South East Clinical Senate

South East

Clinical

senate

Examples of Best Practice Case Studies – for illustrative purposes

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Introduction

The following six case studies are synopses of services who have changed the way they work in line with the developing and changing clinical landscape in which we all work. These are examples of where teams have implemented new ways of working due to the needs of patients. They all aim to provide effective evidence-based care, work smarter and provide care that meets the needs of patients at an earlier stage in the trajectory of their condition.

Considering the Figure below, we encourage you to read the summaries of the case studies as illustrations of how we may adapt, be agile and creative. It is worth noting how each individual case study can map their innovative service changes to the infographic which conceptualises what we aim to capture as we consider the way forward for the future. We hope you find these case studies useful in your thinking and preparation.

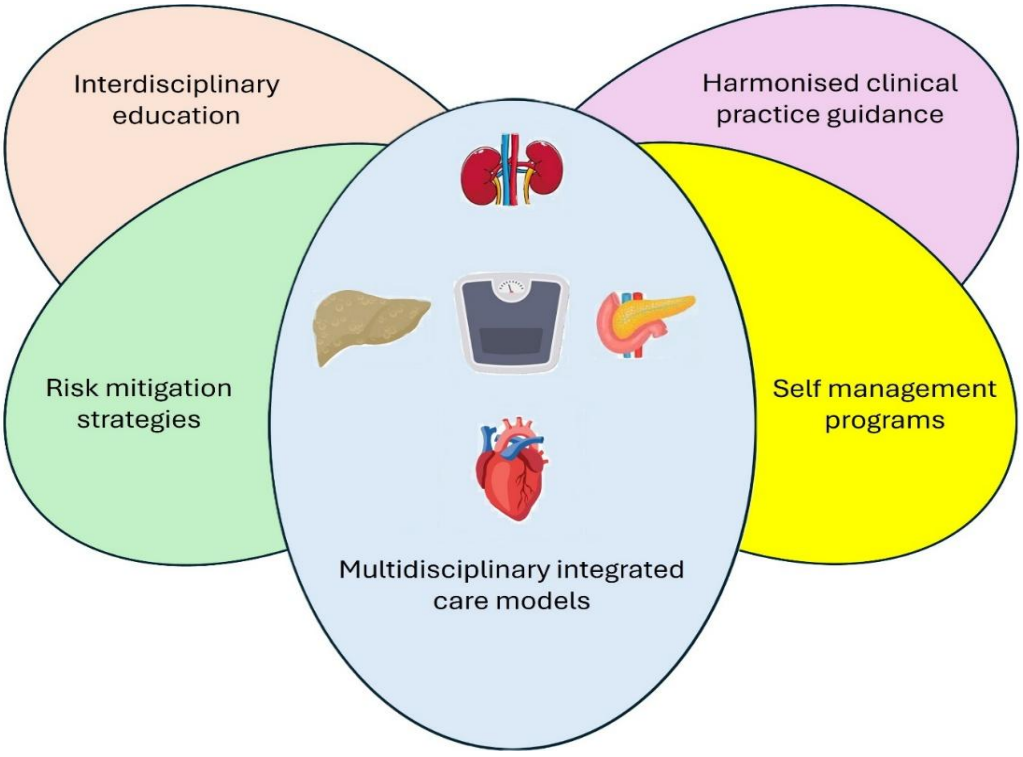

Figure 1. Integrated Cardiovascular Kidney Metabolic Model

Case Study One:
Pharmacist-led cardio-renal-metabolic service

Chronic kidney disease (CKD) is a leading cause of premature death disproportionally affecting socioeconomically deprived and vulnerable populations. It is an independent risk factor for cardiovascular disease (CVD) and is associated with diabetes mellitus, hypertension, and CVD progression, reduced quality of life and rising healthcare costs. Together CKD, CVD and diabetes coexist and share common risk factors including obesity, hypertension, hypercholesterolaemia and smoking. These are further exacerbated by a General Practitioner (GP) workforce crisis and in communities where resources and service provision can be lacking.

The premise of the initiative was that single disease models of care may have limitations and potential harms for individuals experiencing multimorbidity and associated polypharmacy, therefore a holistic approach was deemed necessary to address modifiable risk factors, improve survival and quality of life.

For more than 20 years General Practice Clinical Pharmacists (GPCP) roles have been effective at addressing challenging areas of prescribing, optimising chronic disease management for single conditions and freeing GP capacity. In Scotland GPCPs, non-medical prescribers, are well positioned within GP teams to care for the polypharmacy as part of complex interventions.

This study aimed to scope the potential of a GPCP-led intervention to optimise cardio-renal and metabolic risk factors in CKD stages 3–4 with 255 participants from two general practices in Glasgow, delivered by two experienced GPCPs from November 2021 until January 2024.

Prior to the first patient appointment, individual care plans were developed for the participant. At the first appointment, which was face to face or by telephone and 20 minutes long, the participant's CKD risk factors and disease progression were discussed based on their most recent tests, co-morbidities, medicines and lifestyle. Therapeutic targets were set for blood pressure, HbA1c (for those with Type 2 diabetes), and lipid reduction and treatment in line with guidelines. Lifestyle advice was given and polypharmacy reviews were undertaken to optimise co-morbidity treatment. Where appropriate follow up reviews were conducted.

Post intervention data were collected during January 2024. The pre and post intervention parameters were compared. Most prescribing interventions involved initiation and optimisation of lipid lowering medications, followed by antihypertensives. Adverse drug effect management and nephrotoxic medicines deprescribing accounted for the remainder.

At 12 months post intervention improvements were observed in eGFR, which was associated with non-significant improvement in the participants' CKD stages. Reductions were also seen in blood pressure measurements, lipid profiles and HbA1cs to varying degrees. Some participants required referral to specialist services for further care during assessment due to cardiac problems being identified.

This scoping feasibility service development study demonstrated the potential of the role of GPCPs in optimising treatments for people with CKD as well as indicating a way of multidisciplinary working to meet participants' needs as part of the solution to the GP workforce crisis. Limitations were that this was an underpowered study, and not generalisable. However, the study has shown that integrated general practice clinical pharmacists are well positioned to improve key cardio-renal and metabolic risk factors in a socioeconomically deprived population. Future studies are required to confirm benefits observed in this study.

Reference

Ramos T et al. (2025) Evaluating a pharmacist-led cardio-renal-metabolic service to reduce healthcare inequities in a socioeconomically deprived population: a prospective intervention study. *International Journal of Clinical Pharmacy*: Vol 47; pages 1395-1405.

Evaluating a pharmacist-led cardio-renal-metabolic service to reduce healthcare inequities in a socioeconomically deprived population: a prospective intervention study | International Journal of Clinical Pharmacy

Case Study Two:
The Buckinghamshire Lipid Optimisation Programme, an innovative data driven approach

This project, based in Buckinghamshire describes a bespoke, innovative and population level search tool that supports clinicians in identifying those patients who would benefit from cholesterol lowering medications.

Using a database that captures the patient information, the search tool initially identifies patients who are suitable candidates for secondary prevention, removing referral errors and ensuring patients are suitable candidates for lipid optimisation.

Utilising bank medical staff there were over ten doctors able to work for the programme, maximising the number of patients who can be reviewed on a single day and reducing the impact of sickness/absence. A simplified protocol allows resident doctors to make lipid optimisation decisions against an agreed protocol (designed by specialists). Patients are then invited to be reviewed. The invite and outcome letters to patients are based on standardised templates to reduce administrative burden. They are addressed to patients in patient-centred language. Following this, an administrative team member speaks to each patient individually to confirm appointments, reducing the 'did not attend' rate significantly. Senior nurses with a research background independently lead medication administration clinics, providing an efficient and highly praised service.

Patients are supported to take better control of their own health. They are given information leaflets and there is access to an advice line. Referrals on to specialist services if required are made, for example smoking cessation, weight management and alcohol reduction.

Clinics are also offered on a Saturday. One Saturday 84 patients were reviewed. Financial modelling has shown that the cost per patient by using this 'mega' clinic model costs £32.11 per patient compared with £67 per patient per injection received of lipid lowering injections delivered in primary care. Despite significant scale, the model keeps costs reduced and staffing lean. Tasks are given to the most appropriate clinical team member. There are two administrative staff, two phlebotomists, four band 7 nurses and one doctor delivering the programme.

The programme has been iterative using rapid improvement cycles that have effected changes. For example, there have been 15 iterations of the medical clinic protocol and six iterations of the clinic invite letter by the patient panel and patient

feedback. Feedback has been that 98% of the users would recommend the medication administration clinic to their friends or family.

At the time of presenting the work thus far (August 2025), 2657 patients within Buckinghamshire with a history of cardiovascular disease and LDL-C (Bad Cholesterol) = 2.6 have been reviewed. Early within the programme, the Trust identified within the data, that patients were having the incorrect pathology test requested. A pragmatic decision was made to adjust testing methodology across Buckinghamshire to ensure full lipid profile taken for every patient (regardless of the test ordered).

More than 1400 patients were reviewed at the medical virtual clinic in nine months and 79% were offered NICE approved cholesterol medications. 2118 patients were reviewed in 18 months. 751 patients were referred for lipid reducing therapies. The team are proud to report that 57% of patients are now achieving the LDL-C target for secondary prevention (of those that have had a repeat test).

With regard to transfer to primary care, 21 primary care teams are discussing transfer of care, and over 150 patients are receiving injectable lipid lowering therapies, are now transferred to primary care.

Moreover, the team are working on breaking down barriers by leading national conversations about removing onerous bureaucratic processes with limited value. They are delivering education across the multidisciplinary team within primary care, and when a patient is ready for discharge from the programme, each patient receiving injectable therapy has a focused clinical review to ensure optimisation of cardiovascular medications, supporting primary colleagues with ongoing clinical review.

In addition, Dr Mclaren is in the process of negotiating with Oxfordshire and Berkshire to deliver the same program for their populations and we have health economic evaluation data from the Oxford HIN.

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Case Study Three:
Integrated primary and secondary care optimizes the management of people with CKD—the LUCID* project

This case study describes a multidisciplinary, virtual collaboration pilot between primary and secondary care in order to improve outcomes for patients living with chronic kidney disease.

Synopsis

*LUCID is defined as 'Leicester, Leicestershire, and Rutland Chronic Kidney Disease Integrated Care Delivery Project'

The research team explain that early diagnosis, risk stratification and medication optimisation are essential to improve the management of chronic kidney disease (CKD) and other long-term conditions. The vast majority of people with CKD are managed in a traditional primary care setting. The introduction of Integrated Care Systems (ICS) in England who allocate responsibility for population health across primary and secondary care, provided the opportunity to revolutionise the management of these conditions. The team state that annual National Health Service kidney disease costs are ~£6.4 billion. Approximately 35 000 people in the UK require some form of kidney replacement therapy in the form of dialysis or kidney transplantation. Due to the number of comorbidities experienced by people with advanced CKD, and the lack of availability of organs for transplantation, dialysis remains the only option for most, costing around £35 000 per person per year. In addition, people with CKD have an increased risk of cardiovascular events, with an associated excess cost of more than £250 million per year for NHS England which can be further exacerbated by prolonged hospital stays adding to the costs.

Recognising the opportunity the introduction of the ICS teams presented, the researchers designed, piloted and implemented an ICS level integrated virtual care programme which was based on the principles of patient and professional education, early disease identification, medicines optimisation and disease surveillance. This involved collaboration between primary and secondary care and was aimed at delivering effective evidenced based care for people living with CKD to improve outcomes at population level.

LUCID is based on the principles of:

(i) Patient and professional education

(ii) Early disease identification

(iii) Medicines optimisation

(iv) Disease surveillance.

These principles were delivered via virtual multidisciplinary team meetings. The programme began with focusing on public kidney education videos. 51 000 views were undertaken. Professional education sessions have been delivered at ICS-wide events and to 18 out of the 26 primary care networks using standardised teaching materials. Primary Care Networks are groups of general practices serving approximately 50 000 people to support improved collaboration between practices for services whilst still providing health and social care in the community. Both the patient and professional education programmes were developed using an informal feedback-driven iterative approach from users and participants of the material. No formal evaluation of this process was undertaken.

Patients were identified by the primary care networks using their electronic health record database. The multidisciplinary teams comprised a consultant nephrologist and a combination of specialist pharmacist, primary care pharmacist, practice nurse and/or primary care physician. The public education videos supported medicine optimisation and were made available during consultations or through an internet link within the medical record that the patient was able to access.

The authors of the study presented the following results. In April 2022 virtual clinics were piloted in four primary care networks and since April 2023 have been available to all 26 primary care networks. As of 31 March 2024, 15 out of 26 primary care networks (57.7%), representing primary care service for an estimated population of 700 000 (58.3%), are participating in the programme. Between 1 April 2023 and 31 March 2024, 1085, virtual patient discussions took place for 821 patients. A total of 590 (54.4%) consultations involved medicines optimisation, 84 (7.7%) avoiding a referral to secondary care and 132 (12.2%) leading to expedited secondary care. A total of 102 clinics were completed between 1 April 2022 and 31 March 2024 with multi-professional input into each clinic from a primary care physician, practice nurse and/or pharmacist with a consultant nephrologist and specialist pharmacist.

The LUCID programme has demonstrated that an integrated programme of CKD care involving close collaboration between primary and secondary care clinical teams can improve the delivery of evidence-based care for people living with CKD.

The increasing complexity of healthcare, particularly in the setting of multiple long-term conditions, has increased the propensity of secondary care towards working in specialist silos without a holistic overview of a patient. Primary care has traditionally held this role for patients and their carers. The introduction of the ICS teams provided the opportunity to bring these two seemingly disparate themes together for people living with long-term conditions by focusing on population health, earlier diagnoses and providing care in the patient's own 'neighbourhood'. CKD and the often related cardiometabolic conditions have profound impact on quantity and quality of life, with costs estimated to rise to at least £7 billion per year for the UK. Approaches to deliver evidence-based early interventions at scale in a real-world setting have been limited. The ICS may be able to support systems to allow early diagnosis, risk stratification and evidence-based medicine optimisation, primarily for CKD but with impact for related cardiometabolic conditions

LUCID integrated virtual multidisciplinary team meetings for CKD led to medication optimisation of 590 people living with kidney disease, many of whom had other cardiovascular comorbidities. The LUCID intervention provides a model of care that could be extended to other conditions such as cardiometabolic, respiratory and mental health conditions. Additionally, future work will focus on non-pharmacological interventions such as lifestyle and exercise interventions.

As mentioned above, LUCID may represent an efficient model to deliver improved patient and professional educational awareness, medicine optimisation and risk stratification for people living with CKD within at an ICS-wide population level. The model may be applicable to other long-term conditions and further work is required to assess this. This will start to address the major challenges healthcare systems face of people living with multiple long-term conditions and the related impact on quality and quantity of life, but further work is required to assess this.

Reference

Major RW et al. (2025) Integrated primary and secondary care optimizes the management of people with CKD—the LUCID project. *Clinical Kidney Journal:* Vol. 18; No. 4.

https:/doi.org/10.1093/ckj/sfaf049

The following are examples of other clinical areas where innovative integrated and personalised approaches to care provision have been adopted.

Case Study Four:
Kent Community Health NHS FT – Frailty Virtual Ward

This example using the virtual ward model of care describes how clinicians in Kent are supporting people living with frailty in their own home, through a frailty Hospital at Home virtual ward.

The frailty Hospital at Home virtual ward was set up in response to COVID-19, to help people living with frailty avoid going to hospital. The ward is run by Kent Community Health NHS Foundation Trust (KCHFT) Community Frailty Team, in an area with a population of 500,000, which includes 275 care homes and more than 6,000 care home residents.

As a coastal area which has traditionally attracted retirees, the team provide services in locations with a higher frailty need than much of the UK.

How does the frailty Hospital at Home virtual ward help people?

The team is composed of consultant geriatricians, doctors and advanced clinical practitioners, who accept referrals from paramedics, GPs, care homes, acute trusts, and community hospitals and teams. They provide an alternative to hospital care in the person's home and in care homes.

Their motto is: "We find out what you would want, and we try to provide it".

The team cite an example where they supported a patient in his mid-80s who had been discharged from hospital the week before. He had been feeling unwell and a blood test showed severe kidney problems. He didn't want to go to hospital if it could be avoided.

The team assessed him at home and took further blood tests using point-of-care testing. They adjusted his medication and worked with the urgent community

response team to provide equipment and personal care. They reviewed him daily either virtually or personally.

He was discharged from their care a week later feeling much better and his kidney function had returned to normal. He was very pleased he had not needed to go to hospital.

A relative of the patient said: “We were over the moon when we realised we could have treatment at home rather than going to hospital. The service the team provided was second to none and he was so much better when he was discharged”.

The Frailty team have found that benefits to the patient include:

- The option of hospital-level care provided in their own home, which patients like
- They can be closer to family support networks, which can help their recovery
- Feedback has been hugely positive.

The team start their day with a virtual board round, reviewing the caseload remotely, and then go out on face-to-face visits, whether to new assessments or reviews. Most contacts are face-to-face, but they undertake some virtual assessments using video.

Team members agree it is rewarding to be part of a dynamic programme. There is a shared culture of learning, always keeping patients’ wishes at the heart of the care they deliver and seeking ideas on how they could further develop our service.

One trainee said: “It’s a truly amazing feeling, when we treat someone with delirium at home with IV (intravenous) fluids and they improve within the hour, being back to themselves.”

“Patients are so thankful to us for being able to stay in their own homes. It means the world to them”.

Key outcomes

By October 2021:

- The team saw 3,721 patients
- They had 200 referrals on average each month
- They helped 90% of patients stay at home
- 45% of the assessments were virtual (higher during COVID peaks)
- 7% of our patients were readmitted to the virtual ward.

Their top tips for setting up a virtual ward:

- It is possible to undertake a good virtual assessment of the patient in their own home, often supported by the paramedic team or a patient's family
- A daily morning multidisciplinary team meeting is vital to make sure the team know what is going on and learn from each other
- They all had to learn new skills
- They suggest not buying point-of-care testing equipment without spending time learning the quality control and protocols
- Virtual assessments using video technology work well for frailty assessments and reviews
- It is important to make sure a team has a really good way to run a caseload
- Pharmacy support is essential
- Hold a steady nerve, especially if you are doing what the person wants.

Authors:

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Shelley Sage, Consultant Practitioner for Frailty, Kent Community Health NHS Foundation Trust

Dr Shelagh O'Riordan, Consultant Community Geriatrician, Kent Community Health NHS Foundation Trust

Reference – for further information:

NHS England » Virtual wards empower the people we care for in east Kent

Case Study Five:
Models of Care, Right Care, Right Time

This case study describes the work of South East Coast Ambulance Service (SECAmb) who are redesigning their clinical operating model to better meet the needs of patients through the introduction of eleven Models of Care (MoC), aligned with their clinical strategy.

The clinical operating model in place prior to the redesign piece did not meet the needs of patients. Feedback described long waits, an undignified experience, being in pain for too long, feeling fearful and sometimes not wanting an ambulance as the patient only needed help to get up, move or be checked over. Paramedics described not getting enough experience in certain situations, feeling unskilled to assess certain conditions, practising in a risk adverse manner, such as conveying people to hospital just in case, and sometimes being called inappropriately to a case, such as a dying patient who really required end of life medication prescribed.

The core principle of SECAmb's strategy is to adapt their existing clinical operating model to ensure that a timely emergency ambulance response, crewed by paramedics, is dispatched to emergency (Group A) patients. The strategy also sets out how the service will adapt to meet the needs of patients who require urgent care (Group B patients) through virtual mechanisms including virtual clinical consultations, remote prescribing, and signposting to other appropriate services.

To enable the delivery of the strategy, the Trust's clinical leaders created the eleven models of care that represent a group of health conditions. Each MoC describes SECAmb's current internal processes for managing patients with that specific health condition and sets out how they intend to manage patients going forward.

This programme of work will deliver the changes required for the 11 MOC to be implemented and embedded into their internal systems and to ensure that external system partners are aligned with the changes.

While the individual models of care describe how SECAmb approach specific patient groups, they operate collectively, giving aggregate and scalable benefits therefore requiring them to be delivered as such and not individually.

The rationale for these improvements was that SECAmb recognised that they did not match their response with patient need, for example the same workforce would respond irrespective of the patient need. In other words, a patient with high acuity, and low complexity of needs would receive the same level of resource as a patient with low acuity but highly complex needs. This resulted in care no longer meeting

the full needs of the patient, and experience and wellbeing of the patient being adversely impacted.

Using the concept of care navigation, the new way of working involves system collaboration and the use of virtual consultations to establish more precisely what the patient needs. They continue to focus on a consistent emergency ambulance response to the most critical patients who present with new, acute onset pathologies with time limited therapeutic windows, for example ST elevation myocardial infarctions (heart attacks), stroke, and trauma cases. These are categorised as group A patients, and the new model of care allows existing resources to be refocused to provide a better response to those with these emergency and critical conditions.

Using virtual consultations, that closely as possible mimic a face-to-face consultation, undertaken by an Advanced Paramedic Practitioner (APP), or someone supervised by an APP, differentiates the patient's need, stratifies and manages the clinical risks, and schedules their care (ranging from emergency paramedic ambulance response, through referral to in-hours specialist service, to self-care/discharge). Those patients may have acute onset pathologies but conditions which do not have a time limited therapeutic window. They may however, still be complex or cryptic in nature requiring senior clinical input. These are the Group B patients. The Table below lists the characteristics of the two groups.

Group Characteristics	
Group A	Reversible Cardiac Arrest Chest pain, Cardiovascular, and Endocrine Stroke and Neurological Maternity, Obstetric, & Newborn Care Major Trauma
Group B	Abdominal Pain, GI (inc OD/poisoning), and GU Palliative and End of Life Care, Dying Falls, Frailty, and Older People Medical/Illness (respiratory, ENT, eyes, skin) Mental Health & Addiction Trauma, Minor Injury, & MSK

SECAmb recognised the need to preserve resources in order to ensure a timely response for reversible cardiac arrest calls, and other time limited pathologies

(Group A patients). They cannot lower the standards of care for patients who call 999 with lower (immediate) acuity calls, or calls with higher complexity, but acknowledged the current operating model was not working well. Through using virtual consultation they aim to improve patient safety, choice, flow, and staff wellbeing (work intensity, case mix).

There is an opportunity to better understand and approach clinical risk at place and system level through the features defined within Virtual Response and to differentiate the patient's needs, stratify (balance, and mitigate risks) and schedule the care to when the system is best placed to receive the patient, and which provides the best experience for the patient.

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Case Study Six :
Right Care Right Time

South Central Ambulance Service (SCAS) have embarked on a new way of working that involves developing and embedding urgent care pathways to ensure patients receive the right care, first time, through improved clinical coordination, digital integration, and future service innovations. They recognised that the current, now historic way of working was to convey patients to the emergency department at hospital, which may then have led to alternative pathways. Their aspiration with this developmental piece of work was to consider appropriate pathways at the start, with conveyance to the emergency department as not being the first port of call.

Workload comprised emergency care, those experiencing cardiac and respiratory conditions, stroke, maternity emergencies, major trauma and other categories, or urgent care comprising mental health, out of hours GP work, palliative care, hospital referrals and much more. Supporting the initiative were four pillars:

1. **Urgent Care Pathways** - Access to key services across the footprint for the clinicians to refer their patients to directly
2. **Clinical Governance** - Ensuring the safety & consistency of all Urgent Care Pathways across SCAS
3. **Digital Software Solution** – 'SCAS Connect' - Visibility of those services for our mobile clinicians
4. **Mobile Data Terminal** - Supporting the reporting, data & metrics to understand the patient journey to improve care.

The aims of the improvement work included improving the quality of care, outcomes, safety and experiences for all our patients, and the number, access and visibility of urgent care pathways. They aimed to embed Urgent Care Pathways into every day clinical practice as well as to support staff to provide the best possible care to their patients, making simple, safe and efficient decisions and to empower them to streamline services to improve their working day. The new ways of working also supported operational performance measures and national & local strategies.

New pathways developed cover hospital care and community care. At the time of writing 170 new pathways have been developed. This has resulted in patients accessing SCAS' services according to care need rather than accessing one of two pathways, either emergency or urgent care, often resulting in a hospital visit.

There now exist more nuanced targeted pathways that utilise a range of hospital services if required, such as frailty and falls, and single point of access, or

community services, such as virtual wards, urgent community response teams, nursing care support teams, palliative care and end of life teams.

Reported benefits include improved outcomes, a holistic approach to care, a patient-centred approach, enhanced emotional support, improved physical comfort, reduction in the need for service recall, and reduced journey time through the healthcare system.

SCAS continue their developmental work with plans in place for further future service developments, and clinical pathway developments.

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