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Health and Social Care National Conference

14th September 2023

Poster Booklet

NHS England

Improving lives together
Norfolk and Waveney Integrated Care System

UEA
University of East Anglia

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Assessing equality of access and provision of Palliative and End of Life Care in a Coastal Community: A mixed methods study

Dr Abigail Hensley [1,2], Professor Morag Farquhar [1,3], Dr Caroline Barry [2]

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Background:

- Coastal communities are known to be disadvantaged when it comes to provision and access to healthcare. [1]
- This is due to factors such as poor transport links, social deprivation and difficulty recruiting health and social care staff.
- Health issues such as cancers and organ failure leading to terminal illness have a high prevalence in coastal populations [2]
- There is no current research looking at whether coastal communities are disadvantaged when it comes to palliative and end of life care (PEoLC), and this study hopes to fill that gap.

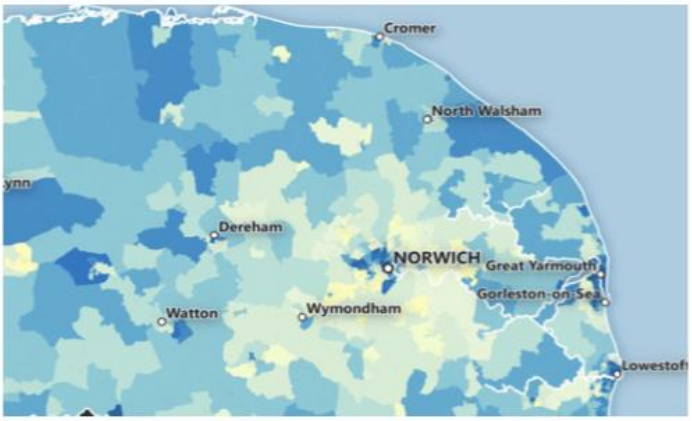


Fig. 1: Norfolk & Waveney Map of Deprivation 2019 (the darker blue, the more deprived)[3]

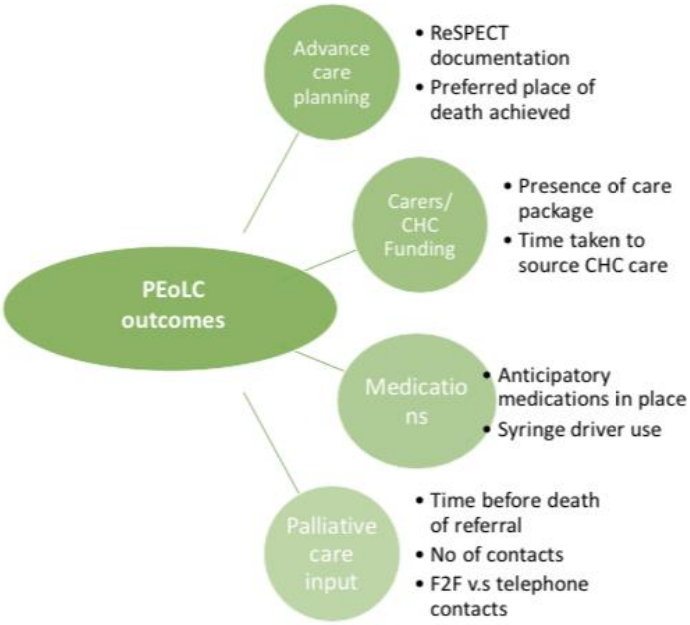
Research Aims:

1. To compare PEoLC outcomes for patients living in coastal regions to those living further inland to examine if there is a measurable difference.
2. To use this information to explore the views of healthcare professionals who provide care to these patients as to why there are (or not) differences in these outcomes for in patients living in coastal regions.

Methodology:

Mixed methods explanatory sequential study (see Fig. 2)

Figure 2: flow chart of the research study showing explanatory sequential design



Next Steps:

- Study ongoing: data collection & focus group recruitment start in Autumn
- Further updates to study:
  - Next NICHE conference
  - Dying Matters Week May 2024
  - NIHR ARC showcase April 2024
- Do you have any ideas/thoughts about how we can improve PEOLC in coastal communities?
- Contact Abi if you would like to get involved: Abigail.Hensley@nnuh.nhs.uk

References:
1. Whitty C. Chief Medical Officer's Annual Report 2021: Health in Coastal Communities. Dept of Health and Social Care. 2021.
2. Public Health England, Cancer Research UK. National Cancer Intelligence Network .Cancer by Deprivation in England Incidence, 1996-2010 Mortality, 1997-2011. May 2014.
3. https://research.mysociety.org/sites/imd2019/area/ccg-nhs-norfolk-and-waveney-ccg/lsoa/

An innovative approach to improving practice education to develop the physiotherapy workforce

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NHS
James Paget University Hospitals
NHS Foundation Trust

Purpose

As a Therapy Department, placements were completed on a 1:1 student-supervisor model, unevenly distributed across specialties. Post-Covid the demand for student placements increased, with specialties having students most of the year. This had a detrimental effect on the educators' wellbeing due to limited capacity for project work and feeling restricted with annual leave. Educators felt increasing student numbers would impact on quality of placement experience.

Our aim:

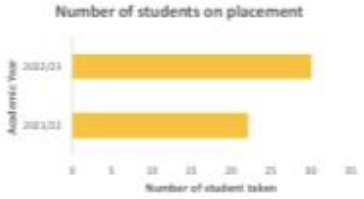
- Maintain a high standard of learning in student placement experience whilst supporting workforce wellbeing
- Standardised approach for student placement experience across all specialties
- Meet increasing demands from universities

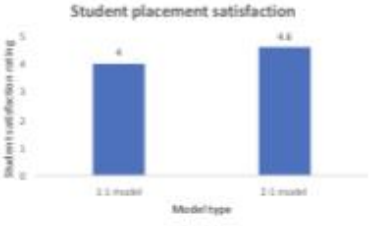
Results

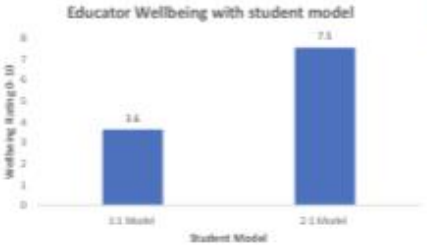
For the academic year 2022/23, our placement numbers have risen by 34% compared to previous years and student feedback has remained positive.

Students enjoyed:

- Peer learning opportunities
- Emphasis of teamwork demonstrated through project work







Method

We used the model for improvement to measure the success of our new student model. Our model aims to cater for increased placement demand whilst maintaining quality experience for students, but also giving educators and specialties space for project work and staff development.

Our outcome measures were:

- Number of student placements within the academic year
- Student feedback questionnaire (Likert scale and open text)
- Verbal feedback from educator debrief at end of placement
- Retrospective educators' wellbeing questionnaire

We used the 2:1 students-educator model, with a team-based approach to education incorporating physiotherapy and occupational therapy students. Instead of having one or two students three to four times a year, specialties have two concentrated blocks of four to eight students, creating time for the teams to focus on team projects and research. This was trialed in two teams as part of the first PDSA cycle. Although there are named educators for supervision, the team share the responsibility of student education. Our support workers completed an online module on how to support students, recommended by the CSP

The students were allocated time each week to work on a group project, which they presented at the end of placement. They attended weekly collaborative learning-in-practice sessions with other health care students. Students were also encouraged to join existing Band 5 training and Preceptorship.

"I felt more involved in the student placement" – Therapy assistant practitioner

"I had more time for team projects" – orthopaedic physiotherapist

Conclusion

We have successfully increased our capacity for the number of student placements, whilst maintaining staff morale and allowing opportunities for service development/project work. A team approach gives less experienced members of staff an opportunity to be part of student education.

Impact

- Placement capacity has increased by 34% with scope for further expansion to meet demands and widen our catchment from one to three universities.
- Student projects developed as part of this model have directly fed into the department's embedded research culture.
- A Senior Occupational Therapist has successfully secured a research fellowship building on a student project. The next stage is to complete a second PDSA cycle to include two more specialties.
- We will aim to gather further quantitative feedback from specialties to support our development.

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Acknowledgements
Thank you, Emily Leeks, placement co-Ordinator and Clinical Specialist OT, JPUH, and Rene Gray, Professional Lead for physiotherapy, Research fellow, JPUH for their ongoing drive to support research and innovation within the department.

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Hylen LM, Caldon PT, Barrett EM. Evaluation of a 2:1 to 1:1 peer placement supervision model by physiotherapy students and their educators. Physiother Theory Pract. 2013 Aug;29(6):749-755.
Martin M, Morris J, Moore A, Sadha, S, Crouch, V 2000, 'Evaluating Practice Education Models in Occupational Therapy: Comparing 1:1, 2:1 and 3:1 placements', British Journal of Occupational Therapy, vol. 67, no. 5, pp. 192-200.

Background

The **Guiding Lights for Effective Workplace Cultures** programme was commissioned by NHS England and jointly delivered and evaluated by the Foundation of Nursing Studies (FoNS) and the former ImpACT Research Group (now NICHE) at the University of East Anglia (UEA). The programme focused on applying the four 'Guiding Lights' to the community (nursing and/or interdisciplinary) team setting.

The anticipated outcome of the programme was that it would enable learning about how current workplace cultures (as experienced by programme participants) map against the Guiding Lights (as a framework to support practice and team development) and the steps needed to facilitate learning and effective workplace culture development at an individual, team, service and systemwide level.

Guiding Lights for Effective Workplace Cultures

The Guiding Lights for Effective Workplace Cultures were developed as part of a three-phase study based on the principles of appreciative inquiry and realist evaluation:

- Collective leadership
- Living shared values
- Safe, critical, creative learning environments
- Change for good that makes a difference

Workplace culture

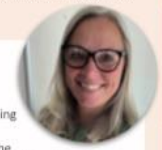
The development of workplace cultures that are effective and person-centred is a key focus for practice development and transformation activity. A number of high-profile reports and investigations highlight its centrality to quality of care, leadership and overall workforce satisfaction. The Covid-19 pandemic has shone a light on the importance of workforce 'wellbeing' linked to resilience and the importance of workplace cultures that are person-centred, safe and effective.

The Guiding Lights built on the authors' experience and understanding of working with 'real world' complexity and being part of practice, team, system and regional transformation, along with earlier published work.[1] Each Guiding Light describes what good workplace cultures are and identifies the intermediate outcomes that result for those providing and/or experiencing care/services.

Together the Guiding Lights account for the following ultimate outcomes:

- Strong, high-performing teams
- Staff retention and low sickness rates
- Sustained positive, improving, workplace cultures not dependent on specific individuals
- Building effective partnerships within and across settings

TABLE 1: PROGRAMME EVALUATION

Questions	Responses were reviewed by programme facilitators, eliciting key themes:
Part 1 Participants were asked to reflect on what was good about the programme and what they had taken away from it. Responses are summarised on the right. They were also asked what could have made the programme better. Many commented that they would have liked the programme to be longer and others would have welcomed the opportunity to share outcomes and reflect on these with the group.	**The programme:** • Acted as a means of reflecting on culture and engaging teams in discussions and action planning • Facilitated learning with and from others • Enabled participants to recognise that they share goals/challenges/issues, helping to reduce any perceived sense of isolation • Provided time away from practice to think, reflect and plan, which was linked to team effectiveness, workplace culture and wellbeing • Encouraged integration of the Guiding Lights into practice and continuation of their development with teams
Part 2 Participants were invited to share their learning and reflections from the programme. Transcripts from group and individual discussion and subsequent blended stories from practice were shared with participants for agreement of accuracy and approval.	**1. How did you approach using the Guiding Lights with your team?** • Bringing the Guiding Lights to team meetings; discussing with individual team members; and sharing widely to enable discussion • 'Context' was identified as a difficulty – working with competing pressures and priorities. The Guiding Lights encouraged team thinking about workplace culture, enabling people to 'look upward, outward' and to the 'future'. This was seen as fundamental to team wellbeing
Reflection on the programme  'Using the guiding lights with my team gave us the framework to consider all the elements of our team culture and how we can make changes that are informed by everyone and have a strong sense of meaning. We held several workshops in which we used claims, concerns and issues to highlight the key areas in which the team felt it needed to change. We developed an action log as previous ideas and changes had been lost and drifted, leading to staff feeling disempowered. Having a live action log and regular reviews meant that staff felt heard and real ownership of the changes being made because they had written them!' *Kirstie Lynn, Head of Service, Children's Community Specialist Nursing and Community Paediatrics, Cambridgeshire and Peterborough NHS Foundation Trust*	**2. What worked well and why in using the programme?** • It provided a structured approach to understanding workplace culture and supported the development of structured approaches to team development • It helped open up discussion about what mattered to staff. Participants used the Guiding Lights based on their understanding of what would add most value to the teams based on where they were currently and the potential for growth and development
	3. What would you do differently and why when using the Guiding Lights? • Better appreciate the importance of language that was 'accessible to all' and the need to adapt and be creative in working with their teams. Working remotely during Covid highlighted this • Help prepare individuals for the feedback received about workplace culture, when there might be different perceptions of how effective the culture is • Ensure the 'time and space' to work with the Guiding Lights amid workload pressures
	4. Who will have benefited and how would you know? Guiding Lights allowing the time to focus on workplace culture, address challenging situations and have difficult conversations. Observable outcomes that benefit staff included: • Better communication across locality based teams • Less duplication of work and more effective use of staff time • New ways of working linked to better outcomes for patients and staff Support for individual and team leadership development and growth
	4. Where and what next? Participants felt they were at the start of their journey with their teams and were committed to progressing the Guiding Lights further. They saw the end of the programme as the start of an ongoing development process for themselves and for their teams, in terms of learning about, improving and sustaining workplace culture

Participants

Participants were nominated by their employing organisations across England. The 21 participants came from a variety of different community nursing and interdisciplinary teams and held a variety of team and clinical leadership roles at Agenda for Change bands 7-8a.

The programme

The programme drew on the practice development principles of Collaboration, Inclusion and Participation (CIP). It ran for six months, followed by an offer to participants to join a Community of Practice for 'Culture Change' as part of the UEA School of Health Sciences' newly launched Collaborative Workforce Transformation Academy.

Covid-19 restrictions meant it was delivered virtually via three workshops/webinars along with two follow-up regional support groups. Additional virtual 1:1 support was offered by FoNS and UEA.

Evaluation

Evaluation was a continuous process throughout the programme. At each workshop, participants were invited to draw from realist evaluation, 'what worked for whom, in what circumstances and why?' The programme evaluation outcomes are presented in **Table 1**.

Conclusion

The programme enabled participants to work together both nationally and regionally, focusing on workplace culture. The Guiding Lights framework acted as an enabler/starting point for them to enter into conversation and dialogue with each other and their teams.

An emergent theme throughout were the multiple challenges faced by participants on a day-to-day basis. However, they consistently focused on wanting to make a difference to care and teamworking, recognising the importance and centrality of effective workplace cultures. While the focus was very much on the 'here and now', there were opportunities to 'look to the future' and 'new possibilities'.

Acknowledgements

Our thanks to Hilary Garratt, former Deputy CNO, and Sam Sherrington, Deputy Director of Community Nursing, NHS England, for commissioning this programme. Our thanks also to all the participants who contributed so actively throughout the programme.

For a copy of the fully referenced report, please contact:

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Dr Kate Sanders: kate.sanders@fons.org

Reference

1 Cardiff, S., Sanders, K., Webster, J., Manley, K. (2020) Guiding Lights for effective workplace cultures that are also good places to work. *International Practice Development Journal*. Vol. 10. No. 2. pp 1-20.

Poster authors

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Care Worker Job Evaluation Framework

In 2021 Norfolk Care Association (NorCA), in partnership with Innecto, a pay and reward consultancy, began work on the Care Worker Job Evaluation Framework. Using research into skills, job descriptions and pay within the adult social care sector, we created a methodology that allows for the comparison of work roles within social care and with other sectors including health thereby promoting parity of esteem and the equal valuing of skills and competences regardless of employer.

Following an extensive desk top study followed by testing with individual social care providers, the Framework was finalised in late 2022. Consisting of 5 levels and 7 key attributes or work factors, it also includes a pay calculator and Guidance on use. In 2023 the Framework was transformed into an online evaluation tool, for providers across Norfolk, the East of England and the rest of the UK to use.

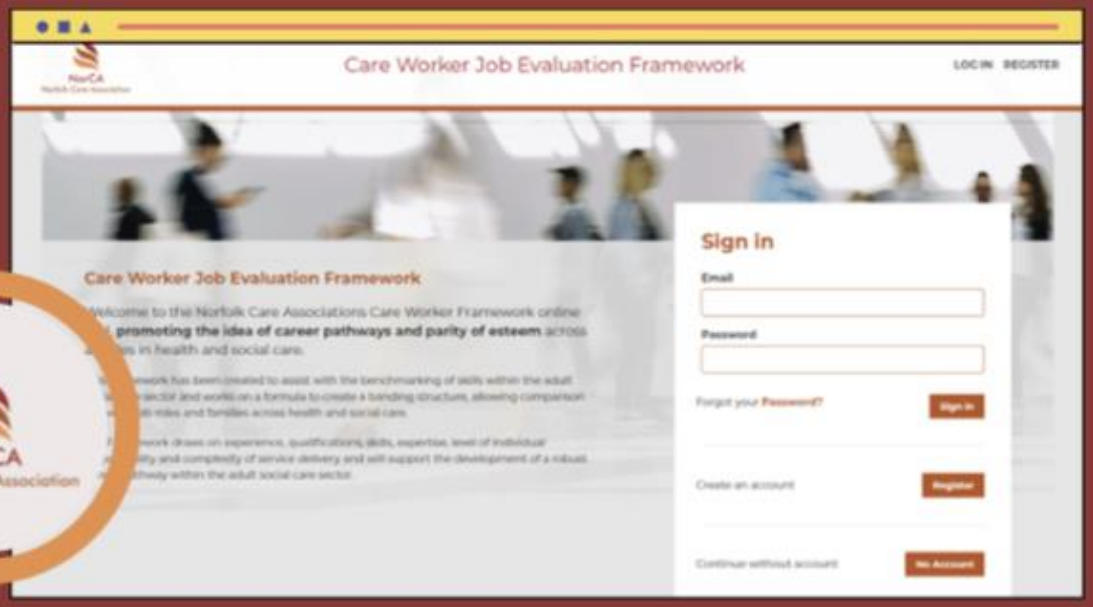
The online tool offers the opportunity for providers to assess the skills of employees, to benchmark their capabilities and review their current training and support offer. It facilitates the creation of a coherent staffing structure that offers clear career development and provides a vital opportunity to gather data on real time pay.

This tool is the first in the country to offer this type of support to the adult social care sector and has already been widely socialised with Partners across the UK, including other Care Associations, local authorities, MPs and Ministers.

The Framework draws on experience, qualifications, skills, expertise, level of individual responsibility and complexity of service delivery and will support the development of a robust career pathway within the adult social care sector.

It provides both generic and social care-specific descriptions of job skills, bringing together transferable and industry specific knowledge and skills. The skill levels selected from each of the seven work factors are fed into an algorithm which gives an overall skill level for the job role being analysed. Th e descriptions chosen for each work factor can be downloaded for providers to use with staff at induction, as part of HR reviews and as evidence of skills audits for CQC.

Feedback on the tool to date has been very positive and NorCA has used the experience of developing both the Framework and online tool to inform its contribution to recent Government consultations such as the social care workforce pathway.



NorCA
Norfolk Care Association

Caring with Kindness

EXCELLENCE STARTS HERE

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Care with Kindness is a programme offered to all staff at the Queen Elizabeth Kings Lynn to enhance their understanding of the impact of them on care.

The facilitators of Care with Kindness supported and worked with an ever-changing environment which embedded, practice centred delivery of the programme ensured that the pace of change was kept up to date.

The design and delivery of the programme has required clear leadership from ward to board and is underpinned by patient feedback and participation.

Care with Kindness was developed as a result of a number of different data sets such as complaints, inpatient survey, FFT etc where staff were, it was being reported care was 'rushed', or not 'kind' with little emphasis on an individualised, person centred approaches. As a result, a programme was developed exploring the fundamentals of care delivery using learning approaches that encouraged staff to reflect on their practice and to encourage a safe psychological space for individuals to talk through care experiences that did not meet the Trust values of 'Fairness, Wellness' and 'Kindness'.

DEMONSTRATE HOW LEARNING IN AND FROM PRACTICE CAN SUPPORT AND ENABLE CARE THAT HAS KINDNESS AND COMPASSION AT ITS CORE

The design and delivery of the programme has required clear leadership from ward to board and is underpinned by patient feedback and participation. Whilst the 'topics' may not change working with people who have accessed and experienced our services does, which enhances positive outcomes for participants and develops understanding and learning from and in practice. We use multimedia approaches to enable patient participation along with practical sessions with service users and voluntary groups, using interactive approaches to support learning in order that we can share and support some of the emotional 'turmoil' explored through reflection from practice.
600 participants (registered and unregistered staff) have attended and report the programme as 'enlightening' and 'breaking down barriers' enabling individuals to develop the courage to challenge practice and the status quo. Many participants have remarked on the feeling of being in a group of like-minded staff who are able to 'carry on' - on a number of occasions we have had reported that staff had felt they would leave their roles before the programme but now having completed the Care with Kindness programme are not looking to do so because they feel both enabled and empowered to question and deliver care that has kindness and compassion at its core.

EMPOWERING PARTICIPANTS TO CHANGE PRACTICE

Speech Analytics Auditing In an NHS 111 Provider

The quality improvement project utilised speech analytics technology within a healthcare setting to reduce waste activity and automate parts of the process in the auditing of NHS111 call handlers

Harry Brackley and Kieran Arkley

NHS

IC24 INTEGRATED CARE

Define

NHS Pathways is a clinical tool used for assessing, triaging and directing the public to urgent and emergency care services by NHS 111.

All NHS Pathways users must be audited in line with Schedule 4 of the NHS Pathways License agreement; this maintains good practice in call handlers and ensures a safe environment for patients. Calls can be audited retrospectively or live.

A review of the retrospective auditing process at IC24 showed several organisational challenges that slowed and complicated the process:

- Manual processes and inconsistencies
- Small sample sizes
- Lack of visibility around auditing

IC24 procured Nexidia which is speech analytics software. A project group was formed which included clinical input to ensure the system was safely implemented to support the safety and care to our patients, whilst delivering in efficiency benefits.

Measure

Retrospective audits took an average of 21 minutes. This was done by manually recording a sample set of audit timings.

In addition, voice recording had to be manually retrieved which took ~ 4 minutes 20 seconds. Live audits took around 13 minutes to complete which was the same as the time taken for the call.

Retrospective Audit Questions:

- 13 demographic questions
- 19 pathways questions

Live Audit Questions:

- 11 demographics questions
- 10 pathways questions

Audits were recorded on excel spreadsheets and results manually sent to call handlers for review

Analyse

Looking at the questions asked during both audits, potential questions were identified that could be automated using a voice analytics software.

Retrospective Audit Questions:

- 8 out of the 13 demographic questions
- 10 out of the 19 pathways questions

Live Audit Questions:

- 9 out of the 11 demographics questions
- 6 out of the 10 pathways questions

Improve

In July 2021, the **Nexidia** software replaced the manual auditing.

This integrated the voice recording retrieval, call auditing assignment, auditing, and result sending into one place, which both call handlers and auditors could use.

We carried out a full in depth analysis to identify the different ways our advisors could question the patient and did rigorous audits to ensure that all our automated queries worked at a precision over our 95% accuracy threshold.

- All 8 of the potential demographic questions were automated
- 1 of the 10 potential pathways questions was automated.

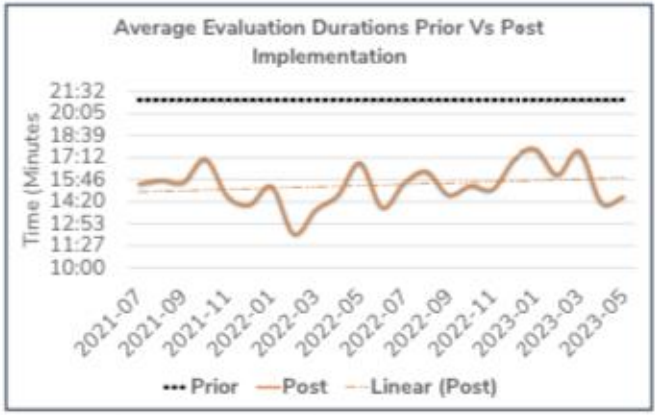
This reduced the average evaluation duration down to 14 minutes.

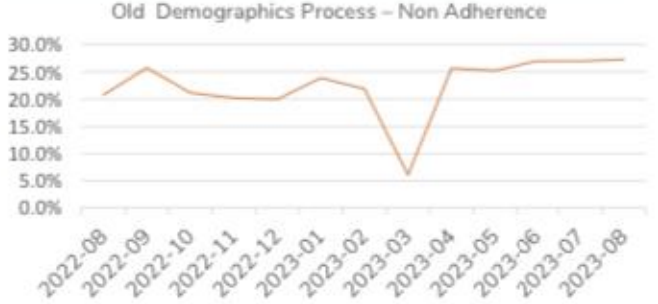
Control

The final 9 potential pathways are being developed in Nexidia to be automated.

The new auditing tool has fully taken over the old process, with training being provided to call handlers and auditors before the rollout. With ongoing development to increase its functionality.

We are also able to see how well staff adhere to new changes in processes.





Our Vision
The best care for every patient

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Norfolk and Norwich University Hospitals
NHS Foundation Trust

Pre-Registration Placement Expansion Project

Introduction

The Norfolk & Norwich University Hospitals NHS Foundation Trust (NNUHFT) needs to be able to deliver sustainable growth in the Nursing, Midwifery and Allied Health Professional workforce.

One of the ambitions of the NHS Long Term Workforce Plan (June 2023) includes scaling up the number of people in learning.

To meet this ambition, NNUHFT placement capacity will need to increase, while maintaining the required quality and level of educational support.

Highlights of the project are:

1. Appraised current capacity picture
2. Reviewed governance processes
3. Streamlined processes and created policies
4. Suggested solutions

Current Capacity

NNUHFT is currently using a Fair Share Formula to calculate placement capacity in each area.

Fair Share Formula
Whole Time Equivalent Registered Practitioner (WTERP) X 0.375 = potential number students allocated to placement at any one time

Number of WTERP	40.52 WTERP x 0.375 = 15.195
No: maximum current placements offered	15

The capacity figures are divided between our local Higher Education Institutes to meet our commissioned student numbers

We also offer elective placements to students outside our existing arrangements

Proposed Capacity

Our aim is to increase placement capacity by 25% by April 2024

Daily Capacity Formula

No of Student an area can take per shift (6) × Hours of shift (12.5) × Shifts per day (2) × 7 days per week (7)

37.5

= WTE of students (28)

This is an example from a NNUHFT ward where the capacity currently is 15 students per week.

With the proposed daily capacity formula, student capacity would increase to 28
(an increase of 86.6%)

This graph shows 12 areas that currently have 4 or less learners per week during their placement block.

Using this daily capacity model could increase the overall capacity by 80% for these 12 areas

Student IT

NNUHFT has recently had issues with providing students with IT access which has had a detrimental effect on the students placement experience.

We are currently working with our Digital Health colleagues to create processes to enable all of our students to have IT access from September 2023

NHS Digital

Student Experience

- Students feel welcomed and valued
- Improved training and education for staff
- Shaping future workforce

Conclusion & Next Steps...

Our next steps:

1. Review our placement map
2. Identify areas to pilot daily capacity model
3. Evaluate and feedback to NNUHFT Board
4. Implement any changes and roll out across all professions (Nursing, Midwifery and Allied Health Professionals) in NNUHFT
5. Share our learning across the Norfolk & Waveney Integrated Care System
6. Our objective is to publish this project

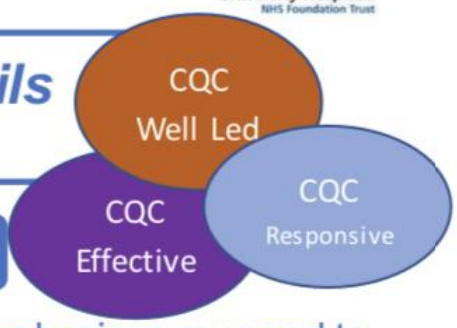
ANCC
AMERICAN NURSES CREDENTIALING CENTER
PATHWAY TO EXCELLENCE

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Shared Decision Making Councils

Led by Jessie Voon & Amy Barton



What were we trying to accomplish?

- Our new corporate strategy, Caring with PRIDE, emphasises our need to focus on building a supportive leadership model. This also aligns with the Clinical Professionals, Midwives and Nurses (CPMN) Strategy.
- Shared Decision Making Councils facilitate a strong collective voice for our staff, creating a non-hierarchical approach to decision making in all areas of practise. We currently have councils across the organisation including Maternity, Surgical Ward Coordinators, TNA/NP/AP and a matron's council with many more on the horizon!

How did we know that our change was an improvement?

- Shared decision making councils are forming across the trust. Our current councils are producing work that has been formulated by discussion in councils that otherwise would not have been proactively shared and resolved.

What change did we make?

So far, councils have identified issues in their working lives which impact positive practice environments and have found solutions through collaborative projects. The Maternity Council has identified that rotational midwives struggled with the regular changes in work placement and orientation was often not sufficient. As a result, they identified where a quick reference guide would be beneficial and created a manual for each area. The Maternity Council are currently reviewing how this has effected working lives and the care patients receive.

If you are interested in setting up your own shared decision making council for your area or specialty, please email the QI team on; NMCP.Excellence@nnuh.nhs.uk

References

- NHS England » Shared Professional Decision-Making: putting collective leadership into practice
- Shared Decision Making Trust Information

Developing a peer supported infrastructure to facilitate continuous improvement and innovation in an ambulance service

East of England Ambulance Service NHS Trust

Author Helen Hanby

Introduction

"Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills, and resources they need to solve them".

The Health Foundation, 2021

Devising a Culture and Capability for Continuous Improvement

The East of England Ambulance Service serves around 6.3 million people across an area of 7,500 square miles, includes 6 Integrated Care Systems (ICS) and 17 acute trusts.

Effective support for small changes across this vast area presents challenges, alongside a desire for reducing variation in practice and empowering staff to improve their working life and the experience of patients.

We are establishing a process that will support staff with protected time and piloting a model for the first of these Innovation Hubs in the Norfolk and Waveney area.

We plan to expand this support to enable coproduction of future projects, we rely on our ICS and Trust partners to contribute and engage to inform this important first step.

Fifteen frontline staff from across Norfolk & Waveney form the first Innovation Hub in EEAST (Longwater, Norwich July 2023)

Way Forward

- Encourage and foster collaboration – Forming a shared sense of responsibility
- Focus on small changes that can be tested – Where results can be easily identified
- Celebrate success – Recognise achievements and motivate staff
- Adapt and evolve – In a changing healthcare landscape, be prepared to continuously adjust
- Be transparent – Build trust by openly sharing progress and outcomes
- Patient centric approach – Working with patient experience teams to understand needs
- Consistency for mindset change – Routine use of shared improvement mindset – daily routines and meetings
- Have a long-term perspective – Building a culture of continuous improvement takes time

Objective 1

- Establish an Innovation Hub contact point

Objective 2

- Provide training for staff who express an interest in leading the Norfolk & Waveney Hub

Objective 3

- Develop an evaluation method for the Hub template, measuring its impact and sustainability

Methodology

- Leadership Support – Sold to executive teams, Chief Operating Officer and CEO
- Clear Goals – Aligned with patient outcomes and operational efficiency
- Engage staff – Peer input and ownership in the improvement process
- Train and educate – Using a consistent improvement model across the organisation
- Collect data and analyse – Track progress over time, using subject experts to support
- Create a feedback loop – Capture insights from staff and patients

Understand the barriers and enablers of establishing an environment for change

Understand the impact and learning of staff involved in this project

Exploring the potential for successful review and spread across EEAST

References and further reading:

Quality Service Improvement and Redesign: https://qsus.nhs.uk/QSIR

NHS Impact Approach – the five components that form the 'DNA' of all evidence-based improvement methods: https://www.england.nhs.uk/nhsimpact/about-nhs-impact/

Quality Improvement Made Simple April 2021, The Health Foundation. Available at: https://www.health.org.uk/publications/quality-improvement-made-simple

Our Vision
The best care for every patient

Norfolk and Norwich University Hospitals
NHS Foundation Trust

Author: Bella Knaapen – Governance and Risk Management Facilitator, Surgical Support, SCEC Division
Sarah Leeks – Professional Nurse Advocate

Background

It is acknowledged within the NHS, that many healthcare professionals have experienced poor behaviours within the workplace or have previously been exposed to bullying type behaviours, at some point during their career. As a result, it has been recognised nationally, through the patient safety syllabus [1] and NHS Just Culture Guide [2], which look at system errors rather than apportioning individual blame, that these types of behaviours can have a negative impact on patient safety and quality care. Therefore, there is an opportunity to further develop a "Just Culture" where staff are empowered to speak up to maintain patient safety and quality care.

Objective

- Further develop a safety and "Just Culture" within the Theatre Complex.
- Provide staff with tools to speak up in challenging situations, through the delivery of "Speak Up for Safety" workshops, building on previous human factors work
- Introduction of PACE communication escalation tool [3]
- Formalise structured de-brief and shared learning following incidents

Methodology

- Use of Plan, Do, Study, Act (PDSA) [4] Quality Improvement (QI) methodology
- Review of qualitative NHS staff survey
- Use of qualitative Likert study to measure current staff thoughts and beliefs around safety culture.

Keywords

Speak Up for Safety, Just Culture, Patient Safety, Patient Safety Syllabus, PACE Communication, Life QI

LifeQI

Next Steps

Stakeholders have been kept regularly informed since the projects inception.

The ideals of "Just and Safety Culture" are being further embedded into practice with the introduction of "Speak Up for Safety" workshops.

Staff will gain understanding of the National Patient Safety Syllabus [1], NHS Just Culture Guide [2], and knowledge of specific communication escalation tools.

Alongside the Trust Professional Nursing Advocate team, staff will be reintroduced to human factors topics such as situational awareness and emotional intelligence, whilst focusing on a specific incident and allow facilitated de-briefing of the incident to share the learning and understand the root cause of an incident.

Conclusion

Speak Up for Safety will give staff the ability to speak up effectively which will lead to; promoting patient advocacy, preventing harm before it occurs and identifying and mitigating risk. Collectively, this is how we will enhance patient safety and quality care.

References

[1] National Health Service (NHS) Health Education England. (2021). *Patient safety, patient safety syllabus.* [Online] Available at: https://www.hee.nhs.uk/our-work/patient-safety (Accessed 01/08/2022)

[2] National Health Service (NHS) England and NHS Improvement. (2021). *A just culture guide.* [Online] Available at: https://www.england.nhs.uk/patient-safety/a-just-culture-guide/ (Accessed 01/08/2022)

[3] Royal College of Obstetricians and Gynaecologists (RCOG). (2020). *Probe, alert, challenge and escalate model.* [Online] Available at: https://elearning.rcog.org.uk//new-human-factors/types-communication/probe-alert-challenge-and-escalate-model (Accessed 01/08/2022)

[4] National Health Service (NHS) England and NHS Improvement. (2022). *Plan, Do, Study, Act (PDSA) cycles and the model for improvement.* [Online] Available at: https://www.england.nhs.uk/wp-content/uploads/2022/01/qsir-pdsa-cycles-model-for-improvement.pdf (Accessed 01/08/2022)

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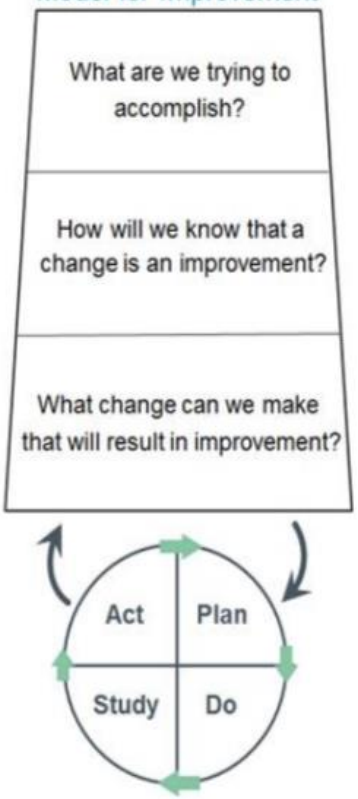
CQC
Well Led

Quality Improvement Training

Stacy Hartshorn, Quality Improvement Lead

Model for Improvement



What are we trying to accomplish?

- Review and improve the suite of Quality Improvement training available in the Trust to increase staff awareness and recognition of improvement tools, techniques and methodology

How will we know that our change is an improvement?

- The number of staff attending our training will increase, including those that progress through the course levels
- Increased numbers of active projects logged on our Trust Quality recording system Life QI and updated monthly
- Increased enquiries to the Quality Improvement Team identifying project ideas and potential areas for improvement
- Continued positive feedback for training sessions delivered

What changes are we making?

- A pre-recorded 30 minute Quality Improvement taster session is available for staff to access at any time
- Quality Improvement overview slides are included in induction slide sets
- Monthly one day Quality Improvement training available to all staff via ESR
- 5 day Quality, Service Improvement and Redesign Practitioner (QSIR-P) courses are made available each year from Autumn 2022
- Working with providers across the Integrated Care System (ICS) to provide further training

References

- Monthly One Day QI Training – log into ESR to book
- QSIR-P - NNUH Staff Information Hub - (tfemagazine.co.uk)

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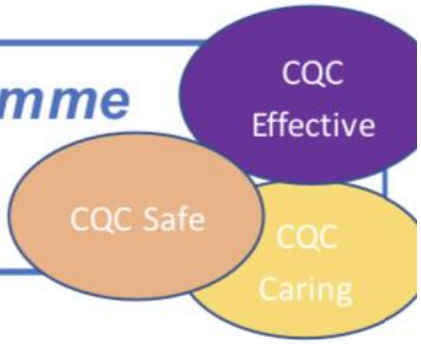
Nutrition & Hydration Programme
Bapen Training

Tanya Moon & Kay Marrison



What were we trying to accomplish?

- As part of a wider programme to improve nutrition and hydration for patients, a gap was identified in staff knowledge with regards to how we understand and assess the nutritional requirements of patients. We looked at ways we could improve the training we offer to staff so they could increase their knowledge of nutritional screening

How did we know that our change was an improvement?

- We worked with a training provider called BAPEN who specialise in interactive e-learning modules on Nutritional Screening, particularly using the Malnutrition Universal Screening Tool (MUST). This training was added to ESR to enable current staff to complete it online and was rolled out to our pilot wards. We collected feedback from staff, who said they found the training easy to access, the content was helpful and they felt more confident in assessing patient's nutrition needs as a result.

What change did we make?

- The training is now being offered to all wards for current staff and new starters. It has also been added to the induction training for newly qualified staff.

Evaluating the quality and impact of preceptorship programme at one NHS Trust; an exploration of experiences of staff involved

Authors: Mehar Shiju, Research & Evaluation Associate, JPUH; Helen Hall, Senior AHP for NMAHP Research & Research Grants Advisor, JPUH; Jonathan Yazbek, Head of QI, JPUH; Claire Whitehouse, Senior Nurse for NMAHP Research; Manju Varghese Viruppil, Practice Development Nurse, JPUH

Acknowledegements We would like to thank UEAHSCP for funding the write up of this project and all the participants of this project.

Background

Globally we are currently facing a 30.6 million shortage of nurses, the UK is in the midst of a nursing staffing crisis heading towards an estimated supply gap of 14,000 nurses by 2030 and 20% of newly qualified nurses are reported to leave the profession within the first year. Improving the recruitment and retention rate of newly qualified nursing staff has never been more important. It is acknowledged effective preceptorship is one way to positively contribute to this agenda. This has been recognised and supported by the introduction of the National Preceptorship Framework for nursing and the NMC preceptorship principles.

Preceptorship is a period of structured transition to guide all newly qualified practitioners from student to autonomous registered professional. It is important because effective preceptorship outcomes are linked to improved recruitment and retention[1] as well as positive patient safety, outcomes and experience[2]. The UK adopted preceptorship in the early 1980s and the NMC have continued since then to recommend all newly registered practitioners receive a period of preceptorship following qualification. Despite the NMC advocating preceptorship and the clear benefits it can bring, evidence in the existing literature highlights barriers such as lack of protected time, lack of preceptor training and engagement and lack of organisational commitment hinder the effective delivery of preceptorship. Lack of clarity still exists how to address these challenges even though there have been several policies, frameworks and standards launched nationally to promote and establish preceptorship.

This poster details a bespoke project using service evaluation methodology to understand and explore the preceptorship programme as experienced by preceptors, preceptees, managers and clinical educators.

Aim

The primary aim of this evaluation is to identify the barriers and enablers of successful preceptorship programme to improve the delivery of preceptorship programme at one acute Trust.

Methods

A descriptive, cross sectional, qualitative approach was used to explore different staff groups' perspectives and experiences of preceptorship which enabled a deep and rich understanding of the local preceptorship programme from a number of angles; Purposive sampling was used to select Preceptors (Pr), Preceptees (Pe), Ward Managers (WM) and Clinical Educators (CE). The six-step CDC framework for program evaluation[3] guided our evaluation.

Data Collection

Phase	Data collection method	Population	Timeline	Comments
One	Testing of pilot surveys	1.Ward Managers 2.Preceptees 3.Preceptors	May-June 2022	To ensure questions were appropriate
Two	Surveys	1.Ward Managers 2.Preceptees 3.Preceptors 4.Clinical educators	July – September 2022	Preceptees included those from 2019 to 2022.
Three	Retrospective preceptees portfolio analysis	NA	May – July 2022	To evaluate if the current portfolio is fit for purpose
Four	Semi structured interviews	1.Ward Managers 2.Preceptees 3.Preceptors 4.Clinical educators	October – December 2022	To gain in-depth perceptions and experiences of staff involved in preceptorship

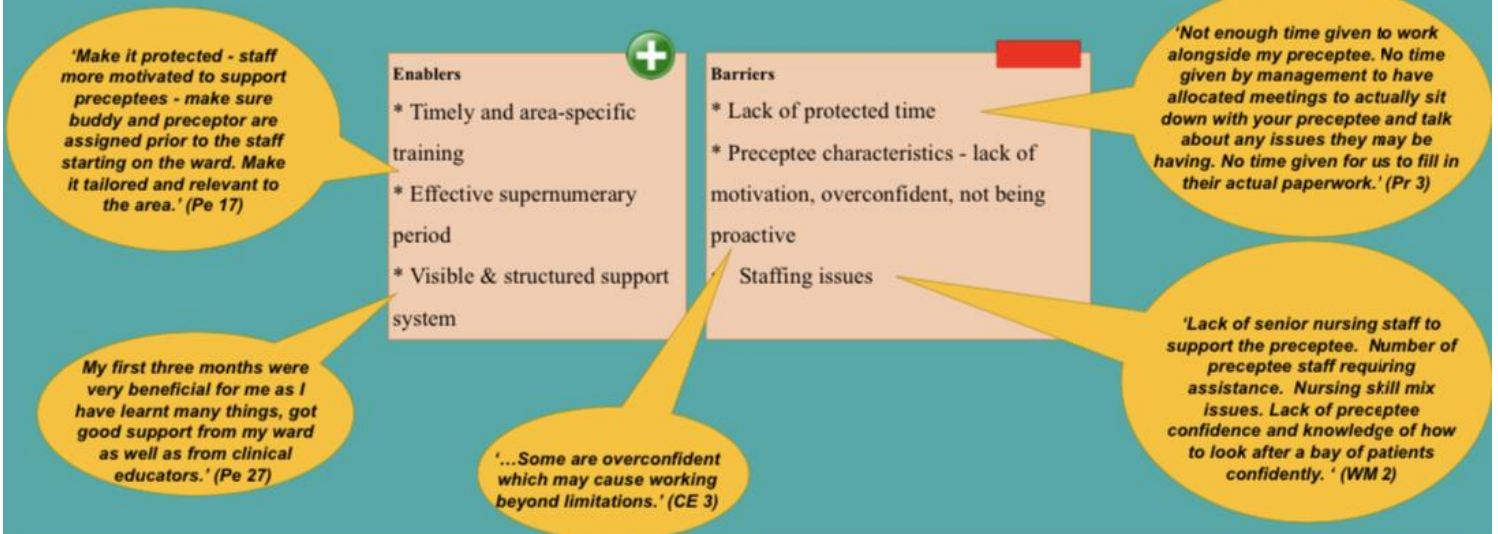
Data Analysis

Qualitative data was analysed using Braun & Clarke reflexive thematic analysis[4].

Descriptive statistics was used to analyse quantitative data in the form of percentages and integers.

Results

The overall response rate was 29.4% with 69 preceptees (Pe), 22 preceptors (Pr), 6 ward managers (WM) and 9 clinical educators (CE) completing the survey. The average rating of the current preceptorship programme with 1 being not good and 5 being excellent was 3.70 . The themes that emerged to describe the enablers and barriers are:



Discussion

The themes emerged after data analysis are consistent with previously reported findings in the literature. Although the perceived barriers and enablers identified were not unexpected, it gave an in-depth insight into the transitioning period of newly qualified nurses along with perceptions of preceptors, ward managers and clinical educators who form the key support system for the young nurses. This study adds to the body of evidence showing a structured preceptorship is advantageous throughout the transition from student to practitioner, even though it did not raise any new problems.

A structured and timely area-specific approach would benefit the new nurses to gain confidence and to work come competently. There was a need for protected time from preceptees and preceptors to: work alongside their preceptors, to talk and share concerns and to complete the meetings and paper works.

This study also highlighted that there is inconsistencies with regards to the implementation of preceptorship programme even within the organisation or the same department. This indicates that thought the Trust has a preceptorship policy, there is lack of awareness and understanding of how the newly qualified nurses could be supported and how to effectively implement the preceptorship programme.

Recommendations

1) Revamp the implementation of preceptorship programme involving all the stakeholders.
2) Develop timely area-specific training programmes.
3) Include robust evaluation alongside the delivery of the preceptorship programme.
4) Raise the profile of preceptorship programme among the different staff groups (seniors nurses, matrons etc) which in turn will increase the value and visibility of preceptorship.

Limitations

The recommendations are based on the lead evaluator's comprehension of the participant responses and the existing literature. Due to lack of engagement from the staff groups, semi-structured interviews did not go ahead as planned. This led to inadequate in-depth exploration of experiences and clarifications of shared responses.

Conclusion

It is high time that nurse leaders and organisations invested in this future nursing workforce by creating and seeking supportive transition period. The strategic implementation of preceptorship programme should also include support and guidance for preceptors, ward mangers and clinical educators. Organisational commitment is essential for taking these recommendations forward.

References:
1) https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-principles-for-preceptorship-a5.pdf
2) Lafrance T. Exploring the intrinsic benefits of nursing preceptorship: A personal perspective. Nurse Educ Pract. 2018 Nov;33:1-3. doi: 10.1016/j.nepr.2018.08.018. Epub 2018 Sep 7. PMID: 30212739.
3) https://www.cdc.gov/policy/polaris/policyprocess/problem-identification/index.html
4) Braun V. and Clarke V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2). Pp 77-102. http://dx.doi.org/10.1191/1478088706qp063oa

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BRAIN Shared Decision Making Tool

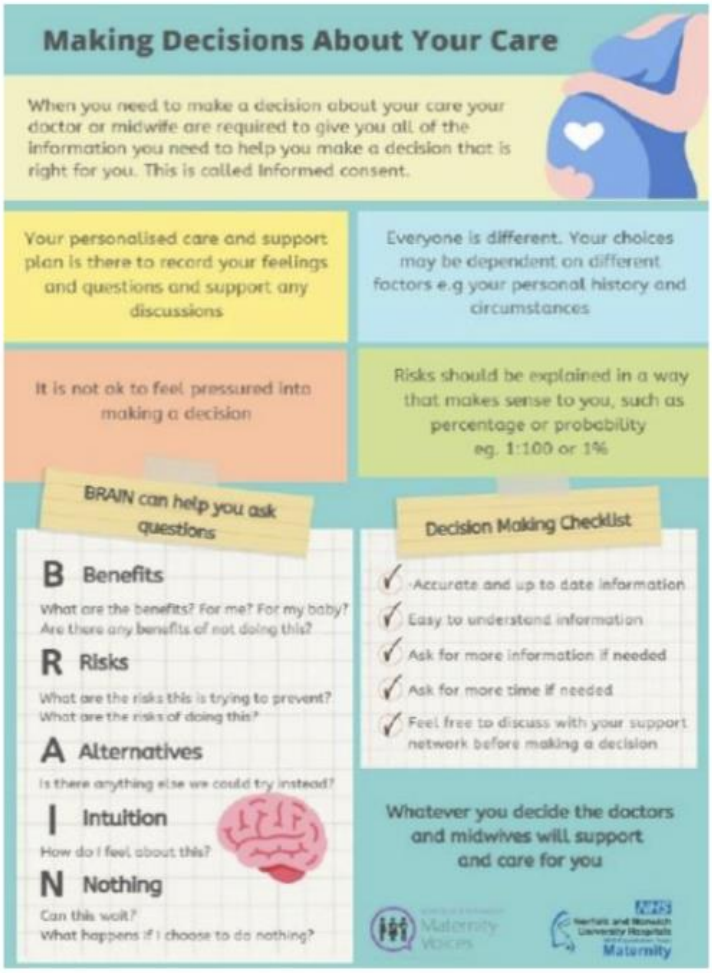
Lisa Mastrullo & Jenny Whatling
Co-Produced with the Maternity Voices Partnership

What were we trying to accomplish?

- We were looking at ways to encourage informed choice and shared decision making when maternity service users are required to make decisions about their care.

How did we know that our change was an improvement?

- Posters detailing the BRAIN Shared Decision Making Tool were distributed throughout maternity units and shared on social media, verbal feedback has been positive so far and formal audits will be completed to measure the impact and effectiveness.



What change did we make?

- BRAIN stands for Benefits, Risks, Alternatives, Intuition and Nothing. The tool helps patients to explore these areas further and provides a decision-making checklist to encourage them to ask the right questions and make sure they have accurate and up to date information. It also acts as a prompt for staff to support fully informed choice without bias.

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REFLEX THEATRE

The Project

Our project on dementia has aimed to create a suite of 17 videos, using the input of providers locally and case studies direct from services to develop bespoke training for our local region. The videos have been a collaborative effort across the system, with the ICS, Adult Social Care, Local VCSE Sector and local colleges and universities, bringing together the expertise across health and social care to promote best practice and share learning and knowledge.

The videos are all available online, with a link available for a self certification CPD certificate to note that the training has been completed. Many providers across the local region are now using these videos as part of their planned CPD training and staff inductions.

The filming took place with a local theatre company, Reflex Theatre, using locations and tools that are available to support the local community, bringing investment back to the adult care sector.

Outcome /Consulsion

The videos have also been shared nationwide, with buy in from the Care Association Alliance and other Care Forums who have advertised and encouraged the use of this resource. As well as this NHS England have added these videos to their futures page.

Bringing together interactive elements, with questions and case studies submitted ahead of time, as well as the convenience of online learning, the videos have seen how bespoke learning can encourage excellence across the system.

Norfolk Care Awards 2022

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

NHS The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

NHS Norfolk and Suffolk NHS Foundation Trust

UEA University of East Anglia

Alzheimer's Society

Norfolk Safeguarding Adults Board

east coast community healthcare

Feedback

"These are great!" "We are going to use them as part of our Dementia Pathway, to support their learning..."

"A great resource... fantastic that this is from the individual's perspective too

13 videos over 9,400 views to date

1.3k views

1.3k views

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Out of Hospital Cardiac Arrest Pathway

Led by; Claudine Inyang & Helen Moerdyk

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What were we trying to accomplish?

- The UK is seeing an increase in the number of survivors post cardiac arrest and it has been identified that there was no established pathway for this group of patients during their in-patient stay and post discharge. This patient group can be complex with hypoxic brain injury and cognitive impairment often a feature.
- Our aim was to create a pathway from ITU to post discharge intervention which was in alignment with the BCIS Position Statement (2022) and ERC Guidelines (2021).

How did we know that our change was an improvement?

- Attendance at educational conferences confirmed that NNUH were aligned to centres of excellence and are now part of a trial implementation national audit across 4 heart attack centres across the UK (Kings College Hospital Trust , Barts Health Trust , Mid and Essex Trust)

What change did we make?

- Patients are provided with an individualised patient care plan
- The Specialist Occupational Therapist assessment includes standardised assessment of cognition, fatigue, mood and functional assessments pre-discharge
- We created a patient information leaflet for patient and family
- Improved access to Clinical Psychologist is available if required
- From June 2023 (17 month pilot project) we will have planned follow-up clinics with further assessments available
- Access to Cardiac Rehab is now available for all
- We are setting up a Peer Support Group (start date tbc)

References

- Mion, M. et al., (2022) 'British Cardiovascular Intervention Society Consensus Position Statement on Out of Hospital Cardiac Arrest 2: Post Discharge Rehabilitation' ICR3-Interventional Cardiology Reviews

An Acute Frailty Unit with focused MDT input decreases inpatient length of stay for older persons presenting with frailty syndrome(s)

A Warner

James Paget University Hospitals NHS Foundation Trust

Introduction

Older persons experiencing frailty are at risk of prolonged hospital stay causing adverse outcomes including mental and physical deconditioning, infections and falls (1). Tackling length of stay by ensuring patients return to their usual place of residence promptly, improves patient's health and hospital flow (2)

An Acute frailty unit (AFU) consisting of 3 male, and 3 female beds was established on the older persons ward (OPW) providing treatment by dedicated allied health and medical professionals.

Method

Patients presenting to ED were assessed by the Early Intervention or Acute Frailty teams and were selected for admission to AFU unit if meeting specific criteria. Each patient received a comprehensive geriatric assessment, holistic physiotherapy assessment and rapid approach to discharge planning with the integrated discharge team. Data collected for patients attending AFU for March 2021, MDT cover provided Monday to Friday, 8am – 4pm. The remaining 32 beds on the OPW were covered by the existing older person's team.

Inclusion Criteria

- Rockwood of 5 – 6
- Presenting to A&E or EADU Monday – Friday 8am – 4pm
- Experiencing 1 or more frailty syndrome
- >65 years old
- PDD or 2 – 3 days

Results

Length of stay for Acute Frailty Unit vs Older persons unit

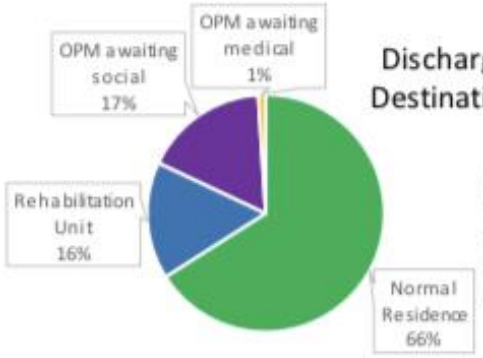
AFU had 38 patients over 6 beds, with an average **LOS of 3.6 days**. OPW had 47 patients over 32 beds, with an average LOS of 9 days.

Percentage of patients discharged within time limits of Acute Frailty Unit Vs Older Persons Unit

AFU: **45% of patients were discharged within 24 hours of admission,** increasing to 56% at 48 hours and 77% within 72 hours.

OPW: 15% of patients were discharged within 72 hours. 75% of patients returned to their normal residences.

Discharge Destination



66% patients discharged to their normal residence, 16% to a community rehabilitation unit prior to normal residence, 17% to the OPW due to delay in sourcing a care package and 1% required onwards medical attention.

Conclusion

The implementation of AFU was highly effective and significantly improved the length of stay of frail older persons, patient health, patient flow and reduced the cost of in-patient care. The obstacle preventing more discharges to normal residence is the lack of community care availability at point of requesting.

References

1. *NHS choices*. NHS. Available at: https://www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/ (Accessed: April 25, 2023).
2. *Same-day acute frailty services - NHS england* (no date). Available at: https://www.england.nhs.uk/wp-content/uploads/2021/02/SDEC_guide_frailty_May_2019_update.pdf (Accessed: April 25, 2023).

Acknowledgements:

Dr. J Wyllie, Early Intervention Team, Rene Gray, Ward 12 staff

Test of competence route to return nurses to the NMC register and into practice in an acute hospital

Norfolk and Norwich University Hospitals NHS Foundation Trust

Introduction

- Nurses who's NMC registration has lapsed are required to undertake a Return to Practice programme or take the Test of Competence (OSCE) to return to the register.
- Whilst most nurses undertake a 3-6 month university based programme to regain their registration, the Norfolk & Norwich Hospital offers an intensive 4 week in house OSCE preparation programme via an employment pathway.

Rationale

- The expertise and facilities to deliver a comprehensive and highly successful OSCE preparation programme was already in place for our international nurse recruits.
- The employment model ensures that we support nurses who wish to return to a RN role at the NNUH and that they receive an income whilst doing so.
- The pathway provides a staged approach to returning to the RN role, with the manager having a key role in facilitating a RN into their team.

The pathway

- Advertisement for the pathway occurs 3x per year (RTP enquiries are steered towards these adverts)
- Candidates are employed into a band 5 vacancy as a Health Care assistant for 2-3 months
- When ready, they are uplifted to a band 4 pre registration nurse and supported to prepare for their OSCE with NMC application and part 1 computer based test and preparation materials.
- They attend a full time 4 week OSCE preparation programme alongside our international nurses and other RTP nurses.
- They attend the OSCE and await PIN
- On receipt of PIN they are uplifted to a band 5 and commence preceptorship

Benefits and outcomes

- Clinical support is focussed on returning nurses to the role of a RN within their preferred area of work.
- HEE fund the cost of the OSCE
- Commencing as a HCA enables
  - A comprehensive induction and refreshment of basic essential care standards and Trust values.
  - Reacquaintance and settling into the acute hospital environment, pace and expectations.
  - Opportunity to observe RNs in practice.
  - Time to settle into the team and start to prepare for practice.
- A significantly quicker return to the register.
- Reduced cost to the Trust as release for supernumerary time to attend the programme is 4 weeks compared to up to 6 months.
- We currently have a 100% pass rate
- Our robust preceptorship programme facilitates a practice based return to the role in the work area.

"It's a really good way of returning to practice if you have the support of a good team behind you it really does make all the difference. My manager has been absolutely great!"
Laura RTP OSCE nurse 2022

Part time and flexible working opportunities encourages returners

Authors:
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Norfolk and Norwich University Hospitals NHS Foundation Trust.

Drinking Well at Our Age: partnership working between UEA and Age UK Norwich

Amy Zile[1], Florence Jimoh[1], Abbie Parish[2], Sam Gandy[2], Dan Skipper[2], Diane Bunn[3] & Lee Hooper[1]
[1]Norwich Medical School, UEA; [2]Age UK Norwich; [3]School of Health Sciences, UEA

UEA Hydrate Group research shows that one in every three older adults (aged 65+) living in the community is dehydrated due to insufficient fluid (drinks) intake (Parkinson 2023). Low-intake dehydration is strongly associated with mortality, multiple long-term health conditions, disability, pneumonia, and hospitalisation. Support to drink well could reduce low-intake dehydration, improving health and wellbeing.

'Drinking Well at Our Age' is a collaborative partnership between UEA Hydrate (expertise in research and developing resources to support hydration) and Age UK Norwich (running innovative Health Coaching programmes to support vulnerable older adults in Norwich and Norfolk). Age UK Norwich Coaches support older people to adopt healthier diets and increase exercise. We also aim to advise on drinking well. We are working together and with older adults to adapt and improve UEA Hydrate Group materials supporting drinking in long-term care (DrinKit: UEA Hydrate Group - Groups and Centres) for Age UK health coaches to use with older community-dwelling adults. We are also developing a training package to equip Health Coaches to support their clients to drink well. We will provide materials for Age UK's web-based community of practice and e-learning platform to disseminate across the 160 partner charities, allowing older adults, carers, family members and coaches to access the created materials.

This is a local system collaboration and partnership which we believe will lead to transformational system change for the benefit of older adults locally and nationally in raising awareness about low-intake dehydration and its consequences, and supporting drinking well for healthy ageing.

Co-creating materials with Health Coaches and older adults allowed appropriate, bespoke materials to be developed. These will support older adults to improve hydration and Health Coaches to maximize their support for older adults. The materials created will benefit older adults locally & nationally in raising awareness about dehydration & supporting drinking well

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Spinal Cord Injury (SCI) Transformation Programme

Led by Cherry Cubelo

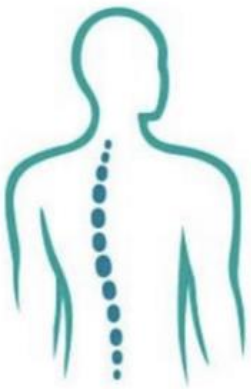
CQC Effective

CQC Caring

What were we trying to accomplish?

- We operate a hub-and-spoke model of tertiary spinal care for Queen Elizabeth Hospital Kings Lynn (QEH) and James Paget University Hospital (JPUH) meaning that once a patient's acute spinal care is completed they are either referred to Sheffield Spinal Cord Injury Centre or repatriated to QEH or JPUH. This project was initiated to strengthen the care provided while a patient is waiting for transfer and improve the follow-up care offered to the patient

How did we know that our change was an improvement?



- Six different change ideas were tested using Plan Do Study Act (PDSA) cycles. These included trialling a new tool to assess whether patients were ready to start rehab early, rolling out a teaching programme (including delivery at JPUH and QEH), and creating an SCI protocol button on EPMA to assist with prescribing.
- A measurement plan was created to monitor the impact of our change ideas. This included a feedback survey for the training, a patient survey completed at follow-up appointments and tracking the incidences of pressure ulcers.

What change did we make?

- All six of the change ideas have been successfully implemented, which means patients are starting rehabilitation earlier, staff are receiving training in how to care for SCI patients and spinal manual handling, and there is now more comprehensive information available to staff, patients and carers focusing on collar care.
- The Life QI platform was used to track and monitor the project, please follow the below link for more detail

References

- Life QI: General - Spinal Cord Injury (SCI) Transformation Programme - Projects - Life QI (lifeqisystem.com)

Healthcare Professional (HCP) Portal

This quality improvement project sought to improve the healthcare professional referral process, by providing a faster and more efficient access, for paramedics to get HCP advice from 111 service in Norfolk & Waveney and South Mid Essex.

This supports our purpose of providing responsive, safe, high-quality urgent health care at the right time, in the right place, supporting our patients to ensure they live their lives to the full.

Harry Brackley & Julie Woolf

NHS

IC24 INTEGRATED CARE

Define

Registered Healthcare Professionals (HCPs) can access NHS 111 on behalf of patients in their care to refer to another Health Care Professional without the need for an NHS Pathways assessment during out of hours.

This means the HCP is taking the clinical responsibility as they have assessed the patient. The scenarios when an HCP-to-HCP route may be required are:

- Paramedic calling from ambulance control requesting GP advice
- Paramedic on scene with the patient wanting to speak to a GP
- Paramedic assessed patient but not staying on scene and requesting a GP speaks to the patient

HCPs can select an option when calling 111 to bypass the standard patient line and access a call handler quicker. However, wait times and delays are increasing, in 2021 over 10 months, **39 incidents were raised in relation to delays.**

Measure

Waiting times for the HCP line were measured for October 2021

Region	Average Wait Time (October)	Range
South Mid Essex	**11 minutes**	3 to 21 minutes
Norfolk & Waveney	**15 minutes**	6 to 28 minutes

HCP calls are also short, with an average handling time of 280 seconds, compared to 600 seconds for a triaged call. Although they are short, the call sentiment (overall call tone) was much lower compared to standard patient calls – 1.27 vs 1.96

Analyse

It was calculated that eliminating HCP calls by using an alternative referral method would save the service **an equivalent of 2.6 WTE** call handlers.

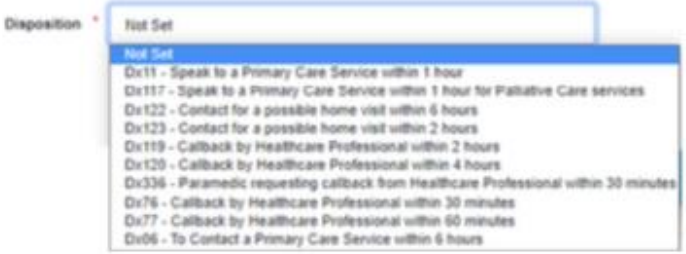
A pilot to create an HCP Portal, working collaboratively with East of England Ambulance Service was assessed. The pilot would allow Registered Paramedic HCPs to be given authorised access to the CLEO HCP Portal and make direct referrals without the need to phone 111.

This would save wait times and also allow Paramedics to add more detailed clinical notes to the referral.

Improve

A portal was developed that was available to Registered HCPs i.e. Registered nurse, Paramedics, or Ambulance Techs etc that have been authorised access by IC24. The referring HCP must ensure a clinical assessment has been completed prior to referring via the portal.

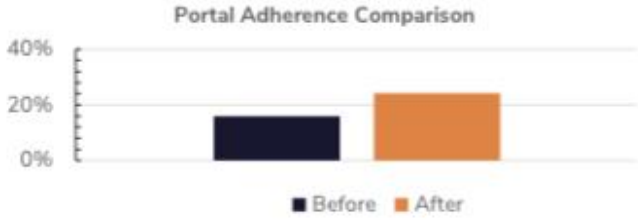
Below is part of the user guide which shows the user being able to select which disposition they believe the patient they are referring to should have.



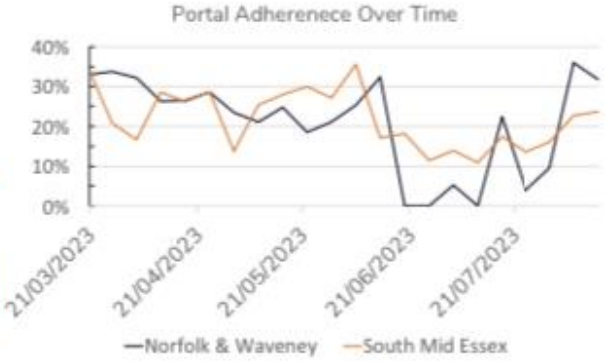
Control

A dashboard was produced to measure the adherence of the HCPs using the portal to make referrals. This showed average adherence by dividing HCP cases by calls. It is also able to monitor feedback and user activity.

After noticing low adherence, we made changes to improve accuracy. We excluded postcodes which our ambulance partners did not attend, as other providers/private ambulances attended who did not have access to the portal.



After our initial release, referrals via the portal temporarily dropped. Therefore more stakeholder engagement wil need to be completed to understand why paramedics may not be using it.



The positive impact of a virtual elective joint replacement pre-operative therapy clinic on carbon emissions

Stock, S., McGuire, S., Taylor, M. Gray, R.

James Paget University Hospitals NHS Foundation Trust

Background

As part of the Paget Enhanced Recovery Programme (PERP) for elective joint replacement surgery all patients attend a therapy clinical pre-operatively to improve outcome and length of stay[1]. Prior to Covid-19 this took place in person but we adapted to restrictions by developing a virtual appointment process. We wanted to identify the benefits this change has offered to our patients.

Method

We used The Centre for Sustainable Healthcare carbon calculator[2] to determine avoided carbon emissions since changing to virtual appointments. As part of the triple bottom line we also calculated the average miles saved and the cost of this to patents. We used a car fuel calculator[3] to determine the cost saving*. In March 2023 there were 76 patients attending virtual clinic and this was used to calculate and extrapolate over a 12 month period for a yearly average carbon emissions and fuel cost.

Results

Avoided carbon emissions (KgCO2e)	6.8 KgCO2e Per person	
	516.9 KgCO2e Per month	
	6, 202 KgCO2e Per year	
Mileage (miles)	23.2 miles Per person	£3.22*
	1, 761 miles Per month	£246.10*
	21, 132 miles Per year	**£2, 953***

Based on 76 patients per month

Discussion

This sustainability quality improvement project demonstrates how a change in our service delivery has resulted in significant avoided carbon emissions for the Trust and the environment and also provided a financial saving for our patients.

References

1. Takwale, E. Elective hip or knee replacement pathway: Good clinical and operational practice guidance post-covid transformation & recovery programme, *Get It Right First Time*. 2020 [Cited 6th June 2023] Available from https://getitrightfirsttime.co.uk/wp-content/uploads/2020/08/GIRFT-Hip-and-Knee-replacement-pathway-May-2020-003.pdf
2. https://networks.sustainablehealthcare.org.uk/resources/remote-consultations-do-they-reduce-greenhouse-gas-emissions-your-guide-calculating-0
3. https://www.fleetnews.co.uk/costs/fuel-cost-calculator/?FuelType=Unleaded&PencePerLitre=144.47&Mileage=21132&ManufacturerId=67&ModelGroupId=540&DerivativeId=14941&Mpg=47.10

Acknowledgements

Thank you to the JPUH QI team for support with this project.

Our Vision
The best care for every patient

CQC Well Led

Emergency Department (ED) Aftercare Project

Led by Laura Hall, Dr Nikki Wallace-King, Helen Attwell and Alice Cook

CQC Caring

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The Aftercare Project

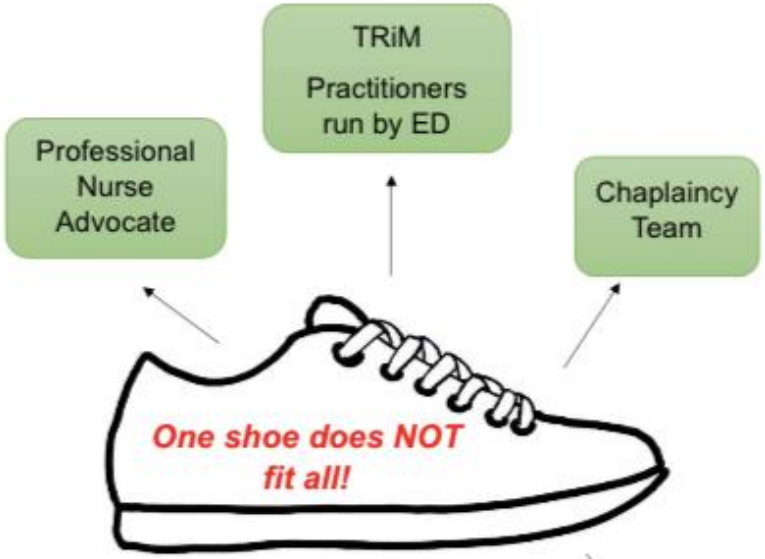
Is a standardised process to provide support to staff following a traumatic incident.

Research shows that staff involved in traumatic incidents can experience adverse effects.

A 'hot' debrief will occur after all traumatic incidents and then the aftercare process will begin.

A 'designated person' will offer support options following a traumatic incident within 72 hours.

Support Options Available with 72 hours of incident



Staff are responsible for accessing the support options themselves

Designated person responsibilities:

- ✓ Collate data from incident.
- ✓ Organise a reflective discussion if required.
- ✓ Undertake 'check-in' on staff and follow up one month post incident.
- ✓ Communicate any relevant information to the team e.g. post-mortem results.
- ✓ Close case after 6 weeks.
- ✓ Direct staff to services for ongoing support.

T.A.K.E
S.T.O.C.K
HOT DEBRIEF TOOL

Does this event meet the criteria for a hot debrief?
Unexpected death ○ Paediatric Standby ○ Distressing event ○
Staff request ○ Unexpected Outcome ○

Take an instruction sheet
Ask "Is everyone OK?"
Know if anyone needs a break
Equipment issues?

Summarise the event
Things that went well
Opportunities to learn
Cold debrief necessary?
Know who is present

"People can be viewed as having a bank account of courage and determination; this is not limitless and once the account is empty, psychological breakdown may be imminent,"

(Lord Moran WW1 Veteran)

We need to appropriately support ED staff in their role. The goal is to ensure that psychological support becomes the norm and not the exception.

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Maternity Ward Visiting Times

Led by Kat Greaves, Gayle Richards and Pip Noble

CQC Safe

CQC Caring

What were we trying to accomplish?

- Our aim was to review and update our visiting hours and ward conditions to ensure that we provide the best support for our new parents, their birthing partners and other visitors as well as enabling our staff to conduct clinical observations and procedures in a suitable environment.

VISITING GUIDE

NHS Norfolk and Norwich University Hospitals Maternity

We are here to provide you with the best possible care for your family. We aim to do this in a polite and courteous way and believe that our users have a right to be heard, understood and respected. But this relationship works both ways. Failure to adhere to these visiting recommendations will result in you being asked to leave the ward. Whilst it is understandable that people sometimes behave out of character in times of high emotion, **we take a zero tolerance approach towards physical and verbal abuse.**

One birth supporter can remain on the ward to support overnight. Adult and sibling visiting between 3pm and 6pm. NO OTHER CHILDREN PERMITTED ON THE WARD.

Ward quiet time is between 1pm and 3pm - No supporters or visitors on the ward during this time.

PROTECT

- ✓ Wash your hands regularly.
- ✓ Do not touch any equipment or clinical items.
- ✓ Supporters and visitors must not sit on the bed. Chairs are available.
- ✓ Ask for assistance, but please be patient with staff.

SAFETY

- ✓ Keep floor space clear of belongings. Storage available in the bedside cabinet.
- ✓ In an emergency, stay calm and call for help.
- ✓ Ensure your baby is in the cot if you feel tired.
- ✓ Do not distract staff during clinical tasks.

RESPECT

- ✓ Noise should be kept to a minimum.
- ✓ Respect the privacy and dignity of others.
- ✓ Silence devices or use headphones please.
- ✓ Remain fully clothed at all times including shoes and shirts.
- ✓ If you leave the ward after 9.30pm entry will not be permitted until 7.30am unless visiting baby on NICU.

REFRESH

- ✓ Use the visitors' toilets only. Showers are for patient use only.
- ✓ We cannot provide food to visitors.
- ✓ A hot drinks station can be located on the ward. Please help yourselves. This is out of action during open visiting times. Hot drinks should be contained within a lidded cup (please bring your own lidded cup).

How did we know that our change was an improvement?

- Prior to making the change we asked all staff on the department about the good and the challenges of both the current 24 hour visiting for birthing partners and also the general visiting times.
- Staff were asked to provide suggestions for the future.
- This will be followed up once the changes are in place.

What change did we make?

- New visiting hours are in place. Birthing partners are now able to visit across 22 hours, allowing for quiet time between 1-3pm each day. This ensures women have time to rest, and also allows for other clinical interventions that are best in a quiet environment such as difficult hearing screens or confidential conversations.
- General visiting has moved from 2-5pm instead to 3-6pm to reflect standard school and work times.
- A new visitors poster is available that explains the guidelines in clear language.
- Another important change is that birthing partners can stay overnight and leave at any time, however they cannot re-enter the ward between 9:30pm and 7:30am as this will help staff to concentrate on their patients rather than answering the doorbell.

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Paediatric Mental Health, Learning Disability and Autism
Sensory and Self Soothe Project
Led by Kieron Loane & Fiona Springall

CQC Responsive

CQC Caring

What were we trying to accomplish?

- Research suggests experiences of trauma reduces a child's ability to regulate emotional experiences and manage physical arousal when in a mental health crisis. Therefore, we were looking at ways to provide distraction, grounding, emotional regulation and sensory engagement activities.
- Research for children with a learning disability and/or Autistic children identifies they often require reasonable adjustments to support them to undergo to clinical interventions. These packs aim to provide an intervention that offers appropriate distraction and supports the child's sensory needs to better enable them to accept and receive access to treatment.
- We hope to provide a better experience to children when attending hospital, that helps to build a trusting, positive experience with a view to enhancing their engagement with services in the future.

How did we know that our change was an improvement?

Did the pack help you? Yes = 100%

How much would you recommend the pack to another child? Avg Score 4.85 out of 5

My daughter was brought in or self-harm and suicidal thoughts, this was so kind and helpful, such a lovely thing to do

Because it helped me deal my fear out on something that wouldn't get damaged

Allowed them to focus their mind on something else, relax and co-operate with treatments also to build trust

What change did we make?

- There is now a trolley available for ChED staff to offer sensory and self-soothe packs which contain 3 items of the child's choice.

Orthopaedic Out Of Bed Project (OOBP): Improving early mobilisation following femoral fracture using a therapy-led education programme

Rene Gray MSc MCSP, Melissa Taylor MSc MRCOT, Ryan Bullock BSc MSCP

NHS
James Paget University Hospitals
NHS Foundation Trust

OOBP
OUT OF BED PROJECT

Introduction

Delayed mobilisation following hip fracture surgery is detrimental to patients and health systems with prolonged hospital stay [1], decreased function [2], and increased mortality [3-6] the consequence. There are established national guidelines that promote early mobilisation (day one post-operatively) in order to improve survival rate and reduce the negative sequelae of prolonged bed rest [7-8]. The Physiotherapy Hip Fracture Sprint Audit (PHFSA) audit [9] found significant variation in performance in relation to mobilisation out of bed by the day after surgery. Our Trust was underperforming on this metric between the years of 2017 to 2020 and as a Trust we were also an outlier for 30-day mortality [10].

Patients not assessed by a physiotherapist were three times less likely to mobilise than those who were assessed Day 1 [11] and day one mobilisation is often seen as the sole responsibility of the physiotherapist [12]. This potential lack of wider MDT engagement can negatively impact on early mobilisation in the absence of the physiotherapist [11] and our own Hip Sprint re-audit in 2019 found that in the absence of a physiotherapy assessment only one patient (1.7%) was mobilised by Day 1 post-surgery [13].

Training and collective action to engage the wider MDT in early mobilisation has been identified as a way to help overcome some perceived medical barriers that prevented nurses from considering early mobilisation [12] and having direct supervision by an experienced orthopaedic therapist versus a more distant supervision programme increased the likelihood patients were mobilised by day 1 post hip fracture surgery [14].

This service improvement project aimed to develop and deliver a therapy-led training and education programme to the trauma ward healthcare assistants (HCAs). The purpose of the project was to improve the percentage of patients mobilised out of bed by the day after femoral fracture surgery from 60% to at least the national average for the UK, which is currently 81% [10]. We theorised that this project would provide other staff with the ability to support achievement of this metric. Furthermore, we hypothesised that common barriers to getting out of bed, such as postural hypotension and pain [17], could be identified and addressed prior to physiotherapy assessment. This approach would then offer two opportunities to mobilise by the day after surgery and could potentially allow therapists more time to engage in other rehabilitation activities such as acute rehabilitation in the first week after surgery [9].

Method

Primary outcome measure - percentage of patients mobilised by the day after surgery:

- National Hip Fracture Database (NHFD) data collected between 2019 and 2022
- Hip Sprint audit data collected in 2019 and 2022

Secondary outcome measure - percentage of patients mobilised by HCAs prior to physiotherapy assessment:

- Hip Sprint audit data collected in 2019 and 2022
- Baseline data collected retrospectively from hip sprint audit in 2019
- Data collected prospectively from hip sprint audit in 2022

Comprehensive training resource delivered by the orthopaedic therapy team on the ward:

- 2:1 teaching structure
- Theoretical and practical components
- Guidance to improve consistency of patient care for the metric of early mobilisation by the day after surgery

Two Plan-Do-Study-Act (PDSA) cycles were completed in 2020 and 2022.

Results

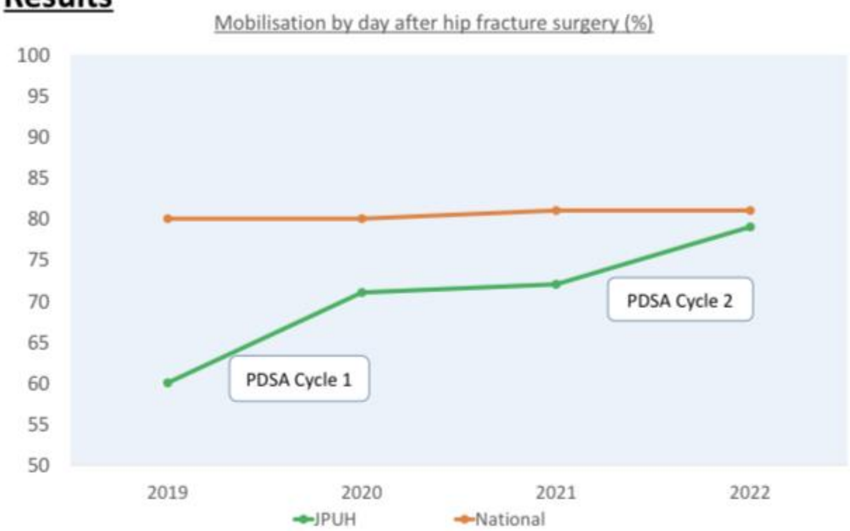

Figure 1 Comparison of the number of patients mobilised at the JPUH and the whole UK by the day after femoral fracture surgery using the National Hip Fracture Database (%)

Table 1 Comparison between baseline (2019) and post-intervention (2022) patient cohorts

	September and December 2019*	September and October† 2022*
Patient demographics		
Number of patients	60	51
American Society of Anaesthesiologists (ASA) 1-3 (%)	72	75
From own home (%)	74	81
Hours to operation (%)	30.4	29
Female (%)	72	72
Less than 80 years old (%)	21	18
Age (years)	83 (60-98)	83 (60-94)
Assessments completed		
Orthogeriatrician assessment (%)	97	100
Delirium assessment (%)	95	100
Physiotherapy Assessment (%)	82	100
Outcome		
HCA mobilisation prior to physiotherapy (%)	**1.7**	**30**

** Patients 60 years old and above receiving surgical fixation for femoral fracture*
†Unable to complete full month due to covid-19 outbreak and ward closure

Discussion

Therapy team research and innovation can have a positive impact on national hip fracture metrics.

It is important to invest time in MDT collaborative working & stakeholder engagement.

For others seeking to replicate this project it will be important to consider potential barriers and facilitators to success including organisational support, working relationships within the MDT, perception of therapies role within a speciality and ward, and the support for research and innovation within the organisation.

A limitation to this project is the use of both retrospective and prospective data collection.

Implementation outcomes were not formally measured, therefore further work is needed to understand the underlying mechanisms of success.

Conclusion

The success of this project provides evidence of the current embedded researcher pilot within integrated therapies department at JPUH [18, 19] and how this can improve patient outcomes. The positive and proven reproducibility of this work over two PDSA cycles supports future replication of the project across other organisations.

Next steps

A UEA NICHE funded collaboration with Queen Elizabeth Hospital (QEHKL) will seek to investigate reproducibility of the project and measure implementation as well as clinical and service outcomes.

The aim will be to identify implementation facilitators and barriers to expand and embed this service improvement project on a larger scale.

References

[illegible]

Acknowledgements

To the orthopaedic therapy team, healthcare assistants and the wider orthopaedic team and division for the support in developing this project and achieving the improvements seen. To Claire Whitehouse for her invaluable feedback as a critical friend. Funding to complete the paper for publication was provided by the University of East Anglia HSCP scholarship. Publication in the BMJ Open was funded by The Health Foundation.

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Piloting a novel Carer Support Nurse role

Morag Farquhar (University of East Anglia: UEA), Carole Gardener (UEA), Alison Leary (London South Bank University), Roberta Lovick (PI), Adam P Wagner (UEA), Jennifer Lynch (University of Hertfordshire), Guy Peryer (UEA), Susanne Lindqvist (UEA)

Background

- Unpaid/family carers play a crucial role but need support to both look after their own health/wellbeing & boost their skills/ confidence to care. Healthcare policy mandates this[1], however clinicians rarely achieve it while also supporting the patient

Carer Support Nurse role

- Novel award-winning[2] 'Carer Support Nurse' role (CSN)[3] developed with carers & cross-sector professionals, hosted by East Coast Community Healthcare (ECCH)
- Helps carers with complex health/wellbeing needs & promotes best practice in carer support among other healthcare providers

Aim

- To pilot & evaluate the CSN in ECCH's Gt Yarmouth & Northern Villages Primary Care Home Team

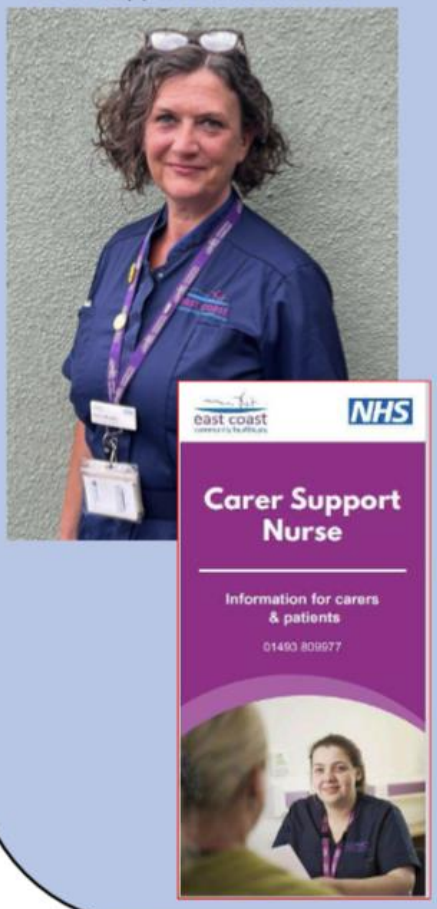
Methods

Stage 1
- Identified existing local/regional/national resources to support carers
- Developed the operational model for the CSN role

Stage 2
- Commenced once the CSN was appointed
- Ongoing data collection/analysis exploring role activity, & the experiences/views of carers

Stage 3
- Will develop recommendations for whether/how the role could roll out

Karen Murphy:
Carer Support Nurse at ECCH



Results

- The Carer Support Nurse role is endorsed by 70+ East of England cross-sector stakeholders, 100+ carers & patients (Patient & Public Involvement work), & regional/national cross-sector leads in carer support
- The level & universality of enthusiasm among these stakeholders has been remarkable, with lack of provision for carers' health-related needs being a repeated key message

Conclusions

- Stage 1 produced a carer asset map & operational model for the CSN role
- Stage 2 data collection ongoing, but interim findings (carer views) overwhelmingly positive

Award-winning

Regional winner – NHS Parliamentary Awards 2023 Nursing & Midwifery

Shortlisted – RCNi Awards 2023 Finals in November

References:

1)https://www.longtermplan.nhs.uk/online-version/
2)Farquhar M et al. Is it time to create a new nurse role dedicated to helping carers? *Nurs Times* 2017;113(9):39-41
3)https://nhsparliamentaryawards.co.uk/shortlist/

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University of East Anglia

HEALTH & SOCIAL CARE PARTNERS

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Interprofessional Student Schwartz Rounds: Students' experience and perceived benefits for well-being and reflective practice

Amy Zile, Dr Georgia Panagiotaki, Joel Owen, Julia Hannewald, Dr Harriet Cooper
Norwich Medical School, UEA

Background. Schwartz Rounds are a structured forum in which health professionals reflect on the emotional aspects of their clinical work. In healthcare settings, Rounds have been shown to:

- Improve staff wellbeing and morale[1]
- Promote interprofessional working[2]
- Decrease feelings of stress and isolation[3]
- Foster positive compassionate care[1]

Aim. This project will evaluate UEA's Interprofessional Schwartz Rounds in Higher Education for healthcare trainees. It will help us understand whether (and how) the benefits of Rounds reported in the literature translate to an educational setting. The potential of Schwartz Rounds to influence the development of professional resilience, compassion for self and others, and the possibility for Rounds to contribute positively towards student well-being and retention will be explored.

Method. Five UEA Interprofessional Student Schwartz Rounds will be evaluated in 23/24. Rounds are optional events and open to all health and social care students in UEA's medical, nursing, pharmacy, social work, clinical psych and psych therapies courses.

1. Evaluation survey
Using a standardised evaluation form we will gather information about attendee demographics, and their perspective on the usefulness and effectiveness of the Rounds for their reflective practice

2. Individual interviews
Individual, semi-structured interviews (n= 25) will further explore students' experience of attending Rounds, perceived benefits of taking part, and whether student experience varies across programme/year of study and Round theme

1. Maben J, Taylor C, Dawson J, Leamy M, McCarthy I, Reynolds E, Ross S, Shuldham C, Bennett L, Foot C. A realist informed mixed-methods evaluation of Schwartz Center Rounds® in England. Southampton (UK): NIHR Journals Library; 2018 Nov.
2. Robert G, Philippou J, Leamy M, Reynolds E, Ross S, Bennett L, Taylor C, Shuldham C, Maben J. Exploring the adoption of Schwartz Center Rounds as an organisational innovation to improve staff well-being in England, 2009-2015. BMJ Open. 2017 Jan 5;7(1)
3. Clancy D, Mitchell A, Smart C. A qualitative exploration of the experiences of students attending interprofessional Schwartz Rounds in a University context. J Interprof Care. 2020 May-Jun;34(3):287-296.

The Point of Care Foundation | NICHE Anchor Institute | Centre for Interprofessional Practice | UEA University of East Anglia

Preceptees
Norfolk & Norwich Hospital

HCSWs
East Coast Community Health

AHPs
Queen Elizabeth Hospital

Legacy Mentors
Championing workforce retention!

Preceptees
Queen Elizabeth Hospital

Preceptees
Norfolk Community Health & Care

International Nurses
James Paget Hospital

Newly Qualified staff
Norfolk and Suffolk FT

Midwives
Norfolk & Norwich Hospital

Norfolk and Norwich University Hospitals Trust Clinical Biochemistry: Advances in Drug Detection

Michelle Frost, Dr Nicholas McArdle, Paul Brookes and Dr Emily Leach

Department of Clinical Biochemistry Norfolk and Norwich University Hospital NHS Trust.

Abstract: The Analytical Specialist Chemistry (ASC) section in the Clinical Biochemistry department of the Norfolk and Norwich Hospital (NNUH) has been providing a drugs of abuse analysis service across the East of England for over 30 years. Until last year this was based on a mixture of established analytical techniques, such as immunoassay, gas chromatography, and thin layer chromatography. However, the service offered to Norfolk, and the wider rural and coastal regions of East of England, was demonstrably improved with the introduction of a quadrupole time of flight (Q-ToF) instrument. This analyser has moved the service from being able to identify approximately 100 toxicology compounds and metabolites in urine samples to more than 2000, and has enabled a considerable improvement in the service provided to rehabilitation, post-mortem, and clinical service users. From this improved analytical capability, the Anti-Spiking project was born. Late 2021, a member of the ASC section envisaged and developed the Anti-Spiking Campaign, with the analytical component based on the aforementioned Q-ToF, rolling out a pilot scheme in Norwich, and then moving to a full campaign covering the rest of Norfolk in early 2022. This scheme is aimed at members of the public who suspect they may have had either had their drinks spiked with unconsented drugs, such as cocaine or amfetamines, or have been physically spiked with compounds via a hypodermic needle type device. This has given the public direct access to a laboratory based toxicology screen that is normally only available at specialist forensic toxicology centres via collection kits in bars, clubs, festivals, and emergency GP practices.

Introduction

The analysis of urine for the detection of drugs of abuse and prescription compounds has been performed at the Norfolk and Norwich University Hospital (NNUH) since the 1980s, in the Toxicology section of the Biochemistry department and covering assays/analysis such as:

- Urine toxicology screens,
- NPS/legal high screening
- Therapeutic drug detection
- Ethanol monitoring (along with biochemical markers of long term ethanol abuse).

For > 15 years the Toxicology section has performed the toxicology workload for the Norfolk rehabilitation services, Coronial services and NHS Trusts across the UK. Since its inception, the Toxicology section has a track record for developing and innovating and developing tests/methods to detect new compounds as they become available on the street.

This advancement in the methods for the toxicology analysis at the NNUH is presented in **Figure 1**.

Quadrupole Time-of-Flight Mass Spectrometry

Quadrupole time-of-flight mass spectrometry (Q-ToF-MS) offers both high sensitivity and specificity in drug-detection and is an established technique across the fields of pharmaceutical and biological research, including metabolite analysis and drug discovery. The method offers comprehensive drug screening to the field of toxicology

- Substances present in a sample are separated at the molecular level, using a technique called liquid chromatography.
- The separated molecules of each substance enter the Q-ToF-MS, where they become electrically-charged.
- These then enter the 'flight chamber', a vacuum tube with an electrical field applied across it, where they are separated further on the basis of their mass and charge.
- As if on a racetrack, the smallest, lightest components reach the 'finish line' first (i.e. the mass detector).

Using this technology, we can robustly identify in excess of 2000 substances.

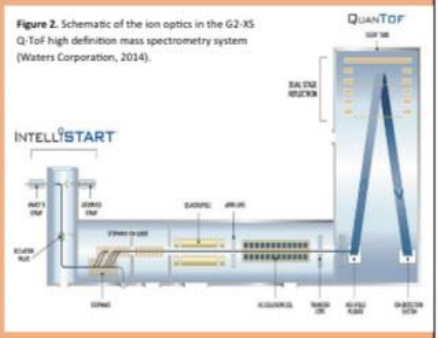

Figure 2. Schematic of the ion optics in the G2-XS Q-ToF high definition mass spectrometry system (Waters Corporation, 2014).

History of drug detection methods

Figure 1.

Clinical improvement for Norfolk and Waveney

The introduction of a Q-ToF-MS toxicology screen has enabled the population of Norfolk and Waveney access to a 'gold standard' toxicology service. This standard of service is found in fewer than 10 NHS laboratories in the UK and the closest to this region are in Birmingham and London. The high sensitivity and large number of drugs in the screen has helped patients who have ingested unknown substances, overdosed and unable to confirm the drugs taken, and assisted in the investigation of both adult and child deaths. By having the service at the NNUH site, it has resulted in faster turnaround of results to the region's population. We have also been able to help patients who are in drug recovery. The analysis by Q-ToF is both more efficient in staff time and more accurate than the previous methods demonstrated in Figure 1. Q-ToF-MS toxicology analysis does however require an advanced knowledge of analytical and toxicology skills, and having this type of expertise at the NNUH means that the development of patient and community care strategies based on these skills sets are always evolving. A very good example of this is the UK leading campaign to assist in the combatting of the spiking of drugs with drugs for nefarious reasons. The NNUH lead campaign has been highlighted by the House of Commons Select Committee in to spiking as an example to the UK on how the NHS and partners should help combat this crime.

We are part of the

Anti-Spiking Campaign

antispikingcampaign@nnuh.nhs.uk

Working together to help keep you safe

Anti-Spiking Campaign—Social Awareness Project

In December 2021, Eastern Pathology Alliance (EPA) launched a pilot Anti-Spiking Campaign in Norwich city centre. Working with clubs and bars in the city, the initial aim of the project was to keep party-goers safe from 'spiking' over the Festive period and beyond. Due to the success of the pilot, we gained funding by the Norfolk Police and Crime Commissioners, and as such, this has enabled us to extend the project to include other areas across the EPA region.

Spiking is the surreptitious addition of drugs or alcohol to a person's drink, and has become more prevalent nationwide, with a number of incidents being reported in Norfolk. In addition, there has been a spate of incidents where individuals have been spiked by direct injection into their person. To try and help combat this alarming social issue, the Toxicology laboratory (part of the Analytical and Specialist Chemistry section of EPA) has joined forces with Norfolk Constabulary, the Norwich SOS Bus, selected clubs and bars, and the UEA to offer anti-spiking sample collection kits. Anyone who thinks that they (or a friend) may have been spiked can ask the bar staff or the SOS Bus staff for a free sample collection kit to provide a urine sample, and/or a sample of their drink, which is then submitted to our lab for analysis.

Using Q-ToF enables us to identify a wide variety of different substances. Using laboratory testing removes the pitfalls of toxicology point-of-care drug testing devices ('dipstick' urine tests), while still offering a relatively fast turnaround of results to the affected individuals.

Samples are submitted anonymously, and tested for substances connected with spiking, with results offered (if desired) via encrypted barcodes linked to the sample.

By reducing many of the previous reporting barriers, the initiative has also been gathering important data on how prevalent the problem actually is, what spiking agents are in use, and supporting emergency and urgent healthcare workers to treat and support people more effectively who fear they may have been affected by a spiking incident.

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