FOR HEALTHCARE LEADERS
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MAKE IT BETTER

TAKING NHS STANDARDS TO THE NEXT LEVEL

SERVICE IMPROVEMENT

EVIDENCE WE CAN ALL USE

David Haslam warns against unnecessary duplication of guidelines on treatments and explains how NICE will meet the challenges posed by new medical technologies

"The NHS belongs to the people." These powerful and important words start the NHS constitution – the contract between everyone who works for the National Health Service and everyone who uses it.

It goes on: "The NHS is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most."

The NHS constitution really matters. It guarantees the rights of all of us who use the NHS – no matter who we are.

It does not matter if you are rich or poor, skilled or unskilled, a professor or apprentice, an octogenarian or premature baby; you should expect the same quality of care. To do otherwise must surely be unethical.

For me, the NHS is one of the few organisations in the world that meets the challenge of one of the great post-war works of philosophy – John Rawls' *A Theory of Justice*. Rawls suggests that in designing a new society you should act from behind a "veil of ignorance". If you do not know what your status or abilities will be, then you will design a fair and just society.

This is all very well. But how do we decide what fairness and justice mean in practice?

One of the fascinating roles of the National Institute for Health and Care Excellence, which I am proud to chair, is to grapple with these big philosophical questions of fairness and justice, and make them real – not just for the NHS but for social care organisations, local authorities, charities and anyone involved in commissioning or providing health and social care services. When you are dealing with these big questions, you will make difficult decisions which people disagree with. You will also face other intense pressures, such as financial ones.

'As I travel the country, I have heard of CCGs and hospital trusts continuing to develop their own guidelines'

Financial pressure

In these challenging times, with budgets being squeezed from all sides, I am frequently asked if we should continue to aspire towards excellence or should we settle for the best affordable outcomes? Would "good enough" be good enough?

For me, the NHS constitution is clear. Our job is to bring "the highest levels of human knowledge and skill to save lives and improve health". And I do not accept that excellence is not affordable. Waste, duplication, disorganisation – they are not affordable, but we should not offer care to others that we would not be happy with ourselves. The practice of gathering evidence, developing ideas, implementing them and measuring their impact to start the process of improvement again goes back to the Greek physician Hippocrates 2,500 years ago. It is a model that has had incalculable benefits for our society.

But this onward march brings its own challenges, especially for providers grappling with shrinking budgets or GPs trying to keep abreast of the latest developments. As I travel the country in my role as chair of NICE, I have heard of clinical commissioning groups and hospital trusts continuing to develop their own guidelines and formularies. At a time of financial challenge, I would argue that this duplication is hugely wasteful and unnecessary.

NICE has a comprehensive programme of support and resources to help maximise uptake and use of evidence and guidance, which includes advice on do-not-dos. There is a huge amount of research and opinion being published all the time. To keep up to date is a near impossible task for individuals. This is precisely where NICE can help.

To develop NICE guidance, the best evidence on a topic is gathered and assessed. An independent committee of experts discusses the data, hears from other experts – including patients and service users – deliberates over the topic in hand and reaches a consensus view on their recommendations. At this point, we seek views on the draft through consultation. Then the committee agrees the final guidance. The aim is to add value in terms of incremental improvement and using

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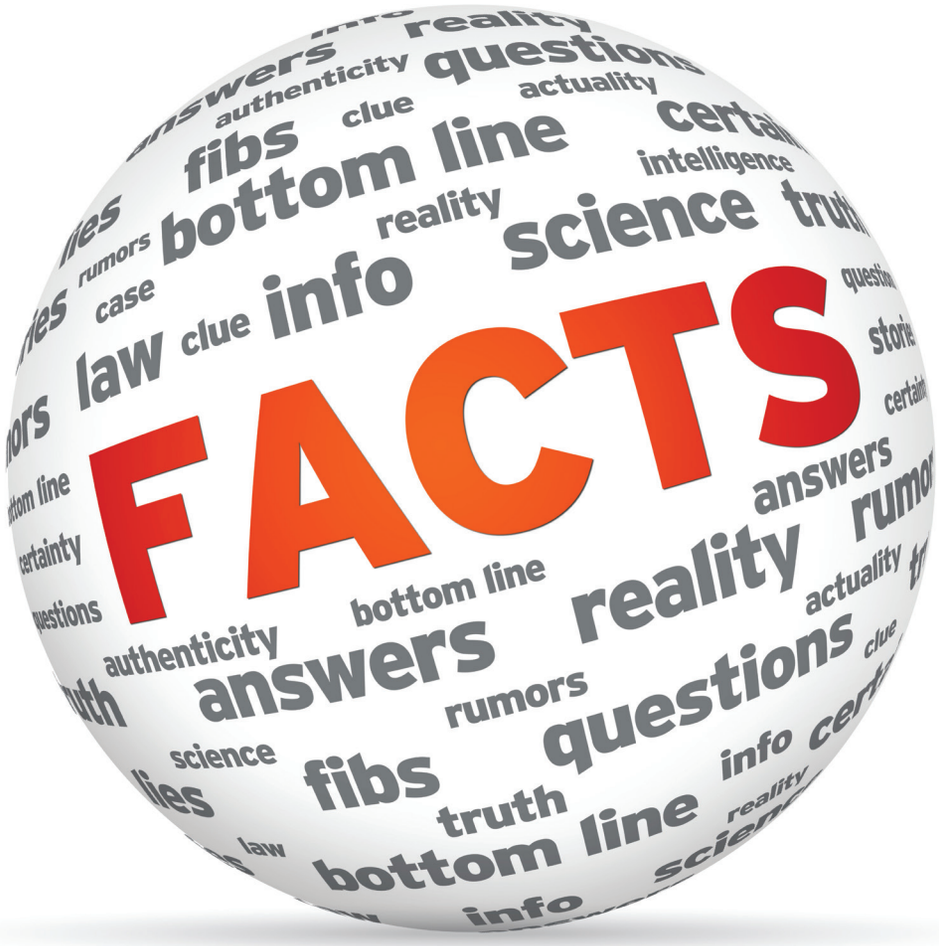

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‘We need to challenge pharma companies to provide evidence that will support the routine use of their medicines’

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resources effectively. Over my career, including over 35 years as a GP, the problems affecting patients and the health service have changed remarkably. People are living longer, immunisation programmes have seen some diseases wiped out and others marginalised. Public health programmes have prevented the spread of diseases which once ran amok. New drugs are increasingly turning once deadly diseases into chronic conditions. But trying to get new ideas adopted can be difficult.

We hear complaints from the pharmaceutical industry that our processes and methods are a bar to introducing new medicines. There is a reason for this. Everything that NICE does is underpinned by evidence. It is an incredibly evidence hungry organisation, particularly when it comes to perhaps the most controversial area of our work: our decisions about whether or not new medicines and other medical technologies should be funded for routine use by the NHS; and in particular when we are considering whether or not to recommend innovative cancer drugs.

The landscape for development, regulation and adoption of new health technologies is changing rapidly and so we must reflect on how we work. For instance, NICE and NHS England are working in partnership to reform the management of the cancer drugs fund. The aim is to give patients access to promising new drugs but challenge pharmaceutical companies to provide evidence that will support the routine use of their medicines.

Healthcare and medical technologies generate a lot of interest and a lot of controversy, claims of benefit, and demands from patients. NICE’s role is to find the signal in the noise. It is a very tricky task, particularly when you are assessing new health technologies.

To help pharmaceutical companies as they try to gather the data we need when appraising new technologies, we will pull together activities that we already have in that early life science space. We want to push NICE to the earliest stages of discussions about evidence gathering.

The aim must be to ensure that the NHS will be able to provide the most cost effective therapies to patients, supported by the best evidence. Above all, we – like everyone in healthcare – are continually trying to improve, to be fair, make decisions based on the very best data, deliver high quality care, and to make sure that the NHS is for the people. Every one of us. ●

Professor David Haslam is chair of NICE.

ROSS SELBY ON THE BEST USE OF MEDICINES

You can have the best medicine in the world, but it must be prescribed to the right patient, at the right time – and then taken in the right way.

If it is not, then it is a waste for the clinician who prescribes it, the pharmacist who dispenses it, and the NHS that pays for it. Most of all, it is a wasted opportunity for significant health improvements for the patient.

Getting this right and helping to ensure that patients get the most out of their medicines is in everyone's interests – from a patient, pharmaceutical company, prescriber and payer perspective. If our medicines work effectively and improve patients' health, this can enhance their ability to lead productive lives and overall costs of care can be reduced.

Fortunately, there's never been a better opportunity to see how medicines are performing. This goes beyond simply analysing clinical trials to also focusing on real world patient experience. Although clinical trials remain the foundation of this process, they are only part of the story.

Technology is now allowing us to measure dynamically what's going on in practice in a better way. It's a real opportunity for clinical commissioning groups, for example, to review outcomes for patients by using new technology that essentially brings visibility to data across patient record systems.

This is a leap forward when it comes to seeing how medicines are performing, real life, in real time, and is particularly important in managing long term conditions such as diabetes, end to end, focusing on outcomes.

This much fuller picture helps us to identify

'If our medicines work effectively to improve patients' health, this can enhance their ability to lead productive lives and reduce costs of care'

where the potential challenges can arise: are clinicians using the optimum medicine for each patient? Are patients taking their medicines correctly? Are there mechanisms in place, such as patient education programmes, to help patients get the best out of medicines?

This is not just the job of commissioners and CCGs; the pharmaceutical industry needs to play an important part too. Takeda UK is committed to playing an important role in the future of medicines optimisation. We all have to work together, from commissioners to the healthcare providers, industry and patients themselves in delivering patient focused care.

Ross Selby is director of market access at Takeda UK.

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DIABETES CARE

THINK ON YOUR FEET

CCGs looking to avoid foot amputations, strokes and other complications of diabetes need to consider medicines management, patient education and care planning. Jennifer Trueland reports

ALAMY

Ask Sanjay Desai about the consequences of failing to get medicines right in the care for people with diabetes and his answer is pretty grim. "Foot amputations, stroke, heart disease, and much more," he says. "This stuff is really important."

Mr Desai, associate director for medicines optimisation at Berkshire West clinical commissioning groups – a federation of several CCGs – has been involved in a radical redesign of the diabetes pathway to improve care for patients and ensure a better deal for the NHS.

As a pharmacist, he knows the value of good medicines management, and believes that patients need support to get the best out of their treatment. Mr Desai says: "Sometimes there can be side effects or dosage problems. A lot of patients simply don't take their medicines, and we know that the more drugs they are prescribed, the higher the chance they won't take them all."

When it comes to diabetes care, the stakes are high, in financial as well as human terms. Simon O'Neill, director of health intelligence and professional liaison for the charity Diabetes UK, says diabetes accounts for a big part of NHS spending. Most estimates put it at around 10 per cent. Medicines for diabetes are part of that, accounting for around £1 in every £10 in the primary care prescribing budget. But the real cost comes when diabetes is not well controlled.

"Around 80 per cent of the spend on diabetes is actually spent on treating complications, such as amputations and dialysis," he says. "Good medicines management is part of preventing complications – it's about prescribing the right thing, and supporting and enabling people to manage their condition."

But who should be responsible for ensuring that patients get the best out of

‘Using pharmacists in general practice can be a good way to help people manage their medicines more effectively’

their drugs? “Five or six years ago, diabetes wasn’t seen as being as much of a priority as it is now,” says Mr Desai. “And 15 years ago, it wasn’t really on the agenda for primary care; it was a secondary care issue. But now I’d say that, along with respiratory [diseases], diabetes is one of the main priorities in primary care.”

People with type 2, the vast majority of those with diabetes, will mostly be looked after in primary care. This has made it vital to upskill primary care professionals, including GPs and practice nurses, he says, as well as supporting patients, through education, for example.

The relatively recent shift to GP practice based care brings its own challenges, he adds. “The primary care workforce is at breaking point. We need to manage care in the most effective way we can. Using pharmacists in general practice can be a good way to help people manage their medicines more effectively.”

Mr O’Neill says CCGs have a vital role in medicines optimisation – but getting prescribing right is part of a bigger picture.

“Some 50 per cent of people with type 2 diabetes don’t take their medicines as prescribed within two years,” he says. “But you’re not going to improve medicines optimisation without lots of other things in place, such as education and care planning, which put patients at the centre of care. If you haven’t got elements like that, then people aren’t necessarily going to understand what the tablets are for.”

The Berkshire West federation – made up of Newbury and District, North and West Reading, South Reading, and Wokingham CCGs – has taken precisely that approach, and it is beginning to pay off, says Richard Croft.

A GP, Dr Croft is diabetes lead across Berkshire West CCGs, and clinical lead for diabetes at the Thames Valley Strategic Clinical Network. “This means I have strategic input to CCGs beyond my own,” he says.

“So I’m aware that in some CCGs, medicines management isn’t aligned with everything else that’s going on – there are people doing their own thing. We’re very fortunate in Berkshire West that medicines management is certainly on board with everything we’re doing to improve care for people with diabetes.”

The approach of Berkshire West’s “Diabetes sans Frontieres” project is relatively new. Service redesign began in 2012, when the then Berkshire West Primary Care Trust was identified as third worst performing PCT on a key measure of diabetes control (HbA1c attainment) in the 2010-11 national diabetes audit.

This shock result drove a major change to the diabetes pathway that has included, among other things, appointment of a consultant community diabetologist who works between primary and secondary care, a focus on patient education, and a shift to a care planning model.

Half of those with type 2 diabetes do not take their medicines as prescribed within two years

Importantly, however, there is also a strong focus on medicines optimisation. “From the beginning, our medicines management colleagues have been singing from the same hymn sheet,” he says. “For example, there’s heaps of evidence that cheap human insulin to control type 2 diabetes is every bit as good as more expensive insulin analogues, so we should be prescribing it across the whole area.”

Prescribing quality schemes – where GPs are essentially incentivised to prescribe in line with agreed guidelines and use human insulin with the lowest cost – are one way of making it happen, says Dr Croft. “Secondary care is now on board too, so we’re saying the same things across the board.”

Companies selling insulin have been very responsive and happy to engage with the new regime, he says, ensuring a better deal for the NHS and, indeed, for patients.

Results so far are good, with the proportion of patients hitting target HbA1c levels increasing from 46.5 per cent in June 2012 to 59.5 per cent by December last year.

Dr Croft agrees that medicines optimisation, while important, is not the silver bullet to solve every issue. Other important steps in Berkshire West have included setting up multidisciplinary virtual clinics to discuss patients with poor control, and changes to the medical records system to give a clear view of how care is delivered at a practice level. He points out that getting diabetes care right is hugely important, not just to individual patients, but to the health service budget as well, and that includes making the best use of medicines.

“Renal failure, for example, can cost £35,000 per year [cost of hospital based dialysis]. There’s a big focus at the moment on prevention of diabetes. Well, what we’re doing is secondary prevention – we’re stopping eye disease, kidney failure, foot amputations. Getting medicine right is helping us to do that.” ●

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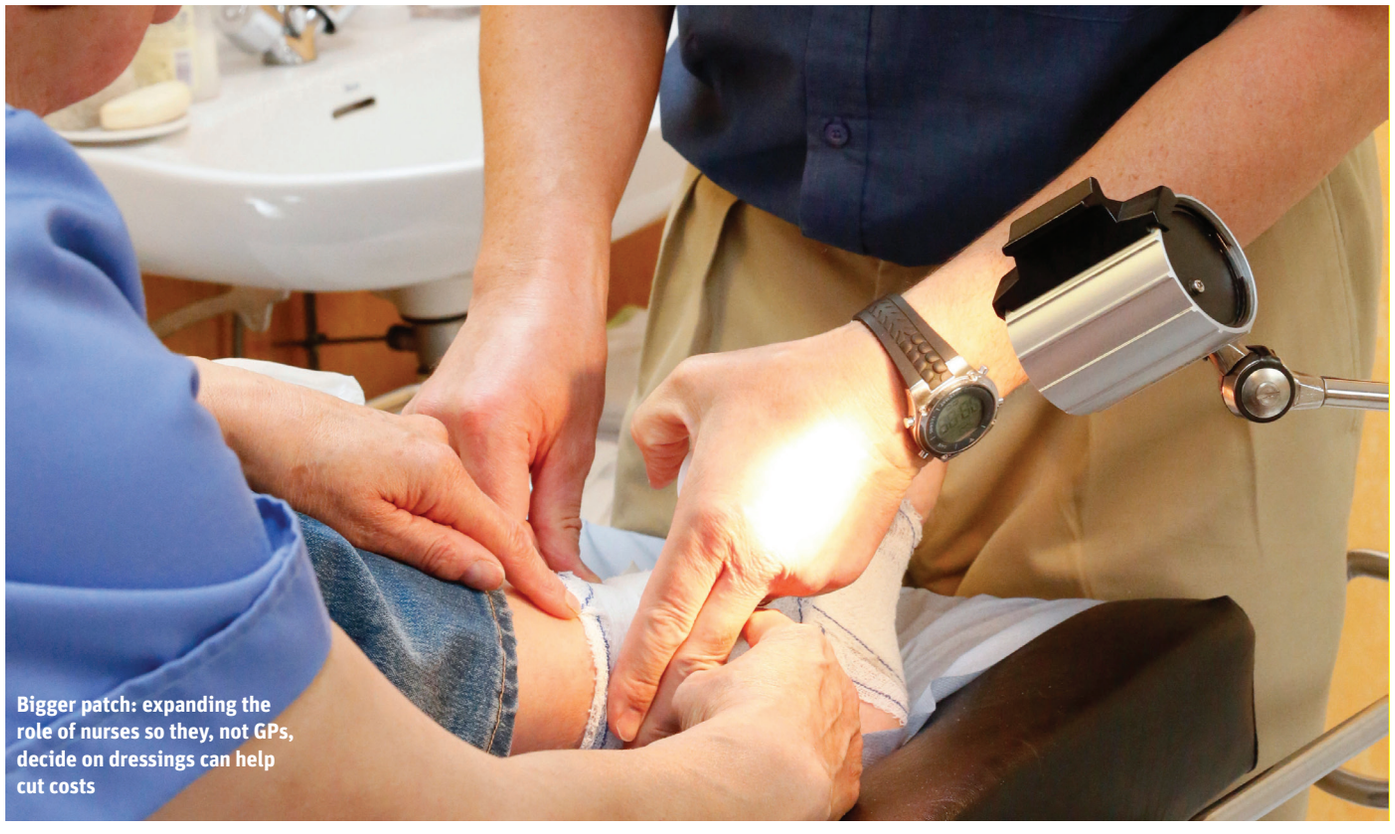

Bigger patch: expanding the role of nurses so they, not GPs, decide on dressings can help cut costs

ALAMY

SERVICE IMPROVEMENT

IT'S TIME TO HEAL

Older people's wounds heal more slowly. With an ageing population, this means the NHS must rethink wound management. By Claire Read

When Mark Collier joined United Lincolnshire Hospitals Trust, he was the organisation's first tissue viability nurse. Almost a decade later, he leads a team of seven, all of whom focus solely on the management and treatment of wounds.

The expansion of the team shows the growth and increasing importance of this speciality. It is estimated that 200,000 people in the UK have a chronic wound – generally defined as one which does not heal within three months – and a 2008 study put the cost of care for these individuals at £2.3bn-£3.1bn a year. That means 3 per cent of the NHS budget is now spent on chronic wound care.

The numbers are already significant but incidence and costs are only set to grow, warns Mr Collier: "The reality is it's going to get worse, it's not going to get better."

Estimates suggest that the number of wounds will rise by 10 per cent in the next five years alone. The main reason is the ageing population.

"Surgeons are doing surgery on older patients that they wouldn't have entertained even 10 years ago," explains Mr Collier, who in addition to his role at United Lincolnshire is a council member of the European Wound Management Association. "And obviously you've got advances in medicine and surgical techniques and equipment, so consequently you've got older people who are having more complex surgery.

"With the ageing process, the reality is that even if a 96-year-old were fully fit, went to the gym every day, never smoked, never drank, had a well balanced diet, the healing process would be slower than it is if you're 46. And if the wound isn't healing as quickly, it's more prone to potential complications.

"The incidence of chronic wounds is rapidly going up, because a percentage of the acute wounds [are] becoming chronic, but also because of things like leg ulcers which are associated with diminished circulation and so tend to happen later in life."

The scale of the issue is such that staff at many organisations are considering ways to make wound management processes more efficient. And that is not just the case in hospitals. The reality is that the focus on care closer to home and the long term nature of chronic wounds means much of the burden will fall in the community setting.

Until recently Heather Joy was senior operations manager for adult nursing and modernisation at Hull's City Health Care Partnership Community Interest Company. She reports that wound care has been a particular area of organisational focus for around five years.

"We had taken over the budget for the

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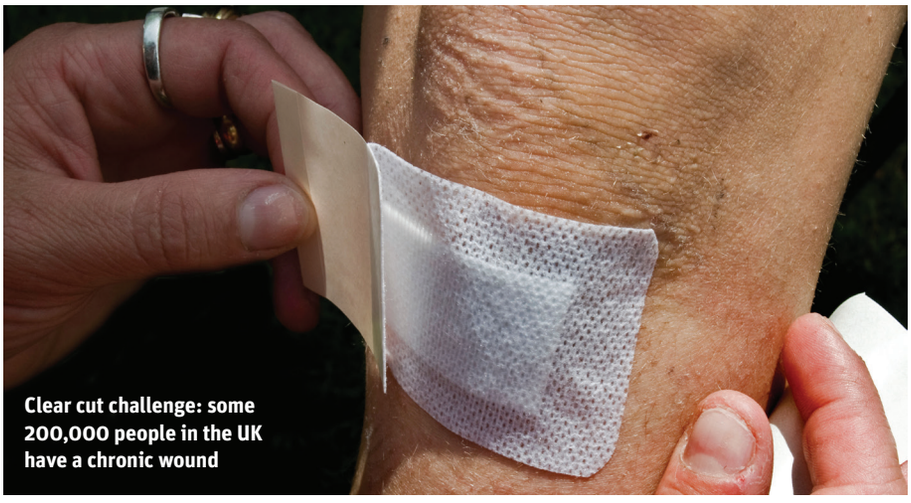
PAUL TRUEMAN ON THE BETTER USE OF NURSE TIME



Clear cut challenge: some 200,000 people in the UK have a chronic wound

consumables that were needed for wound management," she explains. "So whereas traditionally in many areas nurses would ask GPs to write prescriptions, we'd worked very closely with the CCG and top-sliced that prescribing budget so we had ownership of it. The nurse would say, 'This is the dressing you need,' the dressings would be taken in, and the patient didn't have to rely on a prescription going to the GP.

"In doing that, we had seen some significant savings and reduction in waste. We were continuously looking at ways of improving and making efficiencies."

That exploration centred on two issues: first, the number of dressings used and, second, the number of visits community nurses were making to wound care patients. However, one specific change made it possible to address both issues at once. The organisation started to use a new dressing, which needs replacing less frequently. It also has a surface which changes appearance when a new dressing is needed – helping patients to better understand their condition.

"The dressing was slightly more expensive compared to some of the others, but the value was in reducing the amount of visits," explains Ms Joy. "We were increasing the amount of time that nurses have to be with patients by them not undertaking unnecessary visits.

"We also got the patients and the carers involved by saying, 'Our plan is to see you in a week's time. Here is a guide – if the dressing looks like this contact us and we will come out to you.'"

'Estimates suggest that the number of wounds will rise by 10 per cent in the next five years'

An evaluation of the change – conducted with the dressing supplier – showed near universal reductions in visit frequency for dressing change in patients using the new product. Ms Joy admits that not all people were suitable for the change: long term patients who had become used to regular visits were resistant, particularly if they were socially isolated.

"But it gave us time to look at making every contact count," she says. "What else have we got around us, and what voluntary organisations could help with social isolation if we're not visiting you as often?"

Following the evaluation, the dressing is now on the local formulary "with strict guidelines as to who it's used for", says Ms Joy. The value of having a clear and considered formulary, with advice on which dressings to use for which patients, is also emphasised by Mr Collier.

"I think it's about taking the long term view rather than going for quick wins," he suggests. "If you only go from cost, what we've found is that you actually use more of that dressing: in principle it might be a similar product but it'll be less absorbent. I would never say expensive is best, and I would never say discount a product because it's cheap. But it's making sure you're aware of the whole picture.

"Obviously it's very easy to save money by simply changing the dressing to a cheaper one, but actually the outcome could then become that it takes longer for the patient to heal. It's taking a long term view and investing to save."

What is undeniable, he argues, is the scale of the need – and that it is increasing. "With the ageing population, I can put my hand on my heart and say there is not one patient in the country who will go into any healthcare setting who doesn't have a tissue viability need. It will be preventative – for example, preventing pressure ulcers – or it will be management, because they will have an existing wound or skin condition that needs to be managed." ●

For over a decade, health policies have promoted shifting patients from acute care settings to community and home on the basis this can improve access to care, make care more patient centred, and reduce the use of high cost acute care facilities. All fine principles in theory but in practice this is a more challenging proposition. With no significant investment in extra capacity in community nursing, these changes create additional demands on an already overstretched resource.

Community nurses often highlight the management of patients with a chronic wound as consuming significant amounts of their time.

While chronic wounds are rarely life threatening, they can consume a disproportionate amount of nurse time compared to other chronic conditions. Just consider how often a patient with adequate control of their diabetes is seen by a GP or community healthcare provider – perhaps once a month, maybe once a quarter?

'Chronic wounds aren't prioritised'

In contrast, a patient with a chronic wound will typically require 3-4 nurse visits per week, simply to change their dressings and monitor the progress of their wound. Furthermore, many patients require ongoing care over months and often years. Despite this, chronic wounds rarely figure on a list of priorities for commissioners, which tend to be dominated by conditions like diabetes, respiratory illness and cardiovascular disease.

Yet simple actions can be put in place to make better use of nurse time: reducing the number of nurse visits required for dressing changes; educating patients to play a greater role in self-care; simplifying dressing formularies to make product selection easier for nurses; and intervening actively and early to avoid wounds reaching a chronic stage, resulting in the need for time consuming ongoing care. The best practice guidelines and wound care technologies required to achieve improved efficiency are readily available.

At Smith & Nephew, we recognise that delivering high quality wound care is no longer just about providing dressings and innovative technologies.

We also have a role to play in partnering with healthcare providers, helping to think about how our products might support changes in service delivery and reduce the burden of wound management.

We believe that embracing innovative wound solutions can help to release nurse time to care and ultimately deliver improved patient outcomes.

Paul Trueman is vice president market access for Smith & Nephew.
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