

Joint Working with the
Pharmaceutical Industry
Guide and Case Studies

NHS England North Foreword

“Our ambition is to enable an open, transparent, participative and inclusive NHS that delivers high quality care to every patient, every time”

(Putting Patients First: The NHS Business Plan for 2013/14 – 2015/16)

Working in partnership represents a fundamental shift in the relationship between the pharmaceutical industry and the NHS, moving away from the traditional sponsorship model, and towards Joint Working in a way which is both fair and mutually beneficial, with the shared aim of achieving pre-determined improvements for patients.

The pharmaceutical industry, apart from supplying medicines that improve patients' lives, can contribute expertise arising from its extensive knowledge of the therapy areas relevant to its medicines. It can also share its experience in business and financial management.

The Department of Health, the NHS and ABPI developed a support package for both the NHS and industry on successful Joint Working, which includes a number of recommendations looking at strengthening the relationship between the NHS, ABPI and the pharmaceutical industry.

This booklet aims to highlight that Joint Working can help the NHS to provide high quality care. It details a framework and shows examples that have achieved measurable improvement in outcomes for the health of the local population.

We hope that these will inspire you to identify areas where Joint Working could be beneficial within your locality.



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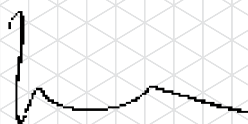
ABPI Foreword

The NHS and the pharmaceutical industry share a common goal in improving patient outcomes and this has been the foundation of several dozen successful Joint Working projects in recent years. The potential of such projects to deliver improvements that benefit patients has been proven time and again in a range of services and therapy areas – as this booklet shows. It is our shared ambition to see many more Joint Working projects that will support innovation and high quality patient care.

I hope that the case studies in this booklet will inspire you to look for opportunities to set up new Joint Working projects between the NHS and the pharmaceutical industry that will bring innovative ways of working, benefit patients and make services more efficient and effective.

Where there are challenges to setting up Joint Working projects, support is available. This booklet outlines the seven steps to setting up a joint working project and the ABPI's *Joint Working, A Quick Start Reference Guide for NHS and Pharmaceutical Industry Partners* provides further guidance and resources. The ABPI is committed to supporting Joint Working and also has a regional team dedicated to helping industry and the NHS to work together.

As these case studies show, your idea for improving services can be made reality, by working together with common purpose and remembering always that our priority is to deliver better patient outcomes.



Stephen Whitehead
Chief Executive, ABPI

Joint Working Framework

Introduction

Joint Working describes situations where the NHS and pharmaceutical companies pool skills, experience and/or resources for the benefit of patients and share a commitment to successful delivery. Many such projects have been successfully implemented, across a range of health economies and disease areas.

However, feedback from some partners found that Joint Working can be difficult to initiate due to the number of parties involved and the lack of clear shared objectives. To facilitate this, the Department of Health and the ABPI worked together with key stakeholders to develop a guide. This was produced in 2009 and will be updated shortly to reflect the new NHS architecture.

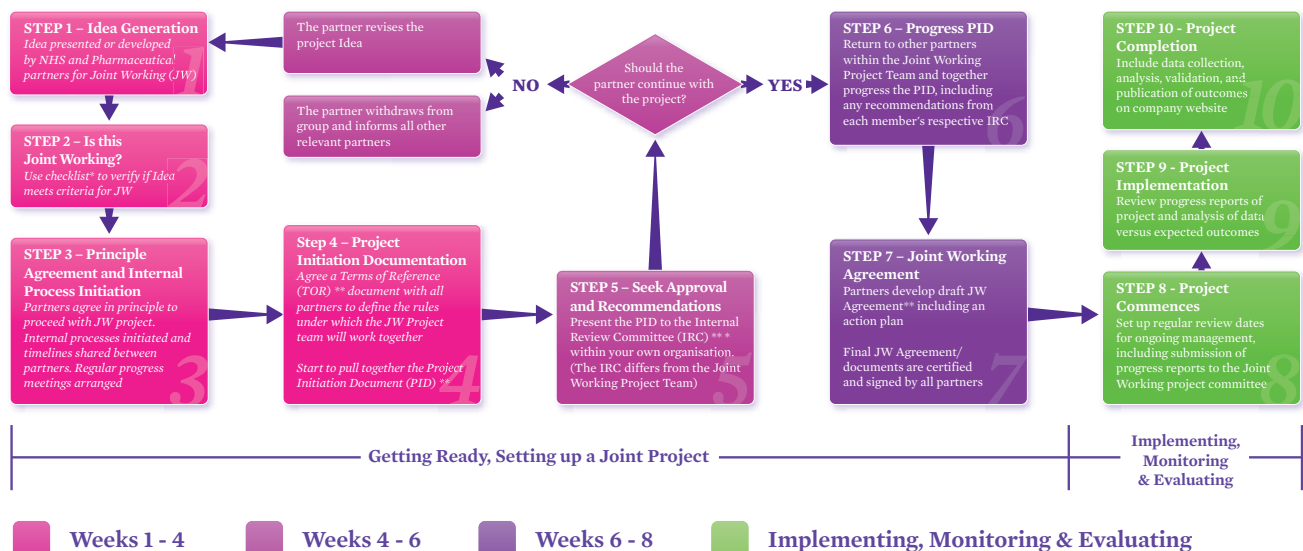
In 2012, ABPI produced a Joint Working booklet called 'A Quick Start Reference Guide for NHS and Pharmaceutical Industry Partners'. This details a coherent and user friendly '7 Steps' approach which should be considered when embarking on any Joint Working projects between the NHS and pharmaceutical companies.

These '7 Steps' are detailed in the flowchart below which outlines the systematic approach, from the initial concept right through to the projects' commencement. It also outlines a Joint Working criteria checklist of questions that should be used throughout the working process.

7 Steps to Joint Working

The flowchart describes the standard steps suggested to start a Joint Working project, and is applicable to both single and multi-company projects.

Any obligatory internal processes should be completed in tandem.



* refer to the JW checklist in this guide
 ** the template can be found in the JW Toolkit (refer to recommended reading)
 *** a description of the IRC can be found in this guide at Step 3

Step 2 - Joint Working Criteria

All potential parties should review this checklist and satisfy themselves that each criterion would be met under the project. The parties should also establish that their respective organisations have the required structures in place to enable successful delivery in line with Clause 18.5 of the ABPI Code of Practice for the Pharmaceutical Industry. If the answer to any of Red Questions is **No**, the project is not a true Joint Working (JW) arrangement and should not be viewed as such. Appropriate steps to address the outstanding areas should be taken before proceeding further under the heading of JW.

Red Questions	Yes	No
1 The main benefit of the project is focused on the patient	<input type="checkbox"/>	<input type="checkbox"/>
2 All parties acknowledge the arrangements may also benefit the NHS and pharmaceutical partners involved	<input type="checkbox"/>	<input type="checkbox"/>
3 Any subsequent benefits are at an organisational level and not specific to any individual	<input type="checkbox"/>	<input type="checkbox"/>
4 There is a significant contribution of pooled resources (taking into account people, finance, equipment & time) from each of the parties involved	<input type="checkbox"/>	<input type="checkbox"/>
5 There is a shared commitment to joint development, implementation and successful delivery of a patient-centred project by all parties involved	<input type="checkbox"/>	<input type="checkbox"/>
6 Patient outcomes of the project will be measured and documented	<input type="checkbox"/>	<input type="checkbox"/>
7 All partners are committed to publishing an executive summary of the Joint Working Agreement	<input type="checkbox"/>	<input type="checkbox"/>
8 All proposed treatments involved are in line with national guidance where such exists	<input type="checkbox"/>	<input type="checkbox"/>
9 All activities are to be conducted in an open and transparent manner	<input type="checkbox"/>	<input type="checkbox"/>
10 Exit strategy and any contingency arrangements have been agreed	<input type="checkbox"/>	<input type="checkbox"/>

A negative response to the Amber Questions signals potential issues that may arise. These should be

addressed as soon as possible to ensure successful and timely project delivery.

Amber Questions	Yes	No
11 Will the project be managed by a joint project team with pharmaceutical industry, NHS and any appropriate third party representation?	<input type="checkbox"/>	<input type="checkbox"/>
12 Do all parties and their respective organisations have appropriate skills and capabilities in place to manage the project thus enabling delivery of patient outcomes?	<input type="checkbox"/>	<input type="checkbox"/>
13 Have all partner organisations got clear procedures in place for reviewing and approving Joint Working projects?	<input type="checkbox"/>	<input type="checkbox"/>
14 Are all parties aware of and committed to using the Joint Working Agreement Template (or equivalent) developed by the DH and ABPI?	<input type="checkbox"/>	<input type="checkbox"/>
15 Are all partners clear on who within their organisations is the signatory to ensure Joint Working agreements can be certified?	<input type="checkbox"/>	<input type="checkbox"/>

If all the answers are 'yes' you should proceed with internal compliance discussions. Pharmaceutical partners must

verify that the project complies with the ABPI Code of Practice.

Joint Working Examples

The following pages give examples of Joint Working case studies. For further information, please refer to the contact details at the end of the booklet.

Acute Coronary Syndrome

- AstraZeneca: OneHeart – A Personalised ACS Patient Support Programme with Bristol Heart Institute

Asthma

- AstraZeneca: Improving Asthma Care in Partnership with NHS East Surrey CCG

Chronic Obstructive Pulmonary Disease (COPD)

- AstraZeneca: Improving COPD Disease Management in Partnership with Wirral CCG
- AstraZeneca: Improving COPD Services in East Surrey
- GlaxoSmithKline: LloydsPharmacy Ltd and Hull PCT – Improving COPD Care
- GlaxoSmithKline: Wearside PBC Group – Improving COPD Care
- GlaxoSmithKline: Walthamstow West PBC Group – Improving COPD Care

Epistaxis

- Baxter: Management of Epistaxis – A New Paradigm

HIV

- Bristol-Myers Squibb: Dean Street at Home – Postal HIV Testing in Collaboration with Chelsea and Westminster Hospital Foundation Trust

Parkinson's

- Lundbeck: Integrating the Parkinson's Care Pathway in Sunderland

AstraZeneca: OneHeart - A Personalised ACS Patient Support Programme with Bristol Heart Institute

Acute Coronary Syndrome (ACS) comprises a set of life-threatening health conditions affecting the heart. In a 12-month period in 2009-10, there were 150,802 hospitalisations due to ACS in the UK (65% due to heart attacks and 35% to chest pain)¹ Managing and treating ACS represent a significant direct cost to the UK healthcare system and, if not treated quickly and adequately, can lead to death. In fact, ACS is one of the top five causes of death in the UK, after different forms of cancer and stroke.¹

Nearly fifteen per cent of patients (14.8%) still die within one year of their first ACS event and 39.2% within four years². Patient non-compliance to therapies and rehabilitation services is thought to play a significant role in these outcomes. Nearly half (46%) of patients prescribed oral antiplatelet (OAP) therapy to help manage their condition stop using it within 12 months and they are more than likely to experience death or a non-fatal heart attack as a result³.

Additionally, although on the increase, still only 44% of eligible heart patients take up on the opportunity to

participate in cardiac rehabilitation⁴.

Through the development of an innovative personalised patient support programme – called OneHeart – that works to address individual patient beliefs causing non-adherence, the project is starting to see successes. The OneHeart pilot – which will be evaluated through a randomised clinical trial (RCT) conducted by King College London – aims to enrol and monitor outcomes in 500 Bristol Heart Institute patients. The trial will take 2-3 years to complete and is due to commence in the summer of 2013.

Objectives

Demonstrate improved OAP therapy adherence, increased uptake of cardiac rehabilitation and reduced re-admissions to hospital amongst 500 Bristol Heart Institute patients with ACS.

Strategies include:

- Identify the reasons for patients with ACS to not adhere to prescribed therapies and services
- Develop an innovative and individualised patient support programme for patients with ACS – who have been prescribed an OAP therapy – to address these negative reasons for non-adherence and reinforce positive behaviours (such as exercising, attending cardiac rehabilitation, stopping smoking, etc)
- Implement the patient support programme with 500 Bristol Heart Institute patients with ACS and measure its success over a 2-3 year period via an RCT

¹ Charles River Associates, The burden of acute coronary syndromes in the United Kingdom, 01 March 2011 Accessed on 19.12.12 <http://www.crai.com/uploadedFiles/Publications/Burden-of-Acute-Coronary-Syndromes-in-the-UK.pdf>

² Tang, Wong, and Herbison, American Heart Journal, 2007, 153(1), 29-35

³ Boogon et al. European Heart Journal, 2011, doi:10.1093/eurheartj/ehr340, 1-11

⁴ 2012 National Audit for cardiac rehabilitation. Accessed 14.02.2013 http://www.bhf.org.uk/pdf/NACR_Report_Final_2012.pdf

Project Administration

Step 1: Building the OneHeart programme around patient beliefs

Having established that the majority of non-adherence for patients with ACS is intentional, OneHeart was set up to address patient beliefs in order to change patient behaviour, helping them to better self-manage their disease and improve outcomes. The steering committee looked at shaping the RCT in order to allow it to measure the key outcomes including better patient understanding of their illness and proactivity in seeking further information, improved patient adherence with their prescribed OAP therapy and recommended lifestyle changes, increased uptake of cardiac rehabilitation services and reduced re-admissions to hospital. This was done independently of the Bristol team.

Step 2: Establishing a cross functional steering committee

Representatives from the Bristol Heart Institute, AstraZeneca, King College (who are leading the RCT) and Atlantis Healthcare (who are supporting the development of the patient support programme) came together to drive the project forward

Step 3: The OneHeart programme resources

A range of on-line and off-line communications were

developed to address a range of unhelpful patient beliefs. The combination of welcome pack, website, text messaging, emails, DVD, magazine, letters and calls was employed to deliver these messages in order to harness the flexibility of digital, whilst providing patients with the familiarity of printed material and phone calls

Step 4: Gaining buy-in from the healthcare team

Bristol Heart Institute cardiac rehabilitation teams were presented with the rationale and research on which the programme is based, and trained to talk to patients about enrolment into the programme following admission with ACS and having OAP therapy prescribed

Step 5: Individualised, bespoke communications

Following enrolment to the programme, a customer relationship management (CRM) system uses the patient's initial responses to a questionnaire provided in the welcome pack to personalise the frequency and content of the communication for each individual patient

The Joint Working Project began in April 2012 to embed the OneHeart programme into the cardiac service ahead of the RCT starting in the summer 2013. The results of the RCT are expected in 2015/2016

Benefits

Patient	<ul style="list-style-type: none"> • Better patient understanding of their illness and proactivity in seeking further information • Improved patient compliance with their prescribed OAP therapy and recommended lifestyle changes
NHS	<ul style="list-style-type: none"> • Reduced re-admissions to hospital • Improved use of NHS resources through increased uptake of cardiac rehabilitation services
AstraZeneca	<ul style="list-style-type: none"> • NICE have recommended the use of AstraZeneca's Oral Anti Platelet therapy (TA 236), and as a result of increased patient adherence within this programme, AstraZeneca, as well as other medicines and therefore pharmaceutical companies may benefit from an increase in the number of prescriptions per patient • Improved corporate reputation amongst local and national stakeholders

AstraZeneca: Improving Asthma Care in Partnership with NHS East Surrey CCG

The prevalence of asthma in England is amongst the highest in the world, estimated to affect 3 to 5.4 million people⁵. Between 1,000 – 1,200 people a year still die from asthma in England, and it is estimated that 90% of those deaths are attributed to preventable factors.⁵ Asthma is managed predominantly in primary care with patients taking responsibility for lots of the management of their condition themselves outside of the healthcare setting.

Despite emergency admission rates being low (84 in 2010/11⁶) across the CCG's patient population, it was recognised that the care patients received from the 18 practices was variable and that this variation could lead to suboptimal patient outcomes and ultimately unnecessary spending.

Following a highly successful Joint Working project focusing on COPD, NHS East Surrey CCG approached NHS Improvement to participate as an asthma test site for the Lung Improvement Programme. This gave the

CCG an opportunity to improve asthma patient care, and reduce unnecessary spending by optimising and standardising the approach taken to the condition's management across their 18 practices.

Through a second Joint Working project with AstraZeneca, and in collaboration with local stakeholders, the CCG was able to develop a fully integrated pathway that focused on every aspect from case finding and accurate diagnosis, chronic disease management, through to acute care.

Objectives

Reduce unwarranted variation and deliver consistent standards of care across the entire pathway for patients with asthma from the CCG's 18 practices.

The strategy is to work together with NHS Improvement, practices, patients, PCT pharmacists, the Local

Prescribing Committee (LPC) and secondary care specialists to create centralised guidance, education and resources that allow practices to autonomously manage their asthma patients in the most effective and efficient manner

⁵ Department of Health, An outcomes strategy for people with chronic obstructive pulmonary disease (COPD) and asthma in England, 18 July 2011. Accessed on 14.12.2012 via http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127974

⁶ South East Coast Quality Observatory, EsyDoc hospital admissions with asthma as a primary diagnosis (18+ yrs), 2012

Project Administration

Step 1: Consistent patient cohorting

- AstraZeneca provided a data interrogation tool which defined specific cohorts to help practices group and manage their patients
 - Four cohorts were identified and profiled – with the largest being patients who were receiving asthma medications but had not received a formal diagnosis – which went on to inform the types of other resources required
- Risk stratification was a key outcome, and through three “Plan Do Study Act” cycles, four key cohorts were identified through risk stratification for intervention

Step 2: Creating central resources

- From cohort profiling, the team developed standardised read codes and two types of formal self-management plans – one pictorial and one text-based – for use by practices with patients
- Local asthma diagnostic guidelines and a treatment pathway were developed in line with the BTS/SIGN Guideline, in a collaboration between the medicines management team, PCT pharmacists, LPC representatives and patients from each practice

Step 3: Engaging and upskilling practices

- An asthma education day was held with guest speaker, Professor Martyn Partridge, which was attended by 60 GPs and nurses
- Practice specific cohort breakdowns were presented individually to practices alongside the management resources to enable and empower them to put in place appropriate plans of action
- AstraZeneca nurses helped mentor practice nurses on optimal management for different cohorts
- PCT pharmacists visited practices to carry out medication reviews and went into care homes to do patient medication reviews
- A monthly newsletter was developed by the project team to keep all practices up to date on project progress

Step 4: Working with secondary care

- Data sharing between the hospital trust and practices was established to allow proactive case management by practices following A&E attendance
- Standardisation of hospital paperwork was agreed and that a discharge summary would be sent by the hospital to a patient’s practice to allow primary care follow up within 7 days

Benefits

Patient	<ul style="list-style-type: none"> • Formally identified 154 additional asthma patients⁷ • Increase patient recognition of having a formal self-management plan up to 73%⁷
NHS	<ul style="list-style-type: none"> • Reduce emergency asthma hospital admissions by 21%⁷ • Willing and engaged practices across the CCG, allowing the new tools and guidelines to become the natural way of consulting, and standardised optimal care becoming the norm
AstraZeneca	<ul style="list-style-type: none"> • Medicines during this project were optimised, meaning that patients were stepped up and down in line with BTS recommendations, and AstraZeneca as well as other pharmaceutical companies benefitted from the appropriate use of inhalers • The number of patients with a self-management plan increased, as well as number of patients having inhaler technique checked, meaning that there was support for optimal adherence through structured education and decision making, ensuring patients received the optimal benefit from AstraZeneca’s medicines and those of other pharmaceutical companies • Improved corporate reputation amongst local and national stakeholders

The success of the project was recognised across the NHS when it was nominated as a finalist at the 2012 National Association of Primary care (NAPC) Vision Awards

⁷ Pulse Practical Commissioning, Raising the Asthma Care Bar, Dr Vijaykumar, December 2012

AstraZeneca: Improving COPD Disease Management in Partnership with Wirral CCG

COPD is estimated to affect more than 3 million people in the UK and, as a result, poses a significant challenge to the NHS and its resources⁸. Optimising chronic disease management is a core part of UK health strategy⁹. Primary care is expected to provide most of the chronic disease management and much of the task is undertaken through nurse-based review¹⁰. Unwarranted variation of health outcomes has been identified as a key issue by the Department of Health.

Research has confirmed that numerous National Institute for Health and Clinical Excellence (NICE) guideline interventions that can improve patient quality life – such a smoking cessation, pulmonary rehabilitation and inhaled medications – are not reaching patients.¹¹

In 2009/10, there were approximately 103 COPD admissions to hospital from patients from the 7 Wirral

Alliance CCG practices. This admission rate was above that of the PCT and the national average. The CCG recognised this as an area for improvement and, as it was outlined as a key priority in their 2011/12 Commissioning Plan, sought methods to improve personalised care planning for COPD patients in order to reduce the rates of exacerbations and lead to improved patient quality of life.

Objectives

To use new computer-guided consultation software - LUNGHEALTH©- in COPD patient assessments across Wirral Alliance CCG's seven practices to assess whether it could improve COPD management in line with NICE guidance, and consequently improve patient outcomes.

Work with nurses from the seven practices to:

- Use the software as part of optimisation assessments with COPD patients
- Review assessment outcomes
- Understand the benefits and challenges of using the software

⁸ National Institute for Health and Clinical Excellence. Chronic obstructive pulmonary disease: management of chronic obstructive pulmonary disease in adults in primary and secondary care. London: National Clinical Guideline Centre. 2010. <http://guidance.nice.org.uk/CG101/Guidance/pdf/English>

⁹ Department of Health. Chronic obstructive pulmonary disease (COPD) indicator set: dataset and business rules: new GMS contract QOF implementation (Version 14.0). London: Department of Health, 2009

¹⁰ Upton J, Madoc-Sutton H, Sheikh A, Frank TL, Walker S, Fletcher M. National survey on the roles and training of primary care respiratory nurses in the UK in 2006: are we making progress? Prim Care Respir J 2007;16:284-90. <http://dx.doi.org/10.3132/perj.2007.00068>

¹¹ Royal College of Physicians of London, British Thoracic Society and British Lung Foundation. Report 5 of the national chronic obstructive pulmonary disease audit 2008: survey of COPD care within UK general practices. December 2008.

Project Administration

A review of the COPD registers of the practices were conducted and a third (29.8%) of those registered (256 patients) were invited for review.¹²

Computer-guided consultation software

AstraZeneca funded the licencing of a new computer-guided consultation software package, LUNGHEALTH©, and provided a full training software training programme run by AstraZeneca clinical services and AshfieldIn2Focus as to how to use the package to deliver COPD assessments

Nurse-led assessment

Following training, practice nurses conducted 45 minute consultations with the identified patients, using LUNGHEALTH© to ensure consultations were conducted thoroughly in line with NICE's COPD guidance

Shared patient assessment

A two page consultation summary was printed at the end of each patient review and, as well as being provided to the patient, was also sent to other relevant healthcare professionals across the pathway – such as the pulmonary rehabilitation community team lead – as part of referral management

Benefits ^{12, 13}

Patient	<p>Of the 227 patients with a confirmed diagnosis of COPD:</p> <ul style="list-style-type: none"> • 80.2% of patients received a written management plan – supporting delivery against NICE COPD QS 2 and QOF 2 & 4 • 100% of patients were offered oral or inhaled therapies – supporting delivery against NICE COPD QS 3 and QOF 1 & 2 • 96% of patients were provided with an education plan – supporting delivery against NICE COPD QS 7 and QOF 1,2,3 & 4 • 80.2% of patients were provided with a crisis plan – supporting delivery against NICE COPD QS 7 and QOF 1, 2, 3 & 4
NHS	<ul style="list-style-type: none"> • Full assessment using the computer-guided consultation method was completed in 256 patients (24.4% of the expected national patient population) – supporting delivery against the NICE COPD Quality Standard 4 (QS4) and Quality and Outcomes framework domain 1 (QOF 1) • COPD diagnosis was revised for over 11% of patients assessed (29 of 256) – removing them from the COPD register and onto a correct diagnostic pathway – supporting delivery against NICE COPD QS 1 • Of the 227 patients with a confirmed diagnosis of COPD: <ul style="list-style-type: none"> - 55.6% of eligible patients were identified for smoking cessation services – supporting delivery against NICE COPD QS 5 and and QOF 1 - 56.8% of patients met NICE eligibility criteria for pulmonary rehabilitation services – supporting delivery against NICE COPD QS 6 and QOF 2 - 3.1% of patients were identified through initial assessment for long term oxygen therapy – supporting delivery against NICE COPD QS 8 and QOF 1
AstraZeneca	<ul style="list-style-type: none"> • Increased use of AstraZeneca's medicines as well as those of other pharmaceutical companies in line with NICE guidelines • Improved corporate reputation amongst local and national stakeholders

¹² Wirral Alliance CCG COPD raw data, 2012

¹³ LUNGHEALTH and NICE indicators data, 2012

AstraZeneca: Improving COPD Services in East Surrey

Every 20 minutes in England and Wales, someone dies from chronic obstructive pulmonary disease.¹⁴ Over 12,300 people in Surrey suffer from COPD which accounts for 1.1% of the population¹⁵. In 2007/8, there were 178 hospital admissions for COPD in the ESyDoc area¹⁶. The cost of these hospital admissions can be estimated at £311,000.* In 2007/8, the NHS Surrey COPD budget expenditure was around £8.3 million.¹⁷

Objectives

Several issues affected the treatment of COPD in the area:

- Limited clinical leadership existed for COPD in the community
- Frontline nursing staff required support to further develop clinical expertise in COPD
- Lack of uniform understanding and implementation of existing guidelines and pathways
- Communication between primary and secondary care was suboptimal and no agreed referral or discharge pathways existed
- Disjointed working between primary care, secondary care and outreach teams hampered the provision of care

The ESyDoc project set out to improve the quality of patient care, reduce hospital admissions, re-admissions, and length of stay by:

- Developing a patient focussed COPD pathway in line with NICE COPD guidelines
- Working in collaboration with secondary care, GP practices, NHS Surrey Medicines Management team, community pharmacy, community respiratory outreach team and South East Coast Ambulance Trust
- Upskilling and supporting healthcare professionals

¹⁴ Consultation on a Strategy for Services for Chronic Obstructive Pulmonary Disease (COPD) in England

¹⁵ QOF.NHS Information Centre. 2007/08

¹⁶ Hospital admissions data 2007/08 provided by The Information Centre for Health and Social Care

¹⁷ NHS Programme budgeting data tool. 2007/08

* Based on applying the 2007/8 National Tariff for COPD without complications/co-morbidities

Project Administration

Roles and responsibilities were agreed between the cross-functional project team composed of 20 practices from ESyDoc, Surrey and Sussex Healthcare NHS Trust (SASH), Surrey Community Health, Surrey Medicines Management team, South East Coast Ambulance Trust, Breathe Easy and AstraZeneca.

The approach centred on devising and implementing a long-term condition model, improving communication and stakeholder engagement. The following changes were implemented:

Stakeholder engagement

- All GP practices signed up to the project
- The local Breathe Easy Group was re-launched

Systematic register validation and review

- An audit was carried out including COPD register validation, patient identification and risk stratification

Upskilling/COPD education service

- A training needs analysis was conducted and a nurse mentorship and respiratory education programme was put in place
- 80% of practices were visited by a consultant respiratory physician who discussed COPD management and referrals with GPs and nurses

- Practice nurse and outreach nurse education meetings were held monthly and fortnightly

Patient reviews

- COPD qualified specialist nurses supplied via AstraZeneca provided a patient review service whilst upskilling frontline nursing staff based on findings from their training needs analysis in a clinical setting

Service re-design

- Referral pathways were re-designed with multi-stakeholder input
- A patient-centred care pathway was developed with Surrey and Sussex Healthcare NHS Trust (SASH), the medicines management team, Surrey Community Health, South East Coast Ambulance Trust and Breathe Easy in line with NICE COPD guidelines and disseminated
- Referral templates were developed and embedded for the outreach team and pulmonary rehabilitation

Communications

- Communication processes expanded to effectively cover South East Coast Ambulance, pharmacy, Air Alert, the medicines management team and patients (including out of hours)

Benefits ¹⁸

Patient	<ul style="list-style-type: none"> • A fall in average length of stay from 6.8 days to 5.0 days • Patient reported outcomes increased dramatically with 95% patients saying they were “very satisfied” with the care they had received and 88.9% saying they were “totally aware” of the next steps in their self management of the condition
NHS	<ul style="list-style-type: none"> • A 21% reduction in COPD hospital bed days • While 90 day admission rates increased in the SE Coast SHA, ESyDoc and SASH saw a 12% reduction (from 43% to 31%) from the end of 2009 through to Q3 2010 • Based on the success of the long-term condition model in COPD, a similar process is now being applied to the treatment of asthma
AstraZeneca	<ul style="list-style-type: none"> • Improved corporate reputation amongst local and national stakeholders • Built trust with East Surrey CCG leading to a further joint working project on asthma in partnership with NHS improvement • An increase use of AstraZeneca’s medicines as well as those of other pharmaceutical companies in line with NICE guidelines

¹⁸ AstraZeneca data on file DOF\099\Apr2011

GlaxoSmithKline: LloydsPharmacy Ltd and Hull PCT – Improving COPD Care

It is recognised that COPD is a significant burden on the NHS. An economic analysis in the UK estimates that the direct costs of COPD are more than £491m per year which equates to roughly £819 per person with the disease¹⁹ The British Lung Foundation suggests that there are an estimated 3.7 million people with COPD in the UK, yet only 900,000 have been diagnosed with the disease.²⁰

The Hull PCT area faced the second greatest challenge from COPD in England and the highest in Yorkshire and Humerside.²⁰ People in Hull are 55% more likely to be admitted to hospital with COPD than the UK average.²⁰

Objectives

Patient	<ul style="list-style-type: none"> • Reduce exacerbations of COPD and possibly improve patient outcomes • Receive more accessible care through pharmacy • Create a more joined-up care pathway involving GP, Long Term Conditions (LTC) team and pharmacy • Drive better understanding of their condition • Improve their ability to self-manage
Hull PCT	<ul style="list-style-type: none"> • Practices to be able to enhance patient care by working with member pharmacies • Identification of patients at risk of exacerbations and proactive provision of rescue medication • More efficient use of existing services
LloydsPharmacy	<ul style="list-style-type: none"> • Up-skill pharmacists and pharmacy teams to identify and better support COPD patients and further develop soft skills e.g. communication proficiency to support better patient relationships and improved patient experience. • Provide evidence that LloydsPharmacy can contribute to enhanced patient care and potentially improved patient outcomes which may support future commissioning of these services. • Provide extended experience of working with the local PCT to meet joint objectives. • Increase recognition for LloydsPharmacy for their efforts to improve patient care and deliver optimal services.
GlaxoSmithKline (GSK)	<ul style="list-style-type: none"> • Increased acknowledgement of the role of GSK in supporting pharmacy to generate evidence that supports the value to patients of the interventions they undertake • Generating evidence that Joint Working between LloydsPharmacy, GSK and Hull PCT has improved COPD patient management and impacted positively on patient outcomes.

¹⁹ Economic costs of COPD to the NHS. Thorax 2004; 59

²⁰ BLF report, Invisible Lives, 2007

Project Administration

Patient Pathway and Protocols

Through Joint Working, LloydsPharmacy pharmacists played a role in patient care through COPD Medicines Use Review (MUR), monthly progress checks and dispensing rescue medication packs with the support of GP practices within the PCT. A protocol setting out the increased role of pharmacy, the exact nature of the interventions and specifically the process for requesting and dispensing rescue medication was developed in conjunction with and endorsed by all involved parties.

Education and training

In order to support pharmacists to deliver COPD Medicines Use Reviews (MURs) to a high standard, LloydsPharmacy pharmacists completed an independently validated training module on COPD. Additionally all participating pharmacists and their staff attended a training event in order to equip them with the knowledge and skills necessary to deliver the project.

Pharmacy-based interventions

Pharmacists conformed to an agreed flow-chart of interventions including validated tools such as COPD Assessment Tool²¹ and MRC Dyspnoea Scale²². Under this protocol, Pharmacists identified diagnosed COPD patients based on dispensed medication or through GP/nurse referral and recruited these patients into the 6 month pilot. There were a number of assessments and checks completed as part of the pilot.

Data collection

In order to demonstrate the impact of this project on both patient outcomes and on measures such as A&E admissions, data was collected. LloydsPharmacy were responsible for collection, collation and management of patient data. Subject to patient consent the data identifying patients through their NHS number was sent to Hull PCT to enable the exact patient admissions history and outcome to be tracked.

In accordance with the Data Protection Act, GSK only had access to fully anonymous patient data.

²¹ Jones et al. European Respiratory Journal 2009; 34:648-654

²² Fletcher et al. BMJ. 1959; 2:257-66

Benefits ²³

Patient	<p>The feedback of the experience was positive, particularly the inclusion of the inhaler technique training. For patients where enrolment and follow-up CAT scores were captured, a decrease of 6.6 points indicates that the project had the potential to benefit the impact of COPD on patients lives (experts involved in developing the CAT suggest that a change of 2 or more units may indicate a clinically significant change in health status). ²⁴</p> <ul style="list-style-type: none"> • Average number of exacerbations in last 3 months = 3.6 • 16.1% of patients referred to pulmonary rehabilitation (5 patients)
Hull PCT	<ul style="list-style-type: none"> • Number of CAT tests carried out = 23 • Average CAT score = 23.4 • Number of dyspnoea scores taken = 20 • Average dyspnoea score = 3.1 • Average initial CAT score for patients that were followed up using CAT = 27.2 • Average follow-up CAT score = 20.6 (change of -6.6 points, 5 patients)
LloydsPharmacy	<p>An average CAT score of 23.4 indicates that COPD had a high impact on the lives of the patients involved in the project²³</p> <ul style="list-style-type: none"> • 31 COPD patients were signed up to the pilot through 15 LloydsPharmacy outlets • Inhaler technique training delivered to 71% of pilot participants (22 patients)
GSK	<p>23.5% of current smokers attempted to quit during pilot (4 patients). For future projects, the programme could be improved by streamlining and simplifying the intervention methodology and improving the engagement with primary care to facilitate higher levels of enrolment.</p>

Challenges

There was a general perception that COPD patients were disenfranchised from the healthcare system and there was limited belief that their condition could be improved. Overall, this project provided limited evidence that pharmacy can be implemented into a local care pathway for COPD. However, there were significant challenges in relation to enrolment of patients and their on-going engagement with the programme. Thirty one patients were enrolled over 6 months, compared to an initial aim of enrolling 150 patients. The main challenges

were a lack of interest from patients to be recruited into the pilot and pressure on pharmacist's time to deliver the service. Patients also had a high dropout rate during the project, with only 16% of patients who completed the initial CAT assessment completing the follow-up CAT assessment after the 6 month period. The main feedback was that the assessment process was time consuming and represented a significant investment of time and effort from both the pharmacists and patient.

²³ GlaxoSmithKline, data on file

²⁴ CAT for healthcare professionals, accessed online at <http://www.catestonline.co.uk/hcpinterpretscores.htm>

GlaxoSmithKline: Wearside PBC Group – Improving COPD Care

A 2007 report by the British Lung Foundation found that Sunderland Primary Care Trust (PCT) faced the sixth highest challenge nationally from COPD and the greatest in the North East region²⁵. A third of the city’s population were smokers, and it had the eighth highest proportion of people at increased risk of a COPD-related hospital admission (51% more likely than the average) in the UK.²⁵ Wearside, a former coal-producing area²⁵, had a COPD prevalence rate of 2.8%: 3,070 people in a population of 107,935 (38%²⁶ of the PCT’s population). Wearside’s COPD hospital admissions spend in 2008–9 was £1.1m.²⁷

Objectives

Patient	<ul style="list-style-type: none"> To provide a service to support patients in managing their condition through earlier intervention and education, thereby improving patients’ quality of life
NHS	<ul style="list-style-type: none"> To establish a framework of consistency across Wearside Consortium practices, reducing inappropriate hospital referrals through the development of more appropriate patient pathways and treatment protocols
GSK	If successful, patients will be treated in line with NICE COPD Guideline ²⁸ , leading to more rational and appropriate use of relevant medicines, including GSK’s medicines

Project Administration

- Development of treatment protocol by Wearside Consortium, in line with NICE COPD guidelines and agreed with secondary care and Sunderland PCT
- Installation of the POINTS* patient audit tool in all practices, to enable effective prioritisation of COPD patients for review, and the measurement of change from QoF to NICE standard of care
- A practice-by-practice analysis of training needs, based on the POINTS baseline, which informed the development of practice COPD action plans, supported by the GSK Respiratory Care Associate (RCA) in line with NICE COPD guidelines
- A bespoke, consortium-wide training programme to up-skill healthcare professionals to deliver NICE COPD standards of care. This training programme was developed by GSK and Wearside Consortium together with local respiratory specialists
- A Wearside Consortium incentive scheme of £2 per patient per practice in each financial year, encouraging achievement of pre-specified objectives
- A patient experience survey to measure the quality of patients’ annual COPD review, to review areas of strength as well as those in which improvements could be made

²⁵ British Lung Foundation, “Invisible lives. Chronic Obstructive Pulmonary Disease (COPD) finding the missing million.” November 2007. Page 7

²⁶ Data on total list size, COPD list size and prevalence have been taken from the England Quality and Outcomes Framework (QoF) 2010/11 database <https://catalogue.ic.nhs.uk/publications/primary-care/qof/qual-outc-fram-08-09-pct/qof-eng-08-09-pct-tabs-prev.xls> Accessed 11th March 2013

²⁷ Wearside Hospital Episodes Statistics Report 2007/2008, report prepared by GSK October 2008. HCM/MAM/08/38502/1 – Page 7. Sources – Outcome Data

²⁸ NICE COPD Guidelines 2010 <http://www.nice.org.uk/nicemedia/live/13029/49397/49397.pdf> Accessed Feb 2013

Benefits

The total number of patients diagnosed with COPD in the Wearside CCG (from QOF 2008/09) was 3070, a prevalence of 2.8% (in QOF 2010/11 it was 3141 and

2.9%). The reviewed subgroup was 1541 COPD patients, 50% of the total diagnosed PBC population based on QOF 2008/09.^{26, 29}

Patient	<ul style="list-style-type: none"> • The percentage of patients with exacerbation frequency recorded in the patient notes during the previous 12 months increased from 58% to 93%²⁹ (n=1541) • Patients with a Medical Research Council (MRC) score for breathlessness increased from 77% to 94%²⁹ (n=1541) • Patients with a measurement of FEV1 increased from 74% to 84%²⁹ (n=1541) • The percentage of patients who obtained the maximum NICE standard review score of 4 points (i.e. had a COPD review within the previous 12 months and where the FEV1, MRC score and exacerbation frequency were recorded in their notes) increased from 72% at baseline to 93% at the two-year audit²⁹ (n=1541) • Of the 241 patients who responded to the patient experience questionnaire, 90% said they were very satisfied with their review and a further 8% that they were fairly satisfied³⁰ • The percentage of the 241 patients who stated they had a high understanding of their condition increased from 68% before their review to 85%³⁰ • Regarding their knowledge of what to do if their symptoms became worse, 30% of the 241 respondents stated it had increased a lot, 24% that it had increased a little, 43% that it had stayed the same and 3% that it had decreased³⁰ • Of all 241 patients, 78% said they were shown how to use their inhaler and 47% that they were given a self-management plan sheet, while a further 22% already had one³⁰
NHS	<ul style="list-style-type: none"> • The variability in the quality of reviews across 16 of the practices, measured by the coefficient of variation of the mean practice NICE score, decreased by 70% from the baseline audit to the two-year audit²⁹ (n=1541) • Of 15 respondents (11 from practice nurses) to the 50 Healthcare (HCP) experience questionnaires distributed, the percentage of respondents recording a high knowledge score (8 to 10) was higher after the educational sessions across several aspects of the management and understanding of COPD³¹ • All 15 respondents to the HCP experience questionnaire stated that the educational sessions had been successful or very successful in building their confidence, improving their skills and knowledge and increasing their enthusiasm for managing their COPD patients³¹ • The rate of COPD admissions in Wearside PBC was 13.6% lower in the first year of the project (Sep 09-Aug10) and 3% lower in the second year (Sep 10-Aug 11) than in the base year (Sep 08-Aug 09). By comparison, the admission rates for the rest of Sunderland PCT decreased by 2.5% and 1% in the first and second years respectively, and admissions for the whole North East SHA decreased by 3.2% in the first year but rose by 7% in the second year compared with the base year. The higher admissions observed for all localities in the second year were most likely related to the more severe winter.^{26, 32, 33}
GSK	<p>There was an increase in the appropriate use of medicines, including GSK's medicines within this locality over the period of the joint working project²⁹</p>

²⁹ POINTS data reports for 16 practices, 1, 541 patients. Collected and supplied by Quintiles, data analysis by GSK, Aug 2012

³⁰ COPD patient experience survey. Data collected from 216 patients and analysed by Ipsos MORI, September 2010

³¹ HCP Joint Working Experience Questionnaire, data from 15 HCPs collected and analysed by Ipsos MORI, March 2010

³² SUS data based on HRG DZ21. Data provided by NHS Sunderland PCT and analysed by GSK, August 2010

³³ GSK data on file [UK/PPM/0052a/12] Dr Foster's COPD report on the North East SHA based on HRG DZ21 and analysed by GSK, August 2012 <http://drfosterintelligence.co.uk>*

* This information was generated by the Regional Healthcare Analysis tool, which is proprietary software of Dr Foster Limited and IMS Health Limited. All rights reserved. No further copying or reproduction of this information is permitted without consent from Dr Foster Limited and IMS Health Limited.

GlaxoSmithKline: Walthamstow West PBC Group – Improving COPD Care

COPD was a significant burden on the NHS; the disease was the UK’s fifth biggest cause of mortality³⁴ and second most common cause of emergency admissions³⁵. At the time of project set-up, NHS Waltham Forest and Walthamstow West PBC Group reported a lower than average prevalence for diagnosed COPD (0.9% v 1.4% national average)³⁶, with the actual prevalence rate thought to be closer to 4.1%.³⁷ NHS Waltham Forest ranked 148 out of 152 Primary Care Trusts Nationwide for COPD.³⁸ This was based on length of stay, number of emergency admissions and number of emergency bed days for patients with COPD.

Objectives

There was a documented need to reduce health inequalities across NHS Waltham Forest³⁹. Before

project initiation, there was no intermediary COPD service within NHS Waltham Forest.

Project Administration

Patient	<ul style="list-style-type: none"> • Improve the quality of the annual COPD review by implementing NICE COPD Guideline 2010⁴⁰ • Increase patients’ understanding of their condition and treatment options
NHS	<ul style="list-style-type: none"> • To ensure adherence to the evidence based care pathway and treatment protocols. Patients to be treated in line with NICE COPD Guideline 2010⁴⁰ and local NHS Waltham Forest guidance • To increase the number of newly diagnosed COPD patients • More appropriate use of resources e.g. increased appropriateness of referrals to secondary care, reduction in unplanned admissions to secondary care, resulting in ‘care closer to home’
GSK	<ul style="list-style-type: none"> • Increased use of appropriate respiratory medicines, including GSK medicines, in line with NICE COPD Guideline 2010⁴⁰ • Demonstration of how Joint Working between GSK and Walthamstow West PBC Group has improved COPD patient management and experience • Increased acknowledgement of the role of GSK in supporting the locality group and NHS Waltham Forest

³⁴ Death Registration in England and Wales: 2005, causes www.statistics.gov.uk/downloads/theme_health/hsq30.pdf Accessed April 2011

³⁵ Commission for Healthcare Audit and Inspection. Clearing the air: A national study of chronic obstructive pulmonary disease, 2006

³⁶ QOF Database 2008 www.gpcontract.co.uk/browse.php?year=8 Accessed April 2011

³⁷ Modelled estimates and projections of COPD for PCTs in England, East of England Public Health Observatory <http://www.erpho.org.uk/viewResource.aspx?id=18025> Accessed April 2011

³⁸ Disease Management Information Toolkit (DMIT). Department of Health (DH) 2007. www.dh.gov.uk/en/Healthcare/Longtermconditions/DHL074772 Accessed February 2013

³⁹ NHS Waltham Forest commissioning case for COPD Pilot

⁴⁰ NICE COPD Guidelines 2010 <http://www.nice.org.uk/nicemedia/live/13029/49397/49397.pdf> Accessed February 2013

Benefits

Patient	<ul style="list-style-type: none"> • The percentage of patients receiving an annual COPD review has increased from 20% to 73% (from 90 patients to 370) ⁴¹ • Recording of breathlessness has increased from 18% to 75%⁴¹ in line with NICE standards⁴⁰ • 96% of patients (total patients n=56) were satisfied with the level of service given to them during their check up and felt that the review was thorough⁴² • An increase from 43% to 70% in patients having a high understanding of their condition⁴² • Patient understanding for the reason of why they have been given a type of medicine has increased by 50%⁴² • Whilst the following were not primary objectives of this project, it is of interest that: <ul style="list-style-type: none"> - Patients who were told how to access flu vaccines during their review increased from 26% to 85% (total patients n=56)⁴² - Patients offered pulmonary rehabilitation has increased from 26% to 65%⁴² - There was an increase from 20% to 75% of current smokers being told how to access help to stop smoking⁴²
NHS	<p>Overall improvement in the quality of patient review to NICE standards⁴⁰ from 22% to 56%⁴¹ (total patients n=508)</p> <ul style="list-style-type: none"> • The prevalence of diagnosed COPD patients increased from 453 to 508, an increase of 12.1%⁴¹ • A 16% reduction (from 80 to 67) in year-on-year COPD non elective admissions in the period September 2009 to August 2010 ⁴³ • The cost of non elective COPD admissions has been reduced by 18.6% in the period of September 2009 to August 2010 estimated to be equivalent to £35,000.⁴³
GSK	<p>There has been an increase in the proportion of COPD patients with moderate or severe classification receiving ICS/LABA combinations from 65.6% to 75.3% – an increase of 9.7%.⁴¹ This increase in ICS/LABA combinations is for all ICS/LABA combinations, including GSK ICS/LABA combination licensed for COPD</p>

⁴¹ POINTS data reports for 10 practices, 508 COPD patients. Collected and supplied by Quintiles, data analysis by GSK 22nd June 2010

⁴² COPD patient experience survey. Data collected and analysed from 56 patients by Ipsos MORI, October 2010

⁴³ Data from NHS Waltham Forest (provided by Frank Hamilton, GP Commissioning Business Manager) November 2010

Baxter: Management of Epistaxis – A New Paradigm

Epistaxis is the most common ENT emergency and in England, over 27,000 patients presented to secondary care in 2008-9⁴⁴. The mean length of stay (LoS) for epistaxis in the UK is over two days; the aim was to reduce length of stay without compromising quality of care. In 2009-10, Aintree University Hospital NHS Foundation Trust had 250 admissions for epistaxis. Patients stayed a mean of two days at a minimum cost of £400 per day. Reducing this by just one day could yield savings of around £100,000 for the Trust.

Objectives

Baxter and Aintree jointly agreed that to truly address the challenges within the current treatment regimen the service needed to be redesigned. This was primarily intended to address the training requirements within both A&E and with the junior doctors who often found it easier to use nasal packing and habitually admit patients rather than to identify the bleeding point and decide on a further course of treatment.

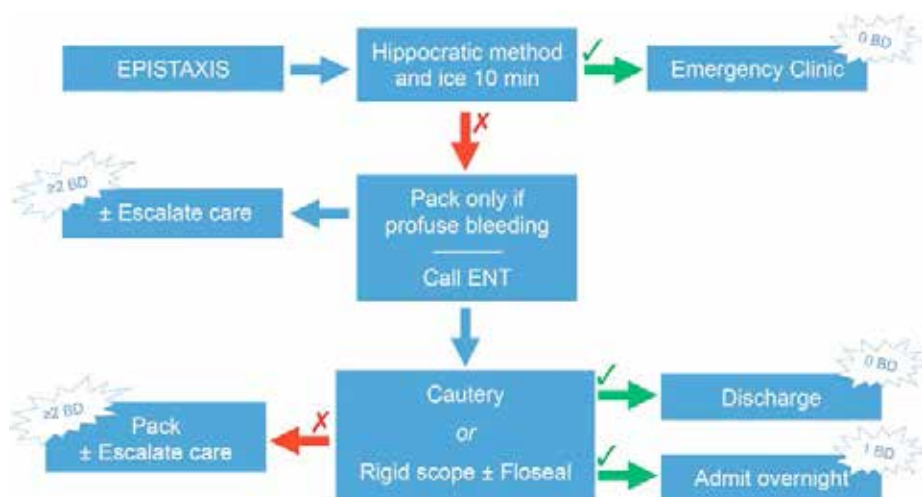
Floseal® haemostatic matrix is a paste-like haemostatic matrix designed to stop bleeding quickly. The median time to haemostasis is 120 seconds. The product consists of expansile bovine gelatin granules coated in human thrombin. The use of Floseal® in persistent epistaxis has already been trialled⁴⁵ and showed statistically significant improvements in both patient and physician experience compared to nasal packing.

⁴⁴ Hospital Episode Statistics for England per Epistaxis: Why change the treatment pathway. Baxter Healthcare. May 2011

⁴⁵ Côté et al. Otolaryngol Head Neck Surg. 2010 Jun; 39(3):304-8

Project Administration

A new treatment pathway was designed and implemented in December 2010 (see below).



Flowchart 1: Our new epistaxis management pathway (BD = bed days)

Baxter and Aintree worked in partnership to implement training, materials and multi-disciplinary approach to implement the pathway and the introduction of Floseal®. A “How to; Why to Guide” was created to

highlight the need to change the treatment pathway. The guide includes current costs versus tariff, clinical evidence a financial impact model, implementation plan and supporting patient education materials.

Benefits

Patient	<p>This innovative approach to treatment is aligned to the QIPP programme and enables patients to have a significantly improved experience, including:</p> <ul style="list-style-type: none"> • A shorter length of hospital stay • A reduction in pain and discomfort compared to nasal packing • As a result of proactively implementing the new pathway, some patients require no additional treatment
NHS	<p>When compared to the preceding three years, the Baxter/Aintree audit showed that in 2010-11:</p> <ul style="list-style-type: none"> • The total number of bed days due to epistaxis was reduced by 30% • Mean length of stay was reduced by 21% • Floseal® was successfully used to treat epistaxis in 20 patients, including some who were on warfarin or aspirin. The overall success rate was 75% in selected patients • The treatment was unsuccessful in 7 patients, all of whom had complications:- two patients had septal perforations; two had posterior bleeding points and three had anterior bleeding points <p>The reduction in hospital stay improves productivity and reduces costs to the NHS. The saving that could be realised by introducing this programme is a conservative estimate of £100,000 per Trust, including the cost of treatment</p>
Baxter	<ul style="list-style-type: none"> • The team at Aintree plan to continue to work with Baxter to assess the safety of discharging patients a few hours after they have undergone Floseal® treatment • Baxter plans to promote the pathway to other Trusts and extend it for use in the community

Bristol-Myers Squibb: Dean Street at Home – Postal HIV Testing in Collaboration with Chelsea and Westminster Hospital Foundation Trust

HIV is now a treatable medical condition and the majority of those living with the virus remain fit and well on treatment. The project involves a novel approach to reaching undiagnosed sexually active ‘men who have sex with men’ (MSM) outside the traditional routes for testing in more typical GU medicine settings.

56 Dean Street, Chelsea and Westminster NHS Foundation Trust’s HIV and sexual health centre in Soho, is the first NHS clinic to offer HIV home testing. “Dean Street at Home” is a collaboration with

the social networking website Gaydar and the online medical service DrThom, and is funded by Chelsea and Westminster Health Charity and a joint working agreement with Bristol-Myers Squibb.

Objectives

The aim is to ensure better access to services by the hard to reach MSM community thereby ensuring early treatment of infected individuals which can reduce morbidity and may be life saving. The project

is designed to complement existing HIV screening services by leveraging innovative channels such as social networks.

Project Administration

The project focuses on sexually active MSM in London through a revised website ‘Dean Street @ home’, and invite them to take a postal HIV test via a third party provider which has existing governance links to Chelsea and Westminster sexual health services. Innovative technology is used to target and interact with MSMs.

- Ensure patients testing positive for HIV are transitioned into specialist services as smoothly and quickly as possible
- Reduce onward transmission of HIV in the MSM community
- Reduction in late diagnosis which is a major cause of HIV mortality

The objectives are:

- Identify patients with previously undiagnosed HIV through targeted testing of the local population

The project is designed to complement existing HIV screening services by leveraging innovative channels such as social networks.

Benefits

Patient	<ul style="list-style-type: none"> • To make HIV testing more accessible to people at high risk of infection, who may not be currently accessing services and to reduce morbidity and mortality through earlier diagnosis
NHS	<ul style="list-style-type: none"> • To reduce undiagnosed HIV to reduce morbidity, mortality and onward transmission as early diagnosis and treatment has been shown to be more cost effective • The initiative is in line with the QIPP agenda to reduce late diagnosis and onward transmission of infection
Bristol-Myers Squibb	<ul style="list-style-type: none"> • An increase in the number of patients identified with HIV is expected to lead to higher number of patients going on ARV medicines, including BMS’s medicine, in line with HIV London Consortium Tender guidelines and BHIVA guidelines • Improvement in the relationship and trust between BMS and the NHS

Lundbeck: Integrating the Parkinson's Care Pathway in Sunderland

Lundbeck's Parkinson's disease specialist worked with partners across the Sunderland health economy, including City Hospital Sunderland and Sunderland PCT, to develop an integrated care pathway for local people with the condition.

Lundbeck was able to provide local performance data via its Parkinson's data manager tool, and after discussions with key commissioners and providers it

was agreed that the initial main work should be to map local services through a facilitated local workshop.

Objectives

The project began in February 2012 and the half-day workshop was run in May, with Lundbeck providing project management and facilitation support. The workshop had five objectives:

- To identify the key building blocks of a local integrated care pathway for Parkinson's disease patients and their carers across Sunderland, in line with the recently developed rehabilitation strategy.
- To improve liaison between Parkinson's disease service commissioners, health and community care providers and local patients in order to enhance a

local integrated care pathway.

- To improve awareness of each service and its roles and responsibilities, and develop processes to support seamless integrated patient care for those with Parkinson's.
- To identify any gaps in the present service and identify solutions.
- To establish a baseline of key performance indicators to inform performance frameworks and assist evaluation of changes.

Project Administration

Many of those present at the workshop were specialists in neurology or Parkinson's disease in Sunderland. However, the representation of community services was sufficiently wide to promote new introductions, new ways of working and mutual support.

The workshop looked at the four phases of the care pathway– diagnosis, maintenance, late-stage intervention and palliative care – and addressed

these through small-group discussions involving professionals with various clinical and organisational backgrounds.

Key recommendations from the workshop were identified to develop an action plan, intended to be taken forward by a local steering group. This work is currently on going.

Benefits

Patient	<ul style="list-style-type: none"> • Use of the new Primary Care Centre outpatient and diagnostic services at Houghton-le-Spring • Access to the new Integrated Care and Rehabilitation (ICAR) service with GP/nurse-led intermediate care and rehabilitation beds (step-up facility to prevent hospital admissions) • Identification of ICAR charge nurse with a special interest in Parkinson's disease • Patient-centred outcomes and integration within a rehabilitation strategy
NHS	<ul style="list-style-type: none"> • Facilitation of clinicians in the acute sector keen to work with community colleagues from healthcare and local government • A cohort of GPs working with ICAR and willing to work with Parkinson's disease clinicians • Development of a local neurological forum to link to CCGs across the south of Tyne and Wear (sharing learning for other neurological conditions), with potential to become a clinical engagement forum • Potential efficiencies through enhanced and improved working in partnership • Greater understanding of local data (provided by Lundbeck and local audits) • Local commissioners and providers seen as best practice examples
Lundbeck	<ul style="list-style-type: none"> • Enhanced engagement with customers (working beyond the traditional NHS role) • Development of process map that can be replicated across other disease areas

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