient experience using the Community Pharmacy Patient Questionnaire/ FFT

How MO indicators support OF

High level Indicator	Medicines Optimisation Principle	NHS Outcome Framework
1. Reduction of medicines related admissions	3. Effectiveness	3a Emergency admissions for acute conditions that should not usually require hospital admissions
2.Increase in the proportion of patients taking their medicines as intended	3. Effectiveness	3a Emergency admissions for acute conditions that should not usually require hospital admissions 2.1 Patients feeling supported to manage their condition
3. Increase in reporting of medication incidents from primary care	2. Medication safety	5.4 Incidence of medication errors causing serious harm
4. Proportion of Trusts Compliant with Home care recommendations	2. Medication safety 3. Effectiveness 1.Patietn experience	2.1 Patients feeling supported to manage their condition 2.2 Employment of people with long-term conditions 2.6.ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life
5.Increase in the proportion of reporting medicines reconciliation rates (Medication safety thermometer)	2. Medication safety 3.Effectiveness	5.4 Incidence of medication errors causing serious harm
6. Demonstrable reduction in wasted medicines	3. Effectiveness	
7.Increase in support for patients taking medicines in the community	1.Patient experience 2.Effectiveness	2.2 Proportion of people feeling supported to manage their condition
8. A measure of patient experience for those taking medicines	1.Patient Experience	4. Ensuring that patient have a positive experience of care. 4a. Patient experience of primary care

Medicines Optimisation Progress Update 1

- Held 2nd national conference in November 2013. Well attended (over 800 delegates NHS and Industry) and the concept is now widely accepted.
- The MO measurement work progressing. Wider reference group and a technical group. Prototype dashboard May…
- York and Sheffield Centre for Health Economics are considering the economics of Medicines Optimisation
- NICE have started their short clinical guideline process. (publication in 2015). Engaged with chair of Guideline Development Group
- Kings Fund published Polypharmacy and Medicines Optimisation: Making it safe and sound in November 2013

Medicines Optimisation Progress Update 2

- RPS and ABPI are engaged and supporting the strategy development. ABPI secondee started Jan 2014.
- Specialised Commissioning MO CRG now operational. First output released January.
  http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/medicines-optimisation/
- NHS England Community Pharmacy "Call to Action" published in December. Local events being organised by Area Teams to consider questions asked. Most Local Professional Network chairs appointed. All will impact on MO implementation.
- The first NHS England patient engagement event was held in Leeds on 21st November 2013. Report published.

Medicines Optimisation Progress Update 3

- Innovation Expo - medicines optimisation master class.

Next steps

Develop comprehensive public, patient, CCG, AHSN and industry engagement plan

“prototype dashboard” planned for May

Strategy will be scoped and PID developed with possible publication in May/June

Role of AHSN

- Patients and local population. Unmet need.
- Speed up adoption and innovation
- Build culture of partnership and collaboration
- Create wealth co-develop, test spread.

Medicines Optimisation

- Service development. Improve quality. Grey literature. Safety.
- Spread good MO practice e.g. NOACs service in Bucks. NMS MURs
- Work with CCGs to move focus from cost to value. Evaluate dashboard?
- Optimal use, good adherence, great outcomes from drug development onwards. Real world clinical effectiveness.