FOR HEALTHCARE LEADERS

HSJ 2013 AWARDS

BEST PRACTICE REPORT

The judges

Jules Acton, director of engagement and membership, National Voices

Fiona Adshead, independent health consultant

Dr Charles Alessi, chairman, National Association of Primary Care and NHS Clinical Commissioners

Suzie Bailey, service improvement director, Sheffield Teaching Hospitals FT and Fellow Health Foundation"

Tim Ballard, vice chair, Royal College of General Practitioners

Professor Juliet Beal, director of nursing: quality improvement and care, NHS England

Professor Viv Bennett, director of nursing, Department of Health and Public Health England

Helen Bevan, chief transformation officer, NHS Improving Quality

Dr Amit Bhargava, GP and clinical chief officer, Crawley Clinical Commissioning Group

Steven Birnie, head of operations, NHS Professionals

Chris Bull, local government advisor, Local Government Association

Stewart Buller, marketing and communications director, NHS Professionals

Professor Alistair Burns, national clinical director for dementia

Lynn Callard, director, Verto Vis

Heidi Carter, head of healthcare marketing, Sanofi

Miranda Carter, executive director of assessment, Monitor

Dr Peter Carter, chief executive and general secretary, Royal College of Nursing

Lord Patrick Carter of Coles, chair, Co-operation and Competition Panel for NHS Funded Services

Sir Andrew Cash, chief executive, Sheffield Teaching Hospitals FT

June Chandler, national officer, UNISON

Nick Chapman, chief executive, NHS Direct

Karen Charman, director of engagement, NHS Employers

Sophia Christie, director, UKPrime

David Colin-Thomé, independent healthcare consultant, DCT Consulting

Jane Cummings, chief nursing officer, NHS England

Ann Deehan, infrastructure workforce senior manager, Department of Health Research Networks

Dr Mo Dewji, national clinical lead — primary care, NHS England

Dr Mike Durkin, director patient safety, NHS England

Peter Edwards, senior partner, Capsticks

John Egan, clinical innovation director, Medical Technologies Innovation and Knowledge Centre University of Leeds

Dr Sam Everington, chair, Tower Hamlets Clinical Commissioning Group

Mike Farrar, chief executive, NHS Confederation

Katherine Fenton, chief nurse University College London Hospitals FT and visiting professor, London City and London Southbank Universities

Dr Steve Field, chief inspector of general practice, Care Quality Commission

Alistair Finney, portfolio director (north central London and north east London), NHS Trust Development Authority

Simon Gilby, chief executive, Wirral Community Trust

Chris Gordon, programme director of QIPP, NHS Leadership Academy

Dr Shane Gordon, GP and chief officer, NHS North Essex Clinical Commissioning Group

Dr Sara Hedderwick, deputy chair consultants' committee, British Medical Association

Paul Hodgkin, founder and chief executive, Patient Opinion

Marisa Howes, national officer, Communications and Policy, Managers in Partnership

Dr Judith Hulf, responsible officer and senior medical advisor, General Medical Council

Paul Jebb, assistant director of nursing (patient experience), Blackpool Teaching Hospitals FT

Charlie Keeney, director — CCG and primary care capacity and capability programmes, NHS Improving Quality

Dr James Kingsland, president, National Association Primary Care and chair, NHS National Primary Care Network

Professor Mayur Lakhani, GP and chair, The National Council for Palliative Care"

Shirley Law, director of learning and development, Dementia Services Development Centre University of Stirling

Geraint Lewis, chief data officer, NHS England

Toby Lewis, chief executive, Sandwell and West Birmingham Hospitals Trust

Dr Rebecca Lumsden, clinical development manager, Association of the British Pharmaceutical Industry

Karen Lynas, deputy managing director, NHS Leadership Academy

David Maher, programme director, NHS City and Hackney Clinical Commissioning Group

Jill Matthews, head of public health and primary care, NHS England (Midlands and East)

Sir Neil McKay, consultant, Neil McKay Associates

Dame Julie Moore, chief executive, University Hospitals Birmingham FT

Mark Newbold, chief executive, Heart of England FT

Shaun O'Hanlon, chief clinical information officer, EMIS and Rx Systems

Sir John Oldham, chair, Independent Commission on Whole Person Care

Doug Patterson, chief executive, London Borough of Bromley

David Peat, partner, David Peat Solutions

Radhika Rangaraju, advancing quality programme manager, Advancing Quality Alliance

Paul Rice, head of technology strategy, NHS England

Dr Keith Ridge, chief pharmaceutical officer, NHS England, Department of Health and Health Education England

Neil Riley, assistant chief executive, Sheffield Teaching Hospitals FT

Laura Robinson, policy and communications advisor, National Voices

Sonia Roschnick, head of unit, Sustainable Development Unit

Dr Rebecca Rosen, senior fellow, Nuffield Trust

Dr Andrew Rowland, member of the consultant's committee, British Medical Association

Peter Shergill, head of strategy, Celesio UK

Sam Sherrington, head of nursing and midwifery strategy, NHS England

Professor Janice Sigsworth, director of nursing, Imperial College Healthcare Trust

Inderjit Singh, head of enterprise architecture, NHS England

Dr Jagdeesh Singh Dhaliwal, medical advisor — technology and innovation, NHS Direct and Keele Medical School

John Sitzia, chief operating officer, NHS National Institute for Health Research Clinical Research Network

Tony Spotswood, chief executive, Royal Bournemouth and Christchurch FT

Dr Chris Streather, managing director, South London Academic Health Science Network

Baroness Glenys Thornton, former parliamentary under-secretary of state, Department of Health

Christine Walters, associate director of IM&T, The Pennine Acute Hospitals Trust

Steven Weeks, policy manager, NHS Employers

Stephen Welfare, managing director, Health Education East of England

Dr Jonathan West, clinical director, Adult Mental Health Directorate Oxleas FT

Dr Suzette Woodward, director of safety learning and people, NHS Litigation Authority

Spreading best practice

2013 has been a record breaking year for the HSJ Awards. We received 1,101 entries – the largest number ever received in the awards' 32 year history — and 139 unique organisations made the shortlist. Our 81 judges were kept busy, and had the privilege of reviewing some of the best work in UK healthcare, as well as the challenge of deciding who our winners should be.

Selected from those entries, the winners and finalists are presented here in the *Best Practice Report* so that their innovation can be an inspiration and blueprint for change for other organisations working in healthcare.

2013 will be remembered as the year the *Francis Report* exposed the full scale of the care failings at Mid Staffordshire Foundation Trust. It painted a picture of an organisation where the basic values of compassionate healthcare had been lost.

There can surely be no better time, then, to recognise and celebrate those healthcare organisations working to ensure that compassion is at the centre of everything they do. We have therefore introduced a compassionate care category to this year's awards, supported by the Department of Health and secretary of state Jeremy Hunt.

These award entries show a health service successfully finding ways to deal with very complex challenges in a very complex time. Spreading best practice is crucial to the continuing drive to improve the quality of healthcare. This report will help in that process.

I am sure you will find it both inspirational and useful.

Alastair McLellan
Editor, *HSJ*

Contents

University College London Hospital FT

University College London Hospital UCLH is a large group of hospitals run by clinicians. During a period of considerable change and challenge for the NHS it has consistently delivered excellent outcomes for patients, innovative service change and world class research. We have made quality of care our first priority. As a result of a decade of focus and investment in patient safety and quality improvement, we are delighted to have reduced the risk of mortality so that we now have the best survival rates in the country.

The past year has been an exceptional one for UCLH: providing inpatient care for the Olympic Family, opening an outstanding new facility for cancer patients and improving clinical synergies by working with local NHS partners to welcome a new hospital to the group; the Royal National Throat Nose and Ear Hospital (RNTNEH).

Our achievements include:

- lowest mortality rates in the country;
- second best patient satisfaction score in London;
- major reductions in risk of harm;
- top performing acute trust in London;
- 85.3% of staff would recommend us (NHS mean 62.8%);
- A&E in the top five trusts nationally as rated by patients (scored 9.0 in inpatient survey) and achieved the 95% access target;
- achieved £100m+ savings over last three years;
- achieved highest NHSLA ranking — level 3.

UCL is founder and very active member of UCLPartners, now the largest academic health science system in the world. We have been committed to clinical leadership for the past decade and we operate a mature, devolved model, over half our board of directors are clinicians.

In 2012 our innovative 'Making a Difference Together' programme began, focusing on providing the best patient and staff experience. This included developing the trust's values with patients and staff — safety, kindness, teamwork and improving — these are now integrated into everything we do.

We have also focused on getting the basics right, for example our mandatory training compliance, which was at 37% in 2011, has increased to 82%. Staff appraisal rate is over 90%, in 2011 it was 46%.

We opened the UCH Macmillan Cancer Centre which offers the most advanced services of its kind, designed with patients, around their needs and aiming to keep them home-based with their families for longer. With a goal of ambulatory independence, it has no beds, but offers holistic support, wellbeing and survivorship at its heart. It is also technically extremely advanced including the UK's first PET MR scanner.

We launched alternatives to inpatient admission including our Hospital@Home service, which provides care in a patient's own home. Our strategy is to be the best in Europe in cancer and we have made progress in some key areas such as proton beam therapy and discussions around strategic service shifts in cardiac and cancer care in London.

Digital health services are providing communities with remote access to Queen Square clinicians, enabling MS patients to manage a relapse without an inpatient admission and, through text messaging, reducing readmission rates for adolescents with epilepsy.

We have increased patient access to reduce inequalities, including "London Pathway" which provides compassionate care to homeless patients to end a cycle of health service dependency. We worked with Camden CCG to better understand inequalities and provide integrated care particularly to our frail elderly population.

Over recent years we have increased the range and depth of our collaborative partnerships such as those with Macmillan Cancer Support, Camden CCG, the Royal Free Hospital, British Olympic Association, Barts, the Epilepsy Society and our joint venture partners, to transform patient care including:

- creating world class brain cancer services;
- a centre of excellence for head and neck services;
- advancing the London cardiac/cancer collaboration.

In addition we established innovative joint ventures such as Radiology Reporting OnLine, providing 24/7 image interpretation.

We also opened the Institute of Sport, Exercise and Health, an Olympic legacy collaboration between UCLH, UCL, British Olympic Association, English Institute of Sport and a private hospital group. The institute is a clinical and research centre of expertise.

Contact

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Award sponsored by

NHS Leadership Academy

Judges' comments

- *This was an excellent example of comprehensive clinical leadership and delivering outstanding patient care and treatment.*
- *Demonstrated that the board clearly leads for quality.*

HIGHLY COMMENDED

"Punitive to supportive" — a 12 month transformation

Avon and Wiltshire Mental Health Partnership Trust

In just over 12 months, AWP's trust board has led a transformation in the leadership, culture and approach of the organisation, reflected in the publication of two starkly contrasting independent reports by the same review team.

The trigger for radical change was an independent review of governance and management arrangements in Avon and Wiltshire Mental Health Partnership Trust completed in January 2012 which severely criticised the organisation. Published by the strategic health authority in June 2012, the independent report noted a trust culture that was "centralist, top down, and target driven, bureaucratic and controlling". It said, "There is an urgent need to change the culture and leadership from one of central control to one in which all staff are positively engaged in determining and delivering safe, high quality care."

In May 2013, the same investigation team revisited the trust and described it as "open, honest, transparent, and supportive and focused on the delivery of high quality care". It described the trust as "completely different and unrecognisable from our previous visits in a very positive way."

The team's report says organisational culture has shifted from "punitive to supportive" and that clinical engagement is now much more evident. The trust board, under the leadership of new chair Tony Gallagher and chief executive Iain Tulley, led this transformation, enabling and empowering a restructured leadership team, managers and staff.

It drove through significant change, involving widespread engagement with staff, service users, carers, commissioners and other stakeholders. It has revised its strategic objectives, established a trust motto "You matter, we care" and agreed a new set of values:

PRIDE

Passion, Respect, Integrity, Diversity and Excellence.

Contact

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FINALIST

Engaging the public and stakeholders in the priorities of the governing body

Erewash CCG

As a newly formed CCG we have paid considerable attention to the importance of getting the functioning and working of the governing body correct.

In the wake of the Francis report it was made very clear the failings of various boards in their responsibilities for the safety and experience of the patients. Board leadership involves not just the clinicians and directors but also the lay members. We have had enormous support and encouragement from our lay members to ensure the governing body functions to the highest standard it possibly can.

The continual improvement cycle that we have employed for the board means that the outcomes for the attendees is one of motivation, encouragement and improved morale.

We now have a fully engaged board membership where the qualities of listening, challenge, feedback and learning are deployed. Several external and public attendees have commented on the open transparent culture apparent when they have attended. The other welcome comment was around how they felt the governing body really cared about the patients and public we were discussing.

Contact

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FINALIST

Leading the way in care and compassion

NHS Southern Derbyshire CCG

Patients are at the heart of NHS Southern Derbyshire CCG, where the board is leading the way in creating a high performance culture of care and compassion that is making a significant difference to people's lives.

This progressive leadership has resulted in significant successes with:

- a £32m productivity improvement from services;
- a new older people's centre;
- a falls prevention service;
- improvements in the quality of care for people with diabetes.

The local patient story begins every board meeting and serves as a strong reminder of the organisation's unswerving commitment and dedication to improve the lives of the population it serves.

Leading by example and setting a tone from the top has ensured that the values of support, trust, innovation, communication and clarity have been embedded into the organisation, resulting in highly motivated staff and clinicians who are working together for patients.

A positive and compassionate environment has been established where each member of staff is aware of the role that they have to play and the difference that they can make in the organisation. A champion of patient participation, the board ensures that patients have a key role in decision making through lay member representation and the CCG's health panel of over 300 local patients.

Patient focus has been strengthened by the strong governance structures put in place which has resulted in 97% of GP practices having active patient participation groups. A caring, compassionate and committed board has created a truly patient focused organisation where CCG staff, GP practices, patient participation groups, Healthwatch and local authority colleagues are all working closely in partnership to deliver the best health outcomes for their communities.

Contact

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FINALIST

Northumbria Healthcare FT: board leadership for quality

Northumbria Healthcare FT

The Northumbria Board demonstrates a stable and active leadership for quality. This includes:

- consistent articulation of organisational vision and values;
- structured ward assurance walk rounds by board members;

- visible board leadership for specific quality and patient safety days;
- positive feedback for highly engaged staff;
- the development of an extensive patient experience programme capturing the views of 30,000 people annually.

Recent achievements associated with effective board leadership include:

- three year programme delivering a 50% reduction in patient harm;
- 95% MRSA reduction over six years;
- 81% reduction in trust apportioned *Clostridium difficile* rates over five years;
- 80% reduction in orthopaedic surgical site infection;
- 51% reduction in hip fracture mortality since programme instigated by trust board in 2010.
- multi award winning stroke service recognised for acute service redesign, quality of clinical care and innovative peer support programme;
- nationally recognised HIP QIP programme — best in NHS for timely surgery, consistently delivering best practice;
- identified by the Health Foundation as an exemplar site to deliver "Dignity in practice for frail older people";
- National Lean Academy award for the development of the Quality Council and Northumbria Improvement Way;
- innovative, award winning programme with real time measurements reported back within 24 hours of speaking to patients;
- rapid improvement in national CQUIN results improving from 116th in the country in 2009 to 16th by 2011;
- Northumbria identified by King's Fund researchers in 2012 as one of only 30 trusts to be delivering consistently good patient experience in acute, outpatient and emergency care;
- development of a patient helpline resulting in orthopaedic readmissions being halved.

Contact

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FINALIST

The board of the Clatterbridge cancer centre, providing the best cancer care to the people we serve

The Clatterbridge Cancer Centre

The Clatterbridge Cancer Centre board offers exemplary leadership, providing a clear vision for the organisation and driving forward improvements in cancer treatment and care. The trust board excels at bringing together the board of directors and the council of governors.

This dedication to excellence in leadership has seen the trust become one of the largest networked cancer centres in the UK, treating and supporting more than 27,000 patients each year with pioneering chemotherapy, proton therapy and radiotherapy treatments.

Board leadership has been a key factor in driving forward the development of the organisation, which sees it now poised at one of the most significant points in its history. Proposals to build a new world class cancer centre on a large acute teaching hospital campus will bring integrated cancer care along with life saving research, closer to even more patients across Merseyside and Cheshire.

A clear focus on quality has brought numerous benefits to patients, and the trust regularly features as one of the top performers in national patient and staff surveys and consistently achieves the highest grading in NHS performance ratings. The board strives to establish vital partnerships across the region and through this partnership approach has been able to:

- improve services;
- increase choice and convenience;
- improve patient experience.

A comprehensive acute oncology team now sees 92% of all acute oncology patients across a network of seven acute hospitals speeding up the diagnosis and treatment of cancer related illness in A&E settings. The trust's state of the art mobile chemotherapy unit is significantly increasing the number of patients able to access treatment closer to home. The board continues to strive to develop services to ensure they are cost effective, efficient and better for patients.

Contact

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FINALIST

West Cheshire Clinical Commissioning Group

West Cheshire Clinical Commissioning Group

West Cheshire Clinical Commissioning Group was one of only eight first wave CCGs authorised with no conditions. The ethos of the group is one of a "double helix" where managers and clinicians cooperate in an equal partnership, getting the best out of each profession to deliver the organisations goal: "making sure you get the healthcare you need".

During 2012/13, operating as a shadow body, we managed a fully devolved commissioning budget of £300m on behalf of our PCT predecessor. Our plan for 2013/14 includes in-year QIPP targets as well as programmes of transformational change to address this gap.

West Cheshire CCG is a leader of Altogether Better Cheshire, one of four national "whole place" community budget pilot areas that will test new, radical and local approaches to delivering public services. We are using innovative ways to bring clinicians and social care leaders together to lead transformational change, supported by bold attempts to try out new contracting methods.

We have established a local clinical senate, with representation from primary, secondary, community and social care leaders, to ensure that our clinical leadership involves more than just GPs. Our local GPs, acting as clinical commissioning leads, have been at the forefront of delivering quantifiable improvement in health care for stroke patients, diabetes patients and heart disease patients.

Our senior leaders regularly go out on the road to meet local people and listen to their concerns. Our practices have over 1,000 patient participation group members, and the CCG has over 1,500 followers on twitter. We have been highly commended for our patient intelligence work in the National Patient Experience Network National Awards. Thanks to this approach, communicating with the public and engaging with patients is embedded in everything that we do and is a core part of our commissioning delivery plan.

Contact

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Clinical Commissioning Group of the year

WINNER

Sandwell and West Birmingham Clinical Commissioning Group

Sandwell and West Birmingham CCG is one of the largest CCGs, looking after a population of 525,000 with high levels of deprivation. The CCG has a clear vision "Healthcare Without Boundaries" reflecting their ambition to reduce health inequalities. It moved at speed to establish in first wave and was approved with no conditions. The rationale for one of the few cross local authority boundary CCGs is compelling and reflected in stability of membership seen. Highlights include:

- improving patient experience through scrutiny and tight performance monitoring;
- substantial savings from contracts negotiated (£16m in 2012/3), reducing duplication and sourcing community/third sector providers with improved quality and cultural sensitivity;
- working truly in partnership and appointed guardian of Right Care Right Here by partners;
- frontline innovation implemented;
- strategic commissioning for major services and contractual changes;
- playing a leading role for CCGs in challenging contracts;
- implementing stroke (AF) assessments quickly and potentially saving lives and resources through more effective screening;
- top performer in medicines management and delivery in practices;
- designed specialist communications coordination centre and service delivered with 75% less resources;
- appointed as an End of Life pilot area for Marie Curie Cancer Care to look at new social investment models.

The CCG has 110 GP practices set in five local commissioning groups (LCGs) with strong governance. After scrutiny, the CCG was given early delegated authority from two clusters in October 2012, a reflection of confidence in a CCG straddling boundaries.

The CCG secured unanimous strategic support for its approach by undertaking an independent survey and audit for Right Care Right Here partnership. As a result strategic objectives and action plan were agreed with all nine health and local government organisations and gave the CCG ability to move to delivery quickly and bring care closer to home.

The CCG has a commissioning strategy, which it has engaged on with health and well being boards, healthcare colleagues, members and patients. The CCG uses its local LCG structure to analyse the detail of local needs. GP practices and patients have asked for improvements to integrated care in the community and so it is working with existing providers to specify and tender community healthcare to meet needs.

The CCG works in a complex health economy with a wide range of providers. It is lead commissioner for services from Sandwell and West Birmingham Trust, West Midlands Ambulance Service and NHS 111 on behalf of CCGs. It has managed its £609m budget through performance management, successfully reducing A&E activity. Reduction in beds in their two local hospitals and a £16m reduction in acute income was negotiated by the CCG, contributing to QIPP targets. Regular care quality review meetings are held and are already seeing improvement in net promoter scores and no "never events".

The CCG chair leads the clinical collaborative network, coordinating shared commissioning activity across five CCGs. To help manage risk across the health economy, the CCG has brokered financial risk-sharing agreements to minimise risk and raised concerns in areas that are a risk to health. The CCG is part of "The Compact" for Birmingham, Solihull and Sandwell. This shared leadership across NHS commissioning.

The CCG has an organisational development strategy that invests in board leadership and developing future leaders via the LCG structure and clinical leader network involving over 50 GPs in roles within the CCG. As a membership organisation we prioritise communications and engagement to ensure everyone can have a voice and feel they are well informed so they can contribute and feel part of the CCG.

Member communications include *Members News* (30 issued), and an active online forum. A performance briefing pack goes direct from the board so members can contribute and member events. A learning culture is essential so the CCG has delivered multidisciplinary protected learning time (PLT) events attended by 400 colleagues and also local LCG based events.

A "can do" culture pervades and staff are supported in roles with monthly "lunch and learn" sessions, personal email weekly from the accountable officer and a staff council.

Contact

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Judges' comments

- *This is a true recognition of a system under responsibility for the population in healthcare.*
- *A holistic approach to healthcare in changing a real connection with individuals and communities. The importance of the CCG team was evident and central from the start.*

HIGHLY COMMENDED

West Leicestershire Clinical Commissioning Group

We have been operating in shadow form for the last two years, with a fully delegated budget (delivered on plan both years) and responsibility for managing all of our provider contracts.

One of the first 35 CCGs nationally to be authorised, we are now formally established with no conditions. What makes us stand out is the way we have balanced genuine enthusiasm for a bottom up approach, to create local solutions, with the maturity to collaborate with neighbouring CCGs when size matters For us, excellence is evident in the breadth of our commissioning activity:

We are one of the few CCGs who have completed an end to end service redesign, consultation and re-procurement process — commissioning a redesigned urgent care centre in Loughborough

We are developing a new local pathway and referral implementation system and have supported all our member practices through an annual appraisal process. Last year we more than met the national health check target for invitations

Nearly all of our member practices are now registered and trained to undertake spirometory tests. Prevalence rates for COPD, diabetes and end of life have increased by 95%, 90% and 68% respectively. We have rolled out an automated telehealth service.

We are establishing a "virtual ward" structure to help to support patient enablement while reducing the need for hospital admission (proactive care). Built by patients and practices working as partners, so far it has:

- seen 580 patients with long-term medical conditions;
- enabled 80 housebound patients have a level three medication review undertaken by a pharmacist in their own home, resulting in improved understanding of medications and rescue packs;
- enabled 1,085 first contact checklists and 2,669 referrals to be made to low level preventative services via the multi-agency First Contact Scheme within its second year (a 30% increase on the first year) — 80% of these people remain living independently in the community a year on.

Our medicines optimisation and prescribing strategy was developed with 80% of our member practices, clinical experts and more than 1,500 members of the public — saving us a total of £1.7m to date.

We have consistently demonstrated our appetite for getting on with things and not waiting for someone else to come up with the answers or issue an instruction. We also have a different approach to clinical conversations than we did in previous organisational guises. We haven't always got it right, but we've learned from these experiences and are stronger because of them.

Contact

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FINALIST

Bradford City Clinical Commissioning Group and Bradford Districts Clinical Commissioning Group

We have a simple vision of joining up care for people in Bradford so that they get the right care in the right place, first time.

The simplicity belies the enormous complexity of lining up the strategic intent of health and social care organisations, with their own business imperatives and competing organisational priorities.

All recognise their mutual dependency and the need to operate as a whole system to remain viable.

Based on patients' views, commissioners have driven the programme — supporting providers to come together to achieve a shared vision.

We have established integrated care in communities across Bradford, testing out new ways of working to support more people, with more complex needs at home.

Predictive risk stratification of practice populations supports clinical intelligence to enable the integrated locality teams to begin to work more proactively to support patients to stay well. The joined up approach means that we are able to provide a coordinated and rapid response.

"I now know there's all that support I can have . . . it's supportive, it's reactive and it's value for money"

Non-elective admissions are falling and our social care partners are one of the highest performing authorities in avoiding delayed discharges.

We have used non-recurrent, CQUIN and reablement funds to enable hospital services to turn to face the community, developing a coordinated intermediate care tier of services.

Home care reablement is working alongside therapists to deliver rehabilitation programmes. Geriatricians and occupational therapists are working together in A&E to enable older people to be discharged home. A virtual ward has been established and is being expanded this year to incorporate local authority reablement services to deliver a comprehensive care to optimise people's independence, health and wellbeing.

"It's what kids today call a 'no brainer'! It's so obvious to keep patient central, share ideas and resources?"

Contact

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FINALIST

Newark and Sherwood Clinical Commissioning Group

Newark and Sherwood Clinical Commissioning Group have embarked on an ambitious and innovative programme designed to improve care for patients with long-term conditions including older people and those with cancer.

Working with partners across the health and social care community, Macmillan Cancer Support and other third sector organisations, PRISM is delivering patient-centred, integrated care for people living in Newark and Sherwood.

PRISM stands for:

- Profiling Risk;
- Integrated Care;
- Self Management.

These are the three key drivers identified nationally as needing to be in place for successful long-term conditions management.

The PRISM approach provides coordinated, reactive and preventative care, and enables people to take an active role in their own health. The focus of PRISM is on improving the way

that care is provided to give the best possible outcomes for people.

The key principles of this new approach are:

- identifying people early who may have complex health and social care needs;
- providing them with intensive and specialist support to get them well again;
- working with them to self-manage their conditions to ensure they remain well for longer, and maintain their independence.

Taking part as members of this ground-breaking partnership are:

- Newark and Sherwood general practices;
- community healthcare;
- mental healthcare;
- local hospitals;
- Nottinghamshire County Council;
- Macmillan Cancer Support
- local voluntary services.

This means that a person's whole needs can be addressed, and their journey through the health and care system coordinated.

PRISM went live across the whole of Newark and Sherwood in April, with three integrated care teams across the district created to work together to improve the lives of patients. In these teams, professionals from across health, mental health and social care as well as a volunteer services coordinator have come together to improve and coordinate care for people with the most complex needs.

Contact

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FINALIST

South Cheshire Clinical Commissioning Group

Evidence has demonstrated the need to ensure certain groups of patients with long term conditions feel supported. This evidence suggests that increased access to a clinician and involving patients in developing their management plan can achieve this goal, improving outcomes for a targeted group.

Innovation in primary care is key, both in terms of involving clinicians to develop evidence based schemes, but also in delivering these schemes within their practices. South Cheshire CCG has developed the primary care commissioning quality and innovation scheme (CQUIN) to meet these objectives. This scheme, developed by GPs, patients and managers focuses on two categories of patients that data shows are using acute hospital services more frequently and do not feel supported.

Practices are incentivised to carry out an in-depth face-to-face review with patients under the age of 19 who have been discharged with a diagnosis of asthma, and those who are over 75 discharged with a fractured hip or who are on at least four medications with a medical diagnosis. This review must take place within four weeks of discharge and consider a variety of elements including:

- medication compliance;
- mental health issues;
- carer support;
- understandable diagnosis;
- management plans.

Following this, patients will feel they fully understand their follow-up arrangements and will be less likely to be re-admitted into acute hospital services. Patients will be able to immediately respond to the primary care they receive via questionnaires, a completely new step in their management.

The scheme also requires clinicians to participate in further education to provide improved outcomes and quality of care. This scheme is being developed in parallel with the need to implement risk profiling and integrated teams, resulting in further care coordination with community services and decreased pressure on acute trusts.

Contact

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FINALIST

West Cheshire Clinical Commissioning Group

West Cheshire Clinical Commissioning Group was one of only eight first wave CCGs authorised with no conditions. The ethos of the group is one of a "double helix" where managers and clinicians cooperate in an equal partnership, getting the best out of each profession to deliver the organisations goal: "making sure you get the healthcare you need".

During 2012/13, operating as a shadow body, we managed a fully devolved commissioning budget of £300m on behalf of our PCT predecessor. Our plan for 2013/14 includes in year QIPP targets as well as programmes of transformational change to address this gap.

West Cheshire CCG is a leader of Altogether Better Cheshire, one of four national 'whole place' community budget pilot areas that will test new, radical and local approaches to delivering public services.

We are using innovative ways to bring clinicians and social care leaders together to lead transformational change, supported by bold attempts to try out new contracting methods.

We have established a local clinical senate, with representation from primary, secondary, community and social care leaders, to ensure that our clinical leadership involves more than just GPs.

Our local GPs, acting as clinical commissioning leads, have been at the forefront of delivering quantifiable improvement in health care for:

- stroke patients;
- diabetes patients and;
- heart disease patients.

Our senior leaders regularly go out on the road to meet local people and listen to their concerns. Our practices have over 1,000 patient participation group members, and the CCG has over 1,500 followers on twitter.

We have been highly commended for our patient intelligence work in the National Patient Experience Network National Awards.

Thanks to this approach, communicating with the public and engaging with patients is embedded in everything that we do and is a core part of our commissioning delivery plan

Contact

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WINNER
Northumbria Healthcare FT

The north east has some of the worst health outcomes in the country and yet Northumbria Healthcare continues to deliver high standards of care in an extremely difficult and challenging operating environment. We strive to ensure that every individual has an exceptional experience and we have one of the most extensive patient experience programmes of any trust in the country.

We are operating across one of the largest geographical and most rural areas in England, providing health services within North Tyneside and Northumberland and managing adult social care in Northumberland. All our hospitals received "excellent" rating for environment, food and privacy and dignity in the annual Patient Environment Action Team assessment.

Patients are at the heart of everything we do:

- 98% of patients attending for an appointment rate our services as excellent, very good or good;
- 95% of patients would recommend us;
- 94% of patients staying overnight rate their care as excellent, very good or good;
- 89% of patients staying overnight would recommend us;
- 92% of patients attending our A&E feel listened to and treated with respect.

Our strategy for continually improving quality focuses on improvement activities at four levels:

- our staff are actively encouraged to participate in improvement activities and a new feedback channel "We're listening" provides staff with a way of feeding in improvement ideas;
- our care teams work through an improvement plan to understand current performance, identify and prioritise opportunities for improvement and implement small test cycles of change;
- larger programmes of work that focus on change across the whole organisation and addresses some of our most important clinical priorities — organisational development, providing safer care, preventing orthopaedic readmissions, improving quality in critical care and developing an integrated care pathway for older people;
- our organisational readiness — creating a new forum, the Quality Council, to encourage innovation and help projects scale up, spread and change the performance of the entire system. Early work has included identifying a team with the skills to support improvement work and ensuring patients and carers are supported to contribute.

We have introduced an annual assessment programme, devised by the NHS Institute for Innovation and Improvement, to help wards identify potential improvements. Wards are assessed, without notice, at any time of the day or night.

We invest heavily in nurturing and developing our employees. Training programmes ensure we continue to develop our people. We have an open culture where everyone is encouraged to report incidents. We have recently rolled out electronic reporting trust wide, which, alongside the training offered, has led to a further increase in reporting rates.

Our organisation is made up of business units that are led by clinicians as well as managers. Together they have devolved

management, governance and budgetary responsibility. This approach has brought about much success including:

- continuing to meet the A&E target of 95% of patients being seen and discharged within four hours — performance for 2012/13 was 98%. Helped by taking steps such as placing a GP in emergency care to triage;
- introducing ambulatory care units — hugely successful in reducing unnecessary admissions, with around 700 patients a month now using the units. Patients with conditions such as DVT, cellulitis, pulmonary embolus and anaemia can be referred into the service for rapid assessment and intervention;
- a new specialist emergency care hospital scheduled for completion in 2015, will be the first A&E in the UK to have A&E consultants on duty 24 hours a day, seven days a week .

Telemedicine ensured rural areas have access to services. In Berwick a telemedicine service for fracture patients saves journeys to a general hospital to see consultants.

We also have strong links overseas having, for over a decade, supported a partnership with Kilimanjaro Christian Medical Centre in northern Tanzania. Through training their medical staff, they have been able to launch new services previously unavailable within Tanzania including endoscopy, laparoscopic surgery and the setting up of the country's first burns unit. Since 1999, around 4,000 Tanzanian healthcare professionals have received training from Northumbria employees.

Contact

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Judges' comments

- *The trust has excelled in applying the science of improvement. They measure what they care about and they use the data to produce extraordinary results.*
- *They have a long term strategic aim to create a sustainable urgent care system.*
- *They have been working with GPs over many years and are community focused.*

Provider trust of the year

FINALIST

Oxleas FT

At Oxleas, 81% of our staff would recommend our care to their friends and family — the highest score for any trust delivering community based services in the country. Furthermore, our staff rate us as the highest in the country in six further categories including job satisfaction and effective team working.

Our feedback from patients shows that this reflects their experience. This focus on quality, matched by effective management of our finances, is the result of excellent collaboration between clinicians and managers and longstanding productive partnerships with our local communities, our CCGs and our councils.

Quality is the central theme to our work at Oxleas. We have developed structures that promote high quality services and systems that provide assurance that these are a reality.

Our consistent high performance is demonstrated by:

- our patient feedback;
- audit results;
- CQC reviews which in eight services have found us completely compliant without recommendations for improvement.

We have excellent financial planning processes and are consistently rated by Monitor to be low risk (that is, receive the top financial rating). Oxleas' culture achieves excellence by creating an expectation of high standards supported by a skilled workforce with a shared vision.

Contact

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FINALIST

The Christie FT

The Christie bedrock is excellent patient care — recognised in the latest Care Quality Commission annual inpatient survey, where it achieved one of the top scores nationally.

Learning from patients is embedded throughout the organisation and the future of patient treatment is ultimately guided by the immense Christie clinical trials unit — where more than 400 trials could be taking place at one time.

Work has started on the development of the Manchester Cancer Research Centre (MCRC) — a collaboration between Cancer Research UK, The Christie and the University of Manchester that will bring world class research and clinical trials on one site at The Christie in 2014. Another important partnership is with the Manchester Academic Health Science Centre (MAHSC).

Prompt treatment is vital for patient well being and all national targets were met in 2012/13. During the last financial year The Christie generated a surplus that will be used to finance an ambitious capital plan. This includes an integrated haematology and young oncology unit, a regional centre for brachytherapy and an integrated procedure unit.

Each year we treat around 40,000 patients. Due to its specialist nature, 26% of patients are referred to The Christie from outside its catchment area. The Christie's future plans are encapsulated in its 20:20 Vision Strategy — where more than 2,500 members of the public and healthcare professionals shared their views on cancer services in the future.

Contact

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FINALIST

Salisbury FT

Salisbury Foundation trust has an outstanding record of delivering performance targets, maintaining financial balance, improving patient safety, acting on patient views and delivering care with compassion. The trust balances delivery of its district general hospital services with provision of high quality regional and supraregional specialist services one of which covers most of South West England and a population of 11 million.

In addition to achieving key performance indicators, and maintaining financial balance, the trust is passionate about delivering its strategic vision of providing an outstanding experience for every patient. Evidence from local and national sources demonstrates that it is successful in doing this.

Where things do not go well, the trust's approach is to involve patients and learn from their experiences, sharing with them what will be done to make improvements in the future. Innovation features highly in the trust's strategy and is embedded within the organisation. Examples that demonstrate this include:

- clinical — implementation of enhanced recovery pathways and work on venous thromboembolism have attracted national recognition;
- commercial — development of commercial products helps to secure income from alternative sources;
- social — programmes to enhance patient care are delivered on the elderly care wards.

Contact

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FINALIST

University College London Hospital FT

UCLH is a large group of hospitals run by clinicians and during a period of considerable change and challenge for the NHS, has consistently delivered, excellent outcomes for patients, innovative service change and world class research. The past year has been an exceptional one for UCLH and our achievements include:

- lowest mortality rates in the country (SHMI);
- top performing acute trust in London and in top 20 in NHS for the quality of care on the Quality Index (MHP Health Mandate);
- net promoter score of 68.5 in May 2013 (compared with 69 for Apple in 2012);
- second best patient satisfaction score in London.
- 85.3% of staff would recommend (NHS mean 62.8%)
- staff engagement score of 3.91 (top 20% in the country)
- opened the UCH Macmillan Cancer Centre which offers the most advanced services of its kind
- launched alternatives to inpatient admission including; The Cotton Rooms and our Hospital@Home service
- achieved £100m+ savings over last three years;
- achieved highest NHSLA ranking — level 3.

Our A&E is in the top five trusts nationally as rated by patients (scored 9.0 in inpatient survey) and achieved the 95% access target. We are committed to clinical leadership — over 50% of our board of directors are clinicians.

Contact

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WINNER

Development of a dedicated Pancreatic Enhanced Recovery Unit (PERU) to reduce length of stay and improve outcomes following pancreatic surgery

Royal Liverpool and Broadgreen University Hospitals Trust

The initiative

The Enhanced Recovery Programme (ERP) is a set of protocols that are designed to standardise the quality of care and reduce the length of time to recovery after surgery.

These principles, however, have not previously been applied to major pancreatic surgery. Our aim was to develop the first enhanced recovery programme specifically targeted at patients undergoing major pancreatic surgery with the objectives of:

;
- shortening hospital stay;
- improving outcomes;
- reducing complication rates;
- improving patient satisfaction;
- involving patients more actively in their care.

In order to do this we convened a multidisciplinary team to process map the patient journey and completely revised the patient treatment protocol using enhanced recovery principles. The team included representatives from:

- the pre-operative assessment clinic;
- dietetics;
- therapies;
- pain team;
- anaesthesia;
- surgery and nursing staff.

Feedback was also sought from patients regarding their needs and expectations from surgery. The new protocol incorporated as many elements from enhanced recovery as were felt to be possible. Many elements were already in use, but on an ad hoc basis and were not being applied consistently or for every patient.

The new protocol includes pre-operative nutritional assessment and support, pre-operative carbohydrate loading, intra-operative goal directed fluid therapy, post operative early mobilisation and early feeding.

It became apparent that a dedicated unit, specifically for this group of patients, would be beneficial in concentrating nursing expertise and would also enable patients recovering from the same type of surgery to recover together and encourage one another. Two adjacent ward bays were reconfigured to form a dedicated eight bed pancreatic enhanced recovery unit (PERU). The unit was staffed by a core of experienced nursing staff from within the pancreatic unit, with other staff joining on rotation to gain experience

Benefits

The PERU opened in April 2012 and in its first year of operation 114 patients have undergone an elective pancreatic resection for cancer. Of these, 49 were discharged home within the target of 12 days, and 37 were discharged within 10 days

Data has been compared with a historical control group of 193 patients operated upon during 2010/11. Median length of stay fell from 18 days in 2010/11 to 14 days in 2012/13, but without any increase in morbidity or mortality. Complication rate for 2010/11 was 42.5%, versus 43.8% 2012/13, with mortality rates of 3.6% and 2.6% respectively. Patient surveys have shown an improvement in overall satisfaction scores from 81% to 94%.

Financial implications

To set up PERU, we spent £9,000 on refurbishing two ward bays. Staffing for the unit was drawn from within the pre-existing surgical bed base. A planned reduction in overall numbers of beds enabled us to slightly increase the staffing levels on PERU to accommodate the higher than average dependency of these patients. Staffing across the unit as a whole remained cost neutral.

In our previous pathway, patients were routinely admitted to the high dependency unit (HDU) post operatively, for a minimum of 24 hours. In the new protocol, however, the slight increase in staffing levels on PERU has enabled patients to be transferred directly from the post operative care unit to PERU.

HDU is still available for those patients who require more intensive monitoring than can be provided on PERU. Since PERU opened only 12 of the 114 patients treated have required HDU care (10.5%), the remainder have moved directly to PERU. We estimate that in its first year of operation PERU has saved approximately 735 bed days, from overall reduction in length of stay, and of these 130 have been HDU bed days resulting in an estimated total cost saving of over £300,000.

Contact

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Judges

- *This is an ambitious pathway involving complex surgery that has clear goals. At the base is a good team with charismatic leadership that have overcome barriers.*
- *There is good evidence of user involvement and ongoing involvement in the evaluation of the programme. The team now want to roll this out to other specialities.*

FINALIST

Development of the Chelsea Critical Care Physical Assessment tool (CPAx) to grade patients' functional recovery from critical illness

Chelsea and Westminster FT

The initiative

Critical illness results in variable degrees of debilitation for patients depending on the severity and duration of the illness suffered and the individuals' prior health. The effect is a breakdown of energy stores and muscle, which has catastrophic effects on strength and function. This syndrome is known as Intensive Care Unit Acquired Weakness (ICU AW).

The lack of functional assessment measures for ICU AW was recognised by the National Institute of Health and Care Excellence (NICE) in the development of Clinical Guideline 83 entitled *Rehabilitation after Critical Illness* (2009). This guideline recommends an interventional approach to ICU rehabilitation with regular and standardised assessment of functional recovery; however it acknowledges the lack of viable assessment tools.

The aim of this initiative was to develop, validate and implement a simple bedside scoring system which grades patients' physical function, allowing assessment and monitoring of rehabilitation requirements and recovery in a simple, objective way.

In March 2009 the team, consisting primarily of physiotherapists and intensivists, began development of the Chelsea Critical Care Physical Assessment tool (CPAx). The CPAx is a numerical and pictorial system of 10 commonly assessed components of physical function, graded on a six point Guttman Scale from dependence to independence. The work developed through an iterative process, allowing us to see if the CPAx can be administered consistently. It was reviewed by clinicians and ex patients to ensure that it addressed all users' needs.

It was then embedded into clinical practice locally through a quality improvement initiative, which resulted in the integration of the CPAx into our computerised notes system.

Further quality improvement work looking at usability at eight centres enabled us to identify the best implementation strategy and identified the CPAx as a useful teaching tool.

Benefits

The quality improvement projects, both locally and within London, have enabled us to establish the optimal implementation strategies for the CPAx. We have shown sustainability in clinical practice locally, and demonstrated a mean 80% compliance with the comprehensive clinical assessment component of NICE CG83 in the eight centres using it. Preliminary and ongoing work has also demonstrated an association between CPAx scores at ICU step down and hospital discharge location (n=424), hinting that it may possess some predictive capacity.

If this can be achieved, it could facilitate early discharge planning and inform prognosis. Most importantly, the CPAx has benefits to patients at the bedside. It allows us to measure recovery in a transparent, understandable way:

"It is something to look forward to in the day. It builds your confidence up because it's not someone just saying you're doing well. . .you can see it in front of you," (ICU patient)."

Financial implications

The CPAx was initially developed through a NIHR funded Masters of Research via the Clinical Academic Training Pathway in 2009/2010. This funding covered salary only.

The local sustainability project was completed as part of an NIHR Collaboration for Leadership in Applied Health Research and Care fellowship, which provided one day of salary funding per week for nine months. The CPAx is cost neutral as there is no charge for using the tool and, as it is electronic, it does not cost anything to reproduce. The only cost involved in the development of the CPAx was staff time.

Cost benefits have not yet been established; however should the CPAx facilitate early discharge planning then there may be direct cost savings to the trusts using it. Furthermore, if the CPAx can be used as a standardised outcome measure in interventional studies then it will allow us to establish the most effective treatment strategies for ICU AW, which could increase the quality of care provided, improve patient outcomes and reduce length of stage.

Contact

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FINALIST

Crisis response falls team

East Midlands Ambulance Service Trust

The initiative

The Crisis Falls Response Team (CRFT) was created to meet a demand for better falls services and to dovetail with support services provided by Northamptonshire County Council.

The standard ambulance response prior to CRFT was, often, either a manual lift of a person who has fallen, or a further response with appropriate equipment. In both cases, a person who had fallen may be left in situ for a significant period of time, causing secondary injuries, exacerbating primary injuries and, ultimately and potentially, reducing quality of life or reducing life expectancy.

Discussions were initiated between several organisations over the make up of the CRFT. This team would be made up of a qualified paramedic and emergency care assistant using a bespoke vehicle specially converted to carry a wide range of lifting equipment and with an ability to transport patients, where required.

The members of this team would also be trained through the University of Northampton in enhanced patient diagnosis; this education saw paramedics and social care staff training together. This provided each sector with a unique insight into each other's roles. The core aim of the education was to enhance patient safety, experience and reduce conveyance to hospital from around 65% to 40%.

Benefits

Between April 2010 and March 2011 around 12,000 people fell in Northamptonshire and called for support from the ambulance service, representing approximately 20% of the total deployment to demand for the county. The transportation rate of this patient group to hospital was 66%.

Since its inception, the CRFT have been dispatched to approximately 1,400 patients with a conveyance to hospital rate of 40.4%. The performance results for 2012 have seen a net reduction of 2,100 deployments on the previous year.

The conveyance rates for patients to hospital were lower during the hours that the falls ambulances were in service than when only general ambulances were running.

The feedback offered from patients about the service was

overwhelmingly positive; interventions were considered to be timely and staff were considered friendly, approachable and well informed.

Almost everyone responding to the questionnaire felt that they were respected as an individual, treated with dignity and appropriately consulted about their care; 87% of CRT service users felt that the team had enabled them to have maximum choice, control and independence; 98% of those responding to the questionnaire reported the support that they received from CRT had made a difference to them.

Financial implications

The team's intervention either avoided a hospital admission directly or facilitated a discharge directly from A&E in 1,206 cases. After assessment, 156 of these patients were admitted to hospital, giving 1,050 avoided admissions. Based on the average length of stay for a general medical patient, this would then have cost the NHS a total of £1,644,300.

If the estimate for a falls patient is used, this becomes £2,940,000. In this period, the Crisis Response Team accepted 1,311 referrals, giving a total cost to the Crisis Response Service of £1,019,958. This represents a total saving of £1,920,042.

Contact

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FINALIST

Ambulatory care team

George Eliot Hospital

The initiative

This initiative was influenced by our patients to change how acute care is provided to allow patients to be at home more. In 2008 the respiratory team developed a respiratory support service (RSS) on the respiratory ward at a district general hospital. This service facilitated acute outpatient care for patients including pleural procedures and intravenous antibiotics. This tested the theory that this type of service reduced length of stay and avoided admissions. In 2009 we acquired funding to develop our workforce to deliver service, preparing staff for clinical nursing specialist roles.

We have improved patient care for respiratory patients by working in partnership with teams across the trust and in the community. The respiratory team have tested the idea of outpatient care by having a respiratory support room on the ward and this has grown into a dedicated ambulatory care unit.

The unit allows patient care to be improved in a range of specialities by sharing resources and allowed an outpatient intravenous antibiotics service to be developed. In small hospitals there would not be enough activity for individual pathways to make a viable business case.

We are also working with community staff to transfer some of the care into the community and share care responsibility. The ambulatory care team are able to take direct referrals from patients and health care professionals such as GPs and A&E.

The team have also developed a stop smoking service that provides treatment to anyone willing to quit with full support for at least 12 weeks. This innovation has contributed to national recommendations from the British Thoracic Society.

Benefits

In the first eight months we have shown an efficiency saving of 1,050 bed days excluding the savings made by our one stop deep vein thrombosis service, which is run by the anticoagulation team.

We have been able to increase our respiratory pathways by spreading the concept across the trust. By increasing the amount of patients and range of conditions being treated by outpatient IV antibiotics with a range of access this has improved options for respiratory patients.

This project has changed the options for acute care providing a realistic alternative to admission; teams across the trust now want to develop pathways in partnership with the ambulatory care team.

Financial implications

We have worked with commissioners and finance to develop a tariff system based on the "same day emergency care" tariff. This has been essential to ensure sustainability after a one year CQUIN (£225,000).

The ACT team is evolving; initially it comprised a wte Band 3 (admin/support) and Band 6 with a 0.6wte advanced nurse practitioner leading (8a). We have now increased the team with another wte band 6 and have a business case in progress for a seven day service. We have had to spend time ensuring the activity is recorded correctly; this has required several departments working together.

Contact

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FINALIST

Achieving outstanding success rates for fertility patients, improved outcomes and value for money for commissioners and GPs

Liverpool Women's FT

The initiative

One in six couples have difficulty conceiving and over 62,000 cycles of the most common fertility treatments, IVF and ICSI were completed in 2011. Fertility issues are now one of the most common health conditions. It is still a new area of medicine as the first "test tube" baby was born in 1978. There has been a significant improvement in success rates as techniques are refined, but the success rates vary considerably between services.

The scientific director and consultant embryologist implemented a programme to systematically consider all aspects of the laboratory service. This included the latest equipment, consumables and techniques to determine which had an existing evidence base or sound embryological basis for improving success rates, with particular emphasis on the use of new technologies to improve embryo selection.

A detailed review of success rates in leading international clinics in the USA and services in Europe was completed with a view to adopting elements of practice from within leading centres. Making direct comparisons was complex due to the myriad approaches adopted and differences in regulatory constraints on practice.

A major element of the development has relied on the experience and reputation of key members of the team facilitating meetings with international leads to discuss the latest innovations and techniques to maximise success rates.

The introduction of new technologies presents challenges in terms of relaying highly complex information to patients. It is of paramount importance that patients are able to make informed decisions about their treatment and significant time

and effort was dedicated to the development of high quality patient information and systems to allow patients direct access to staff equipped to answer their questions.

Benefits

The HFEA publish validated outcome data for all licensed centres in the UK and, provide a mechanism for comparison both within and between centres.

The improvement brought about by this initiative can be seen by comparing the implantation rate (IR) per embryo transferred. In 2012 the IR for patients aged under 35 at our clinic was 29%. The best IRs achieved in London in 2012 for patients aged under 35 were 38.4% and 36.3% and the national average was 26.6%.

The new package of measures was given to 150 patients in late 2012 and early 2013 and the IR achieved was 44.2% for patients aged under 35. This exceeded our greatest expectations. It is a truly outstanding success rate and is of international significance.

Alongside this significant increase in the chances of patients becoming pregnant, the clinic has seen a marked reduction in the incidence of multiple births with over 65% of all patients now having a single embryo transferred. The effect of this has been to reduce the incidence of multiple pregnancies to less than one in 10 births. The increased chance of embryos turning into healthy (singleton) babies is perhaps the most important outcome measure.

Financial implications

Additional investment was required to enable staff to meet with colleagues to discuss the latest developments in the field. Companies provided some loan equipment for trials and the income received from private payments paid for the developments to be introduced.

Additional expenditure has been necessary on equipment for the roll out programme, however the additional income generated by more patients selecting the service for their treatment means that a surplus will be generated. The costs of the equipment are deemed "commercial in confidence" by suppliers because the service was given significant discounts due to being a "trailblazer".

The fertility service competes with commercial entities and therefore the usual detailed financial information from the NHS are not published by the service. There are significant savings for commissioners and private patients because of the increased success rates.

Contact

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FINALIST

Implementation of a daily quality assurance audit programme with public involvement at its heart

Norfolk and Norwich University Hospitals FT

The initiative

The overall aim of our quality assurance audit programme was to challenge and raise standards of the quality of care we provide to our patients. Following the concerns raised in a CQC inspection, CQC audit prompts were taken and developed further to include an audit of our own action plans in response to the formal CQC DANI judgement. We concluded that to audit any less than daily would be insufficient for a trust our size and planned that as the audit team grew we would expand the programme so that were auditing one to three areas each day and including evenings.

Initially audits were undertaken by senior nurses across the trust. Matrons would not audit within their own areas and over time, ward and outpatient department sisters and charge nurses joined the programme.

We wanted to introduce more independence into the programme and approached patient representatives from more than 50 voluntary and community groups and asked them to become external audit representatives.

Over time the external audit team has grown to over 70 members, supporting one to three audits every working day. The enormous value they contribute is their completely fresh eyes approach to every area they visit. Talking with as many patients and their families as they are able to, they present their findings to the ward teams during verbal feedback by the whole audit team at the end of each audit.

Benefits

All results are collated within a database and the trust's summary position is emailed widely to all senior clinical, executive and managerial leads every week. Where any areas of non compliance are identified, action plans are required within two working days and that they have been received is recorded. Matron's rounds have been developed and are undertaken in between audits.

Over 64 wards/departments are regularly audited within the programme and the number of non compliant judgements has reduced dramatically. This programme has meant that for the first time we have staff from medicine for the elderly wards auditing and commenting on practice in paediatric wards and critical care, while those from orthopaedics are doing the same within areas such as the stroke and acute admissions units.

Good practice is actively shared as a result, and team working and cross department understanding and support has been noticeably enhanced. Information is fed back instantly and issues or required improvements can be immediately addressed.

This has not been easy and it has been challenging. We have learned that this is an initiative to undertake only if you are prepared to also listen to the less positive judgements and be continually committed to act to improve. Our external audit team members keep us on track and focused and they ensure that we are never more generous in our judgements than we actually deserve.

Financial implications

No investment was required.

Contact

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FINALIST

Targeting hypoglycaemic admissions: the Portsmouth approach (Portsmouth hospitals trust and south central ambulance service)

Portsmouth Hospitals Trust

The initiative

Hypoglycaemia is now recognised to be a significant contributor to emergency admissions. The Portsmouth

diabetes inpatient team had noticed significant admissions to be of a recurrent nature, with some admissions being driven by application of QoF targets, inappropriately, to elderly patients or on background of renal disease

Analysing paramedic callouts for hypoglycaemia there seemed to be two categories:

- those that needed admissions to hospital;
- those who were treated and left at home by the paramedics.

Further investigation showed that there was no structured approach for information exchange between the paramedics and primary care regarding the second group of patients. Because of this, changes needed to avoid a repeat episode were not implemented.

There also seemed to be the need for education in primary care as regards areas such as:

- the inappropriate application of QoF to the frail and elderly;
- the impact of medications such as sulphonylureas;
- the appropriate use of analogue insulin;
- the impact of renal failure on blood sugar levels.

The local community care model (Super 6 diabetes model) enabled consultants and specialist nurses to approach each individual GP surgery twice a year. They highlighted medications that could be amended, discussed appropriate insulin and the relevance of QoF targets and individual levels of admissions or paramedic callout.

A pathway — *The Hypo Hotline* — was set up whereby paramedics informed the specialist team about a hypoglycaemic episode. They would contact the patient concerned within 24 hours to check on their well being and if any adjustments were to be made, this was flagged to the GP surgery along with the community team.

Educational sessions were also set up aimed at residential homes and nursing homes highlighting the importance of diabetes control and relevance of hypoglycaemic episodes.

Benefits

Admission rates solely due to hypoglycaemic levels were monitored:

- between November 2010 and November 2011 (pre launch of the community model), there were 124 attendances and 85 admissions;
- between November 2011 and November 2012 (post launch of the community model), there were 83 attendances and 63 admissions.

This showed a 33% drop of attendances secondary to severe hypoglycaemia and an associated 20% drop of admissions subsequently. Patients who received contact from the nurses as part of the Hypo Hotline were unanimously highly satisfied with the advice and care received. Paramedics surveyed have also expressed a high level of satisfaction with the pathway

Financial implications

The setting up of the pathway required minimal financial investment. Records were kept of information left by ambulance staff, contact with patients and this also helped to inform any tariff negotiation the trust had with local CCGs. The expected admission avoidance, as demonstrated subsequently, would reflect in the savings achieved with each paramedic callout.

Contact

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FINALIST

Caring for older people. Engage — improving the emotional wellbeing of older adults in hospital

Salisbury FT

The initiative

The Engage programme of care is designed to promote psychological wellbeing in older adults who are in hospital with the aim of preventing and reducing:

- depression;
- anxiety;
- loss of independence and autonomy;
- loss of identity;
- deterioration in cognitive function;
- isolation and loneliness.

Engage provides psychological support to older people in hospital, providing social interaction and stimulation. Following its introduction onto two of the hospitals wards, the positive feedback led to it being expanded to all of the elderly care wards.

It was agreed that this programme would be sustainable if volunteers could deliver it. Volunteers had an interest in psychology or the care of older people in hospital. Prior to receiving the training, they were asked to commit to working a minimum of three hours a week for a six month period. The clinical psychology team provided a three hour induction programme and five training sessions lasting two hours each covering:

- depression,
- anxiety,
- cognitive impairment and communication difficulties,
- communication skills.

Dementia training sessions were tailored to cover issues that arise for older people. The volunteers provide stimulation and interaction, typically through memory puzzles, discussion groups and reading. They received ongoing supervision from a clinical psychologist to ensure that they felt supported, and worked closely with the programme coordinator.

The trust has developed a manual and a training and support package that can be purchased by other hospitals.

Benefits

The impact of volunteer intervention has been assessed by taking pre, mid and post intervention scores. There was a significant improvement in depression F (2,122) = 94.41, p.

The programme has also been shown to deliver benefits to patients including reductions in length of stay and improved patient satisfaction. Staff benefited from improved communication with patients, enabling them to find out more about the patients they are caring for. This is especially valuable where patients have dementia and concurs with the national campaign to "remember the person".

Financial implications

A Band 3 coordinator has been trained to arrange and deliver the training courses for volunteers. Ongoing costs are limited to this post. There is the opportunity to generate income by offering to help other hospitals to introduce this programme, and strengthening the trust's application for capital funding to improve the environment of care for older people.

Contact

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WINNER

Empowering patients to make decisions about research participation

Sussex Partnership FT

The initiative

The trust's research culture has expanded rapidly — over the past five years the R&D department has grown to over 40 members of staff. We are now the most active mental health research organisation in the south of England, yet our surveys revealed that there were many people in Sussex that did not know about opportunities to be involved in research.

To continue to grow in research activity we wanted to find novel ways of engaging all stakeholders. The research network began as a way to approach patients about research opportunities and to facilitate recruitment. The research network team is led by the R&D manager and the network was developed with the help of patient focus groups and a pilot project.

We found a real desire to get involved in mental health research. Members sign up via email, post or phone and can find a video on our webpages about the benefits of becoming a member. Staff and members of the public asked whether they could join and we responded by establishing a community open to everyone.

We then began to think about members' experience once they had joined the research network. We wanted members to feel part of a vibrant and evolving community. Our research magazine was created to keep members fully informed of the progression of our research culture and to help them appreciate the difference being made by our research.

The magazine was designed and developed for a wide audience — we needed to ensure that the messages could be understood by members of the public, patients, carers, staff, members of the board, our NIHR colleagues, anyone who might pick it up.

Benefits

We currently have over 1,000 members of the research network. Over 50% of patient members have been invited to take part in relevant NIHR portfolio studies of whom 60% have participated.

The first issue of our research magazine was distributed to 3,000 people. Our second has been distributed to 4,000 people with a short questionnaire asking readers for their feedback and ideas about future communications.

We will also shortly be launching our "Better by Experience" roadshow that will bring together members of the research network to have conversations about their experience of research activity. Themes from these conversations will inform our research strategy and be fed back through the research network and magazine to inspire and engage others.

Our communication initiatives have increased awareness of and engagement with research among clinicians across the trust. This has huge implications for enthusiasm and motivation of staff and ultimately for service delivery:

Team participation in research is a great way of bridging the gap between academic thinking and what clinicians really do. It can generate curiosity, stimulate interest in research findings

and increase the desire to improve practice. It can relocate the ownership of research in the direction of the clinician and the patient. Perhaps most important of all, it can show our patients how much they are valued by demonstrating that we want our practice to be the best we can offer.

Financial implications

The research network and research magazine are led by the R&D manager (0.05 wte) and supported by the R&D communications administrator (0.2 wte) at a cost of around £6,000 per annum.

Initial design and print costs were approximately £10,000 in the first year; and £5,000 per annum thereafter. The research network was launched in September 2012. More than 50% of service users signed up to the Network have been offered an NiHR portfolio study and over 60% of these have gone on to participate.

The primary saving is the service support cost associated with the time of clinicians and others who review case notes to identify eligible patients and introduce studies to them (estimated at £100 per participant). In its first year the research network is on target to recruit an additional 200 service users into NIHR studies. This will represent a saving of £4,000 in year one and £9,000 per annum thereafter.

Every additional 100 service users recruited to studies will generate a further £10,000 saving. More significantly, these service users are unlikely to participate in NIHR Portfolio studies without being engaged through the Research Network, so the contribution to the NIHR HLO of increasing recruitment to studies is evident.

Contact

For more information on this initiative please contact Tanya.Telling@sussexpartnership.nhs.uk

Judges' comments

- *Very clear and engaging presentation.*
- *Demonstrated pride and passion in enabling patients to take part in research.*
- *Excellent, well realised strategic plan to embed research throughout the trust with clear goals and milestones with the aim "every patient a research patient".*

Award sponsored by

NHS
National Institute for Health Research
Clinical Research Network

HIGHLY COMMENDED

"Every Patient offered an opportunity to participate in research" – A structure and strategy for research growth

Barts Health Trust

The initiative

The merger of three trusts in 2012 provided the opportunity to design a corporate structure to bring together best practice to actively support research. Barts Health NHS Trust is one of Britain's leading healthcare providers and the largest trust in the NHS, working across six hospitals and community services.

The merger presented an opportunity to refocus the organisation's approach to research, and engaging our large, diverse patient population. We adopted a simple vision on which to base our strategy: we want to offer all our patients receiving care at our hospitals the opportunity to be involved in research.

To achieve this the trust has reorganised its structures from board level to front line departments, raising awareness among all of our doctors, nurses and support professionals, that research is now a core part of our business.

Targets were set for patient trial recruitment and performance monitored by the trust board. A cultural change has been stimulated in the organisation, with research now a key component of our care offer.

The trust invested in a new section to stimulate patient engagement, led by an associate director, to engage our patients in research and ensure that our research is put into practice. A wide ranging campaign using posters, videos, leaflets and events has helped to spread the research message.

It was recognised that in order to support growth in our research portfolio, the trust needed to ensure it had the right level of resources in place across all departments. An associate director of research development was appointed to work with departmental research directors to maintain oversight of infrastructure seeking solutions to any blocks that arise, identifying new funding opportunities for clinical trials. Partnership is key. We have engaged closely with our National Institute of Health Research Comprehensive and Topic specific Research Networks (hosting two CLRNs and five topic networks), Industry partners and numerous funding bodies.

Benefits

The profile of research has been raised at corporate and departmental levels, with positive engagement reflected in achievement of ambitious targets. Patient recruitment to studies for the year was approximately 20,000, with NIHR study recruitment increasing by 17% and significant decreases in time to study opening.

The drive to increase activity in order to promote wider participation options for our patients was further exemplified by a 16% increase in the number of active trials and our pipeline assured with a massive 37% increase in new project announced values.

The patient engagement initiatives that we have implemented means that more information is now available to patients who want to be involved in research, from both a care perspective and also as patient research designers or advocates. The diffusion initiative has resulted in change to best evidenced care for individual patients with overwhelmingly positive feedback from both trainees and consultants.

Financial implications

Generating funds from external funding sources enables the trust to offer a different and directed range of care packages, to our patients, many in advanced technologies; something that trusts cannot afford to do from service budgets. The offer of advanced care packages with separate income streams enables trusts to employ additional care professionals and access expensive drugs and devices without impinging on service budgets.

Contributions provide over a million pounds of investment in highly qualified staff, leading edge technologies and provide funds for future investment in infrastructure. The new initiatives have brought into focus the rapid financial impact involvement in research can have.

Growth expectations considerably exceeded initial forecasts, with total research income increasing by 22% in 2012/13 compared with 2011/12, NIHR income by 7% and commercial by nearly 30%.

The wider financial implication of research expansion in our area of East London is extremely important. Every person we employ to support research has a positive economic impact in an area of extreme deprivation.

Contact

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FINALIST

Expanding research across the entire urgent care clinical pathway

Royal Berkshire FT

The initiative

It is notoriously difficult to recruit patients to research in the emergency department (ED) due to the time pressured environment and the critical nature of the conditions we see. Our ICU has a well established track record of undertaking research on critically ill patients. The urgent care research group evolved with the principle objective of establishing a successful and sustainable research team across the urgent care clinical pathway.

We selected two studies that required close collaboration between the ED and the ICU:

- protocolised management of sepsis (PROMISE) and;
- targeted temperature management for patients who have undergone an out of hospital cardiac arrest (TTM).

This latter group of patients require a coordinated approach from paramedics, the emergency department, the intensive care unit (ICU) and the cardiology catheter lab.

Previously those individual areas may have had differing views of the evidence base and therefore sometimes, treatment priorities. For example, the evidence for a benefit from therapeutic hypothermia is unclear as is the ability of clinicians to predict outcome on admission leading to wide variations in practice. Successful research in this area has involved the collaboration of a large number of geographically separate departments and individuals working towards the same goals.

One result of this is a new rota arrangement where nurses are accessible out of hours, expanding the time that they can be involved in research. By using the expertise and experience of our existing ICU research nurse team we are able to institute best practice into the ED by working alongside seconded nurses from the ED.

The nursing team works in conjunction with the medical team in the ED where we have four consultants who work across the ED, acute medicine and the ICU. As a result we have improved

clinical pathways for patients, leading to improvements in patient care through more timely delivery of evidence based treatments.

Benefits

There has been a stepwise increase in the number of NHS portfolio studies we participate in, as well as an increase in the total number of patients enrolled.

Early aggressive management of sepsis has long been a focus in the ED and systematic screening of patients for PROMISE within the ED has allowed this area to remain a departmental priority. Subsequent to this, the rates of antibiotic administration for all septic patients within an hour have increased up from 21% to 82% and helped us to reach a key CQUIN target.

A second group of patients who have clearly benefitted from this initiative are patients who suffer an out of hospital cardiac arrest (OHCA). We saw the opportunity to improve the OHCA pathway by using the template of the targeted temperature management study (TTM) to embed best clinical practice. Patients were randomised to a target temperature of 33°C or 36°C within a short period of time of admission to hospital and this intervention had to be delivered within six hours.

Standard care included clear advice on neurological prognostication and recommendations on treatment of cooling side effects and the need for cardiological intervention. This standard care was based on the best available evidence and has led to a consistent approach on ICU admission and cardiology catheter lab intervention reducing delays in treatment. This improvement has continued after the study finished.

Financial implications

Nursing and consultant time has been negotiated from the CCRN through the trust research and development department. The research is cost neutral for the trust. It includes two consultants who both work across the ICU and either the ED or the clinical decision unit who each have a session of programmed activity funded.

This is in addition to our nursing team numbering three whole team equivalents. On the team we have a research coordinator and two research assistants providing research support. We have also received grant funding from the College of Emergency Medicine and funding from the trust research and development innovation fund.

Contact

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FINALIST

Including a requirement to promote research, in fifteen mental health service specifications — aiming to widen patient participation in high quality studies

Bristol CCG

The initiative

The Health and Social Care Act 2012, places increased emphasis on research and the use of research based evidence in treatment choices. The Act places a statutory duty on CCGs to "promote research on matters relevant to the health service and to ensure that the evidence obtained from this research is used across the health service".

Bristol CCG believes that a key way they can promote research is through ensuring that their providers have processes in place to facilitate the recruitment of patients into studies. This is especially important as the Act is simultaneously driving a widening of the provider base to include any qualified providers (AQP). There is a risk that increased numbers of new providers could result in reduced choice for patients and a reduction in the quality of research evidence.

We recently embarked on tendering all its mental health and dementia services in one of the largest recommissioning exercises of its kind. With support from the South West dementia and neurodegenerative research network (DeNDRoN), the CCG has included specific requirements for providers to promote research in every one of its 15 service specifications.

The aim was to keep the process as lean as possible. SW DeNDRoN were starting a project specifically around supporting CCGs in their role to promote research and were looking for CCGs in the South West who were commissioning dementia services.

Once it was agreed that Bristol CCG would consider including a commitment to research in their dementia service specification, an appropriate form of words was drafted and consulted upon. As wide a reference group as possible was consulted in recognition that this could be a model for national adoption. It included senior NIHR figures such as the director of the Comprehensive Clinical Research Network, as well as CCG leaders.

A final wording regarding research responsibilities was agreed and included in the Bristol CCG dementia wellbeing service specification. It was decided to apply this "form of words" to the other 14 service specifications that are in development for the Bristol mental health procurement.

Benefits

Benefits include:

- a clear commitment from a large CCG to promote research through ensuring its providers have processes in place to recruit patients into studies;
- incorporating a model "form of words" requiring a commitment to research from all potential providers of 15 mental services;
- a shared understanding with senior members of NHS England on the importance of this subject, with a view to including the topic in the next Standard NHS Contract and national guidance issued on the NHS England website;
- the West of England AHSN is considering supporting this initiative following its authorisation;
- the formation of an innovative and productive relationship between the NIHR Clinical Research Network and a CCG;
- on the basis of this initiative, the Association of Medical Research Charities has included the role of commissioner contracts in their Research Charter for NHS England and CCGs.

Financial implications

There were no new financial resources required for this initiative. Furthermore, there are few or no negative financial implications for the commissioners leading this approach or the providers who will have appropriate processes to permit their patients and clients access to research. The costs of delivering NHS research are largely covered by the NIHR Clinical Research Network.

The benefits to providers include better outcomes for patients, opportunities for patients to gain access to new treatments that may take years before they are widely available, and collaboration with local academic institutions to improve care from a robust evidence base and appropriate service evaluation.

Contact

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FINALIST

Building a trust wide research culture by embedding research in clinical services

Coventry and Warwickshire Partnership Trust

The initiative

Healthcare organisations that participate in research are more efficient and deliver better quality care. But prior to 2008 the trust had almost no research activity (just 52 patients were recruited into portfolio studies in 2008/9).

The aims of this initiative were to:

- develop successful, high performing research delivery business;
- build research infrastructure with robust governance;
- widen access to research among patients and professionals;
- engage managers and clinical governance groups;
- engage the trust board;
- increase research grant income.

We started by creating a trust research executive team (TRET) to:

- develop strategy;
- exploit funding opportunities;
- build key partnerships;
- organise research events;
- manage recruitment.

We initiated the Improving Access to Psychological Therapies Research Ready (IAPT RR) scheme in 2010, including "opt in to research" field into assessment and triage, so clients are notified about studies. Several studies have recruited through this service, including one (OCTET) for which CWPT is one of the highest recruiters.

In 2010 we appointed our first trust research champion to extol the benefits of research to colleagues. Recruitment to portfolio studies increased, research naïve colleagues were mentored and studies were opened in every clinical directorate. We opened our first commercial trial in 2010 and six more since, culminating in an MHRN award in 2013.

We recently appointed two service user research champions, who present information about portfolio studies to service user groups across the region, and promote service user engagement in research.

Benefits

We achieved a 2000% increase in annual recruitment between 2008/9 and 2011/12, and recently recruited our 3,000th participant.

By 2013, all clinical directorates and nine out of eleven service areas had participated in at least one study. A service user research development officer was appointed in 2009, creating a network of research interested service users and securing nine RDS PPI bursaries (total £4,225) to facilitate new funding applications.

The trust board was first in the region to adopt research KPIs (2010). We have run annual R&D events since 2009, chaired by board chair. Over 90 staff attended in 2012.

IAPT RR has been a catalyst for engagement. We have opened five portfolio studies in this service since 2010. IAPT therapists are trained in cutting edge therapies, extending research benefits beyond trial participants.

Financial implications

At the start of this initiative, the trust had no R&D income and no research staff. We have built steadily from there. West Midlands (South) CLRN has funded most of the developments described here, amounting to a total investment of circa £1.5m since 2008/9.

The key to securing this inward investment has been performance managing research delivery. Although the network agreed to invest in capacity building, opening more studies and delivering increasing numbers of portfolio studies to time and target has been key. Despite the developmental nature of some of our funding, we achieved reasonable value for money in terms of cost per recruit. This stands at £107 over the four years to 2013 — in the mid range for the region.

The trust has also made significant investments, including office space and overheads, a clinical trials room, finance, HR and general management support. In 2010/11, the trust agreed to fund a new senior clinical academic post with seed corn funding from West Midlands (South) CLRN We also secured modest research capability funding (from £35,000 to £80,000 pa) which we reinvested in supporting potential applicants to develop new funding applications to NIHR programmes.

Contact

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FINALIST

Integrating research into trust's core business has directly impacted on patient recruitment to trials — doubling recruitment in the last year

University Hospitals Birmingham FT

The initiative

In 2011, University Hospitals Birmingham (UHB) recruited 2,493 patients into clinical trials on the clinical research network (CRN) portfolio, a level of performance significantly below its potential but not unusual for a teaching hospital in the UK. Individual researchers would often manage their own clinical research studies with little or no resource and often failed to recruit to time and target.

The trust undertook a board level strategic review that identified research and innovation as one of the four core principles of business. As a result the trust created the post of executive director for delivery to champion research.

A pioneering clinical research initiative invested a new core R&D team who were employed to increase the trust's research portfolio for cancer and non cancer research activity. The main objective of the team was to work with patients, the research community, CRN and industry to develop the clinical research initiative across the trust.

The team were supported by two clinical research officers, a dedicated finance manager and the R&D governance team. This team approach ensured that all systems were in place for all relevant research studies to obtain R&D approval in accordance with the ethical and regulatory frameworks.

Following the R&D restructuring, a number of initiatives were identified, developed and implemented across the trust to achieve the government's plan for the growth agenda. The main priorities and aims of the CRI were to:

- ensure patient safety — link research data with patient records;

- engage key stakeholders (NIHR CRN) including the patient and public involvement;
- increase number of portfolio badged commercial and non commercial research studies;
- encourage collaborative working across different specialities and organisations;
- support the innovation, health and wealth agenda;
- implement the 70 day benchmark.

The team have a central resource of GCP trained research nurses and trial coordinators assigned to research teams and the senior R&D ops team attended speciality research meetings to present activity and review new research protocols.

A central feasibility service was established to ensure accurate and timely returns were managed for effective industry contract research collaborations and preferred partnerships were actively encouraged at board level.

Benefits

Birmingham and Black Country (BBC) comprehensive local research network (CLRN) is now in the top 10 performing CLRN's. UHB has doubled recruitment. We are one of only four CLRN's recruiting patients into trials in every cancer tumour site.

Data is processed through UHB's own information analysis tool to compare against national targets — for the 70 day benchmark metrics are returned to the Department of Health. A unique initiative via the UHB Health eData platform has linked North American, Western Australian and European data to facilitate international research comparisons.

Birmingham Health Partners (UHB, University of Birmingham and Birmingham Children's Hospital) has increased key stakeholder engagement to drive the strategic research agenda. There is greater public and patient involvement, increasing benefits, participation in research and information on clinical trials.

Financial implications

The investment for the new CRI was a strategy to address reducing income from the BBC CLRN and maximise the potential to attract commercial income. The BBC CLRN implemented a more transparent activity based funding model and banding tariff allocated on the number of patients recruited into research studies. This allowed forecasting of resources and an investment strategy to be implemented.

Potential financial penalties as result of not achieving the 70 day benchmark also focused the trust and leverage support from the finance director. Clinical trials coordinator roles were developed to address a skill mix where research nurses were not required. As a result research nurses can dedicate their clinical skills to more complex studies. The increase in commercial work has allowed patients access to treatment options otherwise not available and has saved drug costs for the NHS.

Contact

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FINALIST

LDC: a novel model of research, innovation, and education

Leicester Diabetes Centre

The initiative

Twelve years ago we started a research programme with one nurse and one researcher. The group has developed organically since then as capacity and capability has increased. We now have a team of over 120 researchers, clinicians and educationalists. The team work on a mix of industry and academic research, innovation, postgraduate education and service reconfiguration. All of this is alongside the clinical service.

The model is central to the success of the group as it enables a number of key activities including the rapid translation and pull through of experimental design and proof of concept studies into larger implementation trials and informing and shaping clinical practice at local, national and international level.

Our programmes of postgraduate education brings local, national and international clinical staff into contact with our academic and education staff ensuring that our teaching is at the leading edge of current thinking in the field. It also builds strong future relationships and networks with clinicians to help improve care delivery.

Central to the success of the LDC is the strong network of relationships that have formed over this period; the LDC has established itself as a partner of choice for many large pharmaceutical companies. Engagement and close working with local GPs and the CCGs ensures that we have excellent attendance at our evening update events for clinical colleagues.

Many of our GP colleagues are co-applicants on our grants, contribute to the post doctoral training programmes, and inform the commissioning of transformation projects via the LDC. University Hospitals of Leicester NHS trust (UHL) hosts our unit and we are considered as a centre of excellence within the trust for our integration of clinical service, research, innovation, education, and transformation work.

Management and allocation of responsibilities is via the senior strategy team, thus work is allocated against the various strengths of the team. The senior team have developed an integrated and organic approach to work which ensures that silo working is avoided and we can creatively problem solve and overcome boundaries.

Benefits

Our group have demonstrated that findings from early phase clinical research can be rapidly pulled through into everyday clinical decision making. For example we have developed a diabetes risk assessment tool (a short questionnaire) which has been made available on the Diabetes UK website and used by more than 350,000 people. The tool has now been developed into software that can be implemented by GPs through their IT systems.

The Leicester diabetes self assessment risk score is also recommended for use in the NICE guidelines on preventing type 2 diabetes. The tool has now also been licensed to Boots the chemist and can be seen in many high street stores.

Financial implications

The LDC has been supported by UHL in the provision of decommissioned ward space at the Leicester General Hospital site. The refurbishment of the facilities has been via NIHR capital funding as part of the biomedical research unit award, industry support from NovoNordisk, and funding received from University of Leicester. The ROI will be realised over the next three years as the centre attracts large research grants and further investment from partners and donors.

Contact

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FINALIST

Engaging children, young people and their families in clinical research: making the step change

Alder Hey Children's FT

The initiative

For many years, the participation of children and young people in much clinical research was viewed as unethical: however this paradigm has shifted, and the importance of their participation is widely acknowledged. Alder Hey Children's FT (Alder Hey) is a specialist children's healthcare provider, offering acute, secondary, tertiary, community and mental health services. Recruitment of children and babies into research studies is particularly challenging, but essential to develop new treatment options and improved outcomes for this vulnerable population.

One of the trust's four strategic objectives is to be "a world class centre for children's research and development". The trust and its major academic partner (University of Liverpool) have published a ten year Integrated Research Strategy for Child Health focusing on key areas of established critical mass, but offering the scope for the development of new areas of research focus.

The trust is organised into six clinical business units (CBUs) one of which is the research business unit (RBU). Senior clinical and managerial positions within the RBU parallel those in the CBUs. This structural configuration ensures that research is prioritised, managed and governed through the same principles as clinical service delivery ensuring that research is an integral part of the corporate fabric.

A research strategy steering group and operational support committees ensure robust systems for stakeholder engagement, governance, delivery and accountability at board level. An increasing number of the children and families who use services within Alder Hey have the opportunity to participate in research studies as an integral part of their management and care

Benefits

In 2012/13 Alder Hey recruited over 7,600 children, young people and babies to studies within the NIHR Clinical Research Network portfolio. Assuming national recruitment data are similar to the previous year, this will place Alder Hey as by far the largest recruiter to research studies among specialist NHS trusts and within the top 15 performing NHS trusts in England.

Expansion in research activity to the level achieved at Alder Hey requires broad speciality and multidisciplinary involvement and engagement. The strategic approach to development of research within the trust is one of inclusivity and incentivisation.

The engagement of sub specialities within each CBU has increased dramatically over the past 12 months. Research now extends to the community setting, particularly for children and young people with complex disabilities: historically a difficult and complex environment and patient group to undertake research.

For example, in 2012 a community paediatrician new to research led a study of a novel medicine in children with ADHD and was supported through:

- the availability of a drug otherwise unavailable through standard commissioning arrangements;
- the provision of specialist clinical research nurse and administrative support.

The additional support provided through the RBU impacted directly on the quality of care provided by the community department and offered families access to a new therapeutic option and more intensive follow up, monitoring and ongoing care.

Financial implications

Investment in research delivery staff has been required. However, the imperative for pharmaceutical companies to develop and test new medicines in children has provided a source of income which was previously unavailable or limited. Research income benefits the RBU by directly and contributes to the overall economy of Alder Hey.

The embedding of clinical research professionals within sub speciality teams also provides a direct fiscal benefit, as many research staff in the course of protocol delivery undertake tasks which constitute activity which attracts income through the clinical commissioning route. This principle is acknowledged within Alder Hey, and the direct contribution of the RBU to commissioned income is now being quantified.

Contact

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FINALIST

The Salford citizen scientist project — community engagement in health research

Salford Royal FT

The initiative

The citizen scientist programme was initiated by the Manchester Academic Health Science Centre (MAHSC) to encourage public interest and participation in health research and improve recruitment to clinical trials.

A public consultation exercise was carried out with invited members of a local citizen and patient panel, which attracted substantial interest. From this event 16 people successfully applied to become members of the Citizen Scientist Public Advisory Group (CSAG). The project also received oversight from a steering committee of local stakeholder organisations (those carrying out research in the local community).

From these meetings it was clear that the fundamental problem to be addressed was making the project community, rather than organisation, focused. Engagement with the scientific and health research community across Greater Manchester helped identify obstacles to research engagement and resulted in discussions used to shape the website and approach.

The commitment was to promote all research where recruitment was targeted at the local community. So the opportunity to promote research was opened up to all NHS and academic institutions in the local area and the NIHR local research networks.

Accessibility issues were addressed with a web based system using various supportive technologies, newsletters and e-bulletins. The information delivered aims to promote trust and support for research.

Benefits

While the initiative is in its early stages, there have been significant outcomes already. The initiative has led to a different way of thinking and approaching engagement in health research and recruitment into studies. It has begun to offer researchers a different approach to finding participants and to

offer the community more accessible information about the research happening within their area.

Continuous engagement is delivered through a variety of means including a website, newsletters, e-bulletins and Twitter to those who sign up to the project, leaving the members free to investigate research on their own terms. This is particularly relevant to "healthy volunteer" studies, as many people who are eligible and willing to take part in research are not given the opportunity because of a lack of knowledge or access to information.

The citizen scientist project has enabled patient and public involvement (PPI) for large NIHR and other grant applications. Those using this structure have been extremely satisfied with the level of response received and the enthusiasm of the individuals involved. The project is now initiating a marketing strategy that it is anticipated will increase both membership and levels of web browsing. The University of Salford has been commissioned to conduct an evaluation of the initiative.

Financial implications

The initiative has received set up funding of £94,000 for the development of the resources and the marketing and communications requirements. This has been provided by the partner organisations including Salford CCG (formerly NHS Salford), MAHSC, SRFT and the Greater Manchester Comprehensive Local Research Network (GMCLRN). The future financial support for the initiative and associated staff will be applied as a cost in grant applications where public engagement and involvement can be supported by the project.

Given the number of projects that can be supported by citizen scientist, the unit cost to each project is relatively small and will deliver major cost efficiency savings. Savings will be found with individual research teams who will see reduced promotional materials costs and time and effort taken to recruit to studies.

Contact

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FINALIST

Rheumatology research – The positive impact on health and wealth in the local community

Wrightington, Wigan and Leigh FT

The initiative

The trust's research strategy states that, "our patients and healthcare teams will be at the forefront of evolving new treatments and methodology resulting in better patient outcomes". We conduct high quality, ethical, clinical research with the aim to improve patient outcomes within the research governance framework and this was the driving force behind this initiative. The key aims of the approved trust research programmes were to:

- promote an understanding of how research complements and supports the delivery of a quality, patient focused health service;
- ensure that patients are given access to new drugs which are not routinely available.

The trust board considered the options available within the organisation for supporting clinical trials and made the decision to invest in the clinical trials unit, which provides full support to clinicians in setting up and running clinical trials.

Research nurses and research administrative staff were employed and training was provided. Policies and standard operating procedures were developed to support good clinical practice standards and the activities carried out in conducting research. Strong links with the trust's clinical divisions were forged.

A reporting structure was put in place that ensured good communication between research and clinical staff. The trust established links with the commercial team in the Greater Manchester clinical research network who were a valuable source of intelligence and funding as well as providing links with industry and the NIHR. This resulted in an increase in live clinical trials and in the numbers of patients recruited to participate. The trust developed strong links with specialist patient support groups including:

- Lupus;
- Arthritis UK;
- Ankylosing spondylitis support groups.

This helped identify and prioritise the clinical trials that could benefit patients with these conditions most. The trust has actively promoted patient participation in clinical trials using the trust web site, electronic notice boards, radio advertisements and GP newsletters issued to all local practices.

Benefits

A significant impact from this strategy for rheumatology clinical trials was apparent from an early stage. A large number of patients recruited into interventional trials were reporting a marked improvement in their general wellbeing, enabling them to lead a normal life including activities such as cycling, swimming and having the capacity to work.

The trust was able to gain free access to drugs that, on average, would have cost in excess of £10,000 per year per patient. These patients would generally have been eligible to receive such anti-TNF drugs on the NHS. By participating in the clinical trials, the trust has saved the local health economy approximately £2.35m over the last five years in drug costs alone.

Raising awareness of these benefits from research has resulted in enhanced enthusiasm for engagement from both patients and clinicians. The current trust commitment for rheumatology trials anticipates significant continued growth and associated clinical and financial benefit to the local health economy.

Financial implications

Greater Manchester clinical research network provided support in recruiting and developing research staff and collaborating with industry. Since their recruitment in January 2012, staff have recruited to both commercial and non commercial trials. Recruitment to anti-TNF trials has almost doubled.

The clinical trials unit achieved a small contribution to trust's finances in the first year of operation. As detailed above, clinical trials have also delivered value estimated at £2.35m to the local health economy.

The trust receives a contribution from the Greater Manchester clinical research network towards the salaries of the nurses who work on both commercial and non commercial NIHR trials. A new research policy has been produced which sets out how the profitable income from research activity will be used to reinvest in the research study areas and to support and encourage research and development within the trust.

Contact

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WINNER
Derby Hospitals FT

Focusing on personalised care for patients with dementia needs is challenging. Reports such as *Hungry to Be Heard* (Age UK) and *Commitment to the Care of People with Dementia* (RCN), as well as negative headlines about dementia care in hospitals inspired us to create a better environment and personalised experience for elderly patients with dementia.

Providing compassionate care isn't just about caring for a patient's immediate illness, it's about putting their wellbeing at the centre of the care we provide. Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, or the smallest act of caring, all of which have the potential to turn a life around.

Our matrons recognised these challenges and knew providing traditional nursing wouldn't result in the best quality care. That's why, with their leadership, nurses, therapists and dieticians were instrumental in launching intergenerational caring.

Our intergenerational care concept aims to treat patients as people and make their hospital experience exemplary from the environment in which they are cared for through to the individual care they receive. A bespoke volunteering role to stimulate patients before meal times was introduced for young volunteers. This helps to engage with patients who have lost their appetites, are lonely or suffering with dementia. Volunteers interact with patients through activities before meal times so they are awake and alert. Nursing care volunteers have time to dedicate to one-to-one support at mealtimes, and also sit and listen to patients without being interrupted or having to carry out another task.

With this we have also created a valuable real life experience for young and old alike bringing generations together to learn from each other. We give aspiring doctors and nurses real life insight into working in a hospital. This is similar to the post Francis recommendation for students to volunteer in hospitals before starting their clinical training. It gives young people a real insight into the personal attributes they will need to show true compassionate care in their work. Our ambition was to attract young people into healthcare careers and to build a future workforce whose commitment is built on an understanding of compassionate care.

Relationships between ward staff, volunteers and schools have grown stronger. We have had excellent, feedback from the ward sisters, staff, patients and carers. The schools, colleges, pupils and their parents have been overwhelmingly positive.

We now have over 100 volunteers befriending and providing mealtime support to patients across 20 wards from oncology and orthopaedics to stroke, respiratory and care of the elderly. Intergenerational caring has proved to be an overwhelming success, enhancing the mealtime experience for patients and resulting in better nutrition and hydration.

Following patient and family feedback we decided to create a familiar, secure environment that helps recovery. Together with the Alzheimer's Society we created ward based reminiscence rooms, memory cafés and rempods — pop up mobile rooms. These were designed to create safe, familiar and secure environments providing stimulation that is therapeutic and supports rehabilitation by evoking memories.

The rooms recreate a 1950s living room complete with authentic furniture with vintage TV and radio playing shows and music from the era. The environment improves the mental wellbeing of patients who may find hospital surroundings cause them anxiety. Family-centred care is also encouraged with the involvement of carers in the memory cafes and overall we have seen improvement in patients' recovery times and reduced length of stay.

We also changed visiting times to encourage the involvement of families in a patient's care. Relatives can now visit when the doctors are on the wards, alleviating anxiety if they need to ask a question, as well as enabling families to help patients with meals.

True care and compassion can only be achieved by giving patients and carers a clear voice — this is the foundation upon which our partnership ethos of care has been developed, our matrons set out with determination and achieved through true leadership, successfully rolling out intergenerational and therapeutic care for elderly patients with dementia across our wards — we really do take pride in caring.

Award sponsored by

Department of Health

Contact

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Judges' comments

- *The judges were inspired and enthused by the compassionate patient care demonstrated. Everyone in the trust owns patient care from staff working in estates, clinical staff to volunteers.*
- *The intergenerational partnership between young volunteers and elderly patients was outstanding.*
- *A real value driven approach demonstrated through a range of exciting innovations across the trust.*

FINALIST

Blackpool Teaching Hospitals FT

Within the child health department we place patients at the heart of our care. A patient experience officer was recruited in October 2012 and she has formed a group "Victoria's Voice" that meets monthly and is working to develop a "Charter of Promises". The young person's group also had some interview training and has sat on interview panels for staff, including a recent consultant paediatricians post. Feedback from other panel members was extremely positive and they plan to introduce this practice throughout the trust.

Engagement with young people is undertaken through a variety of means including artwork, one-to-one discussions and small groups. Information from this engagement is fed through the department's governance meeting and action plans monitored. Examples of feedback obtained and applied include young people:

- not wanting lots of doctors on the ward round;
- wanting to be asked if they are happy for student nurses to be involved in procedures;
- wanting to have time to speak with their consultant alone.

All of these have since been introduced within the wards.

In September 2011 the department introduced a pathway redesign that improved patient care. Historically children had day case surgery undertaken on a day case ward every day of the week. Children would be transferred to theatre along a busy public corridor and back again. Other children on the ward would witness crying children returning from theatre and anxiety levels increased.

We now do all day surgery from the day case unit on one day, operating on 30–40 children each Thursday. Children play happily within a child friendly waiting area and have just a short walk to theatre.

Postoperative children are kept separately until they are ready for discharge so that waiting children do not see them upset. Communication between ward staff, surgeons and anaesthetists are vastly improved as they are all in the same area. If staff have any concerns surgeons and anaesthetists are nearby to ask for a review.

With the increasing number of babies born with complex needs due to prematurity or other medical problems, the department has developed a team approach for these families and a transition plan from the neonatal unit (NNU) to the children's ward. For each child we have named staff members that work with the family and predominately care for the child. Visits to the NNU are first undertaken by staff and introductions to parents made. Parents then have a tour of the children's ward and the opportunity to ask staff questions, a date for the transfer is then agreed with the parents.

Once the baby has settled on the ward, staff then work with parents to introduce some "normalities" to the child's routines, for example supporting parents to bath their baby, go to the play room or take them for a walk. Even though the baby may have complex medical conditions that need support, it is important to create these opportunities and "special days" for families to record showing some milestones for their child.

Staff engagement, involvement and suggestions are always welcomed and encouraged. This initiative has been entirely introduced by the ward sisters and staff nurses. Parents give extremely positive feedback and regularly call in to see the ward staff when in the hospital for clinic appointments.

Contact

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FINALIST

Bradford Teaching Hospitals FT

Bradford Teaching Hospitals FT (BTHFT) has been working on providing dignified care since 2009 with the launch of its first dignity policy. Our recent National Dementia Audit results (2010 and 2012) revealed that improvements were needed in certain aspects of our care. The acquisition of funding from the King's Fund was the catalyst for driving our dementia care strategy.

We identified the following dementia care priorities through engagement with the multidisciplinary team:

- education;
- developing a dementia pathway;
- enhancing the environment;
- improving communication with staff and patients.

We established a dementia project board led by senior managers, with governors, nurses, doctors, and a local mental health trust representative as members. Four workstreams evolved focusing on each priority:

Education

We have implemented a training programme in collaboration with the University of Bradford and Bradford Dementia Group (BDG). The BDG developed a training programme for dementia champions (DCs), previously tested in care homes. We introduced DCs into each trust ward/department to support staff to provide person centred care for patients with dementia.

The trust has extended this programme, introducing a training day with a practical focus to simulate real life care situations in hospital. Currently, 500 staff have completed this training. A two hour session has since evolved aimed at non clinical support staff (80 staff have completed this).

Dementia pathway

Person centred care is an essential component of this pathway with compassionate care embedded throughout. This begins with a comprehensive assessment of the patient on admission including a cognitive assessment, which previously did not always happen. New assessment documentation has formalised the actions to be taken.

Previous ad hoc referrals into mental health services have also improved as a result of this pathway. Mental health liaison teams now see patients within 24 hours of referral, and ward based teams respond in a timely and appropriate manner to unmet patients' needs.

Enhancing the environment

The King's Fund Enhanced Healing Environment (EHE) award resulted in improvements in two wards. The EHE project team in consultation with stakeholders implemented the following environmental changes:

- new reception areas;
- artwork added to windows and walls;
- new clocks;
- ward signage;
- bed areas with lit memory boxes;
- therapeutic lighting;
- reminiscence therapy;
- way finding using colour;
- cinema style seating areas;
- reminiscence café.

The project was evaluated using observation, a patient and carer quality of life questionnaire, an activity audit, and staff focus groups. Overall patients, carers and ward staff perceived the environmental changes as having a positive impact on care delivery.

Improving communication with staff and patients

Using insights from patients and families (informal discussions and complaints), we identified that carers of patients with

dementia feel disempowered when arriving in hospital and lack information. In response to these concerns, we developed an assessment document "See Who I am", kept at the bedside, which is completed by the patient and/or their family detailing information on the patients' personal likes/dislikes and their behaviours.

Additionally, we use a "Forget me Not" patient identifier placed at the bedside, on records and investigation request cards remind people that the patient has a cognitive impairment and to consider this in their communication with them.

We have a carers and patients information package — a carers bag — with a dementia pathway CD, information leaflets, third sector support contacts, an evaluation questionnaire, and "Forget me Not" branded items.

Contact

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FINALIST

North Lincolnshire CCG

North Lincolnshire CCG works routinely with its community to co-design compassionate commissioning strategy and intentions. In February 2012 the CCG leadership team committed fully to compassionate commissioning and was the first CCG to adopt an Experience Led Commissioning (ELC) programme approach.

Over the last year and in close partnership with the ELC team, North Lincolnshire has:

- built organisational capacity and capability to work differently with local people and front line staff;
- walked in the shoes of those who use and deliver services;
- analysed and uncovered new insights into what matters and keeps people well.

It now better understands what adds value and can commission with compassion.

Having aligned member GP practices, strategic partners and senior executives around a set of inspirational shared values, the CCG invited its main NHS trust providers (acute, mental health and community), GP practices, social care, public health, the North Yorkshire and Humber CSU and the voluntary sector to nominate individuals to be trained and coached as ELC practitioners.

Over the course of 2012/13, the ELC team underwent intensive classroom training and on-the-job coaching and completed two initial commissioning programmes in end of life care and redesigning outpatient care for people living with long term conditions. Their dementia programme began in July.

In addition, the CCG applied ELC to inform major service reconfiguration. This work engaged with all sectors of the population and asked: "What needs to happen so that you and yours keep well and live an independent life in North Lincolnshire?"

Led by the CCG's ELC support team and in partnership with North Lincolnshire Council, local Healthwatch and Voluntary Action North Lincolnshire, this programme will inform major transformational change across North Lincolnshire.

ELC insights prove invaluable to both providers and commissioners. They prioritise what matters — and have focused commissioners on:

- articulating value;
- mapping existing assets;
- relationship based care;
- peer support and creative solutions to care delivery.

North Lincolnshire used to be a place where the local community did not engage. Both Council and CCG reported difficulty involving local people. That has changed. Local people and front line staff enjoy participating in co-designed commissioning. Engagement levels are unprecedented. At most recent co-design event, over 60 people shared their experiences of dementia services — a four-fold increase. It proved a moving, humbling experience — and generated invaluable insights that will define compassionate care in dementia.

CCG organisational development continues, with 19 volunteer community networkers trained to support and improve engagement, participation and outreach. They will also spread the word about the commissioning decisions and improvement work arising from completed programmes. Over time, they will become instrumental in leading a community wide movement for quality improvement.

The North Yorkshire and Humber CSU team have had induction training on the ELC approach — how it works and is different — so that they can contribute their best work around supporting the CCG.

The CCG knows that it has controversial decisions to make very soon. The ELC process is now embedded and set to ensure that those decisions are the right one, and that commissioners understand the value people get from current services so that side by side with local people, commissioners can retain what matters and build even greater value into reconfigured services.

Contact

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FINALIST

The Princess Alexandra Hospital Health Trust

At Princess Alexandra every public board meeting now starts with patient care telling the stories of where things have gone wrong and giving complainants up to an hour to tell the board personally how things could have been done differently. Complaints are used positively to prevent them being repeated. The result is that complaints have dropped from 75 a month to 15. Compliments have risen from 30 to over 200 logged a month. The key Friends and Family score has risen from an unacceptable 25 a year ago to 82 from 445 responses in July 2013.

The trust board now has three directors including the chief executive, who have risen through the nursing. Over the last year they have led patient care transformation at a trust that has had its share of problems with patient satisfaction in the past.

Short "shock" slide shows have been produced in-house to tell real stories of patients who have made a complaint. One told of an older patient who felt she was "invisible" in a busy ward where other patients had more urgent needs. Her husband of 60 years was also now ill and all she wanted was updates on where he was and how he was doing plus a friendly chat now and then. The slide show was shown at briefing sessions for staff and helped galvanise them to try even harder to improve every single patient's experience.

The programme has led to major rethinks across the whole spectrum of health care at the Princess Alexandra. The cost has been minimal with staff fully involved in preparing briefings and organising meetings and support material within the hospital.

In A&E staff were asked how best to re organise procedures to cut waiting times and patient "ping ponging" to urgent care. They came up with a clinician-led programme involving complete reorganisation of patient flow, a single patient reception and the demolition of four cubicles to be replaced by a clinical decisions unit with six new recliners. As a result we now hit the 95% of patients treated in four hours target.

Similar programmes have led to seven day physiotherapy on the wards, seven day opening of the discharge lounge and vastly improved patient flow.

A matron also now leads a new team aimed at cracking the "worst case" discharge hold ups. Up to 25 worst cases are now reviewed daily with streamlined NHS liaison and closer involvement with local government social care — the hospital trust straddles two county councils — to get quicker decision making and facilitation at the top of the agenda.

The trust's values and standards have been redrawn with full patient and relative involvement in the consultation on wording in addition to staff, carers and volunteers. The new values of respectful, caring, responsible and committed flow onto service standards that emphasise kindness and compassion, dignity, treating everyone as individuals and empathy. The resultant behaviours are also driven by being open and honest, friendly and treating others as we would want to be treated ourselves at all times and not settling for "good enough" or walking past when you could make a difference.

Contact

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FINALIST

Spiral Health CIC

Bispham Hospital is a nurse led 40-bed rehabilitation unit run by Spiral Health CIC, a social enterprise. Most of our patients are older and visit us for nursing, physiotherapy or occupational therapy or to recover from major surgery. We wish to offer a superior level of care for our patients. To do this, we need to understand what matters to them as individuals and how they wish to be cared for.

To fulfil these objectives we have developed a pioneering patient-centred journey for patients in our care. This was developed in collaboration with Helen Sanderson, widely acknowledged as a leading UK expert in person-centred thinking. Our patient-centred journey comprises a number of initiatives. The key elements are:

- a pre-arrival assessment of the patient during which a one page personal profile (not just a medical one) is developed so we get to know the patient as person even before he/she arrives;
- on arrival, each new patient is greeted by name and introduced to his/her nursing team. With permission from the patient, a short personal profile is posted above the patient's bed, to help staff get to know him/her;
- staff profiles featuring personal interests and hobbies are posted throughout the unit;
- information about patients is collected efficiently so that they only have to tell their story once;
- visiting hours are personalised to suit the patient;
- exercise routines and classes are personalised;
- each day, patients are asked what would make this a good day for them today and staff work hard to fulfil this;
- all discharge planning meetings are held at patients' bedsides and family members/friends are encouraged to attend. Involving family members in open, honest bedside meetings has dramatically improved communications and helped many patients transition home more smoothly;
- finally, patients choose their own discharge times. A nurse telephones them a week after they've returned home to check on progress.

Mid stay, all patients are asked what is working and not working during their stay — and their suggestions for the future in the unit. This information is collated and fed through our Working Together for Change (WTFC) business planning process, which we run through quarterly and which allows us to continuously improve and learn. All hospital stakeholders — patients, staff and managers — take part in assessing the information and deciding action points.

We have experienced significant culture change among our staff, with leadership coming from the top and senior staff being approachable and person centred. Staff have also been empowered to take decisions about the unit, with special staff led working parties set up to decide on key aspects of change. In this atmosphere of transparency, staff have been willing to take on change.

Our initiative has required little financial investment and has achieved dramatic culture change within a six month time frame. We have invested in staff training in person-centred practices to support our patient-centred journey and have purchased notice boards to place above patients' beds and in communal areas. The total cost is around £8,000.

Our aim in being patient-centred is to build up our patients' physical and mental confidence so that they can return to their own homes quickly. The average length of stay in intermediate care is 35 days, but our patients stay for 17 days and a very high percentage of them return to their own homes.

Contact

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FINALIST

United Lincolnshire Hospitals Trust

The care of people with late stage dementia in acute hospitals is a much-neglected area. Such patients too often spend the last hours, days or weeks of their life in an alien environment, being subjected to burdensome, distressing and futile investigations and interventions.

Wishes to improve care of people with dementia in hospital, led to employment of a liaison psychiatrist at Pilgrim Hospital. In late 2009, more than 200 patients, many with dementia were admitted to hospital from care homes in Lincolnshire over a three week period. Clinicians of all disciplines at Pilgrim Hospital felt that admission was often not in the best interests of these patients, and in many instances lead to a more rapid deterioration in function than might have occurred had the person stayed at home. However, no alternative models of care were available locally.

One of these clinicians, the liaison psychiatrist, was often asked to assess patients with dementia who did not have the mental capacity to influence the direction or extent of their care, and as a consequence were less likely to be offered palliative care.

Several studies had shown that advance care planning in care homes was associated with reduced hospital admissions

without change in mortality rates, and another study showed that training for care home staff improved confidence in the management of delirium. Therefore, our challenge was to fund a novel service, which amalgamated existing evidence.

A series of dementia workshops hosted by the East Midlands Strategic Health Authority enabled discussion with local stakeholders, including representatives of carers, voluntary sector organisations, care homes, social services, primary care and mental health trusts. Agreement was obtained from the trust director of nursing, the medical director, and the chairman of the local primary care trust (PCT) to submit a business case to the Bromhead Medical Charity.

The objectives of the service were to:

- improve management of delirium and end of life care for care home residents with dementia;
- deliver an advance care planning service to support carers;
- reduce hospital admissions;
- enable residents to die in their/their carers' preferred place of care.

Funding was secured for a two year period to provide a service to care homes in the Boston area.

Two nurses with extensive experience of nursing patients with dementia were recruited. They developed information about the service for GPs, carers and patients, and attended practice meetings to address any concerns.

The service was introduced to seven care homes in March 2011. It comprised:

- liaison with care home staff, general practitioners and carers;
- functional assessment of residents with dementia;
- training of staff in delirium and end of life care including eating and drinking issues;
- advance care planning, conducted with the resident or on a best interest's basis with carers;
- ongoing support for staff and carers.

Training based on the Stop Delirium! programme developed by the University of Leeds was delivered on several occasions in each care home to ensure all staff had participated. The service was evaluated using Survey Monkey questionnaires, completed by care home staff before and after training, and by carers after care planning. Staff questionnaires addressed confidence and knowledge of delirium.

Carers' opinions were sought on how care planning was conducted. The trust information department provided data for hospital admission. Data on deaths were collected from the care homes.

Marked improvements in staff confidence were seen in the recognition (59%), prevention (57%) and management (50%) of delirium, and an overall improvement in knowledge of factors associated with delirium.

There were high levels of carer satisfaction; more than 92% rated the service better than 9/10.

As a consequence of the training and care planning it became clear that staff and families' understanding of eating and drinking issues in late stage dementia was poor. We were aware that this was an extremely emotive subject, and so further educational material and leaflets were developed by the nurses in collaboration with a speech and language therapist.

We observed a reduction in admissions from baseline of 37% in the first year and 55% in the second year of the service. All residents with a care plan have died in the preferred place of care since the inception of the service.

Contact

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FINALIST

West Dunbartonshire Community Health and Care Partnership

By learning from a patient complaint, this initiative co-produced a resource pack to enable health and social care professionals to better assist patients with a visual impairment to manage their medicines effectively and safely. The "Let's See If We Can Help" resource supports staff to better enable their patients self manage their medication — thus reducing the risk of inappropriate use of medication while also enhancing their independence.

There is an extremely high incidence of visual problems among older people, and an almost equally high incidence of non-recognition of the condition by older people themselves. This adds further complications for those older people living with multiple morbidities —almost 40% of over 75 year olds that have two or more long term conditions.

In October 2009, a complaint was made to the CHCP by a patient with a visual impairment in relation to medication that they had been dispensed. When the medication had been labelled by their local community pharmacy, the dispensing label had been placed over the Braille inscription on the medicine packet — the patient was then unable to read how to correctly and safely self-manage their condition.

In seeking to respond to the concern raised, the CHCP sought to better understand the additional difficulties for visually impaired people in the safe use of prescribed medications. To do this they worked with Focus, a local umbrella organisation for visually impaired people, and local community pharmacies to develop an easy to use and evidence based toolkit, with supportive training. The resource was subsequently developed as a hints and tips guide; "Let's see if we can help" and then successfully piloted before being launched.

A formal evaluation was undertaken to gauge uptake and effectiveness, as well as capture any other positive changes in practice stimulated as a result of the increased awareness of visual impairments and medicines management. NHS Greater Glasgow and Clyde Clinical Governance Support Unit interviewed community pharmacists; and visually impaired patients in the community and those accessing ophthalmology services in hospital.

The evaluation found that:

- previously there had been little awareness of the specific issues regarding medicines management for visually impaired people within community pharmacies. By the end of 2012, over half of the local the community pharmacies had already used the "Let's see if we can help" resource with their patients;
- both patients with visual impairments and staff have responded positively to the resources provided;
- medicines are more effectively used by blind and partially sighted people when using the resource;
- local community pharmacist contractors are able to more effectively monitor medicines usage for people who may previously have had difficulty managing their medicines by being able to have a more open dialogue with patients at the point of prescribing. The resource is easily replicable and easy to use.

The CHCP's lead pharmacist has been working with colleagues in RNIB's research and development department to ensure dosette box compliance for people who are blind and partially sighted is in line with medicines compliance across the UK.

Contact

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WINNER

Right to Request the right decision for Nottingham City now others benefit from the "CityCare Experience"

Nottingham CityCare Partnership

CityCare is a social enterprise that navigates across sector boundaries and is as happy working alongside the private sector as it is the public and third sector. CityCare's success is due to its acceptance of others in the market and that sometimes others have the expertise to deliver.

Transforming Community Services gave CityCare staff a vehicle to move out of the NHS in law, but not contractually or in terms of values. Staff could see the opportunities that leaving the NHS family presented for their patients, stakeholders and themselves. It gave the freedoms to improve outcomes and efficiency, without the red tape that stifled innovation in the past.

CityCare knows what its strengths are and picks and chooses the tenders it responds to carefully. We take the best of the NHS and mix it with the best of business practices to deliver the best we can, quickly and efficiently. We call it "collampetition", sometimes we collaborate and other times we are in direct competition, but that doesn't restrict how or who we work with to get the best outcomes, quality and value for our patients and stakeholders.

CityCare have also added social value along the way, and secured a reserve without destabilising others, in many cases sharing that success. CityCare as a hybrid are accepted by all sectors. Below are three examples of how we have introduced commercial practices such as Joint Venture and Framework agreements, but have also managed to stay with the health and social care infrastructure.

Discharge project — third sector

A call centre was set up within two weeks. Staff rang discharged older patients to ask "how are you?" — this was not just those referred to a service on discharge but everyone, patients say "it's like the old NHS". Not having to order desks in triplicate or wait six weeks for delivery made this happen for commissioners.

CityCare partnered the Carers Federation whose 90 volunteer can undertake small tasks like:

- cleaning,
- shopping,
- sitting,
- picking up prescriptions.

There is a pharmacist to address medication issues, who also goes out to visit patients if necessary. Over 1,700 people were contacted in the first few weeks and there was evidence of avoided re-admissions. As a result CityCare have continued to fund this initiative as social return.

Boots — private sector

CityCare leased the whole clinic within Boots main city centre store. CityCare staff receive Boots discount and have access to all staff facilities.

Patients have access to high quality city centre location and CityCare are able to extend their offer. There are other mutual benefits to this relationship which are being scoped — medicines for example. We are gaining access to the site 24/7, as outlined in Everyone Counts, services need to move to 24/7 working.

EMAS — public sector

A joint branded ambulance with EMAS paramedic and CityCare falls team member teamed up to respond to those who fall. Within weeks had responded to 180 calls of which 149 were maintained at home and not admitted but referred into CityCare crisis response.

On leaving the NHS, CityCare offered a number of financial models the best case being year-on-year £500,000 growth from a starting position of £36m. This means we should be at £37m, in fact the 2013/14 contract value is nearer to £47m.

As a social enterprise we have been able to invest some of our surplus to add social value in initiatives to reduce the number of children entering care, staff training and care home beds.

Contact

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Award sponsored by

Capsticks

Judges' comments

- *Demonstrated a strong case for making a difference within their community.*
- *Totally innovative approach to service delivery.*
- *Passionate advocates for the benefits of social enterprise model.*
- *Very wide view of sustainability, and they appear to be delivering it.*

FINALIST

Developing empath: a new organisational model to deliver high quality and sustainable pathology services

empath

The initiative

The Carter report into pathology services had been well received but largely ignored by most NHS pathology services in England. However by mid 2011 there was increasing realisation within the two largest East Midlands trusts (Nottingham University Hospitals and the University Hospitals of Leicester) that the status quo was not an option. In response to the increasing pressures to maintain a high quality, cost effective pathology services, they agreed to merge and reconfigure their laboratories.

Simple merger of pathology services, as recommended by Carter, was obviously part of the solution but would not be sufficient by itself. Indeed even merger was a challenge; the bringing together of essential clinical support services of two large teaching hospitals situated 25 miles apart had never been attempted before within the NHS. The size of this challenge coupled with the need to address commercialisation and an ambition to provide an inclusive model meant that a careful rethink of how pathology might be delivered both in service terms and in its governance was required.

A radical redesign of the service, by the service, within a structure set up by Price Waterhouse Coopers, produced a flexible delivery model that delivered improved quality with significant monetary savings. The service was to be of high quality, cost effective and sustainable and should also deliver to a set of agreed principles. These principles included:

- the service should retain value for the NHS;
- it should be part of the NHS but operate on commercial lines, trading for income;
- where the NHS did not have the appropriate expertise this would be obtained by partnership or subcontracting;
- be open to participation by other NHS organisations;
- be compliant with the Carter vision;
- have the flexibility to cope with future developments whether predictable and unpredictable in both the delivery of uk health care generally and pathology specifically.

The delivery model uniquely maintained quality by retaining clinical aspects of the service close to patients in clinical service spokes while still allowing major economies of scale from consolidation of routine activity into an offsite hub.

Delivery was facilitated by establishing an arms-length trading entity, empath, embedded within both trusts and governed by a formal board including independent non-executives and a commercial director. The redesigned service delivered savings from staff reductions and lower accommodation costs.

By 2012/13, part way through the transformation, the combined services had delivered annual CIPs of over 5% and the rebased business plan still indicated a projected £10.5m saving on turnover of £69m.

The service reconfiguration results in a reduction of wte staff of 12%. This combined with skill mix changes gives an overall reduction in staff costs of 15%. Removal of routine services from landlocked hospital sites to lower cost accommodation also makes a significant contribution to the overall saving. As of March 2013 payback from the consolidation is within 18 months with a small surplus generated in 2014/15 allowing for transition costs of £1.5m.

Contact

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FINALIST

Increasing theatre throughput and introducing flexible consultant job plans

Guy's and St Thomas' FT

The initiative

At the start of 2011 Guy's orthopaedic centre was failing its RTT 18 week targets and running at a £5m negative variance to budget, with under used theatre lists. There were over 800 patients with an active pathway over 18 weeks, high levels of patients complaints due to long waiting times and up to 16 on-day cancellations a week. Over £600,000 was spent on private waiting list initiative lists, while weekday NHS lists were under used.

In early 2011 a new management team was brought in to address these issues and produce a plan to meet the 18 week target by April 2012. The team did a whole pathway review and restructured admin areas to support the changes.

The theatre schedule was taken over by a new manager who was extremely proactive to ensure theatre lists were crossed covered and was looking at the next six week plan. Parallel lists were introduced which gave our fellows access to more theatre time.

Consultant leave policy was changed to ensure enough cover was available to cover theatre lists and the centre recruited two additional locums with flexible timetables to ensure 100% of sessions were covered. The centre stopped private initiative waiting lists overnight and increased theatre sessions by 37%.

The inpatient schedulers were relocated to the orthopaedic department so surgeons could access waiting and theatre lists easily. Consultant's job plans were made more flexible so we could swap clinics for theatre lists where needed and some surgeons have even included Saturday as part of their job plan or to bank additional leave days.

The centre also introduced "Super Lists" — adding an additional anaesthetist and nurse to a list to reduce turnaround time and increase in list throughput by 50%. To reduce on-day cancellations, the centre added a pre-operative assessment phone call two days prior to admission to ensure patients were fit and ready to proceed with their planned date.

The centre also introduced weekly theatre meetings that included service manager, theatre staff, ward matrons and clinical nurse specialist to improve communication and ensure lists are planned effectively. The centre employed a clinical nurse specialist who supported the inpatient pathway and took responsibility for the on-day cancellations target.

The Guy's orthopaedic centre met the RTT targets in April 2012 and has continued to do so each month. Patient complaints about waiting times are almost non existent now, and have been replaced with lots of compliments from patients who experienced the previous pathways and feel the value of the changes.

The Guys orthopaedic centre underwent a £6m turnaround within 12 months, as a result of using all theatre capacity, reducing on-day cancellations, not spending £600,000 on private waiting list initiative lists and moving to single supplier contracts for implants. On-day cancellation improvement has increased income by more than £500,000. Introducing new consultant flexible job plans to include Saturdays and swap clinical commitments has enabled the department to maximise the current establishment and build efficient new ways of working.

Contact

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FINALIST

Bringing people together to provide quality care for the communities we serve

Southern Health FT

The initiative

In coming years our population will continue to increase, with older people being the fastest growing group. It is estimated there will be 20% more over-65s by the year 2020, with 50% more by 2030 (POPPI 2013). There will naturally also be an increased demand on health services, making it vital to ensure we are delivering high quality care that is providing value for money.

By working closely as one organisation, teams within Southern Health can deliver better patient care through a multi skilled approach and sharing information. For our stakeholders, such as GPs, we are a stronger resource in providing a larger number of services in a more effective manner.

Following the merger in 2011, Southern Health FT began a programme to reduce corporate overhead costs by 30% over three years, releasing £5m from the business. By redesigning corporate services teams and reviewing business critical services and processes, we have found solutions that support our service change programmes. The savings contributed both to delivering the financial challenge faced by the local health economy and supporting vital reinvestment in leadership development training.

In 2011 we established a mock CQC inspection team to continually improve quality and safety by assessing compliance with CQC standards, involving staff at every level, including governors and volunteers. By evaluating our practices we were able to see clear options for improvement.

Through service redesign we have created integrated service divisions (ISDs), dividing the trust geographically, rather than by specialty. Patients and service users benefit from teams working closer together, with fewer assessments, quicker transfers between services and better-shared knowledge of conditions.

Engagement has been vital in ensuring the success of our reorganisation. Staff engagement events allowed clear communication of redesign plans, and the collection of feedback on the impact of changes, ensuring they were carried out smoothly. These events also ensured staff understood the changes, in order to be able to actively support them and continue with their day-to-day work effectively.

Stakeholder engagement activities have also taken place, including primary and secondary care, local authorities and voluntary sector organisations. The relationships we have with these groups are imperative in delivering patient centred care.

Bringing together older people's mental health and integrated community services was the first stage of creating the ISDs. In North Hampshire we worked closely with the local authority and CCG to develop integrated care teams, giving older people and those with long term conditions a single point of contact in a team that works together and shares information.

We believe that our culture impacts the quality of care we deliver. The savings made have allowed investment in creating a positive culture shift, through an innovative new appraisal system and "Going Viral", an ambitious leadership development programme. Designed with staff and trade unions, these are founded on a set of behaviours, aligned to the trust's values and written at ten different levels; applicable to every role across the organisation.

Contact

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FINALIST

Care4today

Guy's and St Thomas' FT

The initiative

We have partnered with industry to improve our patient pathway for hip and knee replacements. Our patients will leave hospital from day two, post surgery (if clinically safe) and our team will then continue their care from the comfort of their own home.

Patients will be provided with an information pack explaining the process from first hospital appointment to discharge from hospital. They also access to an interactive website where they can track their exercises and keep in touch with the outreach team for up to six weeks following hospital discharge. Our main objectives for the project were:

For patients

- earlier transfer home;
- improved medical outcome — faster recovery;
- improved patient experience;
- improved patient satisfaction.

For staff and the department

- overall service improvement;
- increased revenue potential;
- enhanced productivity and operational efficiency;
- improved staff satisfaction.

This service redesign has increased staff morale and patient experience. We started this pathway change in February 2013 and have already seen good results. The staff and patient feedback has been really positive and in the first 20 patients we saw on average a 50% reduction in LOS.

Over the next year we aim to put through 400 patients through the full pathway which will save us approximately 1,200 bed days with the intention to expand this to revisions and fracture neck of femur later this year. The future goal for this project is to enable the trust to re-negotiate whole pathway tariffs in line with future commissioning integrated pathway intentions

We have had some very positive staff and patient feedback:

"The information pack helped me to understand the hospital process; I did not feel so nervous about my operation"

"The website helped me to track my exercises and keep in contact with the outreach team"

"I think it's great that our patients are given an information pack to take home and read"

"Fantastic to see that patients are still able to contact the team after they have been discharged"

"The website is so easy to use"

This pathway is relevant to all other orthopaedic organisations. We are currently looking at adapting this to other specialities within the trust, for example plastic surgery and head and neck.

Contact

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WINNER

Leicester's hospitals select Nervecentre for mobile handover of care

University Hospitals of Leicester Trust with Nervecentre Software

The initiative

Handover is the system by which the responsibility for ongoing care is transferred between healthcare professionals. According to Sir John Lilleyman, Medical Director, National Patient Safety Agency, "Handover of care is one of the most perilous procedures in medicine, and when carried out improperly can be a major contributory factor to subsequent error and harm to patients".

Many trusts are replacing paper handover notes with electronic solutions such as documents on shared drives, but while these succeed in providing improved governance, they do not address the fundamental problem that information is not up to date.

University Hospitals Leicester has embarked upon a transformational CQUIN safety programme called *5 critical safety actions* to provide consistent and high quality care. Two of these actions include improved clinical handover and minimum standards for ward round notation.

Both of these actions have been addressed using mobile technology as part of this project. Using Nervecentre via mobile devices, information is entered throughout the day, for example at ward rounds and transfer of care. Clinicians have access to live, accurate information on the status of patients from anywhere, allowing more informed decisions to be made, and removing the inefficiencies of time spent accessing information.

Nervecentre is a healthcare focused consultancy and software development organisation. Nervecentre's goal is to improve staff productivity and communication and also build a comprehensive picture of the hospital's performance, to provide management with insight into performance.

Benefits

The mobile approach has led to a reduction in the administrative burden on doctors and nurses, while increasing the completeness and accuracy of information captured. Doctors can enter ward round information directly into iPads which can be printed onto labels avoiding duplication of effort.

Evidence indicates that over a typical weekend only 2.5% of information from the first handover is retained at the final handover if there is no written record. Using mobile devices, all patient information is captured at the point that the decision is made and is available anywhere, increasing the accuracy and completeness of information captured and handed over.

Additionally, because information is entered in real time and not at the end of the shift, the information is available to doctors throughout the day as required. This includes transfers of care that are not typically covered by a formal handover process, such as doctors going into theatre.

Doctors and nurses share handover information, ensuring all clinicians are working from a single set of patient information. All tasks associated with a patient are captured and tracked, so there is a significant reduction in the number of tasks that are overlooked at handover. Tasks may be handed over to the Hospital@Night team ensuring continuity of care 24/7.

University Hospitals Leicester is now also looking at how this real time handover information can be extended after a patient has been discharged from hospital, providing integrated care between the acute and GP or community setting.

Financial implications

The main objective of the project was to improve patient safety. Consequently, a return on investment was not sought by the trust. The initiative needed little investment from University Hospitals Leicester due to the usability of the system implemented by Nervecentre. Early feedback indicated that minimal training was required by staff due to the ease at which data could be entered by clinicians, which additionally meant that there was a very low adoption time for implementing the solution.

Although no cost savings have been reported, there has been a significant saving in the amount of time spent by doctors updating patient information. It's estimated that junior doctors at the trust have saved around thirty minutes each day due to information being entered in real time throughout the day rather than at the start or end of a shift. This information is then automatically available to the doctor on duty.

Contact

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Judges' comments

- *This is a great example of impressive sharing of information between nursing and medical staff to improve patient safety. It is an ambitious project that has been executed well.*

FINALIST

Advancing quality; using reliable information to reduce clinical variation and improve patient outcomes across the North West of England

Advancing Quality Alliance (AQuA)

The initiative

Advancing quality (AQ) was launched at a time when there was no systematic way of defining quality care in the North West. The region had a higher mortality rate than the national average, there was no common agreement on what "best care" actually was and the data was not comparative so couldn't be trusted as a benchmark.

In 2008, AQ went live in all NHS provider trusts in conditions such as heart attack, heart failure and pneumonia — conditions highly relevant to the NW population and with clinical consensus of a clear evidence base.

Key clinicians were identified in each organisation to lead the programme in each condition. It was agreed that data collection must be affordable, using data already collected electronically wherever possible. IT systems were set up to:

- allow clinicians to identify patients quickly;
- enable data to be extracted, anonymised and aggregated to identify achievements/failures for clinical teams and management to develop better pathways.

A collaborative approach was adopted with teams meeting regularly to share best practice and seek advice/support on specific measures. For example a trust struggling with smoking cessation advice can identify from data the teams with the highest results and ask for advice.

Clinical leaders were encouraged to own and lead the development and definition of the measures engaging with the clinical community. Monthly reports of latest data published internally enabled management teams and commissioners to be aware of performance results.

The aim was to save lives, reduce re-admissions, complications and length of stay. Following early success, AQ expanded into stroke, dementia and first episode psychosis. Clinicians agreed a number of key quality standards for each specialty, which, if carried out at the same time and in the same way for every patient, would ensure all patients receive the best care.

The data is recorded as part of the normal clinical record and AQ provides a benchmark of how successfully the clinical team deliver the agreed quality standards. Results are publicly reported online enabling patients to monitor local NHS performance.

Benefits

Independent evaluation published in the New England Journal of Medicine concluded that avoidable mortality rates fell by 6% in the NW within the first 18 months, the equivalent of 890 deaths. An aggregate score of patients who received "perfect care" for the original five conditions increased from 61% in year 1 to 81% in year 5.

Clear definitions with simple processes for data collection and analysis has standardised clinical practice making services comparative and reduced variation across region. Clinically led, robust data collection, and independent assurance means data is trusted by clinicians and shared across the clinical community as a credible source.

Transparency of data and public reporting drives clinicians and teams to improve on both personal and the organisation's reputation

Financial implications

The initiative was historically funded by all NW PCTs, each committing 0.1% of annual allocations. The programme initially funded £3.2m of financial incentives during the first 18 months, but AQ is now part of the CQUiN framework so expendable costs have reduced.

Preliminary research suggests AQ offers a 10 fold return on investment using NICE standards for the return expected from any clinical intervention. Additional research indicates 20,000 bed days were saved, an approximate value of £5m.

Contact

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FINALIST

e-Board: an electronic solution merging patient white boards, nursing handover notes and other safety and discharge management information

Basildon and Thurrock University Hospitals FT

The initiative

Information that wards gather on patients during their stay is critical to how well they manage the care of their patients, and to the discharge process. Too often this information is collected in duplicated processes, and as it is written on white boards or in books it is only available to those that can get to the ward to read it.

Making the information digital ensures that the data can be captured and shared quickly, easily and in real time. As well as making nurses' work easier, the ultimate goal was to develop performance metrics to address length of stay issues in the trust.

The project started with the director of nursing wanting evidence based performance metrics so that she could be assured of quality without having to rely on anecdotal evidence. The assistant director of performance took up the challenge, and created a concept version of e-Board. The concept was further refined with a ward manager to ensure that it met her needs.

Before a pilot phase was undertaken it was recognised that e-Board wasn't just for ward nursing staff, but for a whole range of healthcare professionals across the hospital. They were all involved in developing the pilot version, and this also ensured good buy in to the pilot phase. e-Board was piloted on four wards initially, and proved highly successful. As a result, it is now being rolled out to all 16 adult inpatient wards in the trust.

Benefits

Following the pilot a survey was taken of e-Board users:

- 45% said e-Board improves the care they deliver to their patients (41% were neutral);
- 57% said e-Board improves the way the ward works (37% were neutral);
- 79% of staff said they would prefer to keep e-Board, and the remaining 21% were neutral.

Data from e-Board shows that of the 25 mandatory fields for each patient, there was a 95% compliance with completing these fields.

Financial implications

e-Board was delivered at no additional cost to the organisation. Large screens were installed on each ward to display e–Board, but this was just a pull ahead of installations required for the new PAS. The potential savings through improved quality and reduced length of stay are significant. As well as making nurses' work easier, the ultimate goal was to develop performance metrics.

Time savings were identified by using e-Board, and improved bed management will result in better quality care, better patient experience, and faster throughput.

Contact

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FINALIST

Trauma case management without walls: the trauma patient management system (TPMS)

Cambridge University Hospitals FT

The initiative

Trauma patients are often critically ill and they need high tempo decisions regarding immediate clinical care and emergency transfer. The introduction of regional trauma networks has created the additional challenge for ambulance crews of deciding whether to bypass a local hospital's trauma unit in favour of the major trauma centre and increased the need for early inter hospital transfers from emergency departments.

In response we proposed the idea of a cloud based software system that would support individualised case management and allow key elements of the patient journey to be tracked. Client relationship management software is commonly used in industry and we recognised this private sector solution could be applied to this challenge.

In terms of content, the aim was to:

- provide an environment within which key personnel could collect, record and share relevant patient information;
- collect information to support effective, robust case management across the patient pathway;
- effectively and sustainably measure and manage the process, meeting both quality standards and BPT requirements;
- collate patient safety related data to ensure whole picture or sequence of events for each individual patient.

It also needed to be easily accessible, NHS Information Governance Toolkit compliant, organisationally agnostic and easy to use.

The project team, comprising staff from the major trauma centre based at Cambridge University Hospitals and the East of England trauma network, have worked closely to develop and implement the system across the region

After exploring a local bespoke intranet based database we developed sufficient understanding of our needs to procure an off the shelf client relationship management software solution (Microsoft Dynamics CRM 2011).

We now have a virtual trauma register which allows healthcare professionals from any web connected computer in the trauma network to access the system and update key case management events, monitor progress against best practice tariff measures and communicate with each other. Every key event, from an ambulance crew pre-alerting A&E to the completion of a rehabilitation needs assessment is tracked and recorded on the TPMS.

Benefits

The success of the TPMS is entirely reliant on user engagement. Initial buy in was poor because of lack of familiarity with the interface and reliance on existing systems. However, following user training and customisation of the interface to individual user needs, we have secured widespread engagement from key stakeholders.

The TPMS comprises a range of linked tables or pages that are aligned to stages in the patient journey and we have encouraged individual teams to own the development of these tables. The rehabilitation team, for example, customised them to meet their needs. Similarly, the performance and quality pages are owned by the major trauma centre's clinical director and trauma governance group and reflect the data that they need to both see and input.

In the past, there has been no means to quantify the exact number of trauma patients in the system, determine their status in terms of progress along the pathway and monitor timescales for key events. This is all now being undertaken routinely.

Financial implications

We were awarded Regional Innovation Funds of £180,000, which allowed us to both develop our understanding of the information and technology options and test the physical Network Coordination Service (NCS) operation with a live call centre model and call handling agents.

In terms of cost/benefit, the TPMS costs are made up of several components. These include the cloud storage and security architecture and licences to use the CRM programme. The total cost is about £60,000 a year for 100 users, which equates to less than £100 per patient.

The return on investment is related to mortality. NHS England has confirmed that the regional trauma networks are associated with a survival advantage. The cost of a trauma death is in the millions — around £1.2m for a road traffic related death in terms of societal costs, lost life years, emergency care and so on. What the TPMS does is help us coordinate, manage, streamline and understand trauma care pathways. Saving one single life as a result makes it worth it.

Contact

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FINALIST

EOS (electronic offering system) mobile

NHS Blood and Transplant

The initiative

Organ transplantation remains one of the most significant medical innovations of recent times. It has the potential to save and improve thousands of lives, but it carries with it risks.

These risks arise not only from the surgery itself but also the need to ensure a thorough assessment of a potential organ donor and transmission of accurate data regarding their condition. Clearly this is a time sensitive process, where any time saved can bring benefit not only to a potential recipient but also a bereaved family. The project was established in direct response to feedback from transplant centres regarding the difficulty they encountered accessing donor data on existing systems.

Historically, clinicians reviewing organ offers were required to log in to a secure system with multiple layers of authentication to access a 14 page PDF of data which they would review to identify the information they needed to support a decision.

As a consequence, they often relied on other staff either in the hospital or at NHS Blood and Transplant, to relay the information to them by telephone, with significant risk of transcription errors.

A clinical support group was formed to inform the project and provide critical input to the development of a single, expandable webpage with all of the summary data visible on it. Further, the survey identified which devices were used which enabled the project team to develop the solution to function on those devices, ensuring a higher take up. It was also validated on a range of additional devices in order to support more widespread acceptance.

The project team were able to define a summary data set required to support rapid decision making. Identifiable patient data was not required and therefore removed allowing a single login to the system.

Benefits

The EOS mobile application ensures that accurate information about the donated organ is available to the transplant surgeon and the clinical team throughout the donation and transplantation process. It is available in the palm of their hand, if necessary, on a mobile phone or tablet device.

It also supports rapid decision making about the acceptability of an organ for transplant, thereby ensuring that if there is no suitable recipient at one transplant centre, it can be offered to another without delay, reducing the risk of an organ deteriorating during the process. The result reduces the risk of patient harm, minimises the amount of time required from clinicians to access and review organ offers. It enables clinical teams to share vital information quickly and widely when considering whether to transplant an organ.

As a consequence of this project, the use of electronic systems to view offers has increased from 51% to 90% since the project began. To quote one transplant surgeon, "EOS Mobile has revolutionised the way we take organ offers".

Financial implications

The project incurred costs of £72,000. Although a financial benefit was not anticipated in the business case for EOS mobile the project has created significant efficiencies in time saved by NHSBT staff involved in the offering process. It is anticipated that the vast majority of the thousands organ offers made each year which, in some cases, required a twenty minute phone call, will be completed in just a few minutes.

Contact

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FINALIST

RAIDR — a unique business intelligence and decision support tool for GPs and healthcare commissioners developed by the NHS

North of England Commissioning Support Unit

The initiative

RAIDR (Reporting Analysis and Intelligence Delivering Results) provides healthcare professionals in commissioning and primary care with a single portal for all their information needs, integrating previously isolated data sources. It puts the user in total control — no more waiting for reports, no more estimating, just fast answers to critical questions in user friendly dashboards.

RAIDR is a dashboard analysis and reporting tool developed out of the need for GP practices to use the wealth of available NHS data. RAIDR allows users to navigate, select, and drill down to gain intelligence in a variety of ways, from high level trends to detailed patient level data.

Almost four years ago local clinicians requested access to robust, wide ranging and up to date patient based information which had always been difficult for them to achieve. In response, we looked to the market to procure a solution, but nothing suitable could be found. Most commercially available products were either too costly or did not meet all of our requirements.

As a result RAIDR was developed in house by information services at NHS North of Tyne who worked collaboratively with local GPs, considering and incorporating the all their needs and requirements. RAIDR is a business intelligence tool which brings together previously isolated nationally mandated core data sets from several systems and organisations, in an easily understandable dashboard system. The system was originated and developed by analysts, rather than IT professionals, who understand the data and the needs of the user. The result allows users to access their own information and produce reports independently in a simple and intuitive way. This lessens the need for extensive training programmes and data interpretation instruction.

The data held within the system is protected to the highest information governance standards, with tight security, strictly controlled access based on the role of each user, and a highly resilient and reliable technical infrastructure. RAIDR enhances both commissioning and GP practice management by providing users with powerful, fast and intuitive access to a wide range of health information, including secondary care data sets covering inpatient, outpatient and A&E activity, QOF, prescribing, disease area indicators, risk stratification, finance and contracting, weekly urgent care and primary care data direct from diverse GP practice systems.

Benefits

RAIDR has proved hugely effective, now supporting 565 GP practices in 15 CCGs serving 3.5 million patients with 1,800 remote users. The timely, comprehensive information RAIDR provides to clinicians helps support decisions and interventions for those patients most in need, ensuring better long term patient outcomes and driving down costs.

An illustration of this is a practice that identified a patient with 35 A&E attendances over 12 months costing almost £2,000. The patient was attending A&E to receive injections to relieve migraine attacks, and now receives these injections at home, greatly reducing cost while being more convenient for the patient.

"Payment challenges" highlights patients that are recorded by secondary care as being registered at the incorrect GP practice, this represents a significant level of miscoding and associated incorrectly billed cost which can be successfully challenged.

Day cases costing a few hundred pounds are sometimes incorrectly coded as a 365 day inpatient spell. Patients with a length of stay of 365 days are highlighted for possible miscoding errors.

Financial implications

RAIDR was conceived, researched and developed within existing resource, both financial and workforce. Continuing improvements and developments are again implemented by personnel within the existing information team. The principal overhead was the purchase of software licences; thus the cost to the organisation was considerably less than an off the shelf system.

Many examples of savings have already been seen by CCGs using RAIDR; payment challenges, risk stratification and alternative patient care pathways have all been implemented, having a direct impact on practice finances. Financial outlay could be recovered by preventing just 2–3 non elective admissions per year per practice using the risk stratification tools.

Contact

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FINALIST

Providing front line cardiology clinicians with reliable information to understand and improve performance particularly financial, quality, workforce and patient safety

West Middlesex University Hospital Trust

The initiative

The project objective was to develop key performance indicators specifically for the cardiology department to meet both national and trust targets This would enable the department to be much more proactive in improving patient care and determining key areas to address.

Measures such as high DNA rates and an unprofitable service line position were increasingly concerning for the trust and the department. It was recognised that questions were always being raised regarding the data quality and collection, which caused difficulties for both clinical and operational teams to understand what the real issues were.

This initiative brought together a multidisciplinary team from across the trust consisting of the deputy director of finance, a cardiology consultant, the lead CCU nurse and a senior information analyst. Through discussion the team agreed what the priority KPIs should be.

A range of indicators that incorporated quality, workforce, activity, financial and patient safety information were selected. Each measure was defined as was the methodology and data reliability. It was crucial that the data was trusted and reliable. The initiative developed a process in which the KPI's could be regularly reviewed and actions taken to address falling performance.

Benefits

The project delivered a number of benefits including:

- the development of a cardiology balance scorecard which includes monthly activity trends, tables and charts designed to support day to day decision making;
- a clear presentable format;
- SMART objectives for the department for 2013–14 including the submission of new business cases and service delivery plans;
- buy in from the entire cardiology department;
- an enhanced focus on quality of care and patient experience with good engagement with national and local patient surveys. Performance has now become a routine part of the conversation;
- an action focused monthly performance meeting with clear ownership of tasks.

Financial implications

One of the objectives of the project was to understand the financial position of the service via its service line reports. Historically the cardiology department had been seen as a loss making service for the trust.

In terms of the project itself there were no additional resources that the trust invested. The work was undertaken by the project team in addition to current work. The investment in providing accurate and robust data would in turn gradually allow the department to understand key financial drivers of the decisions made. For example the focus on reducing clinic DNA rates would improve the overall profitability of the department by reducing costs and the requirement for additional unnecessary clinics.

Contact

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WINNER

Care Plus Group's intermediate tier is an integrated system commissioned by the CCG to deliver health and social care services

Care Plus Group

The initiative

Care Trust Plus (CTP) is a devolved responsibility from the local authority for adult social care and the primary care trust. Intermediate care in North East Lincolnshire (NEL) had a reputation for being disjointed and difficult to access with limited outcomes for individuals. CTP commissioned a wide scoping review of the service to include the views of community members, GPs, the acute service, community therapy teams, and adult social care. The review identified a number of recommendations:

- to extend its function;
- to integrate teams and professionals;
- to offer intermediate tier to a wider population;
- to pool financial and physical resources.

As a result of the review an intermediate tier project board was set up and chaired by the commissioners, with all the key stakeholders present. Care Plus Group were the main provider. They were commissioned in 2009 to develop a new initiative to deliver intermediate care. They were responsible for reshaping their current services, with support from the acute sector, to provide the therapy intervention that would be required across intermediate tier.

This required the investment of £3.15m and the remodelling of existing services and functions across adult social care, intermediate care, out of hours district nursing teams, community therapy services and discharge liaison.

The aim was to develop a range of short term interventions which would focus on the wider determinants of an individual's health, to include their physical, social and emotional wellbeing helping to:

- promote faster recovery from illness;
- prevent unnecessary hospital admission;
- avoid premature admission to long term residential care;
- support timely discharge from hospital;
- maximise independent living.

The objectives were to support individuals and or carers who are in crisis or where needs have changed, including individuals with long term conditions, where teams help to manage an exacerbation of a condition in the community rather than through secondary care.

The teams are person centred and jointly develop personal outcomes, enabling individuals to remain or resume living at home. The services are time limited, multi professional, have a single assessment framework and a shared health and adult social care record.

Significant staff consultation was undertaken as services were redesigned to take on new functionality. A clinical recruitment programme was completed in the development of the rapid response model to ensure the right level of autonomous practice was available in the community.

The largest obstacle to overcome was the cultural and professional understanding of the staff who were now working with health or social care colleagues. Time has been the biggest healer; individuals need to build professional relationships to deliver integrated care. Primary care was a late adopter to the model, struggling to understand the concept. However with increased involvement from them, the approach is now embedded into the care system

Benefits

The benefits of this joint working initiative, has seen a number of positive outcomes for the local community and the commissioners:

- emergency admissions for NEL registered patients below the national average growth and the same level of growth as last year:
- recruitment of 15 apprentices across the intermediate tier;
- North East Lincolnshire is in the top quartile in the NI 125 performance indicator;
- 1,423 rapid response interventions avoided A&E attendance;
- 1,327 rapid response interventions avoided the need for an ambulance call out;
- On average 55% of individuals leaving intermediate care at home leave not requiring ongoing support, which is 15% above the national average;
- 85% of individuals leave intermediate care at home having met their personal goals;
  "To be able to shower independently without assistance"
  "To complete my own personal care"
  "To be able to use my bath chair with confidence"
  "To be able to get out on my mobility scooter".

Financial implications

Through the intermediate tier project board there was an initial investment into the tier of £3.15m, with a return on investment of £1.2m in the first operational year. Within the first year intermediate tier was able to evidence a saving of £1.3m. This resulted in a successful business case for an additional investment of £1m in the second year, enabling the tier to enhance a number of services and introduce a new one, creating employment opportunities for the local population. Intermediate tier continues to evidence financial savings year on year.

Contact

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Judges' comments

- *Very, very impressive example of integrated services and model of intermediate care delivered by social enterprises in a seamless fashion.*

HIGHLY COMMENDED

Effective joint working between NHS and local authority enabling the children's workforce to identify and improve speech and language

Wirral Community Trust

The initiative

Wirral has a diverse population encompassing both some of the poorest council wards in England and the richest. Narrowing the gap between these communities has been a priority. In 2006, ICAN, a leading children's communication charity, identified that 50% of children were entering school with below average speech and language skills. In areas of deprivation this figure was found to be as much as 83%. Locally the referral rate into the speech and language therapy (SLT) children's service rose from 253 in 2004/5 to 2,034 in 2011/12.

Better Communication (2008) was a cross party review of speech language and communication needs commissioned by the government. An independent review commissioned by the SHA (2010) in response demonstrated the Wirral SLT department's positive outcomes despite having the lowest cost base in the North West.

It was the need to maintain these outcomes despite significantly increased numbers into the service that required Wirral to a develop a strategy supporting the development of speech, language and communication in the early years delivered through a multi agency Better Communication strategy group.

The strategy group consisted of strategic leads from Wirral Council (early years, schools, educational psychology, library service, children's centres) and Wirral Community Trust (SLT, health visiting).

In 2010 the group established a strategy for early identification and intervention through training in pre-school settings — raising awareness and identification of young children with speech, language and communication (SLC) needs. The Every Child a Talker (ECaT) model was adapted, planned and delivered to be sustainable and long lasting.

Support for private and voluntary pre-school settings was offered through cluster groups run by foundation stage consultants in partnership with senior speech and language therapists. Extended training was offered to primary schools providing each engaged school a WellComm screening kit, a speech sound screening kit, training on identification and intervention strategies for children with speech and language delay.

The SLT service moved assessment from clinics to schools, supported by consultation sessions with each school to discuss progress and provide support on implementation of WellComm. School clusters were given the opportunity to buy in additional speech and language therapy to support whole school approach to speech, language and communication.

Benefits

Over 90% of pre-school settings accessed the programme, resulting in intervention with over 1,500 children. Children not in pre-school settings access support from children's centres. There was a demonstrable improvement in early years staff understanding around SLC development in young children — 91% of primary schools signed up to screen and intervene.

Children with identified SLC needs moving from pre-school settings into schools have set goals and targets. Children's centres are working with primary schools to support children with identified delays.

Settings and schools work closely with the SLT service to support those with specific difficulties. Forty primary schools commissioned additional SLT. pre-school settings recorded a 5% reduction in two to three year olds at risk of language delay and a 3% increase in children ahead of expectations. Referral rates to SLT service decreased by 25% from 2011/12 to 2012/13. DNA rates for SLT have reduced from 35% to 8%.

Financial implications

The costs of this initiative have been met through:

- ECaT — government funding to Wirral (time limited 2000/2011) a sustainable model that enabled work to continue within current budgets;
- early intervention grant (LA) — this enabled materials to be purchased for screening kits, launch, training in identification, screening and interventions. Beyond initial outlay for materials and training the aim of the initiative was to build in sustainability within current budgets.

The partnership initiative has resulted in:

- £150,000 investment in the SLT service from school based commissioning;
- cost savings — DNAs in SLT among the school age population were 35% in some areas and have reduced to around 8%. This has increased productivity and reduced waiting lists.

Communication skills can be a major contributing factor in a child becoming NEET (Not in Education, Employment and Training at 16–18). According to the Department for Education and Skills the cost to society of young people who are in NEET is on average £97,000 per young person over their lifetime.

Contact

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FINALIST

Integrating the health and social care workforce using the Calderdale framework

Calderdale and Huddersfield FT

The initiative

The commissioners required a fully integrated Intermediate tier service. In order to achieve this a fully integrated workforce was pivotal. Intermediate tier services were fragmented with multiple small services from three providers (acute trust, local authority, private nursing homes) delivering urgent care, 24 hour ongoing support, specialist rehabilitation, mental health and reablement.

The result was confusion for referrers and service users, duplication, multiple referrals between services, poor communication and waste. Home care packages were increasing in number and complexity, as were admissions to long term care. Successful integration needs to occur at three levels: system, service and team. The aim of the initiative was to develop an integrated flexible, competent workforce built round service users, maximising resources by developing staff and extending roles. Pathway and workforce issues were addressed collaboratively using the Calderdale framework — a seven stage process:

- awareness raising — focus on engagement;
- service analysis — focus on potential to change;
- task analysis — focus on risk;
- competency generation — focus on best practice;
- supporting systems — focus on governance;
- training — focus on staff development;
- sustaining — focus on embedding.

Joint agency awareness-raising focus groups allowed consultation regarding the commissioning intent — concerns were captured and built into the workstreams. The whole workforce was asked what worked well and what could be improved which sowed the seed for how things could be different. Service analysis in each service identified current activity/staff functions; data analysis providing a picture of service users needs. This stage defined the pathways and informed workforce requirements. Emerging opportunities were to:

- personalise services;
- maximise and widen rehabilitation practice;
- reduce numbers of separate assessments;
- manage long term conditions through shared records and knowledge.

Task analysis established objectively who could undertake which elements of provision, and how to make this safe. Evidence based competencies for all level of worker were developed, forming the basis of work based training. Support systems ensured robust governance arrangements were active.

Benefits

Use of the Calderdale framework has led to a fully integrated health and social care workforce. Unique to this was the inclusion of specialist rehabilitation services, meaning service users needs are met across the full spectrum of care.

Skill sets required were defined and staff competency trained in the skills relevant to their role. To date over 100 support staff (health & social care), 20 local authority staff and 20 health professionals have undergone competency training to extend and integrate their roles.

Results from the service user satisfaction survey showed an average score across all 12 questions was 9.2 out of 10. A single electronic record is now in place, reducing duplication of information and improving communication. This is having a positive impact on service user outcomes. Productivity has increased with an increased turnover of service users through the reablement pathway. This has contributed to a reduction in complexity of care packages and a 5% reduction in long term care placements.

Financial implications

A project manager was seconded for 12 months to oversee all workstreams. The initiative was developed to integrate intermediate care rather than save money in the first instance. However there are indications that over the longer term a positive return on investment will be realised through reduction to long term care, improved management of long term conditions and opportunistic health promotion.

Contact

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FINALIST

Warm homes and healthy people in Bradford (WHHP)

City of Bradford Metropolitan District Council

The initiative

Our established warm homes healthy people programme partnership board (WHHP) identified a variety of interventions they felt would have a further massive impact on winter wellbeing and were keen to roll this out.

The initiative aimed to meet the needs of those at risk — individuals in immediate danger of the harmful effects of severe cold, in particular from:

- falls;
- poor nutrition;
- cold and damp houses;
- illness;
- fire risks;
- fuel poverty.

This multi faceted and holistic approach proved highly effective in resolving crisis, alleviating fuel poverty and reducing winter morbidity. The project was effective in reaching identified target groups with significant use of the project by BME groups, people with ill health and people living in deprivation.

Using the extensive connections of VCS networks and harnessing the knowledge of local authority providers, we linked local activity and policy to services to maximum effect. The WHHP programme brought additional resource to bear on illness and accident prevention through the homeless hubs, handyperson service, neighbourhood services, food banks, independent advice sector and other VCS agencies.

The team identified service areas of high need in the Bradford district that would benefit from Department of Health funding. Around these, workstream themes were developed, these included practical support, information and advice, neighbourhood work, fuel poverty measures etc. From within the partnership workstream leads were identified for each theme, and notional budgets allocated to these work areas.

Workstream leads were responsible for developing project proposals on their area bringing these back to the partnership for consideration to ensure duplication of activity was avoided. The partnership approved projects by workstream this provided sufficient flexibility for delivery partners to respond quickly to changes as required by circumstance at the point of delivery.

Benefits

A comprehensive evaluation of the WHHP project by an external evaluator showed the project had a major impact on people of Bradford and Craven giving beneficiaries a real chance to stay warmer and healthier and reducing their isolation.

Between December 2012 and April 2013 the project allowed 8,600 individuals to access the service and activities 25,400 times during the coldest spring for 50 years. The range of delivery was diverse, included a variety of interventions such as:

- food parcels;
- befriending;
- lunch clubs;
- temporary and permanent accommodation for the homeless;
- home energy audits;
- information road shows;
- advice and fuel debt grants;
- free school meals for highly vulnerable children.

We identified one person in four as being new to services — this reflected the impact of recent, multiple cuts in income. The project:

- ensured 3,000 people ate properly by providing hot food and food parcels;
- helped 2,100 people keep warm providing them with clothing and duvets;
- enabled 120 people gain temporary accommodation;
- helped 6,000 people be warmer;
- enabled 300 households to be better off by generating £25,000 of fuel savings;
- reduced isolation of 700 people with WHHP activities;
- gave 3,000 people better knowledge of how to stay warm.

Financial implications

The project spend was £481,149. This was largely from Department of Health grant funding but included a £150,000 contribution from the clinical care group, in applying this to project activities we estimate this generated over £400,000 of added value through donations and volunteering, significantly increasing the range and scope of the project allowing many more people to be supported.

In addition to the direct, immediate financial savings to service users there are likely to be yet unassessed ongoing savings to Health and Local Authority services as a result of the recent WHHP programme activity. For example, the NHS themselves project that every £0.40p spent on winter warmth initiatives saves the NHS £0.40. On that basis the project will have saved local NHS services £192,456. We also estimate our Fuel Poverty measures saved recipients £92,468 of potential wasted costs through energy efficiency measures.

Contact

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FINALIST

Crisis response falls team

East Midlands Ambulance Service Trust

The initiative

The Crisis Falls Response Team (CRFT) was created to meet a demand for better falls services and to dovetail with support services provided by Northamptonshire County Council.

The standard ambulance response prior to CRFT was, often, either a manual lift of a person who has fallen, or a further response with appropriate equipment. In both cases, a person who had fallen may be left in situ for a significant period of time, causing secondary injuries, exacerbating primary injuries and, ultimately and potentially, reducing quality of life or reducing life expectancy.

Discussions were initiated between several organisations over the make up of the CRFT. This team would be made up of a qualified paramedic and emergency care assistant using a bespoke vehicle specially converted to carry a wide range of lifting equipment and with an ability to transport patients, where required.

The members of this team would also be trained through the University of Northampton in enhanced patient diagnosis; this education saw paramedics and social care staff training together. This provided each sector with a unique insight into each other's roles. The core aim of the education was to enhance patient safety, experience and reduce conveyance to hospital from around 65% to 40%.

Benefits

Between April 2010 and March 2011 around 12,000 people fell in Northamptonshire and called for support from the ambulance service, representing approximately 20% of the total deployment to demand for the county. The transportation rate of this patient group to hospital was 66%.

Since its inception, the CRFT have been dispatched to approximately 1,400 patients with a conveyance to hospital rate of 40.4%. The performance results for 2012 have seen a net reduction of 2,100 deployments on the previous year.

The conveyance rates for patients to hospital were lower during the hours that the falls ambulances were in service than when only general ambulances were running.

The feedback offered from patients about the service was overwhelmingly positive; interventions were considered to be timely and staff were considered friendly, approachable and well informed.

Almost everyone responding to the questionnaire felt that they were respected as an individual, treated with dignity and appropriately consulted about their care; 87% of CRT service users felt that the team had enabled them to have maximum choice, control and independence; 98% of those responding to the questionnaire reported the support that they received from CRT had made a difference to them.

Financial implications

The team's intervention either avoided a hospital admission directly or facilitated a discharge directly from A&E in 1,206 cases. After assessment, 156 of these patients were admitted to hospital, giving 1,050 avoided admissions. Based on the average length of stay for a general medical patient, this would then have cost the NHS a total of £1,644,300.

If the estimate for a falls patient is used, this becomes £2,940,000. In this period, the Crisis Response Team accepted 1,311 referrals, giving a total cost to the Crisis Response Service of £1,019,958. This represents a total saving of circa £1,920,042

Contact

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FINALIST

Tower Hamlets TB outreach service

London Borough of Tower Hamlets

The initiative

Tower Hamlets is one of the most deprived boroughs in London with TB rates of 55.5 per 100,000 populations in 2011. This is higher than the London average rates of 43.1 per 100,000 and England's rates of 14.4 per 100,000 for the same year. There are a number of factors contributing to high TB rates such as high level of deprivation, social exclusion, poor housing, overcrowded living conditions and poor nutrition.

Homelessness and lifestyle factors such drug addiction are also important risk factors for TB. Around 16.5% of TB cases in Tower Hamlets were in the homeless or those misusing drugs or alcohol in 2011. Although this group is relatively small, it requires more resources as they have complex needs and consume a disproportionate amount of time and other resources at the TB clinic. They are also less likely to finish their treatment.

The aim of the initiative was to control transmission of TB within Tower Hamlets by provision of effective outreach activities targeting appropriate at risk groups who have complex health and social needs. The TB outreach service is responsible for patient follow up, supporting early discharge of patients and coordinating the London mobile x ray unit to ensure they run sessions in appropriate locations in Tower Hamlets.

By building constructive working relationships with a range of partner agencies, the TB outreach service has ensured TB patients receive all the services they require to enable them to complete their treatment. It provided educational and health promotion sessions to a range of local statutory and voluntary agencies and community groups.

The lead TB nurse at the London Chest hospital has the overall responsibility for overseeing the service, which is delivered by a TB outreach worker (who has a social work background) and a TB nurse both based at the London Chest. The TB outreach

service is commissioned by the public health directorate in Tower Hamlets. It is monitored through regular quarterly data reporting (both quantitative and qualitative) and quarterly monitoring meetings between the TB nurse, outreach worker and the senior public health strategist.

Benefits

In 2012/13 Tower Hamlets TB outreach service followed up 11 TB patients from hard to reach/high risk group who had multiple needs and supported a large number of other TB patients with various levels of health and social care needs.

All patients supported by the service completed their TB treatment except for one who was lost to follow up during that period. Every individual infected with TB can infect up to 10–15 other people through close contact over the course of a year. Patients who do not complete a full course of treatment run a high risk of a relapse or developing drug resistant disease, which is more difficult and slower to cure and therefore much more costly to the NHS.

The service also conducted 266 home visits and 186 outreach sessions in the community, and provided educational sessions on TB for health care staff in Barts Health, primary care and in the community.

Financial implications

The cost of delivering this intervention was around £81,000 a year, which covers:

- 1 wte outreach worker (band 7);
- 0.6 wte TB nurse sessions;
- 0.16 wte administrative support.

The Department of Health estimate that the cost of treatment of a normal case of TB is around £5,000. The cost of treatment of a drug resistant case can be £50,000–£70,000 per patient. Based on minimum infection rates of 10 per patients for just 11 patients treated through the service, two of whom had MDRTB, future savings for Tower Hamlets for one year project funding would be a minimum of £1.8m on drug costs.

Contact

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FINALIST

Developing Sheffield's health and wellbeing board: a different kind of health and wellbeing board brings integration of health and local government services a step closer

Sheffield City Council & Sheffield Clinical Commissioning Group

The initiative

Our commitment to partnership before the Health and Social Care Bill became law can be seen through the Sheffield First Partnership, our work with the Core Cities and transformational projects such as Future Shape Children's Health and Right First Time. Our Board has equal numbers of councillors and GPs and it is co-chaired by the CCG chair and council leader.

We have decided to focus on the difficult problems that people and the system in Sheffield face, rather than be a governance body that attempts to oversee everything. Our aims include to:

- focus on radically changing the way we support people and to tackle health inequalities;
- focus on wellbeing, not just health; on prevention, not just cure; on the wider determinants of health, not just health services;
- engage actively and communicate regularly with the people of Sheffield and with our key stakeholders, creating a revitalised health and wellbeing community in the city.

We set up the board as an early implementer in January 2012 and over the course of the shadow phase councillors and GPs committed to develop the board including:

- getting to know one another, learning the similarities and connections between doctors, councillors, officers, and consumer voice;
- producing and consulting on a draft Joint Health and Wellbeing Strategy and a Joint Strategic Needs Assessment, both of which consider reablement, long term conditions, and a heavy focus on the wider determinants of health;
- agreeing a communications and engagement plan, which included running focus groups for providers, holding a "Meet the Health and Wellbeing Board" event; setting up an e-bulletin and comprehensive website;
- receiving facilitation from the NHS Leadership Academy to narrow down aims and objectives, and discuss any boundaries and problems.

Since April 2013 we have:

- launched at a day of events aimed at members of the public and professionals;
- held formal public meetings at which we have discussed fairness in Sheffield, the Francis Report, the Joint Strategic Needs Assessment, and the CCG's and local authority's commissioning plans in light of our Joint Health and Wellbeing Strategy;
- partnered with Healthwatch Sheffield.

Benefits

Widespread engagement of members of the public and stakeholders, demonstrating significant satisfaction with our approach. Our events have had a cumulative total of over 750 people attending. Our e-bulletin is sent to over 1,000 people every month. Our consultation exercises on the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy have involved well over 100 round tables and focus groups.

We are active on Twitter, YouTube, LinkedIn and Pinterest, and have a detailed website based on suggestions from our stakeholders.

Professional relationships have developed, including with the foundation trusts, local universities and colleges, other statutory bodies, the voluntary, community and faith sector, national and regional organisations, and private sector companies. All were represented at our launch event.

Our Joint Strategic Needs Assessment is fully evidence based, both qualitative and quantitative. This supports the production of a rounded, ambitious, evidence based and action planned Joint Health and Wellbeing Strategy.

Financial implications

We have allocated a yearly budget of £60,000 to support the work of the health and wellbeing board. As it has only formally existed since April 2013 it is difficult to calculate the return on investment but integration and partnership should benefit all our service users and help make best use of our total combined spend in Sheffield.

Contact

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FINALIST

Redesigning the delivery model for mortuary services to deliver a high quality and cost effective service

Stockport FT

The initiative

Public mortuaries are often attached to hospitals and post mortem examinations are undertaken by histopathologists on an extra-contractual basis when ordered by the coroner. The local authority contracts with trusts separately to store public bodies and also to provide the facilities for post mortems to take place. The local authority ultimately pays for both systems, but they have worked independently.

The initiative was started as the number of histopathologists who were willing to do post mortems was falling and a domino effect was anticipated. The service hit crisis before the service started December 2011 forcing the coroner to intervene.

We had to work with Tameside FT to provide a large enough footprint to provide the service previously done by three trusts. There were three Councils involved (Tameside, Stockport (lead), and Trafford), the coroner's office for South Manchester, the police in three jurisdictions, funeral directors and patient representation via the council.

There was a lot of resistance particularly from the histopathologists to this new service model.

The timeline was as follows:

- January 2011 — First formal meeting with councils regarding the fragility of the service and idea proposal;
- September 2011 — tender specification published and Stockport FT as the lead trust submitted an application;
- July 2012 — tender awarded;
- October 2012 — service began.

Benefits

We recruited two dedicated specialist post mortem consultants, which improved expertise and quality. We developed key performance indicators for the service that have been attained, and now attend quarterly contract meetings to discuss problems from both sides.

In 2009, 687 autopsies were performed with an average turnaround time from request to report of 90 days; this is now seven days with an increased workload of 1,100 post mortems. All post mortems are done within three working days from notification, 63% in two including our busy winter period.

The average number of bodies dealt with by the mortuary has increased from 2,000 to 3,000. The coroner and councils are delighted with the increased quality. Our mortuary survey has shown a very good satisfaction rate with users and we have made changes based on the feedback.

The laboratory holds the customer service excellence award. We have also been able to develop a training course for anatomical pathology technicians that has the unique slant of practical training which is not offered elsewhere in the country.

Financial implications

There is some confidentiality around the figures, however it is estimated that the three councils paid in total per year:

- £570,000 for body storage;
- £194,000 to histopathologists;
- total £764,000.

Our contract value, which we tendered for, was £691,000. We had to invest in two diagnostic microscopes for the pathologists (£40,000) however these costs have already been recovered. Our autopsy course also brought in £5,200 income. Overall however have saved the councils approximately £73,000 for a much improved service — approximately a 10% saving.

Contact

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FINALIST

Introducing seven day/week adult social care services in Surrey's acute hospitals

Surrey County Council

The initiative

Historically, adult social care services in acute hospitals were mostly delivered between 09.00–17.00 Monday to Friday. Some staff were volunteering to cover weekends and/or weekday evenings, particularly during periods of peak seasonal pressure; however, this was not consistent.

In 2011, engagement with Surrey residents and user groups revealed that there was significant demand for more accessible services. A poll of 3,000 residents suggested that almost 90% of the public favour 08.00–20.00 weekday opening hours. Surrey's five hospital trusts welcomed the proposal to move to a seven day a week service model.

Adult social care services play an important role in avoiding preventable admissions and reducing length of stay for vulnerable adults. In so doing, it helps relieve pressure on high demand hospital beds and busy accident and emergency units. More accessible service times would help hospital trusts achieve their local CQIN targets to increase Saturday and Sunday discharges, and reduce patient length of stay.

At the end of 2011 we established a project group to implement a new service operating model, whereby all five teams would work consistently within a 08.00–20.00 Monday to Friday, 09.00–17.00 Saturday to Sunday framework.

It was agreed at the outset that the five hospital social care teams would be responsible for working with their local trusts to implement the new service times. This flexibility recognised that the operating environment is different in each hospital.

Social care team managers worked closely with their health counterparts to implement local plans. Meetings were held between health and social care teams to break down historical misconceptions and develop open relationships founded on trust and respect. Hospitals offered office accommodation space in their front line medical assessment units, so health and social care staff could sit together.

Staff engagement was crucial. Workshops were held with social care staff to share why the changes needed to be made. Health colleagues came to two of these workshops to explain how the project would benefit the whole system, and the chief executives of all five trusts agreed a joint statement in support of the project. Health staff from one hospital team starred in a video to staff promoting the benefits of weekday evening and weekend working.

Benefits

From October 2012, all five hospital social care teams have been consistently covering weekday evenings and weekends. The expanded service times have brought significant benefits for Surrey residents. For example, by March 2013:

- more than 770 patients receiving social care support have been discharged at weekends and weekday evenings, enabling Surrey residents to move home sooner;

- more than 210 avoidable admissions have been prevented at weekends and weekday evenings, enabling residents to receive more appropriate care in their own home;
- Over 1,600 contacts and meetings between social care staff and patients, relatives and carers have been held at weekends and weekday evenings.

The changes have supported value for money service delivery across the health and social care system. Reduced patient length of stay and the fall in avoidable admissions has relieved pressure on beds.

Financial implications

Surrey County Council absorbed costs as the initiative was recognised as a high profile commitment to the whole system of health and social care. Furthermore, the overwhelming majority of current staff agreed to volunteer to work the expanded hours within the existing pay and reward framework.

Ten social care staff, two for each hospital, were recruited to help cover the new service times. The county transformation board endorsed a proposal that the new posts should be funded using £800,000 of whole systems partnership grant monies. Further monies were used to recruit reablement and sourcing staff into the hospital social care teams to improve the speed and quality of the patient discharge process.

Our intention is that the presence of extra staffing at weekends and weekday evenings will help reduce patient length of stay and the number of residential and nursing placements.

Contact

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FINALIST

Partnering for quality: raising standards of care in care homes and improving outcomes for people

Walsall Clinical Commissioning Group

The initiative

There are 72 care homes across Walsall of varying size, designation and quality. Prior to this work, Walsall experienced a range of safeguarding interventions. Suspension of admissions reduced the market capacity and choice for people and created financial uncertainty for some smaller homes. In addition the lack of proactive management of patients resulted in avoidable hospital admissions.

The CQC gives responsibilities to CCG and councils to assure themselves of the quality of care provision. The evidence is that there is a range of issues that affect the quality in care homes. NHS England policy on personalisation of care means that care across the different agencies needs to take account of individual needs but also needs to be integrated so that the individual's care remains personalised even when he or she moves between agencies.

A quality partnership board between Walsall CCG and council was developed, and has been key driving forward this quality agenda, which in turn has been supported through collaboration with care homes. Our objectives included:

- development of a self assessment contract monitoring framework;
- development of a local dataset to capture clinical and care activities;
- ensuring care home managers are developed;
- reducing waste in medicines management;
- supporting homes in the management of frail elderly residents;
- reviewing and improving the quality of hospital admissions and discharges;
- supporting care homes in giving highly effective clinical care.

The initial scoping was undertaken through a reactive process, usually as a result of a serious incident or concern occurring in a care home. The setting up of the joint quality partnership board was pivotal in developing a proactive approach to raising quality standards. We have undertaken this through the implementation of a quality infrastructure across the adult health and care sector. Engagement with care homes has been via care home forums and task and finish groups.

Benefits

We have improved sector relationships to a point where honest and open conversation with supporting evidence now drives improved quality outcomes for care home residents. A quality dashboard shows improved outcomes for patients including:

- significant improvements in the reporting of category 3 and 4 pressure ulcers in nursing homes — during 11/12, 23 acquired pressure ulcers were reported compared 9 in 12/13;
- reduction in *Clostridium difficile* infections across homes from nine in Q2–4 in 11/12 to three in the same period the following year;
- increase in contract concern reporting but a reduction in suspensions and restrictions across the same time period.

An incentive scheme for homes, where homes are invited to bid for quality improvement monies has demonstrated a range of outcomes including the setting up of a voluntary visiting scheme for residents and the development of a sensory garden in one home for the benefit of dementia patients.

Improvements in the admission and discharge of residents to and from hospital has been supported through facilitated work with care home managers and acute staff, resulting in agreed protocols for discharge, improving patient flow and experience. This has helped manage winter and surge pressures.

Financial implications

SHA funding supported the appointment of a GP and physiotherapist to set up a medical review team and social care assisted this team in undertaking the initial work. In addition a pharmacist was supported by the CCG and practice and community based pharmacists have also contributed. Staff already in post have undertaken the remaining work.

There have been significant financial savings as a result of a medicines management review undertaken for every resident in a care setting, this process involved the reviewing of regular long term prescribed medication to ensure there were no better alternatives.

Across Walsall Nursing Homes (11 homes) a total of 364 patient's records were reviewed:

- in 201 specific prescribed items were stopped;
- in 109 adjustments were made to the dose or strength;
- in 43 the drug was substituted with a more appropriate item.

A total saving of £76,176 was made, an average of £209 per patient reviewed. This has been replicated across all residential homes (63), with similar savings made. There have also been other cost benefits including reduced avoidable admissions.

Contact

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WINNER

Dean street at home — reaching gay men using social media to offer home HIV testing

Chelsea and Westminster Hospital FT

The initiative

Dean Street at Home is a project to reduce undiagnosed HIV in men who have sex with men (MSM). People with undiagnosed HIV are fuelling on going transmission. Public Health England estimates that 82% of new HIV cases in MSM are caught from an undiagnosed partner. In addition, early diagnosis prevents serious health problems. It significantly reduces an individual's risk of hospitalisation and death.

Chelsea and Westminster Hospital FT developed partnerships with gay businesses and community organisations to reach MSM while they were using social media on the internet and smartphones.

This was designed to reach MSM in an environment where they may be engaging in HIV risk behaviour. Men were directed to an HIV risk assessment website developed in partnership with communications agency 90TEN.

Working with a private sector partner (Thom), users were offered a home sampling kit for HIV. Another private sector partner, TDL laboratory, processed the innovative mouth swab test samples. The trust's sexual health clinic "56 Dean Street" contacted those with reactive results for confirmatory testing, emotional support and follow up care.

Benefits

A key benefit of the service is that it enables MSM to assess their risk and increase HIV testing without pressure on sexual health clinic appointments or jeopardising the 48 hour access target. It facilitates access to HIV testing 24 hours a day.

In the first year:

- 8,846 MSM visited the Dean Street at Home website;
- 7,753 completed the on line self assessment of their risk;
- 2,284 ordered a test kit;
- 1,439 returned a sample for processing (62%);
- 42 were confirmed HIV positive (2.92%).

The 2.92% sero-positivity rate is significant as HIV testing has been shown to be cost effective if greater than one case is identified per 1,000 tests performed (0.1%). It also compares very favourably with the results of eight Department of Health pilot projects designed to increase HIV diagnosis.

Dean Street at Home has proved highly popular with users. All users of the service were contacted by email and asked to complete an online poll about their experience. The response rate was high (59%), 95.6% of respondents said they would recommend the service to a friend.

The project's successful use of HIV oral fluid testing has led the trust to explore other new testing technologies. It is developing an express sexually transmitted infection screening service facilitated by the procurement of a Cepheid Infinity machine. By bringing sample processing into the clinic, the turnaround time for gonorrhoea and chlamydia results will reduce from one week to 90 minutes.

The project's high levels of user satisfaction have demonstrated the acceptability of computer assisted history taking. The trust is developing touchscreen technology to enable sexual health clinic users to record their own medical history in advance of the staff consultation.

The success of self directed care has led to the expansion of self taken swabs for patients that have no symptoms requiring a medical examination in the trust's sexual health clinics. The project's user survey demonstrated that about a quarter were

interested in home point of care tests (23.2%). The trust is exploring options to expand its range of online sexual health and blood borne virus screening services.

The Dean Street at Home model has already inspired the development of similar services. The charity Gay men fighting AIDS were commissioned to run a similar service targeting MSM in East London that launched in September 2012. Terrence Higgins Trust and Public Health England launched an initiative in January 2013 embedded within HIV Prevention England's campaign targeting African and MSM communities. However, the principles are widely applicable to other populations and health conditions. The nature of internet social networks facilitates the targeting of specific populations.

Financial implications

The set up costs of the project were supported by a joint working partnership agreement with Bristol-Myers Squibb, unrestricted education grants from Gilead and ViiV Healthcare and charitable donations from Chelsea and Westminster Health Charity and the Elton John AIDS Foundation.

The project recouped its running costs within 12 months. Analysing the results using cost per diagnosis demonstrates that Dean Street at Home is highly cost effective when benchmarked against the Department of Health pilots. In the Department of Health pilots the average cost per HIV diagnosis in primary care was £3,800 and in general medical admissions was £1,633. The cost per new HIV diagnosis through Dean Street at Home is £1,113.

Contact

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Judges' comments

- *Impressive scale-up from a local to a national initiative.*
- *Creative and intelligent use for different social networks.*
- *Scalable and applicable to other disease groups.*
- *Layered and combined technologies with learning through the programme.*
- *Significant potential in analysis of the collected data.*

HIGHLY COMMENDED

The Mersey Burns app — improving the assessment and treatment of major burns

St Helens & Knowsley NHS Health Informatics Service

The initiative

Major burns are devastating and potentially life threatening injuries. Early, accurate assessment of the extent of the burn, coupled with prompt resuscitation, improves mortality in these patients.

Currently, clinicians worldwide use a paper chart — (Lund & Browder) — with an outline of a patient. The clinician shades in total body surface area (TBSA) burned, before calculating a total. A series of multiple (19) calculations is then needed to produce a resuscitation protocol that can be delivered at the bedside.

Given the complexity of assessment and resuscitation for relatively inexperienced clinicians in emergency departments, who may only see a major burn once or twice a year, a tool was developed that would:

- be readily available to staff who may be faced with a major burn injury;
- guide accurate assessment of the extent of burn;
- correctly prescribe the appropriate fluids needed;
- be easy to use, cost effective and a valuable resource for training and education.

We also needed the information in a format that could be easily shared with another hospital to confirm the crucial and life saving management of the patient prior to the patient's transfer, and allow preparations at the Mersey regional burns unit to receive the patient and provide seamless, high quality care.

The ideal approach was to use mobile technology that can be applied at the bedside to assess injury and plan patient care. Other burns apps exist, but none that accurately calculate burn size to generate a fluid protocol or have been registered with the MHRA.

The development team consisted of the two clinicians who had the idea for Mersey Burns, Rowan Pritchard Jones and Paul McArthur, computer scientist Chris Seaton and Annie Duffy, burns research co-coordinator.

The team quickly produced a functioning prototype that provided all the calculations of clinical parameters required — TBSA, fluid volumes needed to resuscitate the patient, time periods to deliver the fluid over and background fluid calculation based on patient weight.

The manipulation of patient data to drive clinical care in this way demanded that Mersey Burns be registered with the MHRA as a medical device. This necessitated further development work to guarantee functionality of calculations on a mobile device, the production of a detailed manual, and the submission of a clinical data file to MHRA detailing the testing of functionality, and compliance with legislation.

Early versions of the app were constantly shared with burns care and emergency medicine colleagues to test robustness, ease of use and reliability. We have now launched Mersey Burns across Apple and android platforms, registered with MHRA and developed an implementation strategy across the north west.

Benefits

Mersey Burns enables clinicians to quickly and accurately assess the extent of a burn on a patient by shading a diagram on the screen. The app calculates the size of the burn and generates a fluid resuscitation protocol based on the weight of the patient and the time of injury. The app was compared with current paper based methods of burn assessment to confirm accuracy and reproducibility across a range of staff in both A&E and burns and plastic surgery departments.

In the assessment of a simulated burn, Mersey Burns produced a similar assessment of burn size, but a significantly more accurate fluid resuscitation protocol in terms of total fluid volume, fluid delivery rate and background fluid calculation compared with a traditional paper based methodology.

Financial implications

Mersey Burns was developed by a core group of clinicians and a computer scientist without a budget. We have subsequently been awarded the Health Innovation and Education Cluster award for Mersey and Cheshire regions that has covered the costs of regulation of the app.

We have further attracted a grant to implement the app across A&E departments across the north west by equipping them with iPads, training clinicians and collecting data about user satisfaction and patient outcomes. Mersey Burns is offered without cost to all our users (now numbering almost 5,000), and no costs have been incurred in terms of promoting the innovation as it has been featured on BBC Television, and reported on across the media and technology blogs.

Contact

For more information on this initiative please contact elaine.hatch@sthk.nhs.uk

FINALIST

e-Board: an electronic solution merging patient white boards, nursing handover notes and other safety and discharge management information

Basildon and Thurrock University Hospitals FT

The initiative

Information that wards gather on patients during their stay is critical to how well they manage the care of their patients, and to the discharge process to ensure they go home as soon as they can. Too often this information is collected in duplicated processes, and as it's written down (on white boards or in books) it is only available to those that can get to the ward to read it.

Written down it can't be analysed to track patient processing times on a ward or between wards. Making the information digital ensures that the data can be captured and shared quickly, easily and in real time.

As well as making nurses' work easier, the ultimate goal was to develop performance metrics to address length of stay issues in the trust. How accurate are our estimated dates of discharge? Where are the bottlenecks that keep patients unnecessarily in beds? How well run are wards? Is staffing skill mix and numbers sufficient for the patients on a ward at any one time?

The project started with the director of nursing wanting evidence based performance metrics so that she could be assured of quality without having to rely on anecdotal evidence.

The assistant director of performance took up the challenge, and created a concept version of e-Board. The concept was further refined with a ward manager to ensure that it met her

needs.

Before a pilot phase was undertaken it was recognised that e-Board wasn't just for ward nursing staff, but for a whole range of healthcare professionals across the hospital: pharmacists, therapists, specialist nurses, social services, complex case management team, bed managers etc. They were all involved in developing the pilot version, and this also ensured good buy-in to the pilot phase. e-Board was piloted on four wards initially, and proved highly successful. As a result, it is now being rolled out to all 16 adult inpatient wards in the trust.

Benefits

Following the pilot a survey was done of e-Board users:

- 45% said e-Board improves the care they deliver to their patients (41% were neutral);
- 57% said e-Board improves the way the ward works (37% were neutral);
- 79% of staff said they would prefer to keep e-Board, and the remaining 21% were neutral.

Data from e-Board shows that of the 25 mandatory fields for each patient, there was a 95% compliance with completing these fields.

Financial implications

e-Board was delivered at no additional cost to the organisation. Large screens were installed on each ward to display e–Board, but this was just a pull ahead of installations required for the new PAS. The potential savings through improved quality and reduced length of stay are significant. As well as making nurses' work easier, the ultimate goal was to develop performance metrics.

Increased efficiencies from clinical teams managing patients are difficult to quantify, but time savings were identified by using e-Board, and improved bed management will result in better quality care, better patient experience, and faster throughput.

Contact

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FINALIST

The use of movement infra red sensors as assistive technology for nocturnal seizure monitoring in vulnerable patients

Cornwall Partnership FT

The initiative

Just Checking (JC) is an evidenced based tool used in 80% of Health Authorities in the UK in dementia care. JC provides 24 hour charts showing person centred activity and staff intervention. This information is invaluable in patient centred, effective and efficient assessment and care planning.

For inpatients who have nocturnal seizures (NS) night surveillance is advised due to the risk of sudden unexpected death in epilepsy (SUDEP). Unfortunately given the communication and cognitive difficulties entailed in learning disability (LD) a reliable night time history is rarely available.

JC provides assisted technology for the assessment of NS without breach of privacy. JC consists of passive infra red sensors (PIR) that are triggered by movement to generate a chart of activity accessible through the JC password protected website.

JC is easy to install, with sensors being placed on walls or door frames with Velcro, and a control box. The box sends the data collected to the JC website via the mobile phone network. The activity charts can be viewed in real time giving a clear picture of daily, nightly, weekly individual routines.

In all cases a sensor was placed by the bed to pick up night time movement and a sensor placed in the hallway, (ensuring the movement being picked up in the bedroom was of the individual, not staff or family entering the room). Where appropriate, additional sensors were added to other living spaces that an individual may use including bathrooms.

The primary aim of this study was to assess sleep patterns in LD patients where there was an index of clinical suspicion of possible NS. For example one would expect someone with generalised major seizures to have a sudden burst of movement lasting minutes followed by a period of inactivity and some change in mental state or behaviour the following day.

The study looked at five people with a moderate to severe learning disability and complex epilepsy living in the community:

- three in residential care, with 24 hour support;
- two at home with support from the family.

For each of the patients a mental capacity assessment was undertaken to see if they could give informed consent for the procedure.

Benefits

The planned outcomes were assessment of:

- possible nocturnal seizure activity;
- night time routines of an individual;
- the effect of carer monitoring and intervention.

In Case 1 action needed to be taken immediately as it was apparent that one member of staff was failing to carry out regular observations on an individual during the night as per care plan post seizure.

Case 2 resulted in referral for detailed sleep assessment to investigate a high level of unexplained night time movement unknown previously.

In cases 3 and 4 the level of night time support required was assessed by introspecting sleep activity. Both cases showed evidence that during the night the two individuals required no support thus changing the waking staff to a "sleep in" leading to considerable cost saving.

Case 5 (an autistic patient with epilepsy) showed staff checks on the next door neighbour (who had dementia) were disturbing his sleep making him vulnerable to seizures next day. The patient was relocated, leading to over 50% reduction in seizures.

All assessments lasted three months. In this time JC helped assess care delivery and provided a non intrusive mechanism of assessment.

Financial implications

In cases 3 and 4, a projected saving of £15,600 per year per case was made. In case 2, costs increased, as the person required a higher level of care due to unevaluated night activity.

JC is a commercial company that approached our trust for collaborative research and testing of their assisted technology. The costing from the company for us was free to pilot the project. Usually each kit costs £2,200 and there is an ongoing fee of £1,300 annually to use the website and online technology.

Contact

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FINALIST

Innovation! many risk assessments, one system, fingertip fast response

Derbyshire Healthcare FT

The initiative

Derbyshire Healthcare FT sets quality and safety as a top priority and one of its key values. External drivers from the CQC, HSE and NHSLA support the trust's focus on improving risk assessment, risk management and ensuring and further developing an effective risk management culture.

Prior to this initiative, gaps were identified in the paper based risk assessment processes. The process for escalation of risk to senior managers and related action planning to enable risk reduction was time consuming and dependent upon individuals. In addition the ability to access an organisational overview of risk was limited as each team held their risk registers locally.

The aim of the initiative was to:

- design and implement a single, comprehensive, easy to use risk assessment system accessible by all staff;
- develop "pop out" best practice guides and example risk assessments to encourage a consistent approach to risk management;
- automate risk escalation to ensure senior managers are notified immediately of significant risks;
- embed local ownership of risk through individual manager review and sign off of risk assessments;
- simplify risk register reports through the use of standardised queries and simple reporting tools;
- improve feedback and communication between managers and teams and develop mechanisms to ensure actions are implemented;
- implement a training strategy, supported by senior managers, to ensure all staff can access, interrogate and use the system;
- revise the trust's risk assessment procedure to detail the new processes.

The trust project assurance office agreed the project in 2011. The roles of project lead were allocated to risk and assurance manager and project sponsor to the executive director of nursing and quality. Presentations outlining the planned changes were undertaken with the trust's risk management committee and trust operational management groups in late 2011 to early 2012.

At these presentations issues with the current systems and processes were outlined. Plans for improvement were discussed and expected outcomes on safety and quality proposed.

Stages in the design and planning of the project included:

- purchase of a web based front end and the upgrade of the current system;
- system design, development and testing to ensure objectives would be met, including piloting with three clinical teams;
- development and testing of training materials and guidance;
- presentations to senior management committees and groups to raise awareness and gain buy in to the new system and processes;
- training with wider management teams to demonstrate system and detail benefits and planned implementation.

Benefits

The initiative has now rolled out to 120 clinical and 30 corporate teams and over 1,600 risk assessments have been submitted electronically. Currently 80% of the trusts teams have completed all their required risk assessments. Only 12 teams (8%) have five or more risk assessments still to complete.

Immediate notifications of risks have led to a more transparent audit trail of communication and actions by managers and specialist advisors. Instantaneous risk register reports for all levels of the organisation have resulted in more visible proactive management of risks.

Regular health and safety audits, already well established, have been able to refocus to test the quality of controls and actions. All individual teams, divisions and executives have successfully signed up to the process and feedback has been positive.

Contact

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FINALIST

Improving care in the community using Anoto technology

Anoto

The initiative

The Gwent Frailty Programme is a healthcare initiative that aims to improve homecare for the frail and elderly to reduce hospital admissions. Aneurin Bevan Health Board (ABHB) works in partnership with five unitary authorities in Gwent to deliver services to 600,000 people. The PaperIQ solution is a key element in supporting ABHB's Clinical Futures programme.

Previously, carers used paper forms and diaries to manage and record appointments: now, 200 community based staff are using smartphones to manage interactions with patients. Following acceptance of the referral via the smartphone, staff use a digital pen to fill out a paper form during a home consultation. The paper form remains with the patient for family or voluntary carers, while the digital pen encrypts and automatically sends the form via the carer's device to back end systems so it can be accessed by other clinicians and hospital staff.

Staff also now use BlackBerry Calendar to receive detailed referral information and appointments while out in the community with time stamps returned to the central database to track the referral status.

Benefits

The solution has proved popular with carers: it simplifies the collection of information and scheduling of appointments and means that they no longer have to spend unnecessary time travelling to the office to collect their schedules or file paperwork. Using the BlackBerry also helps carers feel safer.

Carer safety is further enhanced as the health board knows exactly where all of its carers are at any point in time. The digital pen technology also means that technology doesn't intrude on consultations.

No referrals are missed, no visits are duplicated and no records are mislaid. Detailed clinical information is passed securely and instantly and with electronic schedules and carers no longer have to frequently go back to the office to return or collect paper forms.

Following Phase 1 deployment, users reported an average of 10 minutes saved per patient visit. With an average of five

visits per shift and a 200–person user group, this equates to projected annual savings in excess of £600,000. Having detailed information readily to hand, whether in a community or hospital setting significantly reduces the time previously taken duplicating history gathering or accessing and implementing care plans.

Financial implications

Based on the first phase of rollout, ABHB projects annual cost efficiency savings of £600,000. Also, because carers no longer need to go to the office to pick up their schedule or file paperwork, ABHB expects to see significant savings on travel expenses.

The intention is to roll out the programme across Wales.

Contact

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FINALIST

EOS (electronic offering system) mobile

NHS Blood and Transplant

The initiative

Organ transplantation remains one of the most significant medical innovations of recent times. It has the potential to save and improve thousands of lives, but it carries with it risks.

These risks arise not only from the surgery itself but also the need to ensure a thorough assessment of a potential organ donor and transmission of accurate data regarding their condition. Clearly this is a time sensitive process, where any time saved can bring benefit not only to a potential recipient but also a bereaved family. The project was established in direct response to feedback from transplant centres regarding the difficulty they encountered accessing donor data on existing systems.

Historically, clinicians reviewing organ offers were required to log in to a secure system with multiple layers of authentication to access a 14 page PDF of data which they would review to identify the information they needed to support a decision. As a consequence, they often relied on other staff either in the hospital or at NHS Blood and Transplant, to relay the information to them by telephone, with significant risk of transcription errors.

A clinical support group was formed to inform the project and provide critical input to the development of a single, expandable webpage with all of the summary data visible on it. Further, the survey identified which devices were used which enabled the project team to develop the solution to function on those devices, ensuring a higher take up. It was also validated on a range of additional devices in order to support more widespread acceptance.

The project team were able to define a summary data set required to support rapid decision making. Identifiable patient data was not required and therefore removed allowing a single login to the system.

Benefits

The EOS mobile application ensures that accurate information about the donated organ is available to the transplant surgeon and the clinical team throughout the donation and transplantation process. It is available in the palm of their hand, if necessary, on a mobile phone or tablet device.

It also supports rapid decision making about the acceptability of an organ for transplant, thereby ensuring that if there is no suitable recipient at one transplant centre, it can be offered to another without delay, reducing the risk of an organ deteriorating during the process. The result reduces the risk of patient harm, minimises the amount of time required from clinicians to access and review organ offers. It enables clinical teams to share vital information quickly and widely when considering whether to transplant an organ.

As a consequence of this project, the use of electronic systems to view offers has increased from 51% to 90% since the project began. To quote one transplant surgeon, "EOS Mobile has revolutionised the way we take organ offers."

Financial implications

The project incurred costs of £72,000. Although a financial benefit was not anticipated in the business case for EOS mobile the project has created significant efficiencies in time saved by NHSBT staff involved in the offering process. It is anticipated that the vast majority of the thousands organ offers made each year which, in some cases, required a twenty minute phone call, will be completed in just a few minutes.

Contact

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FINALIST

SYSTEMTDM®: a fully configurable and individualised toxicity monitoring system for people taking lithium, connecting all stakeholders including service users and carers

Norfolk and Suffolk FT

The initiative

An audit of lithium monitoring frequency in Norfolk in 2000 showed:

- less than 30% of patients receiving the recommended minimum of four blood tests a year;
- 32% receiving one test only;
- 30% of results falling outside the agreed therapeutic range.

In response to this Norfolk and Suffolk FT (NSFT) introduced a lithium monitoring service in 2003/4. Subsequent NSPA and NICE guidance on lithium monitoring provided an opportunity to redesign the service to become more cost effective, efficient and patient centred.

Clinicians were involved in shaping the new system. Design ideas were reviewed and implemented. BipolarUK was consulted on the patient record screen, the patient perspective and delivery aspects of the service. SystemTDM sits at the centre of a historically disparate care network with barriers to effective communication, collaboration and integration.

The system provides a web based bridge between primary care, secondary care, pathology labs, patients/carers and other appropriate stakeholders within a secure ICT platform. It allows rapid communication of clinical results for over 1,250 lithium users across Norfolk and is soon to include all of Suffolk. Integrating information and communication ensures all stakeholders have access to the same information in a variety of settings across a common care pathway.

The system works as follows:

- lithium is prescribed and blood tests taken. Results from the laboratory are transmitted to SystemTDM® for upload;
- the patient is registered and potential risks identified. This is updated throughout the patient's therapy;
- when a test is due, a reminder is sent to the patient. The system generates three reminders. The third alerts the GP by letter, enabling them to be proactive in their care;
- if a patient fails to attend a test, relevant clinicians are alerted.

Should out of range results be found in the test, an email notifies all parties, ensuring prompt action. Results are retained and available for clinical use and service monitoring.

Benefits

By allowing more efficient clinical communication this simple to use service returns care to GPs. In doing so, it also effectively meets monitoring requirements and improves resource efficiency. Since implementation, SystemTDM has provided the following benefits:

- lithium related serious untoward incidents (SUIs) in Norfolk associated with a lack of testing have been reduced to zero. The expected number for Norfolk (based on reported rates for similar catchments) is 35;
- the introduction of the database has increased the number of patients regularly attending three tests per year from 46% to 77%. (100% have at least one test);
- in secondary and community care, over 80% of patients are tested at least three times per year, with 95% meeting NICE minimum standard.

The system has also reduced duplication of testing and established a research pipeline and subsequent output.

Financial implications

The initial cost of developing SystemTDM was £215,000. This included £40,000 for hardware and licences.

The timeframe for a return on the original investment is four years, and income from delivery in Norfolk to date has totalled £35,000 per year. Savings achieved through efficiency gains since its introduction are valued at £20,000 year on year and income is set to increase by up to £40,000 annually from this expansion.

Income from sales to other trusts of SystemTDM will shortly reach £50,000. Discussions regarding additional contracts are taking place and further sales are expected. SystemTDM currently invests £18,000 in research with applications for research and development proposals currently standing at over £500,000.

Contact

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FINALIST

Using next generation sequencing technology to improve genetic diagnosis of familial breast cancer

Birmingham Women's FT

The initiative

Breast cancer is the most common cancer in women in the UK with just under 50,000 new diagnoses each year, accounting for 31% of all cancer cases. Approximately 5–10% of cases are hereditary; caused by mutations in key genes.

It is important to identify the underlying cancer causing genetic aberration within a family to facilitate appropriate clinical management of affected as well as pre-symptomatic individuals, thus reducing morbidity and mortality rates. However, genetic screening is currently limited to those families most at risk.

The West Midlands Regional Genetics Laboratory performs breast cancer gene screening for approximately 600 breast and/or ovarian cancer referrals per year. This number is estimated to triple in light of changes to the NICE recommended guidelines for the care and management of familial breast cancer.

Unfortunately using traditional technology it would not be possible to process the expected increase in referrals with existing staff and financial resources. Traditional technology (Sanger sequencing) is expensive, labour intensive and therefore not conducive to very high throughput. In addition analysis of poor quality samples, such as archived tumour samples (which may be the only source of material from an affected relative within a family due to early death) is usually unsuccessful.

This initiative involved collaboration between the biotech company Fluidigm and the West Midlands Regional Genetics Laboratory to validate innovative technology to overcome the limitations of traditional approaches to genetic testing of multiple genes. The validation process compared results obtained for 96 samples previously tested using Sanger sequencing with results obtained using the new technology. The resultant 100% concordance between the two processes confirmed that the new strategy was fit for purpose.

By using the innovative gene capture and next generation sequencing technologies it is possible to process a panel of 48 patient samples within five working days compared with four weeks using current Sanger technology. This means that the expected three fold increase in referral numbers from 600 to 1,800 patients per year can be delivered with current workforce levels.

Benefits

By offering this test to a greater number of breast and/or ovarian cancer families, diagnostic yields will improve allowing the most appropriate clinical management for both affected and pre-symptomatic individuals to be offered to a larger patient group.

This technology brings another significant benefit in its ability to process poor samples obtained from archived tissue (formalin fixed paraffin embedded, FFPE), genetic testing of which is notoriously problematic and usually refractory to multi gene sequencing. In many families all affected individuals are deceased and therefore genetic testing has not been a reliable option. This new test allows all the benefits of genetic knowledge to be offered to these families.

Financial implications

This new service offers significant cost benefits, costing a fraction of previous technology. On average, this technology saves £300 per patient, equating to £180,000 a year based on current referral numbers.

Based on the expected increased demand, savings may be anything up to £540,000 per year. This initiative required an initial outlay of laboratory consumables and reagents, totalling approximately £10,000 as well as the time of a full time member of scientific staff for a period of two months during the validation phase.

Contact

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WINNER

Sustainability at Barts Health — creating environmental and social sustainability through collaborative partnerships and knowledge sharing across the NHS

Barts Health Trust

The initiative

Our sustainability programme has delivered four key projects:

- Operation TLC — a programme to reduce carbon while positively impacting patient experience;
- NHS sustainability day — a national/ international collaborative day of action on climate change;
- Reducing fuel poverty — reducing fuel poverty in our communities, reducing excess winter deaths;
- Food and nutrition education — delivering food and nutrition education to primary school children.

Operation TLC

This initiative had four aims, to:

- achieve financial and carbon savings;
- discover whether energy efficient behaviours improve patient experience;
- create a replicable model other NHS trusts can follow;
- prove cross sector collaboration is effective.

The message is simple: there are three actions that everyone from domestic services staff to consultants can do "turn off, lights out and close doors". Multiple methods were used to engage staff:

- trusted influencers became advocates, inspiring action in their teams and identifying one off changes to their areas;
- the sustainability team undertook ward rounds to share success stories, troubleshoot problems and reward those taking action to prompt social norming;
- senior staff and prominent advocates reinforced the message featuring on screensavers and a short TLC film;
- support services were reached through 15 minute workshops and posters.

The programme reached 15,000 Barts Health Trust staff and their partner contractors through site wide communications; 2,500 staff were reached through face to face interaction. Patient experience surveys revealed improved sleep and privacy for patients, while staff reported improved mindfulness and calmer working environments. The programme achieved £100,000 in savings with the potential to save £35m across the NHS.

NHS sustainability day

NHS sustainability day aims to make links and break down barriers across professions, organisations and countries in order to support change across the whole healthcare landscape. Over 100 NHS trusts participated in the day in 2013, sharing knowledge and inspiring others with their actions through the online portal. Eight organisations were selected to receive awards for outstanding actions across nine categories:

- clinical engagement;
- biodiversity;
- sustainable food;
- carbon reduction and energy reduction;
- sustainable travel;
- waste and recycling;

Award sponsored by

Sustainable Development Unit

- community engagement;
- best overall project.

Their case studies are available to inspire others next year.

Reducing fuel poverty

A partnership programme between Barts Health Trust, British Gas and Global Action Plan has been established to deliver a programme to reduce fuel poverty within our communities. This is done by identifying local people who are living in fuel poverty through the clinical assessment process. They are then referred into the scheme to receive domestic energy and heating efficiency improvements.

Through the delivery of these interventions the programme aims to reduce excess winter deaths, starting with the 330 cold-home-related deaths that occur each year in one of our poorest boroughs — Tower Hamlets. It is hoped that through these interventions we will also improve the health outcomes of those suffering from associated diseases, such as respiratory issues and support some of the most venerable adults in our care catchment.

Food and nutrition education

The food and nutrition education programme is an integrated partnership programme between Barts Health Trust, Carillion, G4S, Café Spice and Chefs Adopt a School. By delivering food and nutrition education to 300 primary school children across our boroughs over the next two years we hope to start to tackle future obesity rates and malnutrition across our health catchment.

As well as exploring tasting of new foods, the basis of a balanced diet, the effects of fats, sugars and salts on our bodies, the programme will also teach the children how to grow their own fruit, vegetables and herbs in a custom build food garden designed by a local gardening charity.

Contact

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Judges' comments

- *Strong evidence of clinical voice influencing planning.*
- *Excellent example of community leadership.*
- *Real example of why public health in acute trusts can deliver real change.*

HIGHLY COMMENDED

The Natural Health Service — managing our estate and natural woodlands to provide an enhanced environment to provide patient care

Mid Essex Hospital Services Trust (MEHT)

The initiative

MEHT takes its responsibility towards our patients, the local community and the environment very seriously and we are committed to becoming a better corporate citizen and reducing the impact of our services on the environment.

One of the ways in which we are achieving this is by improving the management of and access to the two areas of natural woodland located on our campus. These two areas, Pudding Wood and the Long Shapely Belt, are areas of natural beauty that allow patients, visitors and staff an opportunity to relax and walk through a tranquil environment.

The woodlands are maintained by teams of community and corporate volunteers who improve the site and maximise the habitat by:

- planting new native species;
- encouraging natural regeneration;
- keeping the areas clear of litter;
- encouraging wildlife by siting bird and bat nesting boxes and creating insect habitats.

Since 2009 woodland management activities have been delivered in line with the objectives set out in the trust's 10 year Woodland Management Plan. We follow best practice evidence from various agencies including the Forestry Commission, the NHS Sustainable Development unit, the National Trust. We raise funds and seek external grants — our work is currently supported by a grant from the Heritage Lottery Fund.

Our Woodlands project also supports the NHS Forest initiative, a national project that aims to increase access to green space on or near to NHS land. We have already planted 620 trees on the campus since 2009 in support of this initiative.

The project provides us with an opportunity to engage with our users to promote a better understanding of how we use our estate. Our most recent sustainability survey indicated that there is much local support for more trees and other plants to be provided on the campus to promote biodiversity. We are also developing pedestrian access routes through the woodlands to provide enhanced access to our hospital.

Our woodlands are used as part of our clinical pathway (where appropriate) to enable the transition from hospital to home by recognising the benefits of green spaces contributing to aid the recovery of patients. Our approach also encourages appropriate outdoor play and recreation and it aids rehabilitation through informal physiotherapy. We are also working with the National Trust to pilot a "50 Things to Do" book for older people, using the woodland as a focus while carefully considering the needs of our older patients.

The woodlands deliver various environmental benefits to the area as we are supporting and providing further habitats for local wildlife. We also ensure that we manage our woodland resources effectively by using wood from felled trees as natural bollards and wood chippings and fallen wood for path definition, beetle banks, wind breaks and wood sculptures.

The project requires minimal funding from the trust as it is mainly funded through external grants and donations.

Contact

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FINALIST

Think Green: going beyond compliance for a truly sustainable future

Cambridge University Hospitals Trust

The initiative

Think Green was launched trust-wide in 2008 to steer us towards sustainability in travel, waste and ward management, the use of our buildings and spaces, and procurement. It is integral to our new Sustainable Development Management Plan.

Although the Think Green team is based within estates and facilities, effective delivery can only be achieved through the efforts of all trust staff. Facilitation, opportunism, innovation and communication are the key tools, initially applied by the sustainability and energy team and supported by trust-wide champions and the sustainability steering group.

Six work groups feed in detailed ideas and actions covering energy, facilities, travel, procurement, workforce and community engagement. Despite a 29% expansion of the physical campus, Scope 1 & 2 carbon emissions have fallen by almost 30% (adjusted for growth) from 0.16 tonnes CO_2/m_2 to 0.11 tonnes CO_2/m_2 and by approximately 9% in absolute terms (29,860 tonnes CO_2 to 27,190 tonnes CO_2).

In 2012/13 the trust achieved a recycling rate of 45% (27% in 2008) from a total waste of 3,895 tonnes. The figure would be much higher if we included the clinical waste used to generate onsite heating.

Sustained efforts in travel for work planning have contributed to around 25% of staff cycling to work, around 22% catching the bus and only 32% driving alone. Examples of activities that are contributing directly to these achievements include:

Infrastructure upgrades

A programme of minor and medium retrofit works using contributions from Salix or grant funding, including:

- LED lighting and control upgrades;
- replacement of calorifiers with plate heat exchangers;
- switch to gearless lift motors;
- replacement of inefficient chiller units;
- replacement lagging and draught proofing.
- a new energy innovation centre will deliver a further carbon reduction of around 47% from 2015/16.

Improvements to cycle parking and the introduction of three electric pool bikes. Increased frequency of bus services — there are now up to 60 buses an hour from the onsite bus station to the city and surrounding villages.

Process changes

Implementation of integrated building management systems to ensure effective control of all major heating, cooling and ventilation equipment across the site.

Waste segregation, incorporating a new ward based "bag to bedside" system. A pilot is underway to recycle single use clinical instruments in the emergency department.

Planning of space allocation in new staff car parking. Staff living within two miles of the hospital are not allowed to park on site during the morning peak, and sustainable travel options are supported by salary sacrifice schemes and discounts for cycle purchase and bus travel.

Communication and engagement

The "Switch off Friday" campaign encourages staff to locate and turn off appliances that need not be on. Public transport information, walk to work days, and car sharing are promoted via intranet. Posters and regular events promote recycling.

Contact

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FINALIST

Driving carbon reduction and cost savings through regional collaboration

South of England Strategic Health Authority

The initiative

In January 2012, the South Central Regional Enablement Group of Chief Executives commissioned a programme of collaborative work on carbon and energy reduction across the region's 14 acute, mental health and community trusts.

The work started with a benchmarking study supported by energy and sustainability consultants Verco. The study measured the state of readiness of each trust and identified the priority opportunities for energy and carbon reduction. The four priority areas were:

- large scale finance and procurement for significant infrastructure upgrade;
- a pilot programme for engagement and awareness;
- a pilot programme for transport;
- regular coordinated communications across the region.

This project used the power of collaboration to build momentum across multiple trusts, sharing experience and knowledge, and enabling them to realise greater cost effectiveness in carbon and related cost reduction. Verco's support has been of vital importance in many areas, including the tracking of emissions data and establishing confidence over the data among trust staff.

Before the project was implemented, NHS South Central's annual spend on building energy was £40m, with emissions of 240,000 tonnes CO_2e. Annual spend on water, sewage and waste was £12m, so there was a real need to identify areas for reduction in order to meet the UK Government's CO_2 targets of a 34% cut by 2020.

This programme has to date identified annual utility savings of £7m and a further £4m of potential savings from transport efficiencies (grey fleet and business mileage). In terms of emissions, the projects in the pipeline are expected to save in excess of 12,000 tonnes of CO_2.

The cost of the programme represents less than 1% of the savings identified so is already proving its ROI. The total project potential equates to a £45m investment with payback time of 5.2 years and a 23% carbon footprint saving.

Contact

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FINALIST

Sustainable Initiatives Nottingham University Hospitals: expanding our sustainable food procurement programme, improve waste segregation and combating a throw away culture

Nottingham University Hospitals Trust

The initiative

The trust has implemented projects across different areas aiming to improve the environment, social and economic benefit of its operations.

Since 2003 Nottingham University Hospitals (NUH) Trust has operated its sustainable food procurement programme in the City Hospital, one of its largest campuses. Through this programme the trust is supporting local producers and minimising the carbon miles embedded in the meals prepared for its patients, staff and visitors.

A meal prepared by the trust's catering team has on average 70% ingredients produced within the region, 20% ingredients produced within the nation and 10% ingredients imported, without reducing the nutritional quality of the meals.

In March 2013 the trust inaugurated its central production kitchen (CPK), increasing its meal production capacity to extend its sustainable procurement programme to its other major campus, the Queen's Medical Centre. This has effectively doubled the reach of the programme. The meals produced by the CPK have the Food for Life standard and provide sustainably source food for patients, visitors and staff.

The use of regional suppliers creates more jobs and wealth within the region. Public sector purchasing of food alone will contribute in excess of £3m to the regional economy.

Although capital funding was provided for this scheme it is a cash releasing scheme, providing net recurrent revenue savings of approximately £385,000 per annum.

Waste management

The trust introduced a new waste management system. The new system introduces waste streams across the trust, including multiple recycling streams and an offensive waste stream. The broad aims of this are to:

- ensure full compliance with Department of Health Guidance and Regulatory Framework;
- increase the trust's service value by improving the patient experience. This was achieved by introducing "Bag to Bed to Bin" disposal in ward bays, and silent closing waste bins in all areas, reducing noise at night;
- increase recycling in alignment with the trust's sustainable development targets by embedding the culture of recognised waste streams, leading to higher recovery rates;
- make a contribution to the directorate's £5.3m cost improvement target by reducing disposal costs through the introduction of recycling, cardboard and offensive waste streams;
- improve income generation obtained through rebates secured from profitable recycling waste streams.

Extending the life of equipment

The trust initiated a partnership with a local refurbishment company, Storetec, to introduce a system to extend the useful life of key equipment. Storetec specialises is refurbishing metal equipment using an environmentally friendly process that not only reduces the emission associated with the procurement of new products, but also minimises the emissions associated with the refurbishment operation.

Since 2012 the trust has been refurbishing equipment such as wheelchairs, lockers and trolleys, hence reducing the need to purchase new units and minimising the production of waste in agreement with the waste hierarchy.

The sustainable benefits are:

- cost savings for the trust by preventing £20,000 expenditure in procuring new equipment;
- reducing the production of waste;
- reducing carbon miles associated with the procurement of metal equipment, sometimes imported from abroad;
- supporting the local economy and the refurbishment industry.

Contact

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FINALIST

Greening office supplies

South Essex Partnership University FT

The initiative

In order to implement a comprehensive "green switch", South Essex Partnership University FT (SEPT) worked extensively with Office Depot to review all its office supplies. As part of a quality guarantee, all suggested alternatives were subject to evaluation tests to ensure that they could deliver at least the same level of quality, durability and functionality as the ones they were replacing.

Green product switching is an ongoing challenge, as while more sustainable products are becoming available, there are still some products purchased where there is no green alternative. The switches will be reviewed quarterly so that adjustments can be made where products have been unsuccessful and new products to market can be added.

SEPT has 157 delivery points, and as such, a true reshaping of the trust's previous procurement system into a greener model required an inclusive, multi dimensional approach. Consequently, the project not only incorporated product review, but also an overhaul of the end-to-end process of ordering and delivery.

The key to achieving this has been through consolidating orders to reduce onsite packaging waste and the greenhouse gas emissions associated with deliveries. A decision to change from daily to weekly deliveries was made. A like-for-like first quarter comparison of 2013 and 2012 shows the success of this decision, with a reduction of 269 drops in 2013, giving a potential reduction of over 1,000 deliveries this year. Based on the average Office Depot drop of 3.14 kg CO_2e this equates to a reduction of 3,379 kg CO_2e a year.

Implementation of electronic ordering across all 157 sites has given further benefits by removing paper and postage (reducing both carbon & costs) while improving transparency and streamlining processes. The system has been set up to automatically switch products to trust approved green alternatives making it extremely simple for staff to use. This approach also ensures minimum leakage to non green products where a sustainable alternative is available, while giving staff full visibility of what products are being switched at point of order.

Over 375 products have been replaced with "green" products with an independently verified environmental attribute. Spend on "green" products has increased from 33% to 57% of invoiced sales. The percentage of available "green" products purchased has increased from 44% to 90%. Reduced stationery costs are estimated at over £37,000 per year.

The percentage of available remanufactured toner and inkjet cartridges purchased has increased from 18% to 88% — 475 more remanufactured cartridges are purchased per month equating to a reduction of 1,187 kg CO_2 a month.

Environmental and social benefits include:

- reduction in greenhouse gas emissions associated with deliveries;
- reduction in waste to landfill by choosing remanufactured or recycled products;
- reduction in the requirement for non renewable/virgin raw materials;
- supporting the social, economic and environmental benefits of FSC and PEFC certified products.

Contact

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FINALIST

Sustainability and energy projects

West Middlesex University Hospital

The initiative

The first two phases of our energy project is showing better payback on investment than projected. After degree day adjustment payback is currently running at 3.5 years compared with five years. All energy and utility saving options with a five year payback have been implemented. The technical aspects of the project covered:

- LED lighting to replace T8 (standard lights), fluorescent lighting and downlights in 24/7 communal areas;
- variable speed drives to match flow rates for air handling units and pumps to design flow rates;
- CO_2 control of ventilation flow rates in noncritical areas;
- AHU fan and motor replacements;
- building management system controls enhancement and additional sensors;
- improved controls to link low temperature hot water temperature to external ambient conditions;
- chillers and chilled water system matching of primary chilled water pumping volume to demand;
- dry cycling control on low pressure hot water system gas fired boilers;
- low pressure drop air filters for air handling units;
- adding standalone buildings to building management systems with the addition of new motor control centres;
- insulation improvements lagging of exposed pipe work flanges and valves;
- decommissioning of plant and systems and energy focused maintenance.

An automatic metering solution has been developed to allow forensic assessment of energy consumption, identifying waste and targeting further savings. As Bouygues Energies and Services are contracted for both the provision of the energy contract and for providing services under the PFI they are able to take a "Whole Life" approach to asset management as items require lifecycle replacement.

Awareness campaigns and community involvement are part of our initiatives to promote behavioural change and support central sustainability initiatives. The trust along with our partners and contacts supported the NHS Sustainability Day. These days have helped highlight awareness to visitors, patients and staff regarding social, economic and personal benefits of improving energy efficiency and reducing carbon emissions.

The trust has achieved Transport for London level 3 status and has an active bicycle users group. Having successfully secured 100% funding from Transport for London under the Mayor's Source London Project, three electric car charging points have been provided.

A 95% reduction of waste sent to landfill has been achieved. This was against a target of 70%. The trust works in partnership with service providers and supply chain to support sustainability. New energy saving computers and software solutions are expected to save in excess of £25,000 per year. All communication from our PFI partners is sent electronically to assist working towards a paperless system.

The trust is on target for saving 670 tonnes of CO_2 against the baseline. The monthly report produced by Bouygues show unit usage adjusted by degree days and against baseline figures. The effects had these initiatives not been implemented is also shown.

Contact

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WINNER

Revolutionising catering across learning disability assessment and treatment inpatient services, giving people with learning disabilities opportunities to influence and participate

Tees, Esk and Wear Valleys FT

The initiative

Following the discharge of a patient, feedback is always gathered about their experience with the learning disability service at Lanchester Road Hospital in Durham. This is in the form of a questionnaire and verbal comments are also recorded from patients and carers. Recent feedback from patients indicated levels of boredom on the unit and a desire for more home cooked food. Staff also reported difficulties engaging patients in meaningful activities during their stay.

Involving people with learning disabilities in their care and promoting choice and independence have been high on the agenda since the Valuing People White Paper (2001). The main aim of the project was to completely overhaul the way catering was delivered. It was part of a holistic approach to care and it was vital that patients were involved at every stage of the changes to allow a sense of engagement, involvement and ownership.

After reviewing the recent feedback, a team was formed to move beyond the traditional concepts of hospital food to one where patients and staff work together to prepare home cooked meals. It was hoped that this would enhance the meaningful activity on the unit while also increasing food satisfaction.

Food had previously been bought either frozen or chilled and then heated up on individual wards and served to patients. Staff worked closely with patients and dieticians to plan menus that were healthy and nutritious. They then worked directly with patients to cook the meals that they have planned.

Staff were trained in food hygiene level 3 and there is now always at least one member of staff per shift qualified at this level. Patients also have the opportunity to gain a qualification in food hygiene. Promoting health through a healthy diet and helping people to make healthy food choices is an important element of promoting well being.

Benefits

The project has been a success both in terms of increasing levels of meaningful activity on the units and improving food satisfaction. Qualitative feedback has been extremely positive from patients, carers, nursing and housekeeping staff. Patients report that they enjoy being involved with food preparation and that this helps them to develop new skills.

Patients also feel that this helps them live in a more inclusive atmosphere that is more of a replica of real life, giving an increased sense of independence that helps to build their confidence to cater for themselves when they leave the unit. Patients and staff also have the opportunity to gain a qualification in food hygiene which again promotes a sense of independence along with better equipping staff to improve the quality of food that is prepared within learning disability units across the trust.

The focus for nursing practice has been around challenging values. Previously, nursing staff didn't always sit with patients for meals nor eat the same food. Staff and patients now work

together to plan and cook meals. This self catering model has been rolled out across all trust learning disability services and is something other organisations could replicate. The key to its success was willingness and keenness of staff and patients to make positive changes to the catering within their service.

The project has also led to the scoping of a new gardening activity project for the assessment and treatment units, which we anticipate will lead to the units using freshly grown vegetables in the seasonal meals project. The self catering model has completely changed the atmosphere and culture of the learning disability units across the trust with a much warmer and inclusive feeling that service users are very proud of.

The success will continue to be monitored through feedback from people who have used the service and also through the project group who continue to meet to review the project and ensure menus are updated seasonally and in response to feedback.

Financial implications

The main cost within the project was training the staff to intermediate level 3 food hygiene at a cost of £250 per staff member. The catering budget was transferred to the self catering budget. Each staff member also contributes £10 each month toward the self catering as they share mealtimes with patients as part of the therapeutic relationship. The budget meets the requirements for the menu, with sufficient funds to purchase food on special occasions such as birthdays and celebration days.

Contact

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Judges' comments

- *This project is a fantastic example of how staff and service users can change the culture of care provided.*
- *The passion and enthusiasm of the presenters shone through and this has no doubt helped them engage the local workforce to make these changes happen.*
- *This not just about catering but is about creating a meaningful environment for patients and staff.*

FINALIST

Tom's club — helping people with dementia and their carers

Barnet, Haringey and Enfield Mental Health trust

The initiative

Caring for a friend or relative with dementia is extremely stressful and often has a negative impact on carers' own health and wellbeing. Social isolation is one all too frequent effect of becoming a carer, as people find that they neglect their own needs to support the person with dementia.

While respite services exist many carers either do not want to leave the person they care for, or are not able to do so. This was the issue that inspired the development of the first Tom's Club in Haringey in 2009. Tom's Club got its name from Tom Harmer, who played professional football for Tottenham Hotspur and Chelsea FC in the 1950s and 60s.

After he developed vascular dementia his wife Jean received support from the Haringey Admiral Nurse Service (mental health nurses who support carers of people with dementia). Her particular situation meant that she was unable to go out without Tom and he would not leave her. At that time there were no local resources catering specifically for people with dementia and their carers to enjoy together and as a result she felt increasingly isolated.

When Tom passed away the Admiral Nurse Service, with Jean's support, established the first Tom's Club to provide a service for both the person with dementia and their carer. The Tom's Club model differs from other carers' groups or dementia cafés in that its structure is designed to meet the needs of both the person with dementia and their carers — separately and together.

The ethos of Tom's Club is that it provides a therapeutic information and social forum for carers of people with dementia to come to with or without the person they are caring for. It includes a structured information session or activity, a parallel session for people with dementia, followed by time together as a group. Lunch or afternoon refreshments are provided.

The first Tom's Club was set up and run by the Haringey Admiral Nurses as a once monthly event in our on site day hospital. In line with service changes since then the Admiral Nurse provision has been integrated within the wider memory service. This, coupled with the development of a part time project worker post has meant that we have been able to able to develop a further two Tom's Clubs, produce a regular newsletter, and have developed an infrastructure to support the involvement and training of volunteer workers.

Benefits

Through Tom's Club partner agencies have been able to involve carers and people with dementia in planning and evaluating services. Carers and people with dementia have been able to actively engage in research programmes.

Members have accessed the Age UK befriending scheme and Admiral Nurse support. Carers have become involved in activities in the borough as the result of speakers attending the sessions, for example exercise classes.

Below are some of the comments received from carers:

"It is the only thing we do together";

"He enjoys attending the session, especially the group discussion";

"I have a greater appreciation of his abilities after seeing what he does next door".

From the Tom's Club team perspective the project has been a powerful means of promoting partnership working.

Financial implications

The primary ongoing cost is in salary costs for the Band 4 project Worker (0.6 wte). This post has been pivotal in ensuring the project has been sustainable and able to develop robust infrastructures.

Other posts, including an admiral nurses project lead (one day per week) for one year (now discontinued), and a volunteer coordinator (1/2 day per week) have also been crucial to the project's success.

Other staff input to groups (including admiral nurses, associate mental health workers, social services day centre staff) has been from within existing service provision. Other costs include provision of refreshments and costs incurred in managing a mailing list and newsletter. Contributing organisations provide venues.

Contact

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FINALIST

Big White Wall LiveTherapy: online therapy as part of a digital pathway

Big White Wall

The initiative

Big White Wall LiveTherapy was developed to build on the service's existing SupportNetwork. The SupportNetwork gives members 24/7 access to a supportive, therapeutic peer community, creative art and writing therapies, and materials to support mental health self management. It is moderated at all times by trained counsellors, with clinical back up from the service's joint venture partners, the Tavistock and Portman NHS FT. To date, this service has supported over 13,000 people.

The impetus for LiveTherapy initially came from members, who said that they would like to be able to receive one-to-one treatment through the service. The development of Skype and other VOIP platforms has changed patient expectations of healthcare, and members were frustrated that they could access support online 24/7 but that they could only receive therapy set times and dates.

The national rollout of the Increasing Access To Psychological Therapy (IAPT) programme increased the opportunity for commissioning of talking therapies, and there is strong evidence for the efficacy of the IAPT model. However, many services struggled to meet the needs of full time employees and carers. In response, Big White Wall was funded by the NHS high impact innovations programme to develop a platform for delivering therapy online.

The most significant challenge was ensuring safe information and clinical governance, which required close working relationships with the Tavistock and Portman NHS FT and with technical build partners Buzzumi. The partners created a safe therapy platform that allows audio, video and text interaction, as well as an interactive whiteboard for CBT therapy.

Existing services are not considered clinically safe so this was a specific build for the project, with strict controls on the way session data is recorded. The service also includes an embedded IAPT minimum dataset for patients to fill out before each session.

Big White Wall and TPFT created a full governance handbook for the service, including procedures for risk management and escalation, and for the recruitment, training and supervision of remote based therapists. There are specific challenges to

building a therapeutic relationship online, and therapists received bespoke training in this area.

Benefits

Using LiveTherapy together with the SupportNetwork leads to significantly better outcomes and improved access to care. To date, 45 step three patients above IAPT caseness have completed their treatment. Of these, 58% moved into recovery, compared with a weighted average for IAPTs referring to the service of 44%. This represents a 33% improvement on previous outcomes.

Feedback shows that this is a result of significantly enhanced self management: patients select their own therapist and treatment time, and make use of the SupportNetwork to support their recovery. On average, they have used it for nearly 13 hours before, during and after treatment — over twice the average time they have spent in therapy sessions.

BWW member surveys show that 80% of SupportNetwork users say it helps them self manage their mental wellbeing. Interacting online has a disinhibiting effect: 73% of SupportNetwork users disclose an issue for the first time, and the online therapy often enables patients to share issues with their therapist more quickly than in traditional treatment. Patient feedback from LiveTherapy shows that 93% of clients were 'satisfied' with the service, and 75% who were 'very satisfied' with their therapist. LiveTherapy is particularly suitable for patients who find it difficult to access in hours services. Increasing patient choice also significantly reduces DNA and cancellation rates, allowing better allocation of resources.

Financial implications

LiveTherapy was developed with a grant of £150,000 from NHS National Innovation Centre, to enhance access to talking therapies. This funded the technical development of the service and its clinical management system.

The costs paid by Big White Wall clients cover only service delivery and a small service management overhead. Management overheads are relatively low: a part time LiveTherapy service manager administers the service day to day, overseen by the head of service and the clinical director. A contract manager provides client liaison and reporting.

Therapists work from home, so there are no travel costs or travel time. Early indications from BWW suggest that the cost of the service compares very favourably to traditional services — £75 per session and £100 for SupportNetwork access. On average, this gives a cost per person treated of £532, and a cost of recovery at IAPT step 3 (excluding triage) of £917. National figures give an equivalent cost (including triage) of £2,895.

Contact

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FINALIST

The CNWL recovery college

Central and North West London FT (CNWL)

The initiative

In February 2011 the Department of Health commissioned the centre for mental health and the NHS confederation to lead the implementing recovery through organisational change (ImROC) programme 2011–2012.

The programme aimed to help mental health services be more supportive of people in their recovery. CNWL was one of six national pilot sites for this pioneering piece of work. Ten key organisational challenges were developed in Implementing Recovery: A new framework for organisational change, Sainsbury Centre, 2009. The work undertaken in CNWL in setting up the recovery college worked on several of the challenges including:

- delivering comprehensive, user led education and training programmes;
- establishing a recovery education unit to drive the programmes forward;
- redefining user involvement
- transforming the workforce.

Central to the college is the recognition of the expertise of people with lived experience who use services and the expertise of mental health professionals in a process of co-production. Lived experience of mental health difficulties is as valuable as that of mental health practitioners, both to the individual journey of recovery and to the development and delivery of services.

Peers and mental health practitioners staff the college; and all courses are co-produced and co-delivered by individuals with lived experience, their supporters and mental health practitioners in an atmosphere of mutual learning. Students access the college by choice and are not restricted by the number of courses they may apply for while registered with the college.

We are currently evaluating the impact of the college in several ways including:

- a pilot of the inclusion web to evaluate the impact of the courses on students' lives;
- a BME forum to ensure equity of access to the college, course evaluation;
- classroom observations to monitor consistency in quality;
- development of a quality assurance panel to approve new course proposals.

We are also involved in a recovery colleges characterisation and testing research project with the Institute of Psychiatry looking at the impact of recovery colleges on mental health service users.

Benefits

We have evidence to suggest that both service users and staff are finding the college experience transformational and beneficial to their recovery. Student feedback on the recovery college has included:

"Meeting others who share similar experiences have made me realise that there might be a way out";

"It was quite unique to be among so many service users who have crossed into recovery, I've never experienced that before"';

"I now don't feel ashamed about my mental illness";

"My perception of how I carry out my work and approach towards the people I work with has improved".

Financial implications

There were three distinct processes that assisted with the financial planning to set up the college:

- working to apply for CNWL innovation funding to set up the college on a hub and spoke model from the beginning;
- transforming resources from "traditional style" day service provision
- ensuring sustainability and developing a business case to gather funds from across the services within the trust.

The final step will be one of income generation from external sources.

Contact

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FINALIST

Utilising the power of hope creatively across inpatients services to improve the patient experience

East London FT

The initiative

This is a simple but powerful initiative that has introduced the concept of hope, purpose, inspiration and optimism to every inpatient ward across the trust. The Hope Wall Project allowed unregistered staff to be creative, innovative and work in true partnership with patients.

Patients often feel distressed, disempowered and struggle to find hope when they are feeling at their most hopeless. Believing that hope is the key to recovery, the project introduced the idea of having a Hope Wall on each ward.

We identified one Band 3 and one Band 4 nurse on every one of our 35 wards to lead on this project. At our first half day meeting, we explored the concept of hope, what makes people hopeful, what hope feels like, what it feels like to be without hope and related this to the patient experience.

We gave them the space, time and resources to be creative, Innovative and as daring as they wanted. There were three very clear aims:

- to create a wall dedicated to hope;
- to build on this by creating a range of activities and forums where hope is embedded;
- to work in partnership with patients to determine what works for them.

We met monthly for six months and provided a forum to discuss the barriers and to define the solutions. Some struggled to gain sign up, others found it difficult to start or gain involvement for patients but with determination and an absolute belief in improving the patient experience every ward managed to adopt the idea.

Patients, staff and an artist in residence with lived experience of mental illness worked together to paint images on a wall and then through individual and group interventions, patients wrote messages of hope and inspiration and attached these to the wall. Often those leaving the ward would leave messages of encouragement to those in the early stages of their recovery providing visual peer support.

There is nothing more powerful than support from those who have experienced trauma and illness and these walls are central to this. The wall became the beginning of a range of hope led activities/interventions on all wards: hope gardens, personal hope story books or displays of messages of hope and inspirational quotes in a variety of languages on walls across each unit

Benefits

Patients and staff describe a real sense of achievement, a sense of purpose and a sense of pride. In the forensic learning disability service, they have a hope garden. Others have used metaphors to think about hope.

Some have walls with wonderful trees full of messages of hope and inspiration in many different languages. On one forensic ward where patients have been transferred from a high secure setting, they discovered that many have never had a photograph taken of themselves other than their hospital or prison picture. So they took photographs for them and together they made a picture frame of hope.

Others have used narrative therapy to think about hope and many have used music. Patients talk openly about the positive effect it has had on them and our most junior staff feel a sense of pride in doing something that has truly made a difference

Financial implications

The initiative was completed within our existing resources.

Contact

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FINALIST

Child and adolescent mental health services (CAMHS) "WHO AM I?" website

5 Boroughs Partnership FT

The initiative

Established five years ago, our Five Star Forum consists of young people who attend child and adolescent mental health services across our footprint. Local groups meet regularly to discuss ways of raising awareness of mental health problems and to share ideas for service improvements with CAMHS clinicians.

Young people told us that they wanted to feel less isolated and to have more opportunities to reach out to and interact more with other young people experiencing mental ill health, before they required specialist tier 3 input. They also felt that schools, GPs and families needed a way to access additional sources of information and support, as approved by CAMHS.

Through patient involvement and consultation we established the need for a website for young people — providing a platform for them to engage with each other and other young people on issues around mental health. Researching current social media trends and holding a series of ongoing workshops over a 12–month period attended by more than 30 young people resulted in the development of what they tell us is an engaging, informative and supportive age appropriate site with a really strong interactive element.

Young service users filmed videos in which they each held up a series of hand written cards explaining their personal journey. The videos were uploaded to the website under various headings including depression, eating disorders, self harm and anxiety and accompanied by links to sources of local and national support, vetted by CAMHS.

In order to publicise the website and to encourage other young people to create and upload their own videos or search existing videos, we commissioned an advert which was screened at cinemas across the trust's footprint during the school holidays.

It stars our youngest member councillor seated in a crowded cinema. In a voiceover he explains that if you feel alone even when surrounded by lots of people, there are people and services who can help — signposting the website. The audience included young people from the Five Star Forum and local school children.

Benefits

The website has been viewed 2,151 times with the first new video being uploaded within two days of the premiere. The advert promoting the website was screened 512 times in a network

of cinemas across the northwest over a four week period — reaching an estimated audience of 51,156 young people and their families. BBC Radio Merseyside invited a young person involved in the making of the cinema commercial to give a breakfast interview to an estimated 220,000 listeners. The story was also widely reported in the local and national press including.

Financial implications

The initiative was project managed with the support of the trust's e-communications officer. Using our clinical leadership meant that external input around child mental health was not required and therefore no additional costs were incurred. Young people who participated in the project were recompensed at a rate of £5.20 per hour.

The total cost of the website, workshops and marketing was £20,000 with a further investment of £10,000 to finance the cinema advert. We successfully applied for financing from non recurrent spend monies. Some of this cost is offset by the PR value attributed to coverage of the initiative, which currently totals almost £4,000.

Contact

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FINALIST

Lincolnshire community mental health support networks

Lincolnshire Partnership FT, Lincolnshire County Council and Shine Mental Health Support Network

The initiative

In early 2011 there was a 30% reduction in the adult social care budget. The trust and council designed a new model of integrated health and social care which recognised the crucial role that volunteer and voluntary groups and organisations play in helping people to maintain good mental health, and to recover from periods of mental ill health.

As well as refocusing the trust's own social care services, the new model expanded the role of personal budgets for people to access support from a wide range of providers. However, people who are not eligible for adult social care also need help and so a mental illness prevention fund (MIPF) was established to develop a managed care network (MCN) of preventative support.

At the same time it was recognised that there is a much wider community interested in mental health in the county. The SHINE mental health support network was set up after a local conference asked people to make a personal commitment to improving mental health in Lincolnshire.

The network was proposed as a way of engaging the people of Lincolnshire. The overall aim is improve people's mental health and quality of life by helping them to find personally relevant, safe and effective support. The objectives are to:

- provide easy access to a wide range of support and activities spread evenly across the county;
- promote easy access to specialist services;
- encourage wider community cohesion, engagement with mental health, and reducing stigma.

Benefits

The MCN now has 49 member groups and organisations providing 24 different types of activities at sites across Lincolnshire. These include:

- peer support;
- formal learning;
- informal learning;
- social activities;
- sports coaching;
- indoor and outdoor physical activities;
- one to one help with daily living;
- money advice;
- arts and crafts;
- parental mental health.

Projects that have received an investment of over £1,000 have submitted three quarterly reports. This includes testimonials and outcome measures completed by the beneficiaries of the projects.

Reported improvements include:

- trust and hope;
- self esteem;
- self care;
- physical and mental health and well being;
- engagement in volunteering and work experience;
- confidence;
- social contacts.

People have also reported very positive experiences of attending MCN activities by using, for example, a mood mapping tool. The groups and organisations involved have been surveyed about their experience of the procurement and network development process and have expressed generally high levels of satisfaction. They have identified significantly improved opportunities to work collaboratively on specific projects, and in meeting people's individual needs. SHINE currently has 280 members and coordinates 10 activities including:

- a website which includes information on 224 groups and organisations in the county, and which will develop social networking content;
- 31 SHINE Ambassadors who promote mental health and the network;
- Staying Well project, "for when that little bit of money makes all the difference";
- Lincolnshire mental health independent newsletter;
- Positive about mental health project, supporting customer facing business to be sensitive to and supportive of people's mental health needs.

Financial implications

Total 2013/14 funding from LCC is £375,000. This follows an initial investment of £575,000. This covers the trust's overheads as well as the investment to projects. Ultimately, it is intended that, by 2014/15, cashable savings will be double this investment.

Work has begun to identify savings for health, social care and other organisations. One project is trialling an approach that directly involves its beneficiaries to estimate the social return on investment. Another project has identified direct savings to partner agencies from reduced use of statutory services, in one case saving the police £8,000 through reduced call outs.

Value for money is also considered strong. The average cost per person for those in receipt of specialist mental health services in Lincolnshire is approximately £6,000. The average cost per person for someone benefitting from a managed care network project is under £200.

Contact

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FINALIST

"Involvement to innovate" — improving compassion and dignity through digital story telling

Manchester Mental Health and Social care trust

The initiative

This initiative develops awareness of the impact of services as experienced by patients and their families, highlighting the impact and cost of care that is lacking in dignity and compassion. We wanted to refine our core patient experience tools, extending their prominence and influence while bringing our service users' experiences to the attention of commissioners.

The digital storytelling programme, developed in partnership with the Patient Voices Programme and Manchester Metropolitan University, allows service users, carers and staff to share their experiences of healthcare via short (2–3 minutes) movies they create in safe, carefully facilitated workshops. These 'digital stories' offer viewers the opportunity to learn important lessons by walking in the storyteller's shoes for a few minutes.

The stories form the basis for an online learning resource exploring themes around compassionate personalised care, the importance of swift interventions and individual involvement in care planning processes. The programme was instigated as a direct result of local patient and carer feedback.

Having seen some digital stories on the Patient Voices website (www.patientvoices.org.uk), we contacted Patient Voices and Manchester Metropolitan University to discuss creating stories with a direct mental health focus which could form the basis of an educational programme for staff. Patient Voices delivered a presentation at a service user conference to showcase some existing stories and generate interest from potential participants.

The first storytelling workshop was then held. Participants shared their story ideas with the group, drafted a 2–3 minute script, recorded a voiceover, selected appropriate images and then edited these into a short movie. Digital stories are thus creative, individual and bring experiences to life in a powerful and accessible way. The resulting stories were launched at an event attended by different staff representatives, who reflected on the key messages, identified themes and supported the development of the educational resource.

Four further workshops have taken place, resulting in some 30 stories that represent a spread of service user and staff experiences. These have been used in a wide range of ways to enable staff to learn important lessons, reflect on practice and cultivate greater empathy with patients and their families.

Benefits

The stories are shown at the beginning of each trust board meeting; they are used to support value testing exercises during recruitment, to challenge mental health stigma and discrimination, to raise general awareness of mental health and to promote hope and recovery.

They form an integral part of a much wider patient experience programme to improve clinical outcomes for service users and increase public confidence in mental health services. The stories bring to life issues, concerns and frustrations experienced by patients and their families, resulting in more compassionate personalised care.

In 2012, the trust received the highest score in England in eight of the benchmarked questions in the national patient survey. Out of 2,018 patients, 94% of service users at discharge indicated that the staff who were involved in providing their care were helpful and 95% of service users would recommend the trust as a high quality providers of mental health services to friends and family.

Financial implications

The stories have been funded from within existing patient involvement resources, and have contributed to trust income due to their inclusion within the CQUIN schedule. There has been a clear reduction in complaints received around care (45%), staff issues (9%) and communications (22%), and therefore a reduction in the associated management costs as well as a 50% reduction in CNST claims.

Because of the unique and innovative approach, we also anticipate a much more efficient use of available resources to promote learning and improve clinical outcomes.

Contact

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FINALIST

Using horticultural therapy and outdoor activity to maximise mental health support and wellbeing for the hardest to reach individuals

Midland Heart

The initiative

Spring to Life is an initiative that aims to engage the most hard to reach individuals through the provision of meaningful daytime activities to gain transferable skills and start a CV. Working closely with Midland Heart's complex needs and inclusion service's in Birmingham, customers volunteer on a local allotment, growing their own produce and contributing to the overall development of the space.

In response to findings published by the New Economics Foundation, Spring to Life is based around the five key determinants of health:

- connect;
- be active;
- take notice;
- keep learning;
- give.

The project recognises the fact that a small improvement in well being can help to decrease some mental health problems and help people to develop. The project originally set out to redevelop the Uplands allotment through the support of a bank of volunteers who are currently residing at Midland Heart inclusion services throughout the region.

Following a volunteering event with a local company who achieved a lot in just one day we realised this ad hoc approach was not sustainable in the long term. We then began the process of recruiting a business whose services we could procure to help us with the launch and development of the project.

By entering into a dialogue with Spring to Life, who are a community interest company we were able to discuss what we could afford to pay and the services that they were able to provide, thus defining the project's aims.

The main boundaries to this approach were in the need for good weather to engage participants and bringing

everyone together at a central location. To overcome this, the team extended the programme to include fork to fork cooking sessions and reading for wellbeing at services across Birmingham.

As well as providing meaningful indoor activity this also acted as a hook for participants who hadn't or weren't keen to visit the allotment. Once the project was running we began engaging with stakeholders who were directly involved in the care of these individuals to determine the best ways for them to become involved and monitor their progress.

By helping these individuals connect and be active within a long term project, learn new skills and give something back we believe they will take the necessary steps to fully engage in society and take the pressure off of other areas of the health and care sector, particularly the NHS. Lastly, the project is aligned with, and funded by a nationwide government initiative to raise awareness of mental health issues through the "time to change"' campaign.

Benefits

Early indications are that the Spring to Life project is bringing far reaching benefits for our customers, staff and service delivery. Participants in the project have been among the most vulnerable and excluded members of the community. Those involved in the project are able to shape the outcomes from the very beginning while gaining skills and experience to aid their future development.

We have had success in supporting historically hard to reach individuals, including one entrenched rough sleeper who had been homeless for 15 years. We have also reduced reoffending and antisocial and gang related behaviour.

Staff have developed new skills as part of their personal learning and development to support customers so that we have the best people for the job. Perceptions of mental health among staff and customers alike have been challenged.

Financial implications

The Spring to Life project was a Midland Heart investment costing £30,000, involving no funding from external providers. Since its conception there have been significant savings made in staff time as a result of having more engaged customers.

Furthermore, the incidence of reoffending and relapse in substance misuse will have saved the NHS time and money in appointments, professional's time and treatments. The time frame on return was almost immediate with stakeholders and support workers endorsing the project.

Contact

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FINALIST

A mental health awareness app for Armed Forces personnel, giving information on core MH problems and where to get help

South Staffordshire and Shropshire Healthcare FT (SSSHFT)

The initiative

The objective of this initiative was to create a free mental health awareness app which has appeal and relevance to UK Armed Forces personnel. The aim was to give easily understandable information on signs and symptoms of core mental health problems and where to get help; contributing to reducing stigma in mental health.

The secondary objective, once designed, was to work in partnership with MOD to plan and market the app and also create a template for similar app development for Service veterans and the general public.

The Network is a fully integrated team across Joint Medical Command and eight NHS providers. The Network lead is South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSHFT), who have created this app.

The SSSHFT director of commercial development took the lead in defining the project objectives. The head of comms (ex service himself) project managed and the comms team specialist modern media designer created the overall package to Apple specifications.

The clinical lead was a consultant psychiatrist, who for the last 30 years has been a serving officer in the Territorial Army and is the NHS national clinical lead for the military inpatient mental health contract.

A specialist nurse helped craft the script. The key audience were involved with bench testing at prototype stage The structure of the app and how it would flow was worked up in various mind maps and free thinking sessions in 2012.

The script was based on the definitions of 10 core mental health disorders as described by the World Health Organization but then carefully re-crafted to reduce the jargon. An additional mental health issue was included of relevance to Service personnel — that of operational stress — battlemind.

Relevant video vignettes describing the mental health problems required much tenacity, patience and imagination to create something which was short and appealing. The comms team worked with MOD PR to ensure that there were no copyright infringements on the various imagery used.

As expected once the Joining Forces contract had been awarded, Joint Medical Command and MOD were critical partners to the app's success. Liaison with core Service clinicians and then MOD was essential to ensure that the app was released and that the PR was relevant and high profile.

Benefits

The app was launched on 28 April 2013. It has had over 2,200 downloads and is now on the app health home page. It has created lively social media discussion on the difficult subject of mental health.

The feedback on apple store has been excellent and positive across the rank spectrum (from 3 star officer to private), leading us to believe that we have created something which is very much valued.

Financial implications

This app was not designed to make savings but was part of the value added service to the Joining Forces Network contract, which was re-awarded to the Network in December 2012.

The initial design was created by the modern media design specialist who then became a formal member of the comms team. The initial draft design cost £5,000 for a prototype but much of scripting, editing, PR and finished design was undertaken in house. Similar external app projects in terms of manpower, cost in the region of at least £10,000. The re-award of the Joining Forces contract was clearly not based on this app but undoubtedly it was evidence of value added and additional quality of care to the benefit of potential service users.

Contact

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WINNER

The Pathfinder: voluntary sector led integrated care lifting people with long term conditions out of dependency and building social capital

Kernow CCG

The initiative

Following two engagement events in 2010 and 2011 called *Celebrating Age and Ambition*, it became clear that the same key messages were being reiterated by our local population, namely:

- add value to the support that already exists, rather than continually adding new layers;
- respect and respond to people's own expertise and ambitions for living better lives;
- build strong, sustainable support networks around a community and create social capital.

In an environment of an increasing demand on health and social care resources and an ageing population that is growing faster than most of the UK, it was clear that we were missing a crucial factor: understanding what people want, as well as what they need.

We already had strong partnerships with the voluntary sector in Cornwall and we wanted to build on the successes of a number of small scale pilots to create a model for lasting change — hence the Pathfinder. It aims to fundamentally change the balance of power between people being "done to" and being empowered to take control over their own lives, which also impacts on those around them.

A steering group comprising health and social care commissioners, community and primary care operational leads, Age UK and a GP champion, was created to deliver the Pathfinder, with a sub group responsible for developing the performance framework.

The process began with defining our outcomes, taking a social investment approach. We wished to test the hypothesis that this model of integrated care:

- helped people achieve a better quality of life;
- enabled the providers involved to be more effective and work together more cooperatively;
- reduced activity and spend across the whole health and social care economy.

The next step was the data analysis, to understand which population groups and conditions to target in order to demonstrate a significant return on investment. We used a combination of risk stratification and case finding to identify 100 people for our cohort.

Benefits

From the early results, the benefits so far include:

- significantly improved quality of life — 26%;
- high levels of staff satisfaction — 95%;
- reduction in acute care activity — 30%;
- reductions in primary care activity.

There are more subtle, behavioural and cultural changes starting to happen too, a result of the initiative. An example is the attitudes of local GPs, who find that by asking different

questions and addressing the person rather than the symptom, extraordinary changes are happening in people the GPs themselves admit they had given up hope with.

To give an example:

> Anxious about recurrent falls, Mr B had not left his house for two years and spent most of his time in one room, dependent on his wife who also had mobility issues. Both were frequent users of emergency services, both very depressed. Mr B had physiotherapy some time ago but had been too afraid of falling to keep up his exercises. A guided conversation with a trained volunteer revealed that Mr B was desperate to walk his dog on the beach. The volunteer helped him to do so, managing the risks but supporting him to become mobile. This had a hugely positive impact on his physical and emotional health and that of his wife. Mr B hasn't called the ambulance or been to hospital since. When the volunteer last went to visit, he was out — walking the dog.

Financial implications

The Pathfinder was originally funded by pump priming from Age UK of £100,000. This included delivery costs, administration, training and project management for a cohort of 100 people.

Our performance framework ensures that the financial impact across health and social care as well as the voluntary sector provider is measured, so that we can be clear on the overall economic impact. Early results indicate a £4.40 saving for every £1 spent.

Contact

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Judges' comments

- *Inspirational and moving, truly helping people not patients. Putting their expressed wishes at the heart of a multi-agency care response giving hard outcomes in terms of 23% reduced unscheduled admissions.*
- *We want to grow old in Cornwall!*

FINALIST

"One Stop Shop" service providing seamless care for people with Parkinson's disease — a model for long term conditions

Central London Community Healthcare Trust

The initiative

Parkinson's disease (PD) is a progressive neurodegenerative condition affecting about 120,000 people in the UK. It has considerable impact on the quality of life of patients and their caregivers. With disease progression, patients experience progressive decline in their activities of daily living including walking, dressing, feeding and communication.

In addition patients experience a variety of non motor symptoms including sleep disturbance, depression, constipation and urinary dysfunction and memory impairment, all of which significantly impact on the quality of life of patients and carers. Patients with PD have a significantly higher risk of falls and fractures compared with age matched controls which further increase the burden of illness.

Through patient feedback and personal observations we were able to identify the inadequacies in the present infrastructure for supporting patients with Parkinson's disease. Most PD services are focused on medical management in hospitals with very little support available for patients progressing to the complex and palliative stages of the disease.

Patients felt that lack of continuity and coordination between different disciplines was compromising care, which in turn was contributing to crisis admissions. In 1997 the European Parkinson's Disease Association (EPDA) patient charter was published, outlining the patient's perspective of an ideal service model. This prompted us to set up a multidisciplinary model of service using the patient charter as the benchmark. Our aim was to develop a "one stop shop" model service providing integrated multidisciplinary care from a single point of access.

In 1997, an initial planning meeting was set up with the multidisciplinary team and hospital management, to decide on the service model. A patient care pathway was drawn up in the subsequent meeting. As the day hospital already had its own dedicated multidisciplinary team no additional resources were needed.

New medical and physiotherapy assessment forms were drafted for the service. Letters were sent out to all local GPs informing them about the new service. Local Parkinson's UK branches and patient groups were involved in promoting the service.

A rolling multidisciplinary self management programme was started in 1998 to educate and empower patients and their families. A PD nurse specialist was appointed in 2000, and in collaboration with Age Concern, Tai Chi classes were introduced.

In 2004 the service was extended to become a full time dedicated PD unit with a monthly carer support group. The service was relocated to a purpose built unit in 2005 to accommodate the increased demand.

Benefits

Through the integration of health and social services and the provision of seamless care, patients have experienced a significant improvement in their quality of life. There has been a reduction in referral to treatment time, currently three to four weeks. The introduction of personal medication cards and telephone help line has improved medication compliance.

There is now continuity of care as patients referred to this unit are registered and treated for life. Unscheduled admissions have been reduced through coordinated, timely and targeted care. Our self management programme has informed and empowered patients. We provide a convenient and supportive service for patients closer to home and reduce carer strain through our carer support group

The greatest benefit for the staff is the enormous work satisfaction we get in being part of a team that has helped to improve the quality of life of hundreds of patients and carers.

Financial implications

As this service was set up in a day hospital that already had its own dedicated multidisciplinary team no additional resources were needed at the beginning.

A business plan was submitted to the trust board in 2007, which has resulted in a successful bid to expand the service to accommodate the increasing demand. This service is funded by Central London Community Healthcare Trust and is generating sufficient income to sustain the service long term through increasing number of out of area referrals.

Contact

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FINALIST

Pump partnership between health professionals, children and their families reduces hospital visits and improves diabetes self care

Derby Hospitals FT

The initiative

Insulin pumps are recommended by NICE as a treatment option for children under 12 years of age where multiple dose injections are impractical or inappropriate and for over 12 years of age where blood sugar control remains poor despite a high level of care, or where attempts to improve control result in disabling hypos.

The pump service for children at Derby has evolved from the first patient starting in 2004 to 46 patients currently on this regime (just under 20% of our patient population). Until 2012, patients downloaded their pump data in clinic 3 monthly or when they asked for help.

Increasingly, we were starting to use advanced software packages to view downloaded data both at face to face consultations and remotely. Based on patient and family feedback we recognised wider opportunities IT solutions could offer to provide better home care through an innovative remote diabetes clinic.

Clinicians developed a partnership agreement with children whereby they would download pump data at least every 6 weeks to allow remote reviews to take place. Improving the quality and frequency of contacts with patients and families.

The multidisciplinary team continue to see children in clinics when required. In addition, regular reviews occur at remote clinics. Patients and their families are reminded of the remote clinic and asked to provide additional information about difficulties, changes to daily routine, diet or health.

Data is discussed by the team, allowing us to consider pump settings with knowledge of the challenges faced by the child and family. We comment on basal rates, bolus ratios, accuracy of carbohydrate counting, efficiency of correction doses, blood

sugar targets and exercise management in the context of what each child is able to change within their lifestyle.

Benefits

Diabetes care is complex and very confusing and worrying for children and families. Maximising pump technology to improve the quality of care and experience, keeping children as healthy as they can be is important, as changes are frequent as children grow up.

A pump service audit to the end of 2012 showed an overall improvement in glycaemic control on starting pump therapy. This is sustained at 48 months. There is not yet enough data to be able to compare improvement in long term control on pump therapy prior to the introduction of the remote pump clinic, but the greatest improvement was seen in 2012, which will include the cohort of new pump users.

The remote clinic is also more time and cost efficient, with the following benefits:

- encourages proactive management rather than reaction to crisis;
- patient data is reviewed with meaningful regularity;
- there is a high level of consistency within team and peer review.

The biggest barriers to diabetes control are motivation and confidence. Children and parents have said the service means that they feel more in control with better ownership of their care. At the same time they have the support to fine tune management.

Financial implications

This initiative was undertaken within the current team resource, but reduces unplanned pump discussions, thereby increasing efficiency. By enhancing the quality and frequency of contacts we have successfully achieved best practice tariff for paediatric diabetes. The creation of our remote pump clinic was key to achieving this and resulted in an additional income of £620,000 last year.

Optimising control during childhood by proactively supporting pump users will consequently reduce long term cardiovascular, retinal and renal complications. This is obviously vitally important to every patient and will significantly reduce costs across the whole NHS in later years by reducing hospital admissions and use of dialysis giving patient the very best possible quality of life.

Contact

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FINALIST

The Dudley community neurology and disability team

Dudley CCG

The initiative

It was recognised by both health and social care organisations and the voluntary sector that services for neurological conditions were fragmented across the Dudley health economy. There was a need to have a concerted focus and improve services for people with neurological conditions and their carers.

Commissioned data by the PCT found that the number of people with a neurological condition registered on a GP practice in Dudley totalled 18,734. This equates to approximately one in every sixteen within Dudley having a neurological condition.

The response was for the formation of a strategy group for the development of services for neurological long term conditions, the aims were to:

- deliver on the quality requirements in the National Service Framework for long term conditions;
- develop and redesign clear pathways for people to access and move through services;
- improve access to information, advice, education and support;
- improve patient experience and quality of life;
- strengthen joint working across agencies, developing new models of service provision;
- develop an action plan and setting priorities;
- monitor and evaluate the impact of these changes by on going engagement with service users and carers.

A local workshop consultation was held to ascertain the lived experience of carers, service users and frontline staff. It focused on key aspects of the patient journey. A series of patient outcomes evolved from the workshops:

- patients, service users and carers are better supported in primary and community care;
- patients with a long term neurological condition will have a personalised, individual care plan;
- every patient has access to specialist/expert advice.

To address the patient outcomes the neurological conditions strategy formed a sub group to produce a model of care. At the heart of the model and the key objective was to form a Dudley multidisciplinary neurological community care team. The team consists of

- specialist nurses for Parkinson's disease and multiple sclerosis;
- occupational therapist;
- physiotherapist;
- speech and language therapist;
- psychologist;
- specialist pharmacist (PwSI);
- dietician;
- administrator;
- team leader.

The team holds weekly meetings to ensure referrals go to the most appropriate professional. The team has a single point of access and provides a holistic assessment. There is also a carer support group which could be accessed by any carers who are looking after a patient/client with a long term neurological condition.

Benefits

The community neurology patient feedback surveys demonstrated 98% satisfaction levels. The personalised care plan audit demonstrated improvement with personalised goals in more than 70% of cases with patients with long term neurological conditions. Referrals from GPs to neurology consultants were reduced with the commencement of the community neurology team.

Clients/patients also have access to single point of contact for MDT team and are able to self refer. This has reduced unnecessary GP and consultant contacts. Improved outcomes have been demonstrated with therapy outcome measures.

These are used for individual cases at the start of episode of care and at the end of the episode. The recent personalised care plan audit demonstrated improvement in 70% of cases.

The neurology team PwSI for neurology was awarded Royal Pharmaceutical Society Clinical pharmacist of the year 2012 for her work innovative work in neurology. Over a 12 month period savings of £38,000 were made from effective prescribing.

The success of the pharmacist interventions on effective prescribing combined with an agreement reached with the neurology consultants that a majority of Parkinson's Disease interventions can be undertaken in the community has led the pharmacist to increase her hours to four days a week

Financial implications

A £100,000 investment was supported by the PCT to supplement the MDT for a team leader, specialist pharmacist and administrator. This was via a business case but not undertaken on an invest to save basis. However, there was an assumption that many referrals from primary care to secondary care could be diverted to the new neurological team and this was subsequently included as a QIPP initiative to reduce neurological outpatient referrals by 5% over a one year period. At the end of the year £25,986 in savings were made.

Contact

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FINALIST

Crisis response falls team

East Midlands Ambulance Service Trust

The initiative

The Crisis Falls Response Team (CRFT) was created to meet a demand for better falls services and to dovetail with support services provided by Northamptonshire County Council.

The standard ambulance response prior to CRFT was, often, either a manual lift of a person who has fallen, or a further response with appropriate equipment. In both cases, a person who had fallen may be left in situ for a significant period of time, causing secondary injuries, exacerbating primary injuries and, ultimately and potentially, reducing quality of life or reducing life expectancy.

Discussions were initiated between several organisations over the make up of the CRFT. This team would be made up of a qualified paramedic and emergency care assistant using a vehicle specially converted to carry a wide range of lifting equipment with able to transport patients, where required.

The members of this team would also be trained through the University of Northampton in enhanced patient diagnosis; this education saw paramedics and social care staff training together. This provided each sector with a unique insight into each other's roles. The core aim of the education was to enhance patient safety, experience and reduce conveyance to hospital from around 65% to 40%.

Benefits

Between April 2010 and March 2011 around 12,000 people fell in Northamptonshire and called for support from the ambulance service, representing approximately 20% of the total deployment to demand for the county. The transportation rate of this patient group to hospital was 66%.

Since its inception, the CRFT have been dispatched to approximately 1,400 patients with a conveyance to hospital rate of 40%. The performance results for 2012 have seen a net reduction of 2,100 deployments on the previous year.

The conveyance rates for patients to hospital were lower during the hours that the falls ambulances were in service than when only general ambulances were running. The feedback offered from patients about the service was overwhelmingly positive; interventions were considered to be timely and staff were considered friendly, approachable and well informed.

Almost everyone responding to the questionnaire felt that they were respected as an individual, treated with dignity and appropriately consulted about their care.

Financial implications

The team's intervention either avoided a hospital admission directly or facilitated a discharge directly from A&E in 1,206 cases. After assessment, 156 of these patients were admitted to hospital, giving 1,050 avoided admissions. Based on the average length of stay for a general medical patient, this would then have cost the NHS a total of £1,644,300.

If the estimate for a falls patient is used, this becomes £2,940,000. In this period, the Crisis Response Team accepted 1,311 referrals, giving a total cost to the Crisis Response Service of £1,019,958. This represents a total saving of circa £1,920,042

Contact

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FINALIST

A pilot outreach physiotherapy and dietetic quality improvement initiative reduces IV antibiotic requirements in children with moderate severe cystic fibrosis

GOSH

The initiative

Regular exercise may help to maintain or increase lung function and increase the effectiveness of airway clearance techniques in children with cystic fibrosis (CF). It may also improve aerobic capacity and muscle strength. However, it is important to carefully monitor growth and body composition in children with CF who are pancreatic insufficient, who regularly exercise at moderate to high intensities, as increased energy demands may impact on body mass index that is strongly correlated with lung function.

Two previous observational studies conducted in small groups of children with moderate to severe CF reported that a 12 month intensive outpatient physiotherapy and exercise programme significantly reduced requirements for IV antibiotic treatment and also increased exercise capacity.

The 12 month pilot programme was a quality improvement initiative to replicate these previously reported positive results. The primary aim was to reduce the total number of IV antibiotic days required during the 12 month intervention period, compared with the 12 months pre-intervention. A comprehensive cost analysis was also undertaken. Participants were monitored over the course of the year for changes in their exercise capacity, lung function, growth and quality of life.

A top down approach was applied to enrol the sickest children (4 male, 12 female) aged 4–15 years on the programme, who had each required more than 40 days (range 40 to 148 days) of IV antibiotic treatment in the previous 12 months.

The physiotherapy component included weekly supervised, personal exercise training sessions and monthly reviews of airway clearance. The physiotherapist individually tailored each child's aerobic and strength training programme based on their baseline lung function and exercise test results. High intensity exercise training was interspersed with regular recovery periods.

The physiotherapist approached local gyms to provide

free membership for each of the children, which resulted in a successful collaborative network with 16 private sector fitness facilities.

More regular input from the dietitian included a minimum of 1–2 monthly monitoring of weight, and focused on the child's response to exercise, with additional calorie supplementation prescribed when needed. Oral supplements, enteral feeds, vitamins, enzyme administration and dosage were also more regularly reviewed, and the dietitian developed educational resources for each child based on their specific nutritional knowledge.

Benefits

Comparing the intervention year to the pre-intervention year there was a:

- 21% reduction in the requirement for GOSH inpatient IV antibiotic treatment, from 619 days to 478;
- 24% decrease in shared care inpatient IV antibiotic requirement from 249 to 189 days;
- 20% reduction in home IV antibiotic treatment from 304 to 243 days.

This meant that children were able to spend more time at home and school and experienced less of a dip in their general quality of health. Cardiopulmonary exercise tests showed that children had significantly improved their overall cardiovascular fitness by between 10–50%

Children were reporting that they are now able to exercise at the same level or sometimes even higher than their peers. Subtle changes in a child's clinical status, identified by more frequent contact with them, enabled early intervention and initiation of appropriate treatment.

A disease specific questionnaire showed that children had shown improvements in their quality of life. All patients and parents said they would recommend this type of programme for other children with CF.

Financial implications

The setup cost of the programme was £100,000. This was used to employ a full time physiotherapist and exercise specialist (Band 7) and a half time specialist dietitian (Band 7), and to lease a car for the clinicians to travel out to children's homes and local gyms. We also purchased portable heart rate and oxygen saturation monitoring equipment.

The programme had created a total cost saving of £220,338 comprising:

- £170,610 in GOSH inpatient costs;
- £39,480 in shared care hospital bed costs;
- £10,248 in home IV antibiotic costs.

Contact

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FINALIST

COPD medicines optimisation reduces exacerbations and admissions

Liverpool Community Health

The initiative

A COPD pilot project was carried out in the north of Liverpool over an 18 month period, starting July 2008. This was triggered due to a high rate of hospital admissions. This initial work reviewed all aspects of patient care from accurate diagnosis, both pharmacological and non pharmacological intervention and finally end of life.

The pilot work was a multidisciplinary team approach involving different clinical staff. Following on from the positive outcomes showing improvement in accurate diagnosis, reduction in exacerbation and non elective admissions and as part of QIPP work the initiatives were introduced to all high admitting surgeries across the city to help improve COPD patient care.

The local QIPP agreed drug therapies guidelines were developed by the MMT in line with NICE guidance. The overall aim was to reduce non elective admissions and exacerbation The process involved the following steps:

- all patients currently on a COPD register were reviewed;
- accurate diagnosis with accredited spirometry was checked for all patients;
- those requiring diagnostic spirometry, were referred to the commissioned spirometry service;
- GPs were asked to review those patients where spirometry did not suggest COPD for differential diagnosis;
- patients with accurate diagnosis of COPD were further triaged to determine those patients with more than two exacerbations requiring antibiotics and/or oral corticosteroids or one or more admission in the previous 12 months — these were deemed uncontrolled;
- the remaining patients, were deemed controlled and to remain under usual care;
- the uncontrolled patients were reviewed by either a GP, practice nurse or pharmacist prescriber (MMT), depending on agreed criteria.

Regular updates were provided to the PCT and now CCG to ensure the commissioned optimisation work was achieving its objectives.

As part of the city wide work, the idea of patients having "rescue packs" containing antibiotics and oral corticosteroids emerged. This pack would to help timely management of an exacerbation.

Benefits

The pharmacist optimised 399 patients in the pilot work in line with national guidelines. This included a full holistic medication review. The outcome 12 months post review showed a reduction in admissions from 53 to 35 (34%) and exacerbations reduced from 924 to 660 (28%).

Citywide there are 7,884 patients on the register across 52 practices, outcomes are as follows:

- 15% needed diagnostic spirometry;
- 12% needed the GP to review the diagnosis;
- 43% of the total patients were well controlled;
- 30% of the total patients were uncontrolled and required further intervention from a clinician. These patients were considered suitable for a rescue pack;
- 13% of patients were reviewed by a pharmacist to enable them to have their medication optimised as per guidelines.

12 month outcome data was available for 583 patients reviewed by a pharmacist showing a decrease in exacerbations by 354 (26%) and admission by 47 (39%).

Anecdotal discussions with patients suggested that this process enabled them to self manage with having rescue packs available and with better adherence across the city to local guidelines, helping more patients to be managed more effectively. Overall admissions reduced across the city by 10%.

Financial implications

The citywide work was part of the already commissioned work

from the CCG (formerly PCT) as part of the QIPP work, so no additional resource was needed. COPD medicines optimisation was forecast to increase drug costs.

The optimisation process caused an increase of £73,000 over the three year citywide work. Two years worth of 12 month outcome data related to reduction in admissions and exacerbation shows there is a potential cost saving of £116,000 from the initiative.

Contact

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FINALIST

Community orientated person care

Outer North West London Integrated Care Programme

The initiative

A standard package of care for diabetes and dementia for over 75s has been introduced across a population size of 1.2 million. The package of support has been co-designed with patients. Through working with others it has been possible to ensure high quality care that is standard to all patients across the four boroughs. The aim was to increase the quality of care, reduce variation and ensure that patient concerns about their condition were directly addressed.

The population across outer North West London is increasing and with this has come a relentless rise in unplanned admissions. As CCGs were forming there was an awareness that the old ways of managing demand would not suffice. A funding gap of £30m was emerging across the CCGs. Inner North West London had gained recognition for the work we were doing around integrated care.

The challenge we faced was around handling the fragmentation across services. This resulted in relationships being strained across professionals, IT, governance and most importantly patient care. We had made inroads and noted the biggest barrier were professionals.

The government's new health and social care act placed the problem firmly at the feet of clinicians. NICE was starting to develop more commissioning centric plans. Sir John Oldham's work around long term condition care was disappearing in the transition.

We had to pull together international evidence from places such as New Zealand, Canada and Australia. National evidence was growing and we looked at Torbay and Cambridge.

Under the federated CCG structure a challenge was put out over how we could move towards integration at a bigger scale and faster pace then our neighbours as we were behind and our patients were paying the price. Two pathways were identified for a first wave, diabetes and dementia for over 75s.

There were a number of stages to ensuring the behavioural change in all providers to improve diabetic and dementia care. A clear narrative and case for change was required for diabetes and dementia for over 75s that emotionally connected to all stakeholders.

A team of managers and clinicians who know the boroughs were brought together. A pathways team constructed the initial workshops to bring together all key stakeholders and the evidence. This required translating down to the smallest detail of what the GP system template looked like and even what the patient print out would be.

A patient engagement group reviewed the material. A parallel clinical group was set up to test the evidence and package of care. Incentives were aligned with all stakeholders to retain engagement to ensure it met QoF, QIPP, CQUIN and other targets.

The biggest barrier was GP uptake as they were starting commissioning, busy in their day to day work and we were seemingly adding another layer. This has now turned into our biggest strength as we overcame the sceptics to deliver transformational change that is sustainable. Multidisciplinary groups were set up for true localism with a population based of up to 50,000.

Benefits

We now have a standard package of care for diabetes and dementia for over 75s. There is a community centred patient care plan that is relevant to all stakeholders. Over 90% of patients now report that they are planning for their condition.

We have ensured that the care coordinating practice has access to the wider multidisciplinary group through monthly meetings thereby reducing ongoing referrals.

There are better professional relationships across primary, secondary, community, mental health and social care. Within seven months of starting across all pathways we have 8,000 care plans, and over 1,000 patients discussed at multidisciplinary groups. This equates to adding six whole time equivalent clinicians worth of time into care planning above and beyond the existing resources we have.

Other benefits include:

- the development of mutual respect across all the traditional divides of health and social care — primary and secondary as well as manager and clinician;
- improved skills in managing the needs of the patients;
- developing a community that has an identity, a voice and a common purpose to improve the quality of care.

Financial implications

The initiative required an investment package of over £8m to trial and set up the infrastructure. The actual delivery was 40% under budget and delivered ahead of schedule A number of innovation funds were set up to promote ideas. These were inundated with applications and have accelerated delivery. IT was invested in through developing provider systems rather than any big bang or alternative approach that had 100% uptake as a result

The projected savings were exceeded, as the first year was to embed the change and delivered £500,000 of savings, as well as supporting £11m of QiPP savings. The principles have been applied to three other pathways with direct savings of up to £755,000.

Contact

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FINALIST

Long term physical health problems and co-morbid mental health problems — a collaborative and integrated approach using CBT

Pennine Care FT

The initiative

A team of health professionals from Pennine Care Foundation

trust have pioneered a new initiative across Stockport to improve the health and well being of people with lung disease. Cognitive behavioural psychotherapists from the psychological therapies department, teamed up with the borough's lung disease team from Stockport NHS Foundation Trust on a pilot project that has helped to improve the mental health and well being of people with chronic obstructive pulmonary disease.

Often, people with a long term physical health condition, such as COPD will have an associated mental health condition and commonly this can be panic disorder, depression or anxiety. Evidence shows that several billions pounds is spent every year in England on supporting and caring for these people.

The team worked with other health professionals to identify COPD patients who had a mental health condition and would benefit from cognitive behavioural therapy (CBT).

Benefits

The project produced results that exceeded expectations. Patients reported high levels of satisfaction and many saw the interventions as life changing. Subjectively there were many reports of improved self efficacy and self management of their co-morbid mental health conditions.

There were also Improvements in quality of life outcomes and behavioural changes, such as returning to work, stopping smoking, reduction in medication use and emergency admissions and consultations and greater patient involvement in physical/social activities.

Looking at objective measures:

- WASA, pre-intervention, 18.2, reduced post intervention to 12.3;
- HAD score pre-intervention 11.8 reduced to 8.8 post intervention (anxiety) and for depression from five to 3.6 post treatment;
- the pre-intervention scores for caseness on the PHQ 9 reduced from 12 to 1 post intervention and on the GAD 7, from 12 to 0 on caseness.

Physical health scores also improved with better self management, pacing and addressing breathing dysregulation not associated with the COPD but implicit in the catastrophic misinterpretation of physical symptoms resulting in increased perceptions of breathlessness and poor concordance/compliance.

CAT scores reduced from 26.7 pre-intervention to 19.5 post intervention.

BORG from 4.9 to 1.5 and GHQ from 63.6 to 43.9 post intervention.

A clinical audit was produced and disseminated to report all outcome measures, key findings and future recommendations.

Financial implications

Existing resources were used to deliver the initiative namely two CBT therapists to:

- present the project to the COPD team;
- assess and treat patients;
- deliver training programmes to different members of the multidisciplinary teams.

There will be immediate savings in reduction in emergency and avoidable consultations and admissions. Potential longer term savings in are relation to service usage, benefits, medication use etc.

Contact

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FINALIST

"Hearing voices; do it in STYLe"

Portsmouth Hospitals Trust

The initiative

Didactic consultation techniques are rarely effective forms of communication for young people (YP). Typically half of patient concerns are overlooked and so it is unsurprising that outcomes are not achieved when the goals set relate to professional needs rather than the patient.

DNA rates in adolescent clinics (40–50%) were predominantly due to the YP age group. Screening uptake was variable without defined methods of following up results. Admission rates also reflected the non engagement of this vulnerable patient group.

In order to address this situation, patients were invited to contribute via social media, direct questioning and focus groups. Their ideas and recommendations were adapted to restructure the YP service.

Portsmouth diabetes centre divided its team into service areas, one of which became adolescents and YPs with Type 1 diabetes. Having identified a new dedicated team who would commit to the adolescent and YPs, team meetings were arranged to collaborate with the paediatric diabetes team.

Simultaneously local CCGs were approached to reach agreement that Type 1 diabetes could be separately commissioned from Type 2 diabetes. This process involving education to highlight why Type 1 and Type 2 have different care management needs.

Following patient consultation the YP service was restructured. The adult diabetes service world tends to work in rigid structures dictated by tradition but for adolescents we needed to be more flexible with access to consultations (for example emails) taking into account patient recommendations. The biggest hurdle to overcome was of our own ability to allow the YP to be open and honest about current care provision and then follow through with their wishes to redevelop a service.

Benefits

Benefits of the initiative include:

- transitional and adolescent clinic attendance levels were monitored and the DNA rate which had varied from 40–50% has dropped to 10–15%;
- acute admissions secondary to DKA (a common reason for admission in this group) have reduced by 11%;

Since introducing the "lifestyle identification discussion sheet", consultations have been guided by the individual and conversations have flowed. Patient evaluation of the sheet include comments such as:

"I didn't know I needed to know about tattoos";
"Good prompt as I often forget what I want to ask";
"Allows proper discussion of my topics rather than just being noted at the end";
"Useful that the doctor could see what I wanted to talk about";
"It seems like we are finally in charge!"

Financial implications

This restructure has not required extra financial resources to develop. Cost savings were made in terms of reduced DNA rates and reduced admissions for diabetic ketoacidosis.

Contact

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WINNER

Families reporting critical incidents and near misses in a children's hospital

Great Ormond Street Hospital for Children FT

The initiative

Adverse events occur in approximately 10% of patients admitted to hospital in the United Kingdom (UK). Of these, 37–51% have been judged preventable. The UK level of harm in children has not been published, though results from trigger tool reviews at Great Ormond Street Hospital (GOSH) suggest that 10–12% of children experience some form of harm.

The NPSA published a review of paediatric patient safety and listed the different types of harm that occur. It is clear that current reporting systems trigger tools underreport such events. Barriers to reporting may include the perceived lack of protection from the organisation when revealing incriminating information, a lack of visible feedback, and a perceived lack of value in the process.

Although many lessons have been learnt from other high risk industries, the lives of health care providers are not necessarily at stake in comparison to pilots or staff in the control room of a nuclear power plant directly exposed to potentially disastrous adverse event. "Buy in" and "ownership" from health care professionals appears to be crucial to better meet patient expectations.

A new way of approaching patient safety will more actively involve all levels of the service providers — from hospital management to front line staff. Even with the best intentions, opportunities for learning from mistakes are currently lost, hampering progress in implementing patient safety measures and therefore new strategies are required.

The initial goal of this project was to actively engage families in the reporting of patient safety concerns in order to improve the identification of adverse events and near misses on a designated paediatric in patient ward at Great Ormond Street Hospital for Children (GOSH) over a 12–month study period.

Families are asked to complete a web based questionnaire within 24 hours of anticipated hospital discharge. Reporting is anonymous, with families asked to comment on positive and negative patient safety hospital experiences. Over the course of the funded study period the questionnaire usability was reviewed and reported events analysed and integrated into existing hospital systems based on Deming's established quality improvement methodologies involving the hospital's dedicated transformation team.

Benefits

Over the current study period 91% of families approached have participated in the study. The majority of interviews took place at the patient's bedside (86%), 81% of participants were mothers.

- 87% of families stated positive patient safety experiences.
- 39% reported additional patient safety concerns.
- 78% of families reported events that were judged legitimate after review by two experienced patient safety officers. None of these were recorded using existing hospital risk management systems.

The total number of reported events has increased by 52% with the majority of reports related to medication errors and miscommunication (57%). Mitigation of risks currently focuses on improved staff communication through "Safety Huddles" and staff education through ward based pharmacists. Newly identified patient safety concerns are anticipated to lead to a gradual shift in safety climate through empowerment and shared decision making.

Moving from a retrospective data collection near the time of discharge to a web application-based real-time patient safety reporting system may facilitate more timely mitigation of risks and should increase the likelihood of staff buy in and sustainability of quality improvement efforts

Financial implications

This quality improvement project into patient safety is being funded by The Health Foundation's SHINE 2012 award programme (£75,000). A full time project manager has been employed to run the day to day activities and facilitate quality improvement efforts through:

- data collection and analyses;
- structured staff feedback;
- reporting of events;
- planning of strategies to mitigate newly identified risks.

This project's primary focus is not the reduction of health care costs per se but increasing family involvement as partners in paediatric clinical care. There currently are no published precise data on the magnitude of adverse events in the paediatric setting but national estimates suggest that medication errors in the NHS lead to additional costs of more than £750m every year.

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Judges' comments

- *Triggered by lack of reporting of incidents noticed by parents – only 3% which are reported via the incident reporting system*
- *Anonymised general feedback and real time feedback to make a difference.*
- *A creative and inspiring approach to hearing from parents about when things go wrong. Taps into the under used resource of the parent's voice to enhance incident reporting and learning.*

FINALIST

Earlier identification and escalation of the deteriorating child

Great Ormond Street Hospital for Children FT

The initiative

The initiative aims to keep children safe by combining a robust clinical measurement tool with the introduction of twice daily safety huddles at ward level, and a multidisciplinary approach to handover prioritising early warning scores.

The process aims to both detect and predict if a child is in the early stages of clinical deterioration, based on an early warning observations tool, the clinicians "gut feel" about a patient despite the stability of their observations, and a robust escalation process.

This initiative was the outcome of a "Deep Dive" into the quality and effectiveness of our clinical observation methodology and escalation process.

The wards use an early-warning scoring tool for scoring observations called CEWS. We reviewed over 1,000 sets of observations (CEWS) from two separate wards over a four week period, specifically relating to documentation of the recognition and escalation of a deteriorating child on the ward.

The findings were surprising and a little alarming. The audit (August 2012), identified that while 91% of the observations fell within normal limits and did not need intervention or escalation, a further 9% reached a score that triggered a requirement for action. Of that 9%, there was little to no evidence of escalation in at least 50% of the observations. The primary objective of this initiative was the creation of a safer environment for our children.

A project team was formed in September 2012, led by the paediatric consultant and Head of nursing, and supported by a committed team of clinical and non clinical members. The team initially met weekly to set the project aim, identify objectives, and agree improvement measures and milestones for the project.

While the team identified the high level primary drivers, the first cycle of testing using PDSA cycles commenced in late September 2012. Our three initial objectives were:

- all patients' vital signs need to be assessed and recorded accurately;
- introduce a ward safety "huddle" twice a day to increase awareness of CEWS and escalate CEWS accordingly;
- all CEWS to be scored accurately and reliably on the observation chart.

Benefits

The primary benefit of this initiative was the creation of a safer environment for our children by ensuring all staff members are preoccupied with early signs of deterioration.

The "deep dive" into our previous practice highlighted a false belief that we were completing assessments of patient's vital signs and escalation of the patient's condition in an accurate and consistent manner.

The data provided the platform to undertake a supportive and essential educational programme for all nurses at ward level. This included clinical simulation, leadership training and supportive workshops. The pilot ward is now a beacon of good practice in this area. The most significant accomplishment to date is the profound change in clinical culture at ward level.

Clinical staff say that it feels a much safer working environment with stronger leadership and more robust processes. Before the huddle was introduced the ward had no formal process for discussing CEWS scores throughout the day. The CEWS are now highly visible on the ward's patient whiteboard at all times, discussed twice daily at the huddle and there is consistent evidence of appropriate escalation from our permanent staff.

Initially we had only one nursing KPI measure for clinical observations; completion of CEWS. This was a ward-audited measure that did not give true reflection of the clinical practice, routinely achieving 100%. The new more sensitive measure shows a positive direction of travel on the SPC chart for accuracy of CEWS documentation and escalation, scores of 90% opposed to original achievement nearer 60%.

Financial implications

No extra payments were made for clinician's time; time was carved out from their current workload. Simulation training was offered in house but costs were associated with replacing staff with agency nurses. Band six nurses were taken on two awaydays for leadership and clinical updates. Data collection required 40 hours initially, followed by three hours a week. This was carved out of the improvement manager's schedule.

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FINALIST

Reducing prescribing errors using the principles of reliability

Great Ormond Street Hospital for Children FT

The initiative

The prescribing of medication is fundamental to modern medicine. We have a duty to our patients to ensure this task is free of error. However, prescribing errors occur in all healthcare institutions where medication is prescribed. Children are particularly vulnerable and Great Ormond Street Hospital often prescribes off label and has a particularly complex case mix.

When the first BNF was published in 1949 there were very few drugs and formulations compared with the many hundreds in the current adult and paediatric formularies. Even with extensive formularies, we don't have all the information we need for the drugs that are available to us. We found that prescribing was viewed as being a low status job and was often carried out with lack of resources, interruptions and under time pressures with inadequate training.

We decided to embark on a trust wide medicines error reduction programme, with the aim of reducing prescribing errors by 50% year on year. In the past we had tried:

- extra teaching;
- guidelines;
- checklists;
- standard operating procedures;
- technology such as electronic prescribing;
- performance management.

However, we still had a high rate of prescribing error, so we had to find another approach. We looked to other industries that also have hazardous environments where the consequences of errors are high, but the occurrence of error is extremely low, such as nuclear power and aviation.

We created defences and barriers, using the five principles of high reliability to reduce the potential for harm. We used the model for improvement to test our ideas and interventions. The whole MDT team was involved in testing innovations with the support of an improvement manager.

We tackled culture by using the reliability principle of being

obsessed with failure — in the areas being studied pharmacists would collect errors for every patient every day. We analysed each error and looked for all the reasons it occurred.

We also introduced a prescribing desk equipped with the necessary resources, including speciality specific guidelines and infusion calculators. Pharmacists acted as watchers, like the captain of a ship. We ensured that the improvements were sustained and "violations" didn't occur by helping the people who might make the errors to come up with the solutions and engage in the problem.

Benefits

We began the initiative on one ward, three years ago and used small PDSA cycles to test and spread changes. We have now made sustained reductions in prescribing errors over nine specialties over eight wards:

- PICU saw a reduction of 44.5%;
- CICU saw a 55% reduction.
- haematology and oncology wards saw a 60% reduction. They also achieved a further 55% reduction in out of hours prescribing errors;
- bone marrow transplant, immunology and infectious disease wards saw a 55% reduction.

All the improvements have been sustained, regardless of new junior doctor rotations, changes in staff, changes in case mix on the ward and fluctuations in pharmacy resource. We feel that this is because the culture around prescribing has fundamentally changed and reliable prescribing is now "the way we do things at Great Ormond Street Hospital".

Financial implications

A medicines management specialist was employed to support the projects and four ward-based pharmacists were employed for the haematology, oncology, BMT, immunology and infectious disease wards. The ward-based pharmacists also supported other projects in the trust, however the medicines error reduction programme aimed to improve patient safety and did not aim to specifically reduce costs.

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FINALIST

Reducing the length of time patients spend in the emergency department, using the rapid assessment and training (RAT+) model

Health Education England

The initiative

In 2011 the Department of Health introduced a number of quality indicators aimed at enhancing quality of care in the emergency department (ED). One of these indicators is a median time to treatment by a decision making clinician, of 60 minutes. The trust aimed to introduce new ways of working that placed senior clinical decision makers at the start and end of the patient journey in the ED.

The rapid assessment and treatment (RAT) system places a senior clinician at the beginning of the patient journey in the "majors" area enabling early decision making and thus improving the quality of care and reducing the length of time spent in the emergency department (ED).

We have taken this concept and developed the RAT+ system. RAT+ places two consultants in the patient journey. One as part of the initial assessment team and the other working with trainee medical staff in the "majors" area supporting their decision making, training and development.

The traditional RAT model proposes a sole clinician delivering RAT. RAT+ consists of a consultant and an advanced assessment practitioner, thereby not only developing a team approach but also developing an innovative nursing role.

The trust hoped that this would provide excellent opportunities to improve the quality of training of more junior nursing and medical staff, while improving the quality of patient experience. Assessment in the ED can often be delayed due to a backlog of patients. This is multifactorial, but is predominantly affected by failure to correctly refer or safely discharge patients. By providing consultant input at the initial assessment and review prior to discharge or referral we hope to:

- streamline the patient journey;
- provide reflective training for juniors;
- enhance patient safety in the ED;
- improve the efficiency of the ED.

Benefits

Key outcomes were measured, we found:

- RAT+ consistently achieve the 60 minute time to treatment quality indicator for "majors" patients (median time is 47 minutes);
- it has halved the time to referral from arrival to inpatient teams (median time is 48 minutes vs the previous 102 minutes);
- early evidence suggests where inpatient and ED assessment areas are immediately available, RAT+ can almost halve the median patient stay (2 hours vs the previous 4 hours).

Overall, it has led to improved multidisciplinary working, joint decision making, increased learning experiences for trainees, and better care for patients.

Financial implications

The project was funded, following a competitive bidding process, by the Better Training, Better Care workstream of Health Education England to the sum of £25,000. Further resources were delivered at a trust level.

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FINALIST

Implementation of patient held urinary catheter passport to improve catheter management, by prompting for early removal and enhancing patient compliance

Heart of England FT

The initiative

Urinary tract infections account for almost one in five healthcare associated infections. Over 40% of those affected have had a urinary catheter fitted in the preceding seven days (Health Protection Agency 2011).

The idea of the catheter passport initially came from one of the elderly care consultants within the trust. He frequently had difficulty obtaining relevant information relating to patients with long term urinary catheters. This appeared to be a particular problem for patients admitted from other healthcare facilities.

The passport was developed in collaboration with elderly care consultants, corporate nursing team, urology clinical nurse specialists and infection prevention nurses across three health economies.

A six month project using a PDSA cycle of change was carried out to test it and analyse what was required to fully implement it across the trust. A semi structured patient questionnaire was devised and sent out to patients followed up with a telephone call. Feedback was also sought from ward staff at meetings.

Use of the catheter passport ensures a quality driven, patient focused service, delivering better outcomes and reduction in costs as the patient passes from one healthcare professional to another. A single patient record across the health economy reduces variation in practice and provides documentation for the whole journey and improves communication between health care workers.

Patients who are involved in the decision making process are more likely to comply with the treatment and management of their care, thereby achieving more positive outcomes. The government aims for a "no decision without me" strategy, ensuring patients are provided with sufficient information and are clear about the available continence management options so that they can make informed choices.

To improve the process of implementation of the passport, the message needs to be continually communicated to staff within the trust. The launch of a customised promotional campaign guarantees that the catheter passport remains a priority.

In addition the trust intranet, corporate newsletters, infection control notice boards displayed on wards and departments and ward based teaching are instrumental in sustaining this initiative.

Benefits

Since 2004 there has been a directive to report cases of MRSA bacteraemia. To date cases have reduced dramatically but urinary tract infection remains a focus within the local health economy for this infection.

Over 25% of the reportable MRSA bacteraemia at our trust during 2012/2013 were attributable to urosepsis as a result of the patient having a long term urinary catheter. This has shown a downward trend in 2013/2014. Going forward with a zero tolerance approach, it is essential that no avoidable bacteraemia related to a urinary catheter occur.

The passport has been incorporated into the trust strategy for reducing catheter associated urinary tract infections. This approach has been recognised by the local commissioners and is part of the key performance indicator for 2013/2014. The corporate nursing metrix (used to measure quality of nursing care in the trust) has been adapted to provide an ongoing measure of the uptake of the passport.

In future this will be mapped against a reduction in long term catheter usage and the rates of CAUTI.

Financial implications

Commercial support was obtained for the pilot and initial health economy launch. Artwork has been provided free of charge but printing has been secured from a local external organisation at minimal cost of fifty pence per passport. As the quantity of passports increase this is likely to decrease. Ongoing negotiations are taking place with a range of commercial organisations to secure sponsorship for printing and support for educational events.

However costs of printing need to be offset against the expected savings that would result from a small reduction in CAUTI. Driving down urinary catheter use is key in reducing CAUTIs. The members of the development team were able to absorb the project work into their normal workload as a result the implication for manpower costs were minimal. However this has resulted in the final implementation of the catheter passport being delayed by six months due to workload.

Contact

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FINALIST

Improving safety in airway management by standardising equipment and training across all clinical areas of NHS Lothian

NHS Lothian

The initiative

In 2011 a report by the Royal College of Anaesthetists (RCoA) and the Difficult Airway Society (DAS), highlighted the fact that critical incidents (resulting in serious morbidity and mortality) still occur. This is despite the fact that airway management in the UK is provided by medically qualified staff working with trained assistants. The report highlighted several issues including:

- lack of planning for failure of any airway intervention;
- the fact that patients may require airway management interventions in critical care areas and emergency departments where they are more likely to fail;
- that poor judgement and a lack of education and training were the commonest cause of the airway events reported to the audit panel.

Alongside this were reports from the Coroner in England and the Procurator Fiscal in Scotland, which highlighted both poor understanding of how equipment worked and a lack of cohesive team working in a crisis, leading to avoidable deaths. We sought to address these risks in Lothian by providing:

- a limited range of identical effective standardised equipment everywhere an airway might be managed including the sites away from theatres;
- a way that would naturally guide staff down the agreed and published guidelines of the Difficult Airway Society, removing ambiguity and the need for the clinician to make complex decisions at a stressful time;
- a standardised teaching programme, supported at the highest level that could be locally delivered in every department where the new standardised equipment was introduced.

We convened a working party (Lothian airway training and equipment group, LATE). While open to all interested staff, it specifically included representatives from all areas where airway management might be required. This included anaesthetic assistants, anaesthetists, critical care physicians and emergency doctors from all three adult sites across Lothian. The two major innovative aims of the group were:

- to have a simple, appropriate, identical, supply of equipment (a standardised list) in a trolley everywhere a patient might require airway intervention (rather than having a lot of complex airway equipment at a few specific locations);
- to establish cooperation between three different specialities to ensure uniformity.

We reviewed literature and trialled devices to ensure the list provided a realistic way of following the DAS Guidelines and the recommendations of the RCoA, and allowed for regular

clinical rehearsal with the devices. Members considered the design and function of the trolleys to allow clinicians to use them easily yet comply with local infection control policies.

Designated teams took charge of trolley assembly and equipment provision, teaching, training and implementation. Eighty five identical airway management trolleys were purchased, stocked and rolled out across Lothian in December 2012.

Benefits

Adult emergency airway equipment is now standardised across all three acute sites in Lothian. Trolleys are adaptable to cope with changing equipment lists in the future without further outlay. Regular audits of trolley contents ensure they are stocked and compliant with content list.

There is regular multidisciplinary airway teaching on all sites. Specific training targeting critical care and emergency department staff is delivered within their own department. We hold regular morbidity and mortality meetings dealing specifically with past and future airway issues.

The trolley layout has been used in clinical situations to allow staff to work together as a team and avert airway disasters.

Financial implications

Costs of the initiative included:

- initial outlay for 85 trolleys; these have adhesive graphics and moveable drawer dividers to allow for easy future modifications at no cost;
- acquisition of initial trolley stock — partly offset by savings made from not keeping multiple spare devices on multiple sites.

Cost savings:

- prevention of adverse outcomes related to airway management, with the potential for a huge cost saving (care for a brain damaged patient);
- decrease in spares needed on all sites;
- reduced variety of second generation supraglottic airways purchased;
- the development of a training library means that training can take place without the use of clinical stock.

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FINALIST

Speaking out for patient safety

St George's Healthcare Trust

The initiative

The Francis Inquiry emphasises the need for a culture in hospitals where staff feel able to speak up about their patient safety concerns. Here at St George's NHS Healthcare Trust our own very serious incident, widely reported in the press as the young man who died of thirst, demonstrated the need for a watershed moment in the organisation. The Speaking Out for Patient Safety Campaign combines a number of approaches to influence the culture of the organisation to ensure staff know that they will be supported when they speak out to improve patient safety.

The purpose of this initiative was to create a number of opportunities including staff forums, patient stories and evidence based communication for all staff to learn from serious incidents and other patient safety issues and to do this in a way that would have maximum impact on the organisational culture.

Monthly patient safety staff open forums were set up and led by the chief nurse and medical director where a serious incident case study could be shared in an open and transparent way. The forum use interactive feedback devices to gain the views of the staff attending. Each staff member can give feedback by clicking on handheld devices to indicate whether they have seen similar unsafe practices and whether they were able to take action. Staff give feedback on issues that may prevent them speaking up such as receiving an unfavourable response so that these behaviours can be better challenged within the organisation.

The programme is underpinned by a growing series of patient and staff story DVDs based on incidents and experience of unsafe practice. These have a powerful impact on staff and are used both at the forum, at team events and educational sessions to ensure wider spread. The board also use the DVDs as a means of addressing patient safety concerns. The DVDs show the human cost behind some of the figures used in reports.

The project has been carried out across the whole organisation with an impact on clinical teams and the trust board alike. The emphasis on patient and staff stories has resonated within the organisation and enabled staff to raise difficult issues that were previously under the radar.

Benefits

Although monitoring culture is difficult, there are already some encouraging measures that are being monitored routinely and may give some indicative data related to culture. For example:

- the number of staff attending the forum has steadily grown over the last year;
- the number of serious incidents has shown a reduction over the last year and some of the underlying themes of serious incidents have also reduced;
- data on the National Reporting and Learning Set for incidents shows the organisation as a high reporter of lower level incidents, which is seen as an indication of a good reporting culture.

Also encouraging was the fact that the staff trend for recommendation of the trust as a place to work or receive treatment increased to an above average score in the 2012 staff survey. In addition service improvements have been made in a number of areas following the dissemination of patient and staff stories.

The experience at St George's shows that staff are willing to engage when they identify with patient perspectives. By learning from risk communication evidence in other types of organisation we can tailor messages much more closely to the way staff would prefer to receive communication and evaluate the effectiveness of our staff messages.

Financial implications

The programme has very few financial costs as the input comes from existing staff. The DVDs have been developed in house, unless actors are needed to preserve confidentiality. To date seven DVDs have been made at a total cost of less than £5,000. This has also enabled the development of skills within the trust that make the project sustainable.

The cost of one serious incident is significant both in human and financial terms. Therefore any reduction in serious incidents has the potential to reduce legal and staff costs spent on reacting to these events and more importantly reduce distress to our patients.

Contact

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FINALIST

How we halved cardiac arrests with a collaborative approach in north central London

UCL Partners

The initiative

Cardiac arrests in hospitals are usually predictable, often avoidable and outcomes are very poor with only 13% of patients surviving an arrest.

The Deteriorating Patient Collaborative is UCLPartners (UCLP) first formal Quality Improvement (QI) initiative. It was set up in December 2010 in response to local urgent clinical needs. The aim was to reduce mortality make a 50% reduction in hospital ward cardiac arrests.

An improvement advisor, consultant nurse, intensive care consultant and the director of quality at UCLP lead the work. The leadership team worked closely with clinical leads from 17 participating trusts. They mapped the pathway of deterioration, agreed common drivers (process steps in care) and defined metrics to measure each driver. Each trust implemented solutions tailored to local circumstances, adapting what had worked elsewhere. The five key interventions are:

- reliable recording of patients' vital signs;
- early identification of deterioration and timely referral;
- effective communication of deterioration;
- escalation to higher levels of care when needed;
- appropriate use of treatment escalation plans.

By achieving higher reliability on these key interventions, the team hypothesised that cardiac arrests would fall. QI methodologies are employed and teams ran repeated plan do study act (PDSA) cycles. Great Ormond Street Hospital's transformation team provided the analytical infrastructure to feedback performance to teams using time series run charts and introductory QI training.

Shared learning and discussions around successes and challenges happens at bi-monthly action learning sets. These have an open and highly honest nature, with a commitment from all to learn from each other and to support each other's learning. We have been fortunate to have world class educators in QI contribute to some of these meetings.

Funding has been gained from the Health Foundation through their Building Effective Networks scheme, enabling us to develop a secure social network platform for deteriorating patient collaborative participants. Currently 76% of team members across trusts have signed up to use the system (Doccom.me) providing an effective virtual network.

Benefits

Trusts in north central London achieved an average reduction in cardiac arrests of 36% (33%–50%) by the end of 2012, and a 40% reduction in variance across sites. UCL hospitals achieved a 45% reduction compared with the 2010 baseline, the North Middlesex Hospital a 50% reduction.

The deteriorating patient initiative illustrates several features that are unusual for initiatives within the NHS:

- local ownership;
- strong bottom up culture — the aim, measures and ways of working were all co-developed by the front line clinical teams leading the work in each trust;
- voluntary participation by all trusts;
- creating a community of practice;
- strong sense of shared purpose;
- deep commitment to learning from others to drive local improvement.
- rigorous measurement and use of performance information
- monthly reporting of agreed metrics across trusts.
- openly sharing comparative dashboards from each trust at bi-monthly action learning sets.
- use of quality improvement (QI) analytic system (housed by Great Ormond Street Hospital)
- early focus on acquiring fundamental QI skills.

Financial implications

This initiative was set up with no initial financial investment. Trust leads have continuously driven the aim forward and they see it as a core part of their jobs. Executive teams within the trusts have made individual time and resource commitments to this project in recognition of its value; for example investing in extra critical outreach nurses. There has been great support from Great Ormond Street Hospital's transformation team who have delivered education and provided infrastructure for data analysis and reporting.

After 18 months we invested in 1.2 wte clinical improvement advisors.

Contact

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FINALIST

Using a multidisciplinary team checklist to assure hospital inpatient safety, improve workplace culture, and enhance organisational efficiency

University College London Hospitals FT

The initiative

Failures of the sort that surfaced at Mid Staffordshire were not the result of a lack of medical knowledge, or of the complexity of the cases involved. The reasons were sometimes sophisticated, but the simple fact is that the system failed to maintain basic standards of care for some patients and failed to ensure their safety.

No healthcare organisation is wholly immune from the same risks. Healthcare, particularly in hospitals, is now a complex, multidisciplinary affair, hugely reliant on the successful interaction of services, teams, professions, individual members of staff and, centrally, the patient.

We know, from examples within healthcare and from other complex, safety critical sectors, that there are methods of taking into account human factors to build robust and reliable services that maintain high standards. One of these is to use checklists. Superficially, they act simply to prompt the memory and attention of expert individuals coping with complex tasks and environments. Properly implemented, they are a point of common reference for groups and individuals, providing an opportunity for communication across professional and cultural boundaries, and acting as touchstone for shared standards and values.

We created a ward safety checklist based on the WHO *Safer Surgery Checklist*, listing common but still too often overlooked risks to the safety and quality of inpatient care. We then:

- verified that it covered the most significant generic inpatient risks and issues as understood locally and nationally.
- obtained trust medical director sign off;

- rendered the checklist in a variety of formats, an A4 flyer, a folder insert and a personal security card format, and made it freely available across the trust;
- ran a series of half day training programmes, including simulated ward round encounters using role played patients, training some 700 front line clinical staff;
- incorporated checklist briefings into all junior doctor inductions;
- provided a shadowing service, explaining potential models of checklist use and offering rounding teams feedback on potential improvements to their practice, as well as offering the checklist as a solution to specific issues;
- canvassed senior clinicians, safety, governance and risk leads, and patient governors to endorse checklist use in particular clinical areas.

Benefits

Demonstrating a statistically significant impact of the checklist on the most commonly monitored safety indicators (falls, infection, DVT rates etc) is a complex task, especially in an environment where there are multiple safety initiatives.

The team is currently developing an "at scale" evaluation strategy. Data from short, ward level audits indicates a number of benefits from checklist use, for example Improved likelihood of identifying:

- missing VTE prophylaxis;
- missed falls risks;
- IV site issues;
- antibiotic use beyond prescribed time limit.

Data from observation of ward rounds indicates that checklist use improves consistency in checking known risks, leads to less variant patient encounters and may result in greater cohesion in rounding teams (team members less prone to distraction, less turnover in the team).

Anecdotally, checklist use improves the patient's experience of the round, since it provides a specific pause to check patient understanding and ask questions. Many junior doctors new to the trust appreciate the checklist as an indicator of structure and expectations around ward rounds.

Qualitatively, many staff express anxieties about the extra time initially needed to become familiar with the checklist but believe that reduced variance in rounding practice and more collaborative ownership of patient care plans would improve quality and efficiency.

Financial implications

Development work collating input and formulating the checklist design was done in house by education centre (EC) staff as part of their substantive role, using expertise gained in the surgical checklist programme. Initial artwork costs for final checklist designs, circa £300, was out of EC funds, as were limited runs of laminated A4 versions of the checklist.

Production costs for the credit card version the checklist are approximately 80p per card, and trust medical directors funded an initial run of 2,000 cards. EC staff as part of their role delivered fixed training programmes, and the London Deanery funded the development of a mobile training pack through the Simulation and Technology Enhanced Learning Initiative. Overall, this has to date been a low cost initiative, driven principally as a quality rather than a cost improvement initiative. Nonetheless, there is good evidence that reducing healthcare complaints and errors does result in a net cost saving.

Contact

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FINALIST

The red flag project

West Suffolk FT

The initiative

The red flag project was developed by the trauma and orthopaedic team to improve patient safety and ensure fragile at risk patients with a fractured neck of femur were cared for in the most timely and all encompassing way, while using the available resources most effectively.

We brought together a cross section of staff consisting of nurses, trauma and orthopaedic team, surgeons, geriatricians and physiotherapists, and together they redesigned the existing care bundle. To ensure the multidisciplinary team is aware of which patients are receiving care as part of the project, names are flagged on a central board using a red magnet — hence the initiative's title.

Developing a checklist called a "prescription of care" ensures that hip fracture patients receive early diagnosis and early pain relief, expert care on a specialist ward, rapid surgery, high quality nutrition and therapy to help them regain independence. An hourly high risk rounding tool is used as a prompt and record, in turn minimising the risk of deterioration or further complications.

Our rounding includes assisting patients to take a high calorie drink and snack every two hours, a visit to the bathroom, appropriate footwear and walking aids are available, change of position, repositioning of pressure relieving equipment such as heel protectors and ensuring that the call bell and water is within reach of the patient. In turn, the red flag project identifies the most vulnerable patients that are in need of regular high quality care, reduces the risk of pressure ulcers and falls, and also reduces the average length of stay for the patient.

Benefits

While the main aim of the red flag project has been to improve the care and safety of patients, the project's rounding tool has done much to increase ward efficiency .

One way in which the project has increased patient safety is through tackling and reducing Grade 2 pressure ulcers. Management of pressure damage is estimated to cost 4% of the NHS budget. Since the introduction of the red flag project in May 2009, current audit data reveals pressure ulcers are 91% lower than they were pre red flag.

Hospital falls cost the NHS £15m a year through extra treatment and increased length of stay. They are also hugely damaging to patient health and confidence. Under the red flag project, patient falls have been slashed 58% in three years alone. In addition the mortality rate has fallen by 46% and the average time patients stay in hospital from 13 to 10 days.

Financial implications

There was no financial cost to delivering the project. Through increasing the quality of care and safety of patients, we have saved money in the following areas:

- the 91% decrease in Grade 2 pressure ulcers since 2009 has resulted in annual savings of £116,000, based on the Department of Health pressure ulcer calculator;
- based on the average cost of keeping a patient in hospital of £200–£300 per day, we estimate decreased length of stay has saved our orthopaedic ward hundreds of thousands of pounds a year since the initiative began.

Contact

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WINNER

It's a wonderful life — why every service should have volunteers

Care Plus Group

The initiative

Eight years ago provision of services in North East Lincolnshire for people with COPD and at risk of falls was limited and disjointed. From its inception the HOPE specialist service has been designed and developed through a real cooperative approach between the multidisciplinary team and its users.

We aimed to move away from traditional consultation methods by presenting our patients with the clinical evidence and allowing them to map their needs, rather than presenting established options.

Our initial, handful of volunteers were recruited predominantly by word of mouth from a local respiratory support group, residents of local group dwellings and members of patient forums and older people's groups. Since then recruitment has predominantly been via patients completing rehabilitation programmes and having a new lease of life, experiencing greater energy levels and wishing to give something back to the service.

Two major stumbling blocks stood in our way; the lack of a permanent base and having insufficient funding to develop the clinical team. Then in 2006, Hope Street Medical Centre, a dilapidated GP surgery in a deprived area of Grimsby, was offered to us. The falls and respiratory services joined forces and the Hope Specialist Service was born.

Neighbourhood renewal funding then enabled us to make Hope Street the community rehabilitation setting our patients had asked for during consultation and to employ the multidisciplinary specialist team they wanted.

Our volunteers receive mandatory training similar to that provided for employed staff and they are all DBS checked. As communication is crucial to maintaining positive, motivated volunteers, we hold regular meetings and volunteer workshops and have appointed staff members as volunteer coordinators.

Benefits

The added value of the volunteers is immense. As well as being essential to our rehabilitation programmes as role models and mentors and contributing to the life changing clinical outcomes for patients (both in functional and quality of life (QOL) measures), they:

- facilitate awareness events in the community;
- deliver Tai Chi and chair based exercise classes in community venues;
- take a lead in our smoking cessation clinics;
- run our active support groups;
- cook the food in our café;
- do DIY jobs around the building;
- help maintain our garden;
- act as trustees for our charity (the Hope Street Trust);
- sit on Care Plus Group's council of governors.

In 2012/13, 94% of respiratory patients and 85% of falls patients stated that the volunteers were either essential or very important to the success of the rehabilitation programme,

while 87% of respiratory patients and 73% of falls patients said that they could talk to the volunteers about matters they would not have felt comfortable discussing with a health professional.

Our volunteers led smoking cessation clinic has a long term quit rate of 50%, compared with the national figure of around 20%. The benefits are not limited to the service and its patients, many of our volunteers have continued to show improvements in QOL measures and have aspired to and achieved personal goals. Several have gone on to gain or return to fulltime employment.

Financial implications

Initially, there was not a budget allocated to this initiative. In subsequent years we have appointed a HOPE collaborative worker and our volunteers receive out of pocket expenses resulting in an annual cost of approximately £25,000.

Savings in terms of reduced hospital admissions and A&E attendances for COPD patients equates to an average of £2,600 per patient through the rehabilitation course. Savings for falls prevention are more difficult to quantify as there is no recognised disease progression, however our patient outcomes show clinically significant reductions in falls risk post rehabilitation.

The volunteers themselves contribute an average of 980 hours per month. Based on the national volunteer hourly rate of £11.09, this equates to £130,418 per year. Our volunteers were instrumental in establishing the Hope Street Trust in 2007, it has since gained charitable status and last year recorded an income of more than £24,000. It has financed our outdoor garden/rehabilitation area at a cost of nearly £40,000, as well as purchasing other equipment for the service. The charitable status has also meant that they can apply for funding not previously open to us as an NHS service

Contact

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Judges' comments

- *This is a standout example of empowerment for staff and service users. Owned, led and driven by its community, delivering high quality social, personalised care. It is infectious and an exemplar for the NHS.*

HIGHLY COMMENDED

Successfully delivering a partnership approach to community health

County Durham and Darlington FT, Durham County Council and Northumbrian Water

The initiative

Healthworks was developed to improve health and wellbeing, reduce health inequalities and increase access to local health and community services for the people living in Easington, Horden and North Peterlee.

These areas experience some of the worst health in England with high rates of smoking and obesity, low rates of physical activity and employment and a high proportion of incapacity benefit claimants.

Healthworks focuses on bringing about step changes in health, encouraging local participation and removing barriers to access. Healthworks was launched at the end of 2007, within 12 months providing over 38 different services. It is a formerly derelict building which has now been transformed into a modern facility. It delivers over 80 health and community services/activities from and within the centre; engaging over 120 partners from the public, private and voluntary sector.

The service operates seven days a week from 8.00am to 8.00pm transforming the availability and access of local community based health services. Healthworks was selected as the site for the County Durham, Darzi GP-led walk in service in April 2009.

Healthworks provides a host of community services including free online health information, physical activity programmes, stop smoking support, food cooperatives, educational courses and many others.

Benefits

Healthworks has established better services within the community by innovation, coproduction and collaboration. It is a sustainable, well placed, highly valued and well used community building controlled by local people. It has achieved the following outcomes:

Increased social inclusion — Healthworks has provided a focal point for community development through capacity building and increased consultation and engagement. Eighty percent of services available have been requested by local people, we have response rates of over 50% to surveys and consultations. In addition to this, 70 volunteers have been supporting service delivery; of these 12 have found employment and more than half have received an accredited qualification;

Value for money — the range of activities addresses key problems in health, antisocial behaviour, young people, education and the environment;

Strategic convergence — Healthworks is a focal point for community service delivery that improves access, operational performance and fits with local, regional and national strategic priorities. We have 27,500 visits recorded in 2012/13, and 2,918 new members;

Creation of new partnerships — over 120 partners from public, private and voluntary sector are working together ensuring that mainstream services are more responsive to the needs of local people. Healthworks has also greatly facilitated reciprocal relationships between professionals and local people.

Financial implications

The development of Healthworks came from a mixed funding package of NHS, local authority and external funding (including grant and donations); this paid for the refurbishment works and equipment.

The service is cost effective and requires only six staff for delivery. It was originally commissioned by County Durham PCT (now Durham County Council) who provide staffing and project costs in the region of £200,000; a facilities budget of £100,000 is contributed through room hire, tenancy and agreements.

Services and activities are developed with the idea that they must become sustainable, for example, the gym now pays for itself, support groups have become registered as charities and raise their own funding, learning opportunities have a contribution for continuation.

The coordinator attracted external funding to develop projects including £60,000 for community learning and £45,000 to roll out service to another centre. The return on investment from volunteers has been calculated recently at 1:12.

Contact

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FINALIST

Implementation of a citywide model providing rapid access to 24 hour community based services for adults

Birmingham Community Healthcare Trust

The initiative

The new service model involved the establishment of a 24/7 single point of access to manage urgent and non urgent referrals. This involved the development of a rapid response service to respond within two hours to urgent referrals and integrated multidisciplinary teams which manage all non urgent referrals for all community services and offer a response between four and 48 hours.

The improvements requested by service users were incorporated in the new model and include:

- easier access at any time;
- quicker and appropriate response;
- one person coordinating the care programme;
- one patient record easily accessible and shared;
- closer working with social and secondary care.

A programme management approach was developed to ensure the successful implementation of the new service model. Real engagement with service users, clinicians and key stakeholders was embedded throughout the process.

A series of mapping events were undertaken where stakeholders considered the national/local evidence, the current local state and shaped the future state. The team approach was clinically led by senior clinicians across the health economy including a GP, consultant geriatrician and senior nurses and AHPs. The telemonitoring service was expanded once the single point of access and rapid response service were established. Current roll out of mobile working technology will facilitate greater flexibility and efficiency.

Benefits

The single point of access is receiving an average of 500 referrals a week, of whom 200 are being kept out of acute hospital

thanks to rapid response care being provided in a community setting. The remainder are being appropriately referred to alternative service provision. As a result, increase in A&E activity in Birmingham is less than the national rate.

Acute admissions via A&E were down by 10.5% on average compared with winter 2011/12 and total A&E activity across the city was flat during 2012/13. The new model has radically changed the way referrals and caseloads are allocated and managed. This has resulted in patients receiving appropriate care at the appropriate time by the most appropriate person.

There is evidence of efficiency gains such as a reduction in DNAs and waiting times for treatment and assessment. There has also been an increase in activity and face to face contacts following a skill mix review and workforce redesign.

Other benefits include:

- increase in the ambulatory care sensitive condition activity that is deemed admission prevention;
- increase in the number of face to face district nurse contacts per wte staff;
- development of integrated care pathways to deliver care closer to home — for example the expansion of current IV and DVT therapy services;
- increase in number of patients accessing telehealth technology within the community;
- improved working relationships between partners in the health and social care economy.

The rapid response service is currently responding to 97% of referrals within two hours, which is exceeding the 95% commissioning target.

Financial implications

An initial investment of £2m was required to transform the infrastructure and workforce under previous organisational structures. During 2012/13, a £40,000 investment was made to fully implement a citywide single point of access incorporating rapid response and 47 integrated multidisciplinary teams.

It is projected that the local health economy will realise a return on the initial investment in the service by 2015. The future development of the model supports the introduction of a community tariff aligning income to activity through the identification of QIPP savings eg reduction in hospital beds / length of stay. The telemonitoring service has reduced emergency admissions by up to 70%, resulting in projected £250,000 savings.

Contact

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FINALIST

Improving care within the community setting by redesigning services and implementing an integrated care framework

Erewash CCG

The initiative

This initiative was designed to provide better care closer to home by providing continuity of care within an equitable, needs based, service. This was achieved by forming a project board and an implementation group that included representation by:

- the CCG;
- Healthwatch;
- social care;
- NHS provider organisations including mental health;
- secondary care;
- the voluntary sector.

Key developments were:

- a single point of access to provide seamless urgent/short term care;
- community delivery teams to provide seamless proactive longer term care and case management and care coordinators.

The aims and objectives were to:

- provide a coordinated service to receive urgent/short term care and longer term case management referrals;
- facilitate and coordinate the required provision of care;
- monitor the delivery of care to ensure health and social care input is received in a timely manner;
- improve accessibility to community services (health and social care);
- decrease time spent by referrers navigating services;
- facilitate input from wider supporting services within the community;
- reduce unplanned attendances at A&E and admissions.

In order to do this six new integrated Community Delivery Teams (CDTs) have been formed, with an assigned care coordinator for each team who proactively identifies patients by risk profiling.

Benefits

Each service within the new framework has defined pathways, standards and outcomes. A single point of access is operational, there have been 1,811 referrals since November 2012, and 61% of acute admissions were avoided.

Patients now receive a rapid response service by health and social care. Care coordinators are identifying patients who are at high risk and require case management. More patients are case managed with a clear criteria for responsibility whether social care or health.

Weekly or fortnightly CDT meetings are held within each GP practice to discuss patients, who are risk stratified using various information sources including the RISC tool and proactively managed.

Financial implications

The total additional funding for the framework was £399,648. 1,104 acute admissions are reported to have been avoided since November 2012 by using the SPA. The average cost of an admission for Erewash CCG is £1,653 giving an overall saving of more than £1.4m.

Contact

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FINALIST

Knowsley Community COPD service: "Integrated specialist COPD care in the heart of the community" an expert multidisciplinary team delivering a highly accessible patient centred service

Liverpool Heart and Chest Hospital FT and Knowsley CCG

The initiative

Knowsley is the 5th most socially deprived local authority in

England with 150,000 residents and mortality rate twice the national average. The initiative was developed for Knowsley PCT to address marked health inequalities exemplified by a local prevalence of COPD of 3.2% (5,053 patients), which is more than double the national prevalence.

A seamless, patient-centred pathway was essential to help improve the early diagnosis management and outcomes for patients with COPD. Data is analysed from our web-based platform for performance management, audit and research.

A consultant leads our multidisciplinary team five days a week in six different community locations. The pathway is highly accessible, and was developed in response to patients' views after extensive consultation. The long term benefits include improving health outcomes and quality of life for patients and their carers while reducing the financial burden of avoidable admissions. It provides a necessary link between primary and secondary care services, complementing acute services and reducing waiting times across the whole pathway.

We used patient expert group feedback to amalgamate the skills of different members of the multidisciplinary team to create a one stop service to address the patient needs. In each clinic we have:

- a chest consultant;
- two COPD specialist nurses;
- a physiotherapist;
- two respiratory physiologists;
- a psychotherapist
- a smoking cessation counsellor.

Our template for daily appointment schedule consists of:

- 14 follow up patients;
- 18 new referrals;
- 24 patients for annual spirometry;
- four emergency appointments for patients who are acutely unwell.

Domiciliary visits are done jointly between the consultant, nurse and physiotherapist. The team optimise treatment (including inhaler technique and oxygen assessment), promote education and self management, provide holistic symptom management and advance care planning.

Specialist nurses in the community provide rapid response home visits 7am-10pm (with a 24 hour helpline) to manage exacerbations, prevent hospital admission and provide early supported discharge.

Physiotherapists provide patient education and recruit patients for the eight week, rolling, pulmonary rehabilitation which is available at six local community locations and one hospital based location, five days a week.

The psychotherapist assesses and treats those with anxiety and depression; the "FagEnds" counsellor gives smoking cessation advice and treatment.

We have close links and regular meetings with local palliative care and community nursing teams. Primary care links are enhanced by regular educational meetings and we have liaised closely with acute trusts to promote the early supported discharge service. We also have close ties with tertiary services including lung transplant assessment, domiciliary non-invasive-ventilation and thoracic surgeons.

Benefits

By providing education about COPD, how to recognise a flare up and supported self management, patients are empowered to take responsibility for their own health. Choice is provided in place and time of clinic appointments. Patients have the opportunity to receive supported treatment at home during exacerbations. Other benefits of the initiative include:

- 26% reduction in hospital admissions;
- 96.4% of patients seen within 15 working days of being referred;
- all patients receive a full single visit assessment by the team and have a personalised management-plan;
- all smokers offered support to quit;
- all eligible patients are referred for pulmonary rehabilitation;
- 92.3% of patients requiring face to face contact are being seen at home within two hours;
- all eligible patients are accepted for early supported discharge.

Contact

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FINALIST

Cancer as a long term condition; practice nurses, an untapped resource to support people after primary cancer treatment

Macmillan Cancer Support

The initiative

The cancer story is changing with more than 50% of people living at least five years after diagnosis. However this is not without cost; studies have shown high incidence of unmet needs.

As alternative models of follow up are explored, we wished to see what the learning needs of practice nurses are to take on an extended role in the support of people affected by cancer in primary care, and how best to meet these.

Ten practice nurses met in facilitated groups for nine half day sessions over eight months. Each had the support of their practice and a nominated GP, and was expected to liaise with colleagues between sessions. The curriculum for the course was negotiated and developed as the course progressed; there was user involvement throughout.

Speakers covered the pathophysiology of cancer and different treatments, recurrence and late adverse effects, communication skills and motivational interviewing, information prescription and diet, exercise, lifestyle in cancer survivorship.

A focus of the course was the knowledge and skills to carry out a high quality holistic cancer care review and participants were encouraged to do this, both proactively and opportunistically, reflecting with their peers on successes and challenges.

Benefits

Independent evaluation has shown that as well as a self reported increase in knowledge, skills and confidence, the nurses now feel able to respond to patients' concerns differently. This was confirmed in the one to one interviews three to four months after the course.

One nurse said that now she felt empowered describe herself as "the nurse in the practice who links with patients undergoing cancer treatment" and to invite patients' questions. Another commented that previously she "would not have known the right questions to ask" to allow a patient to discuss her worries.

The nurses identified increased knowledge of cancer and its treatment as underpinning their improved confidence. They reported better understanding of cancer as a long term condition and enhanced knowledge of how to encourage people to self manage.

They reported increased use of tools such as the distress/concerns thermometer in patient assessment and better awareness of the resources and information available. The nurses also identified their role in supporting colleagues, both clinical and administrative who were caring for people with cancer.

Some had taken a key role in initiating services such as scheduled cancer care review appointments and most had shared their new knowledge with colleagues either in formal education session or opportunistically. The PPiP questionnaire score highlighted high satisfaction in being able to ask what the patient wanted, to receive the information wanted, to be able to discuss concerns and fears with high levels confidence in the ability to cope and self care with all results exceeding the national mean benchmark

Financial implications

Macmillan Cancer Support met all costs for this pilot. The costs of the initial course included £1,000 bursary for backfill to each nurse's practice as well as travel costs. Macmillan funded extra time to the leader, a Macmillan GP advisor, for the planning and delivery of the course and gave administrative support. They also paid speakers fees and travel for the presenters who came from outside the organisation and for an external evaluation of the course.

The financial benefits are difficult to assess but many believe that informed patients whose confidence to self manage their condition is high, are less likely to make demands on a variety of services particularly those out of hours. In the longer term a shift from hospital based follow up to appointments in primary care may represent better value though quantifying these savings will be difficult.

If practice nurses are, as we believe, effective in encouraging people to make healthy lifestyle choices and in particular increase exercise, there should be long term savings reflecting improved wellbeing, decreased morbidity and demand for medical care.

Contact

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FINALIST

Northumberland frail elderly pathway

Northumberland CCG, Northumbria Healthcare FT and Northumberland County Council

The initiative

Northumberland has a higher than average elderly population with the all of the attendant issues relating to multiple co-morbidity and complex care needs. It also has a very high rate of non elective admissions across all age groups. A study conducted across Northumberland in 2010 suggested that the integration of primary health care teams had been eroded and that continuity of care for older patients with complex needs may have suffered as a result.

The aim of this initiative was to rebuild integrated ways of working and coordinate care across all parts of the health and social care sector for older patients at high risk of unplanned hospital admissions.

A project board including directors and senior managers from Northumberland CCG, NHFT, Northumberland County Council and the local medical committee was set up. Aims, objectives, metrics and coding were agreed by all parties in order to deliver consistency of approach and the ability to monitor progress. Investment was made into both primary care and community nursing teams in order to free up capacity to deliver the enhanced level of care and develop multidisciplinary way of working.

Practices were engaged with via the four localities of the CCG. All but one of forty six general practices signed up to take part in the initiative. Primary healthcare teams including GPs, community matrons and social workers now meet every month to discuss patients on the frail elderly registers and are proactively identifying and managing risk factors.

Patients receive the same assessment whether they admitted to an elderly care ward or identified in the community. Feedback from patients, GPs and community nurses, and a series of locality based multiagency events have helped to identify issues, share best practice and problem solve as the project has progressed.

Benefits

For the three years to April 2012 there was a steady and continuous rise in non elective admissions across Northumberland. Since the Frail Elderly Pathway was launched in April 2012 we have seen the number of admissions fall from a peak of over 3,500 to just over 3,000 in November 2012. Over the same period we have seen a similar reduction in 30 day emergency readmissions.

As of 30th November 2012 there were 850 patients on the Frail Elderly Pathway across Northumberland and 560 of these had had a multidisciplinary team review in the previous month. Primary health care teams have reported improved morale, communications and relationships within primary care and with secondary and social care colleagues.

Patient feedback indicates that there have been significant improvements in how well patients feel informed, empowered and supported. Overall patient satisfaction has improved to 90% from 68% at baseline.

Financial implications

£700,000 was invested across Northumberland to recruit 12 new full time community nursing posts. These nurses provide backfill for the existing community matrons to enable them to take on the care planning work. The money also provides a full time hospital pharmacist to work in general practices and patients' homes, and consultant geriatrician time to support practices with the management of complex patients in the community.

A further £330,000 was invested into primary care as a local enhanced service. This funding covered backfill for GPs to attend monthly multidisciplinary team meetings, to conduct the comprehensive medical assessments and to complete the necessary administration, including writing of care plans and notification to out of hours services.

The delivery of comprehensive geriatric assessments for patients admitted to elderly care wards was incorporated into the acute trust's CQUIN, so did not require additional financial resource. The initiative is starting to reduce acute hospital admissions and is a key component of Northumberland CCG's financial recovery plan. £2m cost efficiencies are attached to the Frail Elderly Pathway for 2013/14, which has been agreed with the area team to be a realistic target.

Contact

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FINALIST

Breathe well COPD pathway

Oxford Health FT

The initiative

People with COPD are three times more likely to experience common mental health problems than the general population. This co-morbidity results in poorer clinical outcomes and increased costs for the NHS. Evidence suggests that the most effective method of treating COPD patients is through an integrated physical and mental health care approach, as opposed to overlaying psychological interventions onto the existing physical care pathway.

Commissioners in Buckinghamshire re-designed the respiratory care pathway during 2011 and as part of this were keen to include psychological wellbeing. The new pathway took effect from April 2012 and psychological support was integrated into both primary and community interventions.

Key quality issues were:

- untreated anxiety and depression in COPD patients, leading to poorer health outcomes, impaired ability to self-manage or engage with rehabilitation;
- the need to improve diagnosis and treatment early on in primary care;
- the need to prevent unnecessary hospital admissions;
- the need to improve self-management for some COPD patients.

The development team was drawn together to build a case for Department of Health pathfinder funding and comprised of clinical leads from IAPT, GP commissioners, a project manager, a data/evaluation lead and the community respiratory team.

This core team worked with a wider group of stakeholders including the Breath Easy service user and carer group, nursing leads, GPs and commissioners.

Clinical leads defined stages of the respiratory pathway and how psychological care could be integrated within this. The principle was to provide the right level of care at the right time "Least intervention first time".

The views of patients and carers were incorporated in designing an integrated psychological/physical care pathway that was acceptable and accessible. This needed to be offered at the point of delivery of care, within a multidisciplinary team and supported by effective communication — this addressed the stigma often associated with mental health problems.

Primary care and other clinical staff were involved in shaping how the pathway was delivered and encouraged to raise issues/observations in an open and honest way. Problems were discussed in GP locality meetings and solutions brokered by the GP mental health lead, who was very supportive of the work.

Benefits

Though the project is still in its active phase, preliminary outcome data for 63 patients show encouraging results. Patients' self-efficacy — crucial to successful self-management — showed statistically significant improvements post-clinic intervention. Staff have joint training and supervision and report feeling more skilled and confident.

A healthy minds therapist said:

> "We are getting physical and mental health teams talking and working towards innovative solutions in providing effective health care. We have also been able to talk to patients in predominantly physical health care environments about mental health issues and this has resulted in people being able to learn about how to manage anxiety and low mood in relation to their condition. We believe that many of these people would not previously have realised that they could have access to psychological support."

Patients satisfaction questionnaires show 90% rate their care as "good" or "excellent".

Patient feedback:

> "I could talk to Lorna (from healthy minds) about feeling anxious and not going out and doing things I used to enjoy. I now have some tools for coping with this and I've started to go out again."

Financial implications

There was a resource implication of £128,000 for the first year. The economic evaluation of the pathway is not complete, however national evidence would support savings of £1,670 per patient.

Contact

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FINALIST

Improving outcomes and experience for elderly patients with complex health and social care needs; a whole system approach

Royal Free London FT

The initiative

Improving outcomes and experience for elderly patients with complex health and social care needs requires a whole system approach. The Royal Free has an explicit strategy for integrated care that allows us to secure sustainable, patient focused, whole system solutions.

The delivery of an integrated care strategy would not be possible without a determined focus on the continual development of strong and effective partnerships. By having mutually beneficial partnership arrangements with our local community, social care, primary care, third sector and other secondary care providers, we have been able to secure sustainable change and the redesign of critical patient pathways to deliver better quality services in a more cost efficient way.

Detailed clinical discussion took place across primary, secondary, community and social care and the concept of two service models was created; PACE and TREAT. Patients and carers were involved from the earliest stages of planning.

PACE — delivers the later part of an acute episode of care in an out of hospital setting, under the auspices of the acute team. Onsite community clinicians act as case finders, integrated with the acute team, to provide a "pull" system to safely manage the patient to their normal place of residence as soon as is clinically appropriate.

TREAT — consultant led rapid access investigations, interventions, emergency social packages and, with the support of PACE, a safe return to the community. Post discharge follow up includes an A&E based rapid access "hot clinic". The service also provides specialist triage and outreach nursing working with GPs, community teams and care homes.

The services operate as a managed supply chain, with the Royal Free as the lead provider. All partners agreed the pathways and the clinical and operational policies that support them. The services were set up as pilots using an iterative clinical model (and a PDSA cycle) that was refined on numerous occasions during the first year of operation.

The partners meet monthly to review performance against agreed KPIs and consider issues on the shared risk register and issues log. Any complaints, incidents or patient feedback are considered at these meetings and acted upon accordingly

Benefits

The impact of PACE & TREAT on patients cannot be underestimated — both in terms of how the service is perceived and the positive benefits of being able to be cared for in their own homes. Patients' experience is measured continuously across 12 categories including indicators developed by the team and those that matter most to patients.

Between September 2010 and July 2012 there were 2,000 episodes of care completed on PACE. Less than 5% of patients were readmitted during a PACE episode and there has been no negative impact on 30 day readmissions. In the same period 1,220 TREAT pathways commenced, with inpatient admission avoided in 79% of cases.

There has been a three day reduction in length of stay for patients with a non elective admission aged over 70. For acute geriatric medicine is has fallen by over two days. Since PACE and TREAT commenced approximately 20 fewer beds were consumed by acute geriatric medicine.

Comparing 2011/12 to 2010/11 there was a reduction in excess bed days amounting to of £1.9m for NCL commissioners.

Financial implications

The national and local economic context requires very significant levels of cost reduction and efficiency gain over the next three years. This in turn will result in substantial income reductions across the acute sector.

The development of integrated pathways enables us to mitigate some of this income loss while reducing our cost base. The financial situation is a major challenge facing the whole NHS. The Royal Free faced a savings target of £25m having already delivered £33.5m in savings the previous year, identified through our local version of the national quality innovation productivity prevention (QIPP) programme.

PACE and TREAT directly contribute to our QIPP programme, which has a focus on the delivery of sustainable change and the redesign of critical patient pathways to deliver better quality services in a more cost efficient way. Investment in community services by the Royal Free has shown a positive return on investment through the closure of one whole ward as a result of the reduction in length of stay and admissions avoided.

Contact

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FINALIST

Wandsworth community wards

Wandsworth CCG

The initiative

The Wandsworth Community Ward was originally started in 2011 and was derived from two pilot virtual ward projects that had demonstrated some early potential for savings. The programme was in line with the national drive to develop integrated multidisciplinary working across the health and social care sectors.

Wandsworth Clinical Commissioning Group commissioned Community Services Wandsworth to deliver a GP led community ward programme that would:

- identify patients who may benefit from an integrated multidisciplinary approach to their care;
- ensure a collaborative approach to assessing and managing patient's health and social care needs;
- provide ongoing continuity of care.

The principal aim of Wandsworth Community Ward is to prevent hospital admissions and to keep patients safe and healthy at home. Through use of a stratification tool, and by observation in secondary and primary care, high risk and high need patients are identified and supported to manage their conditions at home. Regular multidisciplinary team meetings serve as a practical platform for integrating health and social care staff. The presence of senior clinical leadership in the team serves to facilitate and maintain integrated working. As a result, patients are cared for in a holistic manner which addresses both their health and social care needs.

Patient and public involvement has been at the heart of the process from the beginning. A series of workshops have enabled patients to engage with the development of the model, while an on going feedback process has served to ensure that operational issues are ironed out effectively. The group developed a model that is based on a combination of the best aspects of two pilot projects plus a number of innovative adaptations that emerged during the development process.

The models in Wandsworth are unique in having full time GPs employed on the ward, which has served to facilitate and maintain integrated working, while the addition of a pharmacist and a social worker to each of the core ward teams has enabled a more joined up approach to care.

Benefits

According to NHS England 2012/13 figures (stratified by deprivation), Wandsworth now has the sixth lowest emergency admission rate in the UK and when raw numbers are considered, Wandsworth patients have the second lowest emergency admission rate in the country.

During 2012/13 a total of 291 patients benefitted from the service. By following individual patients we have demonstrated a 34% reduction in emergency admissions and a 22% reduction in A&E attendances at six months post admission. We have also shown a fall in the average length of stay from 10.96 to 9.59 days.

Financial implications

The Wandsworth Community Ward programme has achieved demonstrable success in reducing emergency admission and attendance rates in Wandsworth and in doing so has generated savings of approximately £400,000 in the nine months, April to December 2012 with projected savings of £500,000 in 2012/13. These savings included a disbenefit of increased outpatient appointments as patients were stabilised through the activity of the team.

At full capacity (400 patients benefitting per annum) the potential annual savings delivered through the community ward could be as high as £1.4m gross. Since April 2012 an annual investment of £1m has been made for the day to day running of the community ward (which includes non recurrent development costs). By 2014/15 Wandsworth will be on track to make a saving against the annual investment into the service as well as realising considerable benefits to patients.

Contact

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WINNER

"Right Patient, Right Product, Right Time, Right Outcome" clinical and cost effective nutritional treatment of malnutrition

Leeds Community Healthcare Trust

The initiative

Malnutrition is both a cause and consequence of disease, affecting at least three million UK adults, 93% in the community, costing £13 billion per year. Food should be first line treatment for anyone identified at risk of malnutrition. However, oral nutritional supplements (ONS) are often inappropriately prescribed to treat malnutrition.

An understanding of the complexity of care in the community, aging population and increasing spend on ONS locally led to the setting up of a pilot project to audit current ONS prescribing. A local GP, practice manager and pharmacist were champions and advocates for the work and team, promoting the project and helping the team overcome boundaries and barriers.

This group, alongside the community dietetic department formed the core project team driving the work. The pilot revealed poor compliance with standards of good practice for ONS prescribing, with less than one in five appropriately prescribed. The standards were met with good patient outcomes where patients:

- had access to a dietician;
- were appropriately assessed for ONS;
- received dietary advice; were regularly monitored and supported.

As a result of the findings the project team were successful in achieving transformation funding to undertake this project citywide. The aim was to address malnutrition in the community and reduce inappropriate prescribing.

We recruited a team of dieticians, dietetic assistants and speech and language therapist. The service undertook patient and public involvement in the development and comprehensive marketing campaign.

Benefits

The benefits generated by this initiative are:

- improved patient care — patients have reported improvements in the quality of care received. "You're the first person who has listened to us and given us practical advice about how to gain weight and not just given us a drink or ignored us. Thank you";
- improved patient outcomes — we developed and had validated the first six dietetic Therapy Outcome Measures (Enderby TOMs) to assist in measuring the outcomes for patients and are implementing these scores;
- reduction in expenditure on ONS;
- better screening for risk of malnutrition — we have seen a four fold increase in referrals for under nutrition in the first quarter of activity, against the same quarter last year, with 100% of GP practices referring;
- additional cost savings from reduced GP visits, fewer prescriptions for other medications and a lower rate of hospital admission.

This work has been well received by the CCGs, helped raise awareness of malnutrition and the profile of dietetics locally. The project team's professional relationships have led to other wider benefits and improvements beyond this project in addressing nutrition issues in Leeds.

Smaller scale procurement focused projects have taken place elsewhere. This is the first large scale patient focused work, where dietitians see ALL patients at risk of malnutrition. The additional benefit is the CCG saving, which although not saving the community trust money, does save across the health and social care economy.

Financial implications

The investment in the pilot was £18,000, generating a net saving of over £60,000 in Leeds North CCG for the participating practices. This led to the investment in the LE&DT from November 2012 until March 2014 at £148,000 per annum to establish a city wide service.

The target saving for the 1,000 patients to be seen by the service by March 2014 was set at £450,000; the saving for the first 12 weeks of available data is £360,000 for 290 patients. This will continue to rise as patient numbers increase. This is generated by preventing unnecessary prescribing either at start of treatment or by ensuring correct prescribing, getting the right patient on the right product at the right time for the right length of time.

Contact

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Judges' comments

- *Food-first approach, rather an over-reliance on medicine.*
- *Simple and person orientated.*
- *Well targeted and managed.*
- *A simple and effective intervention to an address an under-recognised and growing problem.*
- *Impressive results from early phase of implementation.*

FINALIST

It's a wonderful life — why every service should have volunteers

Care Plus Group

Eight years ago provision of services in North East Lincolnshire for people with COPD and at risk of falls was limited and disjointed. From its inception the HOPE specialist service has been designed and developed through a real cooperative approach between the multidisciplinary team and its users.

We aimed to move away from traditional consultation methods by presenting our patients with the clinical evidence and allowing them to map their needs, rather than presenting established options.

Our initial, handful of volunteers were recruited predominantly by word of mouth from a local respiratory support group, residents of local group dwellings and members of patient forums and older people's groups. Since then recruitment has predominantly been via patients completing rehabilitation programmes and having a new lease of life, experiencing greater energy levels and wishing to give something back to the service.

Two major stumbling blocks stood in our way; the lack of a permanent base and having insufficient funding to develop the clinical team. Then in 2006, Hope Street Medical Centre, a dilapidated GP surgery in a deprived area of Grimsby, was offered to us. The falls and respiratory services joined forces and the Hope Specialist Service was born.

Neighbourhood renewal funding then enabled us to make Hope Street the community rehabilitation setting our patients had asked for during consultation and to employ the multidisciplinary specialist team they wanted.

Our volunteers receive mandatory training similar to that provided for employed staff and they are all DBS checked. As communication is crucial to maintaining positive, motivated volunteers, we hold regular meetings and volunteer workshops and have appointed staff members as volunteer coordinators.

Benefits

The added value of the volunteers is immense. As well as being essential to our rehabilitation programmes as role models and mentors and contributing to the life changing clinical outcomes for patients (both in functional and quality of life (QOL) measures), they:

- facilitate awareness events in the community;
- deliver Tai Chi and chair based exercise classes in community venues;
- take a lead in our smoking cessation clinics;
- run our active support groups;
- cook the food in our café;
- do DIY jobs around the building;
- help maintain our garden;
- act as trustees for our charity (the Hope Street Trust);
- sit on Care Plus Group's council of governors.

In 2012/13, 94% of respiratory patients and 85% of falls patients stated that the volunteers were either essential or very important to the success of the rehabilitation programme, while 87% of respiratory patients and 73% of falls patients said that they could talk to the volunteers about matters they would not have felt comfortable discussing with a health professional.

Our volunteers led smoking cessation clinic has a long term quit rate of 50%. The benefits are not limited to the service and its patients, many of our volunteers have continued to show improvements in QOL measures and have aspired to and achieved personal goals. Several have gone on to gain or return to fulltime employment.

Financial implications

Initially, there was not a budget allocated to this initiative. In subsequent years we have appointed a HOPE collaborative worker and our volunteers receive out of pocket expenses resulting in an annual cost of approximately £25,000.

Savings in terms of reduced hospital admissions and A&E attendances for COPD patients equates to an average of £2,600 per patient through the rehabilitation course. Savings for falls prevention are more difficult to quantify as there is no recognised disease progression, however our patient outcomes show clinically significant reductions in falls risk post rehabilitation.

The volunteers themselves contribute an average of 980 hours per month. Based on the national volunteer hourly rate of £11.09, this equates to £130,418 per year. Our volunteers were instrumental in establishing the Hope Street Trust in 2007, it has since gained charitable status and last year recorded an income of more than £24,000. It has financed our outdoor garden/rehabilitation area at a cost of nearly £40,000, as well as purchasing other equipment for the service. The charitable status has also meant that they can apply for funding not previously open to us as an NHS service

Contact

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FINALIST

Primary care dementia practitioners provide skilled support for people with dementia from diagnosis to end of life in GP practices

Cornwall Partnership FT

The initiative

An estimated 9,089 people in Cornwall and the Isles of Scilly have dementia, and this number will continue to increase as the population ages. Conservative estimates rate this increase in dementia prevalence as 38% by 2021.

National and local evidence shows that people with dementia and their carers want a named professional who takes the lead in coordinating their care. Previous pilots in Cornwall identified that primary care dementia practitioners (PCDPs) linked to both mental health and primary care services provided the only sustainable option.

Previous services and pathways of care were not meeting the increasing demand to offer support following early diagnosis and had become limited to delivering this part of the pathway and ongoing coordination. We believed service redesign could provide high quality, consistent, anticipatory and effective care that is integrated with GP practices and primary care services.

Efficient, high quality primary care is fundamental. The service integrates secondary and primary care services, the person with dementia and their carer to provide personalised care from pre-diagnosis to end of life. Evidence suggests it has the capacity to reduce crisis and subsequent avoidable admissions. It reduces bottlenecks and duplication and creates a countywide consistent service for the future.

A project team and project board were established to review current pathways including dementia inpatient care, community care and care home support services to develop a plan and to implement the changes required.

The review concluded that increasing demographic need

could be met by one specialist dementia ward of 24 beds with an enhanced specialist multidisciplinary team of staff. These staff would deliver an assessment and treatment pathway supported by enhanced and increased community services and care home service.

The key objective was for the PCDP practitioner to align with primary care, third sector and volunteer services in the local community and to fully integrate these services with secondary care. Feedback from Cornwall's dementia, memory cafes and carers' groups ensured that people with dementia and their carers shaped the service.

There were some barriers in the initial stages in engaging with practices. The service has overcome issues related to information sharing, access to QOF data and record keeping and now all GP practices are using this service.

Benefits

Dementia presents a significant and urgent challenge to health and social care in terms of both numbers of people affected and cost. It is also a major personal challenge to anyone experiencing early symptoms and seeking diagnosis

The service allows for timely interventions when physical/ mental health changes dictate. Due to working relationships with GPs there has been an increase of 41 in people diagnosed with dementia. GPs are diagnosing with the support of PCDPs creating future capacity.

Previous audits show patients were excluded from referrals to health specialists, 111 people have already been referred with evidence of improved physical health. Supported carers can care for longer: one PCDP has implemented 25 carers emergency cards taking the worry out of caring.

People who are end stage dementia have been included in a bespoke EOL pathway resulting in people dying in their own homes and not in acute hospitals/care homes. 1,033 contacts with patients/ and carers resulted in 100% satisfaction from a patient survey.

Financial implications

The approach was has been funded through three key streams:

- remodelling service provision across the dementia pathway within CFT;
- £200,000 pump priming to develop the model through commissioning for quality and innovation (CQUIN);
- successful application to the Prime Minister's Dementia Challenge Fund.

The model has potential to generate savings across the whole health and social care community. More than 9,000 people have dementia; with a cost per person of £28,000 the total expected cost to the economy in Cornwall is £254.5m.

Contact

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FINALIST

Rectory road project

Derbyshire Community Health Services (DCHS)

The initiative

Following a period of change and mergers within a GP practice serving a population of 18,000, the community nursing team were spending a large amount of time (an average of 2.5 hours per day) planning caseloads and patient visits.

The team were finding it difficult to plan daily patient visits and were experiencing a high volume of calls from patients and residential homes enquiring if a member of the nursing team would be visiting. They were struggling to have time for planning, training and managing the workload.

A change in management and staffing provided the team with the opportunity to take a step back and look at the workforce planning and allocation of patient visits.

Staff Nurse Joan Pons Laplana brought a data capture tool from a previous role and identified basic planning requirements with the team and developed the tool.

The tool is an Excel spread sheet used to record:

- patient demographics;
- colour coding, in line with the trust's referral criteria and response times;
- admission and discharge date;
- units allocated by the trust's caseload weighting tool;
- staff member.

The tool is ordered by geographical areas enabling staff to plan their travel efficiently.

The aim of implementing the tool was to plan patient visits geographically, improve patient experience, and manage capacity. Once the tool had been set up, patient data was entered during December and January and the tool started being used for planning in January 2013.

Initially, Joan managed the tool, including data entry, caseload planning and reporting. Following support from IT, the whole team are now using it, and a user guide is being developed.

The project has been a small in-house development to ensure an efficient use of time and the benefits of the tool are now being evidenced to share across other teams.

Further development of the tool including standardising data and consistency of data entry has enhanced the tool. The team have had training in the tool to ensure high quality data and reduce dependence on one member of staff.

Benefits

The tool has been in use since January 2013 and the team have benefited from:

- time and cost savings;
- improved communication between patients, residential homes, the practice, and staff;
- efficient planning and use of time.

The daily patient allocation meetings have been reduced from 2.5 hours to 15 minutes. Daily answerphone messages to enquire if a nurse is visiting have been reduced on average by 90%. Demand and capacity has been evidenced and there followed an increase in staffing levels.

The team are able to plan training for days with lower demand, which has improved the workforce skills and competencies. Patient experience has improved as patients are aware which day a nurse is visiting. Time in residential homes is maximised as the homes are faxed a list of which patients are to be seen, to ensure they are ready.

Patients in residential homes have been educated by the team to reduce unnecessary visits. Weekend working is maximised by efficient planning. Patients discharged from hospital are seen when needed.

Reporting is easier for Datix and management reports. Resources are used efficiently and effectively. Community nurses are been able to spend more time caring for patients improving the experience and satisfaction for patients and members of staff.

Financial implications

There were no financial expenses as the team developed this initiative from their own desktop computer.

Contact

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FINALIST

Crisis response falls team

East Midlands Ambulance Service Trust

The initiative

The Crisis Falls Response Team (CRFT) was created to meet a demand for better falls services and to dovetail with support services provided by Northamptonshire County Council.

The standard ambulance response prior to CRFT was, often, either a manual lift of a person who has fallen, or a further response with appropriate equipment. In both cases, a person who had fallen may be left in situ for a significant period of time, causing secondary injuries, exacerbating primary injuries and, ultimately and potentially, reducing quality of life or reducing life expectancy.

Discussions were initiated between several organisations over the make up of the CRFT. This team would be made up of a qualified paramedic and emergency care assistant using a bespoke vehicle specially converted to carry a wide range of lifting equipment and with an ability to transport patients, where required.

The members of this team would also be trained through the University of Northampton in enhanced patient diagnosis; this education saw paramedics and social care staff training together. This provided each sector with a unique insight into each other's roles. The core aim of the education was to enhance patient safety, experience and reduce conveyance to hospital from around 65% to 40%.

Benefits

Between April 2010 and March 2011 around 12,000 people fell in Northamptonshire and called for support from the ambulance service, representing approximately 20% of the total deployment to demand for the county. The transportation rate of this patient group to hospital was 66%.

Since its inception, the CRFT have been dispatched to approximately 1,400 patients with a conveyance to hospital rate of 40.4%. The performance results for 2012 have seen a net reduction of 2,100 deployments on the previous year.

The conveyance rates for patients to hospital were lower during the hours that the falls ambulances were in service than when only general ambulances were running.

The feedback offered from patients about the service was overwhelmingly positive; interventions were considered to be timely and staff were considered friendly, approachable and well informed.

Almost everyone responding to the questionnaire felt that they were respected as an individual, treated with dignity and appropriately consulted about their care; 87% of CRT service users felt that the team had enabled them to have maximum choice, control and independence; 98% of those responding to the questionnaire reported the support that they received from CRT had made a difference to them.

Financial implications

The team's intervention either avoided a hospital admission directly or facilitated a discharge directly from A&E in 1,206 cases. After assessment, 156 of these patients were admitted to hospital, giving 1,050 avoided admissions. Based on the average length of stay for a general medical patient, this would then have cost the NHS a total of £1,644,300.

If the estimate for a falls patient is used, this becomes £2,940,000. In this period, the Crisis Response Team accepted 1,311 referrals, giving a total cost to the Crisis Response Service of £1,019,958. This represents a total saving of circa £1,920,042

Contact

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FINALIST

Minor injury and illness service

Miriam Primary Care Group

The initiative

Wirral GPCC has a key strategic objective to:

- reduce patient attendance at A&E within standard GP hours;
- create wider access to care for minor conditions throughout extended opening hours including weekends and bank holidays.

The strategic aims also aspired to create at least four localised access points to nurse led treatment points for minor injuries and illnesses spread across its geographical area.

The services were designed to be delivered from local GP premises and available to any patient regardless whether they were registered at the location or not, as an alternative to using A&E.

Analysis of patient activity at established points for unplanned care such as walk in centres highlighted a number of minor conditions that could be treated in primary care settings such as GP practices.

Feedback from patient groups and postcode analysis of patients accessing local centres demonstrated indications that where a facility is localised, patients within the immediate locality showed an inclination to go to a local point of treatment when available in preference A&E.

A full service specification was developed with a comprehensive range of criteria of suitable treatments and clear exclusion criteria put in place that are regularly reviewed annually. The clinical lead, the commissioning lead, the senior nurse practitioner, and practice managers at the four service locations work in close partnership.

The service has developed and adopted a range of policies and procedures that meet all the relevant clinical guidelines and adhere to safeguarding children, vulnerable adult, infection control, and clinical governance.

The biggest challenge to overcome has been to integrate a growing service model into existing busy GP premises without having a negative impact on access and service experience of the registered patient population. The service has managed to be accepted locally as complementary and not a threat to the existing NHS walk in centre venues in Wirral.

Benefits

The success of the first pilot projects has led to further expansion of weekday opening hours from 10.00am to 8.00pm and two further centres being introduced during 2012–13. By the end of the year 17,000 patients had been treated at four service points

Successful evaluation of the Miriam Primary Care Group, based on 2011/12 activity, secured further investment into the project increasing the nursing capacity to meet the increased demand. A further 10 hours service availability was introduced during the week and weekend, and bank holiday opening was trialled at one centre.

The same evaluation process for 2012/13 saw a 30% increase in patient episodes during the increased opening times. In total the main two services points saw growth from 9,000 to 14,000 patient episodes across the year.

The first six months of activity across the second wave pilots has seen a further 3,000 patients make use of the service:

- 61% of patient treatments are seen and discharged after the first attendance;
- 18% receive follow treatment including redressing of wound injuries;
- 15% are referred back to their own GP or practice nurse. For on going support;
- less than 4% of patients are referred onto A&E or walk in centres.

Financial implications

The service is currently run on an annual block contract basis with the main contract for established service locations at the Birkenhead Medical Building and Parkfield Medical Centre costing £403,000. The two pilot projects at Holmlands Medical Centre and Kings Lane Medical Centre have cost £100,000 each. The unit cost of treatment per attendance in 2012/13 was £20.

Based on average further growth at the two established service points and assuming the two pilot venues continue for the full financial year approximately 23,000 patient episodes against a £603,000 investment would cost £26.22 per patient episode.

Applying 2013/14 PBR tariff for Band 5 treatment at A&E Wirral MFF adjusted = £59.74 demonstrates a cost effective service model that potentially delivers QIPP efficiency targets with a saving of £771,018.

Contact

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FINALIST

The Salford children's community partnership (SCCP) provides specialist children's nursing staff at GP level to reduce acute paediatric hospital admissions

Salford Health Matters

The initiative

The Salford Children's Community Partnership (SCCP) is a pilot that puts specialist children's expertise into general practice. It improves children's care in the surgery and prevents them being admitted to hospital if possible and safe to do so. It is the first of its kind in the UK.

The project is run by a multi agency partnership of three social enterprises:

- Salford Health Matters provides GP services in Salford and leads SCCP delivery at their Little Hulton practice;
- Kids Health Matters provides clinical leadership and ambulatory paediatric expertise;
- Hope Street Centre provides independent evaluation.

Two advanced paediatric nurses manage acute illness in the Little Hulton surgery. Parents phone the practice and get rapid access and increased availability to our specialist team.

Children with acute illnesses like an asthma flare up, high fever, or diarrhoea can now be treated, observed and followed up in the surgery as there is an observation area, onsite medications and the option of home monitoring. The team also have back up support from the hospital paediatricians. Previously, this level of care would only have been available in hospital.

Benefits

Preliminary statistical analysis of the SCCP practice site compared with control practices demonstrate significant reductions with regard to project outcomes:

- total paediatric admission spend decreased;
- total number of paediatric admissions decreased;
- paediatric admissions rates decreased.

In addition, at the SCCP practice, the secondary care spend (total) and the admission spend (per child) have decreased by 36% and 40% (respectively). The total number of paediatric admissions and the admission rate per 1000 children at the SCCP practice have decreased by 39% and 43% (respectively).

There has also been a likely decrease in the neonatal admission spend that is thought to be related to the accessibility of the SCCP paediatric expertise. An initial comparison with other local sites suggests that the decrease is about double the saving per child found elsewhere in the local area.

A formal satisfaction survey is underway, but the paediatric list at the SCCP site has increased 6% since implementation of the project (including requests to enrol children in the practice because of the SCCP). There is immediate availability of paediatric appointments and capacity has doubled.

Financial implications

Initial funding was provided by an innovation grant from the Department of Health that provided £130,000 a year over three years (which included project start up and evaluation).

Our pilot demonstrated savings of 40% in paediatric admission expenditure in the first year of operation. The annual secondary care cost per child at Little Hulton decreased from £324 to £236 (2010/11 versus 2011/2012). This would result in a savings of £400,000 per year if the service were applied across the three practices of SHM.

In addition, initial comparison with other local practices suggests that the decreased neonatal spend is over £60,000 from the Little Hulton practice alone (approximately one half of the neonatal spend found elsewhere locally).

Our results are from six months of operation in 2011/12. Anticipated cost savings over the next financial year, when the project will have been operational for a full 12 months, are expected to be even greater. Realisation of the project outcomes, if implemented across the Salford health economy, would return efficiency savings and productivity gains in the millions for the NHS.

Contact

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FINALIST

Impact of training and advance care planning for care home residents with dementia on hospital admission and place of death

United Lincolnshire Hospitals Trust

The initiative

In November 2009, there were more than 200 hospital admissions in three weeks from care homes in Lincolnshire. Studies show that, compared to their counterparts without dementia, people with dementia have:

- worse outcomes with admission;
- are more likely to have interventions;
- are less likely to be offered palliative care.

Doctors and care home staff are poor estimators of prognosis of residents with advanced dementia. Fear that inaction might be regarded as negligence; together with little training about end stage dementia may explain why such people are often admitted to hospital at the end of life.

We decided to amalgamate evidenced interventions to develop a care home service aiming to increase opportunity for residents with dementia and/or their families to determine how and where they wanted to be cared in the last part of their life.

The strategic health authority organised a series of dementia workshops attended by local stakeholders (acute, mental health and primary care trusts, social services, care homes representatives and voluntary services). A business case was presented to the Bromhead Medical Charity to fund a two year care home service.

Two registered general nurses with extensive experience in caring for patients with dementia and frailty were seconded, supported by a liaison psychiatrist. Attendance at practice meetings together with the developing reputation of the service helped resolve initial ambivalence.

General practice dementia registers were found to be incomplete and care home information helped identify additional residents with confirmed or suspected dementia. Interactive training sessions were delivered on several occasions in each care home to ensure all staff had participated.

These encompassed information about delirium and dementia, especially late stage dementia. Concerns about nutrition and hydration led to development of our own educational material.

Assessments carried out in the care homes measured residents' function with reference to the Gold Standards Framework prognostic indicator guidance and established a baseline against which future assessments could be measured.

Mental capacity to participate in advance care planning was assessed; care plans were developed with the resident or on a best interest's basis with carers and filed in the care home, general practice, and where appropriate, hospital medical records.

Benefits

The service covered seven care homes registered for care of people with dementia in the Boston area. Electronic questionnaires, developed to measure the effects of education were completed before and after training.

There were marked improvements in staff confidence in the recognition (20% versus 79%), prevention (11% versus 68%) and management (11% versus 61%) of delirium and an overall improvement in knowledge of factors associated with delirium.

Carers' opinions on how care planning was conducted showed high levels of satisfaction; more than 92% carers rated the service as 9/10 or better.

An example of how much carers valued the service is illustrated by the following:

> "My mum had made a living will and it was something she always talked about with her family, this process has given me the confidence to know my mum's voice will be heard even though she can no longer communicate effectively. As a family we also feel we have been given the opportunity to be heard for the first time."

Admission data obtained from the trust information department showed a reduction in hospital admissions from baseline of 202 to 137 (37%) in the first year and to 91 (55%) in the second year of the service. Data on deaths and place of death was provided by care homes — to date all patients with a care plan have died in their, or their carers', preferred place of care.

Financial implications

This pilot service cost approximately £95,000 a year to operate. The potential savings to the CCG were substantial. Using the lowest or highest admission costs, there was a net saving of between £231,000 and £483,000 over the two year period for just seven care homes.

We believe that resolution of challenges encountered at the outset, which slowed introduction of the service, together with a developing reputation, economies of scale and increasing staff experience would allow further expansion to a greater number of care homes for a smaller proportionate cost.

Contact

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FINALIST

Pharmaceutical screening of repeat prescriptions by primary care practice based pharmacists in general practice

Walsall CCG

The initiative

Estimates suggest that nationally almost 80% of prescriptions are repeats, accounting for 60–70% of total prescribing costs. The primary care repeat prescribing spend in Walsall totalled £34m in 2012/13. It is estimated that the wastage of medicines within the local health economy is in excess of £1m per annum. A number of reasons have been identified for the wastage of prescribed medicines including:

- poor repeat prescribing systems;
- change in treatment;
- prescription quantities are not synchronised;
- patient takes their medicine intermittently or not at all.

Nationally, medication related hospital admissions account for 7.5% of total admissions, with 69% of these considered to be avoidable.

Admissions can be attributable to:

- sub optimal prescribing;
- poor patient compliance;
- sub optimal medication monitoring.

The repeat prescription management service (RPMS) was aimed at reducing medicines wastage, minimising possible harm from medicines and improving the quality of repeat prescribing. The project evaluated the role of practice based

pharmacists to reduce clinical risk and deliver cost benefits for the NHS by making positive interventions at each stage of the repeat prescribing process.

Initially a pilot project was run in two practices to develop a process, confirm need, suitability and outcome measures. A business plan was developed to obtain commissioning approval for roll out across a locality with 14 practices. Practices were allocated at least four hours of pharmacist time each week. Key performance Indicators were developed and used to evaluate performance and outcomes.

Once a successful evaluation of the project was completed at 18 months the service was offered to other localities within Walsall with uptake in 56 from 64 practices (87.5%). Due to this demand the medicines management team recruited additional pharmacists to provide capacity.

The service allowed the pharmacist to elicit any relevant information from the patient and the GP medical system for the purposes of assessing a request bearing in mind:

- waste reduction;
- improving performance against local and national prescribing indicators;
- optimising treatment regimen;
- reducing health inequality;
- enhancing medicine safety.

Pharmacist specific skills were used to:

- produce and sign (if qualified) any relevant prescriptions;
- produce a prescription for signing by a GP;
- modify or change the prescription within the guidelines of the pilot for a more appropriate alternative that meets the QIPP prescribing indicator objectives.

All completed prescriptions were handed to the surgery administrative staff for sorting according to the usual surgery criteria.

Benefits

Monthly summaries of interventions were submitted by each pharmacist. These were collated on two levels.

Efficiencies — 13,055 comprising:

- medication added/stopped;
- formulation changes;
- brand to generic (vice versa);
- simple switches;
- medication alignment;
- housekeeping;
- wastage from over ordering.

Reduction in harm — 2,089 comprising:

- poor compliance/concordance;
- up to date drug monitoring;
- implementation of safety alerts;

Quality — 19,204 comprising:

- QIPP and Better Care Better Value indicators;
- drug choice/ formulary adherence;
- optimise dosage;
- problem linkage/indication;
- discharge summary/ other correspondence updates;
- medication review;
- referral to GP/nurse;
- signposting.

Pharmacists have also submitted evidence of near misses or critical incidents demonstrating that the additional clinical check has enhanced patient safety. Although not quantifiable, it is believed that the service has led to an increased detection and improvement in medicines adherence (NICE guidance estimates that 30–50% of patients with long term conditions (LTCs) do not take their medicines as recommended

In addition to the clinical outcomes recorded above, the process has facilitated shared learning opportunities for practice staff and clinicians, and has resulted in time saving for GP staff involved in the repeat prescribing process. The release of GP time from the repeat prescribing process will allow greater time for more clinically intensive activities.

Financial implications

Data for the period April 2012– March 2013 shows an annual saving from the prescribing spend of over £533,000. This saving equates to 1.56% of the prescribing spend for repeat prescriptions.

Breakdown of the savings was as follows:

- Efficiencies — £472,191
- Reduction in harm — £2242
- Quality — £59,216
- Total — £533,649

Against this there is:

- Pharmacist cost — £270,883

This gives net savings of £262,766.

Contact

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WINNER

Oncology homecare programme

The Newcastle upon Tyne Hospitals FT

The initiative

It was recognised that patients on long term cancer treatment could suffer multiple toxicities and because of the volume of patients that are seen within the cancer centre these patients on oral medication often had long delays. Stephen O'Brien recognised that a number of patients within his clinics could be assessed via the telephone in response to the NHS initiative to treat patients closer to home.

This could not be accommodated in the usual clinic pattern. He recognised that some targeted therapies shared toxicities and decided that with an experienced senior nurse these could be managed as a group of patients rather than splitting them into disease groups. Ian Pedley, urology consultant, became involved and the development of a service was agreed.

Patients often complained of long waiting times, There was recognition that by employing a healthcare delivery company significant VAT savings could be made and these could be used to improve the overall service to patients.

We went through an OJEU competitive procurement process with our trust's supplies department to appoint a home delivery company. The appointed company provided tracked home delivery of medicines and phlebotomy services. A clinical nurse specialist was then employed to develop the service further.

Benefits

Patients' visits are reduced from anything between 4–5 hours to one hour. CML patients now have the option of telephone assessment, with home phlebotomy reducing their hospital visits from quarterly to annually. Renal and CML patients now see the clinical nurse specialist in a dedicated clinic for review. They no longer need to wait to see the doctor, pharmacy or the chemotherapy day unit freeing up space within these areas.

Clinic and day unit congestion has reduced significantly, freeing up nurse, consultant, pharmacist and junior doctors time. A patient survey has been undertaken and satisfaction has soared, patients are happier with support, delivery of medication and overall satisfaction of the service they are given.

New links have been forged between haematology and oncology with a joint focus on improving the patient treatment pathway. Within the first year we saved:

- 434 urology consultant appointments;
- 80 hospital visits for patients with chronic myeloid leukaemia;
- 434 consultant appointments saved within renal clinics;
- 130 consultant appointments saved within CML clinics;
- 292 phlebotomy visits in the community.

Savings made enabled new posts to be created, freeing up time and space in other departments. New patients no longer face any delays seeing consultants as clinics are no longer filled with treatment reviews.

Now most CML patients do not have to come to hospital to be reviewed. Their disease is assessed via the home phlebotomy service and toxicities assessed over the telephone. If there are any problems they are immediately invited back to hospital.

Renal patients do not have to visit multiple departments for a monthly review because they are seen in a one stop appointment with medication delivered two days later. Consistent toxicity assessment has allowed side effect management to improve and patients have better chance of remaining on a full dose of medication.

The initiative could be easily replicated across other specialities and trusts. The model of treating patients by drug, while not always ideal, fits with tyrosine kinase inhibitors because of their specific toxicities. Other drugs could be grouped in this way but there needs to be a recognition that expertise needs to also be developed for individual diseases.

Financial implications

The clinical nurse specialist post was initially sponsored. The savings made demonstrated the feasibility to not only continue the service but also increase the number of staff and patients across numerous disease groups.

Contact

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Judges' comments

- *Excellent presentation with an innovative approach to the delivery of specific medication. Focuses on both quality and productivity.*
- *Scalability now being tested within clinical trial that will cover a sixth of potential patients. Further work can be considered in delivery of patients with more than one drug.*
- *Reasons for decision:*
  disruptive innovation;
  potential for huge productivity savings across the NHS;
  focus on quality for vulnerable group of patients;
  directed clinical expertise at right level;
  already taking steps (clinical trial) for national spread;
  savings could be realised relatively quickly.

HIGHLY COMMENDED

Cutting the human and financial cost of frailty

South Warwickshire FT

The initiative

Frail older people occupy about 70% of acute hospital beds and use most long term institutional care services, accounting for about 46% of total NHS and 55% of social care expenditure.

In Warwickshire we have seen an increase in demand for emergency care of 9% from frail older people over the last three years. After engagement with clinicians, primary and social care colleagues, patients and their representatives, we established that we could do more to prevent frailty and provide alternatives to acute hospital care for a number of older patients.

Following a review with partners we established a four step plan to transform the services we deliver to our local community:

- get in early — identify and respond to threats to health independence and wellbeing of older people;
- assess better before admission — provide a two hour community emergency response to a frailty crisis;
- specialist acute care — provide acute care by old age specialists within 24 hours of admission;
- discharge to assess — discharge to intensive community support within 24 hours of completion of medical assessment, followed by rehabilitation and reablement services as required.

These principles allowed us to undertake a radical redesign of clinical pathways to improve effectiveness, enhance patient experience and provide value for money

Throughout the process we worked with patients and their representatives, GPs, social care colleagues and commissioners. We established joint working arrangements for the strategic and operational governance of the programme.

We developed an early assessment system for older people. GPs identified at risk older people who were then assessed for early intervention opportunities by Age UK volunteers. This is supported by an electronic assessment tool that provides an early service response based on the priorities for that individual older person and a summary record to inform future care.

We doubled the investment in intermediate care and reablement services by reducing community hospital beds. We also changed the model of care for community hospital care to increase productivity resulting in a 30% increase in throughput of the remaining community beds. We invested in additional old age specialists posts so that older people would be seen within 24 hours of admission and transferred to dedicated old age specialist wards.

An electronic health/social care record was developed with a shared database that includes summary assessments in preventive care, triaging to specialist services and support for discharge.

Benefits

Patient outcomes include:

- 4% increase in elderly patients discharged directly from assessment unit;
- 11% reduction in mortality;
- 13% reduction in length of stay for frail elderly in acute setting;
- 22% reduction in discharge to nursing homes for patients admitted from home;
- 31% increase in discharges from community hospital beds;
- 33% reduction in community hospital average length of stay.

Intermediate care expansion into CERT team has increased capacity by 40 patients per week. Consistently higher numbers of patients are using the day room or engaging in positive activities instead of watching TV or sleeping.

Financial implications

Changes to the delivery of care in community hospitals provided funding to be released to strengthen community services to support admission prevention and early supported discharge.

Avoided costs for acute healthcare are estimated at £340,000 revenue costs and £100,000 in capital charges. It is also reasonable to assume that without our community emergency response team the trust would have incurred significant additional costs to deliver elective work and additional contract penalties.

Estimated capital costs of at least £2m have also been avoided by not increasing the numbers of acute beds. Reduced costs to commissioners from reduced emergency admissions was around £780,000 a year, providing the bulk of the trust's contribution to a QUIPP saving of £900,000 in our contract negotiations.

Further analysis is on going to measure benefits in reducing the costs of long term social care and continuing health care provision. These may be considerable, as almost all patients receiving the service were independent at 91 days following discharge.

Contact

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FINALIST

Keep me safe — Derby Hospital's multidisciplinary safety team lead frontline staff in delivering safe reliable care

Derby Hospitals FT

The initiative

Patient safety is everyone's responsibility whether they are a nurse, doctor, porter or manager. We initiated a campaign, Keep Me Safe to improve safety.

Clinical leadership was essential to addressing the challenges we had, in particular, engaging all frontline staff to build a culture putting safety and care at the forefront. We formed a dedicated multidisciplinary safety team, set an aspirational aim to reduce avoidable harm by 50% in one year. We aimed to do this by focusing on three drivers:

- measuring harm;
- standardisation;
- zero tolerance to outliers.

Standardisation of clinical practice was felt to be the most significant way of improving safety. Clinical leads set targets for standardisation and improvement supported by work programmes.

Process and outcome measures were identified for tracking improvements. Events were held to engage clinical staff. Having established the trust's baseline harm level, teams were set up to undertake monthly trigger tool audits and the safety team tracked progress.

Improvement programmes included:

- development of care bundles — pneumonia, acute kidney

injury etc;
- early warning score and improved escalation (SBAR) of deteriorating patients;
- standardisation of care for patients at risk of falls or of developing pressure ulcers;
- medication checks to reduce drug omissions;
- enhanced discharge for patients at risk of readmission — three day education programme, handover to community and post discharge follow up;
- standardising fluid balance and hydration charts for improved fluid balance monitoring;
- ward safety walks.

Benefits

We have:
- reduced harm by over 50% in one year (3,070 less patients harmed in 2012 than 2011);
- improved the timeliness of diagnosis and first antibiotic administration for patients with pneumonia following the introduction of care bundles. As a result pneumonia length of stay has been reduced by two days;
- implemented nine more care bundles already demonstrating improvement;
- decreased falls resulting in harm from 2 per 1,000 bed days in 2011 to 1.75 per 1,000 beds days in 2012 — 80 less falls;
- presided over a 50% reduction in hospital acquired pressure ulcers and drug omissions;
- reduced cardiac arrests from 0.68 per 1,000 bed days in 2011 to 0.53 per 1,000 bed days in 2012 (48 less cardiac arrests per year).

Financial implications

It is known that one in 10 patients will experience something going wrong during their stay in hospital that may lead to harm. Half of these events are avoidable. When something goes wrong it also has the knock on effect of requiring additional treatment for the patient, which can be costly to the NHS in the form of medications, further clinical procedures or litigation. It is also likely to mean the patient has to stay in hospital for longer.

Reducing avoidable harm not only leads to a better patient experience — it also prevents unnecessary costs for the NHS. Clear financial savings from the initiative can be attributed as follows:
- reduced pneumonia length of stay — £540,000 saving;
- reduction in hospital acquired pressure ulcers —£400,000 saving;
- reduction in falls — £14,000 saving.

Contact

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FINALIST

Integrated respiratory service for Central and East Cheshire

East Cheshire Trust

The initiative

The integrated respiratory team was the result of a major review and service redesign to bring services closer to the patient, improve quality of life, minimise hospital stay and promote effective management in the community for patients with respiratory diseases such as COPD.

Prior to integration there was inequity in service provision across the localities, high admission rates, long lengths of stay, no specialist community clinic provision and limited care at home available for the respiratory patients and their carers.

The oxygen prescribing costs for the locality was high at £1m per annum. The evidence from NICE/BTS suggested that at least 33% of COPD admissions could be avoided and a further 30% could be discharged earlier to a specialist team thus reducing length of stay. In addition the provision of a robust evidence based oxygen assessment service could ensure the correct assessment, prescription and modality for patients thus reducing the overall oxygen prescribing costs.

The primary aims were:
- to provide specialist support and education for the patient, carers and family to manage their lung disease effectively, reducing the need for acute management and admissions;
- to support the patient to achieve their preferred place of care for end of life in accordance with the end of life strategy;
- to ensure the provision of formal oxygen assessment services and to support community pulmonary rehabilitation programmes.

The development of community based specialist clinics provides specialist assessment and review in a locality closer to the patient's home. Understanding the health needs of the local population was crucial in the development of the team. The planning phase was extensive and involved a group of cross sector stakeholders including:
- clinicians from the two acute hospitals;
- GPs;
- practice nurses;
- allied health care professionals;
- commissioners;
- providers and managers of services.

A COPD pathway was developed in collaboration with key health care professionals and distributed throughout the locality. A service specification and operational policy was developed which incorporated the inclusion and exclusion criteria, clinical responsibility, KPIs and expected outcomes.

The staffing and the corresponding banding was based on the level of expertise and leadership required to deliver the various aspects of the service across the localities.

Benefits

The integrated respiratory team has managed over 8,000 referrals since its inception April 2010:
- over £275,000 has been saved in oxygen prescribing costs;
- more than 700 patients' have avoided a hospital admission by being managed at home potentially saving 4,900 bed days (average length of stay being 7 days);
- more than 1,300 patients were managed on the same day and early supported discharge aspect of the service.

The team has established a maintenance caseload of patients with severe and chronic lung disease and its links with palliative care teams to assist in the provision of palliative care, hospice day care and hospice in-patient services for patients with end stage lung disease.

An educational programme and respiratory support group for all health care professionals with an interest in respiratory medicine are now on a rolling programme. Individual practice and clinician support and advice is also given as required.

Contact

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FINALIST

Delivering the impossible — prescribing consistently, cost effectively and to the highest quality standards across Greater Manchester

Greater Manchester CSU

The initiative

The joint formulary was created in April 2010 in response to the Greater Manchester medicines management QIPP challenge put forward by the chief executives and directors of commissioning and finance. The aim was to ensure that prescribing and treatment guidance across Greater Manchester were consistent and that patients were receiving safe and effective care.

The 12 CCGs and 13 providers in Greater Manchester spend £650m per annum on medicines. The intention was that the Greater Manchester joint formulary would supersede local formularies. It would also provide links to NICE guidance to ensure patients obtain access to NICE approved medicines. There are also links to local clinical pathways, which has led to consistency in treatment within the provider organisations.

Reports received identified variation in the uptake and prescribing of drugs to patients in different parts of Greater Manchester. For example, patients being discharged from hospital after surviving a heart attack could receive a number of different medicines with little consistency between different organisations.

For this reason, Greater Manchester Medicines Management Group (GMMMG) established a formulary subgroup with medical and pharmaceutical representation from primary and secondary care across the whole of Greater Manchester. This would aim to reduce this variation.

Twelve chapters of the formulary were produced and made available on the GMMMG website. A full, open consultation with key stakeholders including patient groups and clinicians via the open access GMMMG website was undertaken. All finalised chapters continue to be subject to an ongoing review process and are updated on a regular basis.

The formulary highlights first choice drug plus alternatives, based on clinical efficacy, adverse effects, patient acceptability and cost effectiveness. A consultation was also carried with the pharmaceutical Industry and the wider NHS in July 2011. There was a large amount of feedback that was used to improve the quality, process and transparency of the workings of the formulary group.

Benefits

As a result of having involvement from both GPs and hospital consultants, it has been possible to implement the formulary across the interface. This has also raised the profile and standing of the formulary among clinicians, the wider NHS and the pharmaceutical industry as well as improving decision making capacity.

An example of working across the wider health economy has been liaison with the Greater Manchester and Cheshire Cardiac and Stroke Network which enabled investment in new medicines while releasing funding for these by reducing spend on others for which there is less evidence for beneficial patient outcomes. This is illustrated by the reduction in primary care prescribing of a fish oil derived omega 3–acid ethyl esters at the same time as increasing the prescribing of newer anti-platelet agents. Thus the savings from one area have allowed growth in another without an overall increase in spending.

Financial implications

While financial costs have been minimal, all primary care trusts [and now CCGs] provided input and feedback and there has therefore been a significant time commitment from member organisations.

The formulary subgroup is responsible for the production of a "do not prescribe" list. The aim of this list is to reduce prescribing rates of drugs deemed to be less suitable for prescribing due to safety or cost effectiveness. The list has provided the support to stop prescribing ineffective yet costly medicines. Every practice in the PCT has reduced its prescribing of such items in 2013. Overall, this list has contributed to significant cost savings of up to £250,000 during 20121/12 per CCG for commissioners and providers.

Contact

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FINALIST

Dementia voice nurse

Housing21

The initiative

The National Council for Palliative Care and the Alzheimer's Disease Society among others recognise that people with dementia receive inadequate end of life care. The dementia voice nurse service provides support and symptom control for people with midstage to advanced dementia working to facilitate advanced care planning in order to enable the person with dementia to die in their place of choice and to minimise hospital admissions.

The dementia voice nurse works alongside the person with dementia, following them along their dementia journey and working collaboratively with allied professionals to ensure that the care is joined up and appropriate. The dementia voice nurse is a highly specialised individual with a background in both dementia and palliative care; the ethos and models of both areas of nursing overlap with the person being at the centre of care.

The dementia voice nurse service aims to:

- reduce the numbers of costly days in care or in hospital admission;
- fill a perceived and increasingly evidenced gap in service provision around end of life services;
- improve sustained quality of life;
- improve access to end of life choices;
- improve the quality of end of life;
- increase the ability to achieve safe and timely discharge from hospital and care settings thereby reducing stress and anxiety.

For the dementia voice nurse working outside of the NHS it has been essential that they engender a sense of trust with many different colleagues who work with the person with dementia and their families. This again highlights how important partnership working is in order to provide this essential service.

Benefits

The nurse follows the person with dementia wherever they go; this means that they receive a constant level of support, no matter where the care is being provided at the time.

Benefits to carers and families include:

- reducing carer isolation when supporting someone with dementia;

- being a source of advocacy for the family;
- improving family knowledge and understanding of dementia, thereby improving the feeling of being in control;
- enabling family relationships to be supported.

Feedback has been very positive:

"Your dementia voice nurse was able to prioritise need for support from other agencies and co-ordinate their approach to issues. This was invaluable in lessening the stress for Mrs X and myself."

Financial implications

The concept of the dementia voice nurse was developed through funding by the Department of Health alongside the support of the Kings Fund.

The dementia voice nurse improves the use of resources, reducing duplication and overlap and increasing effectiveness of deployment. Removing cost of delivery amounted to savings of £240,000 over the pilot period from a single employee. Second year savings were proportionately greater due to establishment of the service generating more referrals and the attrition in start up costs.

Contact

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FINALIST

Using technology frees up clinical experts' time, gets the best drugs for patients and saves millions

Sheffield CCG

The initiative

The Medicines Management Team Information System (MMTIS) in Sheffield helps ensure that patients are getting the best drugs for their condition and saving millions for the health economy. NHS Sheffield CCG uses the system that supports and records in real time decisions made on the front line in practice by the team.

Our team of clinical pharmacists/medicine management technicians works in 88 practices, without all of the resources available to them at their base. Because of this they were undertaking interventions such as reviewing prescribing and initiating changes then having to leave the front line to undertake recording and quantifying. A smarter way needed to be found that would reduce duplication of effort and maximise the time the team could devote to productive clinical work.

Because the team were working in locations with differing IT infrastructure any solution would need to offer ready access without making excessive demands on existing systems. The work to develop MMTIS was prompted by awareness that there was duplication of effort. A project team was put together to develop a practical solution, this was initially in house within the medicines management team and subsequently supported by IT services.

A web based portal was developed in order to provide full access to reference materials, policies, guidelines and other relevant documentation relating to prescribing. The portal incorporated an advanced recording system which allowed real time recording of changes made to prescribing — instantly calculating the cost benefit and attributable to the team member and practice involved.

The key features of the recording aspects of MMTIS are:

- recording drug switches tool — data recorded includes drug quantity, number of patients and cost of drug;
- medicine management team tool — enables each user to record the number of reviews conducted, drugs changes and quantity of drugs prescribed. Managers can review individual staff and departmental performance;
- interventions tool — allows users to report and record adverse events. Clinical interventions are graded using a clear scoring system (1–5) providing clinical statistics for the department;
- mini audit tool — enables small scale audits to be conducted;
- care homes and medication review record tools — records the number of reviews conducted, number of drugs and drug changes made by each individual staff member for work carried out in care homes.

Benefits

The team now have access to the most up to date resources, they can get the information they need to support them in their work ensuring that patients in Sheffield are treated with safe, clinically effective and cost efficient medicines.

Work can be scheduled and activity and progress monitored in real time. Interventions made are easily recorded, reported and quantified, with the information available instantly to support managerial decision making and priority setting.

Financial implications

All the work was done in house, initially by members of the medicines management team and subsequently with IT input. Staff costs attributable to the development of MMTIS were less than £10,000.

Benchmarking data indicates that compared with comparable health economies prescribing in Sheffield is extremely cost effective, releasing savings of up to £25m per year.

Contact

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FINALIST

The Salford children's community partnership (SCCP) provides specialist children's nursing staff at GP level to reduce acute paediatric hospital admissions

Salford Health Matters

The initiative

The Salford Children's Community Partnership (SCCP) is a pilot that puts specialist children's expertise into general practice. It improves children's care in the surgery and prevents them being admitted to hospital if possible and safe to do so. It is the first of its kind in the UK.

The project is run by a multi agency partnership of three social enterprises:

- Salford Health Matters provides GP services in Salford and leads SCCP delivery at their Little Hulton practice;
- Kids Health Matters provides clinical leadership and ambulatory paediatric expertise;
- Hope Street Centre provides independent evaluation.

Two advanced paediatric nurses manage acute illness in the

Little Hulton surgery. Parents phone the practice and get rapid access and increased availability to our specialist team.

Children with acute illnesses like an asthma flare up, high fever, or diarrhoea can now be treated, observed and followed up in the surgery as there is an observation area, onsite medications and the option of home monitoring. The team also have back up support from the hospital paediatricians. Previously, this level of care would only have been available in hospital.

Benefits

Preliminary statistical analysis of the SCCP practice site compared with control practices demonstrate significant reductions with regard to project outcomes:

- total paediatric admission spend decreased;
- total number of paediatric admissions decreased;
- paediatric admissions rates decreased.

In addition, at the SCCP practice, the secondary care spend (total) and the admission spend (per child) have decreased by 36% and 40% (respectively). The total number of paediatric admissions and the admission rate per 1000 children at the SCCP practice have decreased by 39% and 43% (respectively).

There has also been a likely decrease in the neonatal admission spend that is thought to be related to the accessibility of the SCCP paediatric expertise. An initial comparison with other local sites suggests that the decrease is about double the saving per child found elsewhere in the local area.

A formal satisfaction survey is underway, but the paediatric list at the SCCP site has increased 6% since implementation of the project (including requests to enrol children in the practice because of the SCCP). There is immediate availability of paediatric appointments and capacity has doubled.

Financial implications

Initial funding was provided by an innovation grant from the Department of Health that provided £130,000 a year over three years (which included project start up and evaluation).

Our pilot demonstrated savings of 40% in paediatric admission expenditure in the first year of operation. The annual secondary care cost per child at Little Hulton decreased from £324 to £236 (2010/11 versus 2011/2012). This would result in a savings of £400,000 per year if the service were applied across the three practices of SHM.

In addition, initial comparison with other local practices suggests that the decreased neonatal spend is over £60,000 from the Little Hulton practice alone (approximately one half of the neonatal spend found elsewhere locally).

Our results are from six months of operation in 2011/12. Anticipated cost savings over the next financial year, when the project will have been operational for a full 12 months, are expected to be even greater. Realisation of the project outcomes, if implemented across the Salford health economy, would return efficiency savings and productivity gains in the millions for the NHS.

Contact

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WINNER

Rapid access transient ischaemic attack (TIA) clinic multidisciplinary initiative to create seven-day hospital service for patients at risk of life threatening stroke

Southend University Hospital FT

The initiative

The Department of Health Stroke Strategy (2007), and Royal College of Physicians: National Clinical Guideline for Stroke (2012) acknowledge the challenges in providing a high quality TIA service. The time in which there is a significant risk of having a major stroke is now recognised as much shorter than previously thought.

All patients identified as having a potential transient ischaemic event should be assessed and investigated at a specialist clinic either within 24 hours or, for low risk patients, within a maximum of one week.

An assessment by a specialist in neurovascular disease must establish the diagnosis determine whether the cause is vascular (about 50% are not) and which territory is affected. Where imaging is required, the greater sensitivity of magnetic resonance imaging (MRI) to detect ischaemic lesions makes it the modality of choice.

Carotid imaging must be conducted urgently to facilitate carotid surgery, which should be undertaken within seven days of onset of symptoms. To reduce the risk of recurrent stroke, measures for secondary prevention are introduced as soon as the diagnosis is confirmed. Nationally, only 37% of high risk outpatients are seen the same day, seven days a week.

In 2008, our hospital centred service could see only three patients a day Monday to Friday with only CT brain imaging available. In line with national guidelines, we aimed to provide a seven day service, triaging high risk patients within 24 hours. Low risk is not no risk, so these patients had to be assessed urgently, but definitely within seven days.

The patient centred service was to have no limit on the number of patients seen in clinic. This meant streamlining clinical pathways and involving our patients themselves. We also ensured we discussed in clinic individual risk factors and measures to prevent further episodes. To ensure patients recognised TIA symptoms, the PCT commissioned a social marketing project to raise awareness locally.

Referral is now via 24/7 stroke team bleep or our online electronic risk stratification form. Stroke consultants have introduced weekend TIA clinics in addition to daily stroke unit care. MRI brain scanning has been introduced to our walk in TIA clinics by using reduced MRI sequences to ensure no delays to established lists.

Stroke consultants have undertaken ultrasound degree courses to enable them to perform carotid imaging 24/7 using a ward based machine. Patients with atrial fibrillation (AF) are no longer routinely admitted for warfarin treatment: new medication means they can be safely discharged the same day. Where carotid surgery is urgently required our vascular surgeons are contacted immediately to perform surgery on the next theatre list.

Benefits

Our mean time from referral to clinic assessment dropped from 4.25 days for high risk patients in 2008–9 to less than 24 hours (14.5 hours) this year and from 6.78 days to 2.87 days for low risk patients. Similarly we have reduced the average time to carotid imaging so 96% high risk patients are scanned within 24 hours.

We were third highest in the UK for the proportion of patients having carotid endarterectomy surgery with 14 days (88% compared with 49% nationally). Our median was nine days (national 15 days). Our most recent 2012–13 data shows 89% within seven days.

Financial implications

The only additional funding was for the patient awareness social marketing project, which was funded by Southend PCT, and the provision of one stroke pager to contact a stroke team member. The cost of the ultrasound degree course (£1,800 per person) was funded from Essex Stroke Network's improvement budget.

High risk TIA patients were previously routinely admitted; the majority are now treated on an outpatient basis. Further bed days have been saved by reduction in inpatient waiting time for carotid surgery and the introduction of new medication for patients with atrial fibrillation (AF); patients go home from clinic instead of being admitted to be started on warfarin, avoiding admission of 3–6 days.

Contact

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Judges' comments

- *Outstanding example of risk quality service redesign utilising innovative technology seven days a week.*
- *Excellent presentations. Continue to build on this please, extending into rehabilitation.*

HIGHLY COMMENDED

HIP QIP — a quality improvement programme for hip fracture care

Northumbria Healthcare FT

The initiative

Hip fracture is a common and serious condition. Overall one year mortality is high at around 30%. The pathway of care is complex. Survivors often face a life with decreased function, with 15% to 20% of people needing to change residence.

Our local hip quality improvement programme (HIP QIP) was instigated by the trust board at the beginning of 2010. The best practice tariff, a financial incentive for quality, was due to be launched in that April. We were also responding to an internal concern about safety — our overall mortality rate was high at 13.3% and clear variations in outcomes existed between our two hospital sites.

Our intention was to provide integrated care of the highest quality within a culture of continuous learning, innovation and development.

Using experience based co-design methodology, we defined our quality account, which outlined 12 deliberately ambitious service standards. Our steering group met monthly to review progress against service goals.

Evidence suggests that specifically targeting hip fracture patients for additional feeding could lead to a reduction in our death rate. The surgical care bundle, pain block in A&E, surgery within 36 hours and root cause analysis of every death were further measures adopted to target mortality. Training and support was provided to improve:

- nutrition;
- pain management;
- information provision;
- early mobilisation;
- standardisation of practice;
- compassion at the point of care.

Benefits

The Department of Health best practice tariff (BPT) defines quality measures around timely surgery and orthogeriatric care. We moved from a baseline of 2% in April 2010 to 90% by December. This performance is among the best nationally (2nd and 3rd of 180 hospitals) and has been sustained for 30 months.

Trustwide 30 day mortality has improved from 13.3% to 7.0%. This represents a 47% reduction since the programme started — around 40 lives a year. Of 513 patients interviewed in 2012, 97% believed we did everything we could to effectively control pain. More than half our patients achieve home to home within 30 days.

- 80% of our patients will now receive an x ray within an hour of arriving in A&E.
- 90% will receive a very effective nerve block on hospital admission — previously 0%.
- 95% of patients now enjoy additional feeding each day, with the help of nutrition assistants and volunteers.
- 90% of patients have surgery within the 36 hour target for timely surgery.
- All medically fit patients are mobilised by day one and 50% on the day of operation — previously 4%.

Financial implications

New NICE standards are linked to the Best Practice Tariff (BPT). In addition CQUIN targets were negotiated, earning £585,767. In all for 2010/2012, £891,000 was generated compared with an average unit of comparable size.

BPT performance in 2012/2013 performance generated £766,000. Charitable funds supported our participation in The King's Fund/Health Foundation's hospital pathways programme (£15,000). As well as improving care, this income has enabled us to reinvest some of these additional earnings in practice and service development. Approximately £120,000 has been invested so far.

Length of stay has maintained despite an additional 40 patients a year now becoming survivors. Our data shows the service redesign has consistently reduced mortality, and this trend continues. HIP QIP gained £50,000 from the North East SHA for winning the Transforming Community Services Award. This has supported the development of early supported discharge in year three of the project. This has the potential to save £550,000 a year for commissioners if a conservative five day reduction in hospital stay is achieved.

Contact

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FINALIST

Teachback + changes behaviour, improves care and reduces readmissions

Derby Hospitals FT

The initiative

Readmissions account for 11% of our overall non elective admissions, 6,280 per year equating to £4.4m every year. While not all readmissions are avoidable, we believed that many could be prevented by redesigning our acute care, and working more proactively to enhance patient discharge.

A system wide rapid improvement event was held in June 2012, attended by over 30 clinicians and managers and a review of evidence based projects also took place. This revealed very little work has been published within the UK on readmission prevention. However, an American initiative claimed a 30% reduction in readmissions.

Using the common themes identified within the American study and locally through clinical and patient feedback we worked across our health community, with hospital specialists, community matrons, GPs and social services. In this way we could identify the underlying problems within the current system including:

- lack of knowledge and understanding;
- patients not wanting to trouble people with their problems;
- delays with care interventions;
- breakdowns in communication between health and social care organisations.

The enhanced discharge model follows four simple steps:

- risk assessment;
- Teachback — a three day education and support programme pre-discharge focusing on understanding medicines, self care and recognition of deterioration;
- hot handover — a verbal hand over to community teams to highlight patient discharge and needs;
- post discharge follow up call — a call 48–72 hours after discharge to identify any issues.

We carried out an internal clinical review of readmitted patients; medical non elective patients had the highest readmission rate. A pilot programme in cardiology and respiratory, two of the highest specialities, was launched in November 2012 to test the approach and realise the identified benefits.

Benefits

To date we have enrolled 229 high risk patients on the enhanced discharge scheme with 862 risk assessments undertaken, 88 referrals made to other health professionals.

Less than 13% of patients have been readmitted, respiratory and other medical specialities readmission rates have also reduced. Despite a very busy winter the overall readmission rate for the trust was the lowest it has ever been at 4.88%. Patient experience has significantly improved.

Financial implications

Following the introduction of electronic prescribing across all our medical wards in 2012, nurse time on drug rounds was reduced by half thus releasing more time to care for patients. We chose to reinvest this time into the introduction of our new discharge support package.

We estimate savings of £94,545 per year for cardiology and respiratory alone with potential bed day savings equating to £450,000 recurrent per year within our medical division.

Contact

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FINALIST

Improve patient health and wellbeing and increase health and social care efficiency through service redesign; enabling secure information flow across care pathways

Health and Social Care Information Centre

The initiative

Before the start of this programme, documentation sent between organisations was often hand written, sometimes posted or, more likely, faxed. Learning from previous initiatives, we decided to take an evolutionary approach, and make the most of what was already available to make tangible improvements in incremental steps.

A number of options were reviewed to determine how best to support the secure sharing of information across health and social care as well as provide cost effective, resilient solutions that could be taken up across London (and elsewhere).

A short, medium and long term plan was agreed to enable the point to point information flows that are critical to support health and care. For example, each London hospital treats patients from many different local authorities and therefore has to communicate with multiple social care departments.

Our initiatives include:

- secure email — formal admission and discharge notifications and continuing care assessment forms are being sent between health and social care organisations using pan London electronic automated forms via NHSmail/GCSX secure email;
- web services —a web service offered by IGspectrum providing admission and discharge notification e-forms and enabling automated population of patient demographic details from the hospital system;
- the Adapter — working with the software company Quicksilva, we have developed the Adapter. Patient information, including NHS number verification, can be sent using secure email and national messaging standards (ITK) directly into the three largest social care information systems, Corelogic, Liquidlogic and OLM, enabling them to become ITK compliant. Workflows include GP referrals to social care and admission and discharge notifications;
- patient discharge information — we are developing improved integrated patient discharge Information in a range of formats.

As part of each of our initiatives we provide project management including:

- facilitating meetings to engage staff at all levels;
- conducting multidisciplinary care information process redesign workshops;
- identifying the initiative that most benefited the organisation;
- delivering multiagency staff training;
- working with the interoperability national team to improve the national messaging standards to meet the needs of patients, clinicians and social workers.

Benefits

Benefits include:

- automated standardised pan London documentation saves data entry time;
- improved communication between staff within and across health and care organisations;
- an improved electronic audit trail which minimises risk to patient;
- significantly reduced information handoff times;
- improved staff productivity — the Adapter sends information directly in a system; eliminating the need for staff to file attachments promptly in the right place;
- forms are recorded accurately;
- less likely for information to go missing;
- more legible than handwritten forms;
- no need for staff to fax and manually file information easing their workload.

Financial implications

By switching to an automated workflow, Ealing Hospital and Council saved approximately 245 staff days through implementing new admission and discharge processes, saving 50,000 sheets of paper for just this one workflow.

Before introducing the system, Homerton hospital had 12 patient deferrals per year due to illegible paperwork, which resulted in patients having to stay in hospital until the next continuing care panel two weeks later. They completely eliminated these by implementing automated continuing care forms. This saved them about £30,000 a year in bed day costs and 16,000 sheets of paper.

Contact

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FINALIST

Knowsley Community COPD service: "Integrated specialist COPD care in the heart of the community" an expert multidisciplinary team delivering a highly accessible patient centred service

Liverpool Heart and Chest Hospital FT and Knowsley Clinical Commissioning Group

The initiative

Knowsley is the fifth most socially deprived local authority in

England with 150,000 residents and mortality rate twice the national average. The initiative was developed for Knowsley PCT to address marked health inequalities exemplified by a local prevalence of COPD of 3.2% (5,053 patients), which is more than double the national prevalence.

A seamless, patient-centred pathway was essential to help improve the early diagnosis management and outcomes for patients with COPD.

A consultant leads our multidisciplinary team five days a week in six different community locations. The pathway is highly accessible, and was developed in response to patients' views after extensive consultation. The long term benefits include improving health outcomes and quality of life for patients and their carers while reducing the financial burden of avoidable admissions. It provides a necessary link between primary and secondary care services, complementing acute services and reducing waiting times across the whole pathway.

In each clinic we have:

- a chest consultant;
- two COPD specialist nurses;
- a physiotherapist;
- two respiratory physiologists;
- a psychotherapist
- a smoking cessation counsellor.

Our template for daily appointment schedule consists of:

- 14 follow up patients;
- 18 new referrals;
- 24 patients for annual spirometry;
- four emergency appointments for patients who are acutely unwell.

Domiciliary visits are done jointly between the consultant, nurse and physiotherapist. The team optimise treatment (including inhaler technique and oxygen assessment), promote education and self management, provide holistic symptom management and advance care planning.

Specialist nurses in the community provide rapid response home visits 7am-10pm (with a 24 hour helpline) to manage exacerbations, prevent hospital admission and provide early supported discharge.

Physiotherapists provide patient education and recruit patients for the eight week rolling pulmonary rehabilitation which is available at six local community locations and one hospital based location, five days a week.

The psychotherapist assesses and treats those with anxiety and depression; the FagEnds counsellor gives smoking cessation advice and treatment.

Benefits

By providing education about COPD, how to recognise a flare up and supported self management, patients are empowered to take responsibility for their own health. Choice is provided in place and time of clinic appointments. Patients have the opportunity to receive supported treatment at home during exacerbations. Other benefits of the initiative include:

- 26% reduction in hospital admissions;
- 96.4% of patients seen within 15 working days of referral;
- all patients receive a full single visit assessment by the team and have a personalised management-plan;
- all smokers offered support to quit;
- all eligible patients are referred for pulmonary rehabilitation;
- 92.3% of patients requiring face to face contact are being seen at home within two hours;
- all eligible patients are accepted for early supported discharge.

Contact

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FINALIST

Heart2Heart

Oxford Health FT and Oxford University Hospitals Trust

The initiative

The specialist cardiac service at the John Radcliffe Hospital had recognised that their patients had unmet emotional, psychological and mental health needs and that this was having an adverse impact on:

- quality of care;
- outcomes;
- quality of life.

They ran a small project to address this, which showed promising results. Work started in 2011 to assess the evidence and bring together:

- commissioners;
- GP leads;
- the cardiac service user panel;
- the IAPT service;
- community heart failure nurses;
- the secondary care specialist cardiac service.

We intend to measure impact on quality of life and resource use of an integrated pathway for cardiac patients. The initial objective was to provide a stepped care psychological intervention to 100 cardiac patients. The purpose was:

- to evaluate clinically and financially the delivery of stepped care psychological interventions for patients who present with both LTC cardiac disease/cardiac failure and anxiety and/or depression;
- to improve patient care and satisfaction measured by a number of validated measures for cardiac care, quality of life, depression, anxiety, work and social adjustment, patient reported measures;
- to identify the skills and confidence needed by both therapy and cardiac staff in working with co-morbid patients;
- to evaluate the financial impact of providing integrated care by comparing health care usage before and after the intervention and at six months post intervention.

The development team was drawn together to build a case for Department of Health pathfinder funding and comprised of clinical leads from IAPT and cardiac nursing, a project manager, a data lead and the community heart failure team. This team worked with a wider group of stakeholders.

Early discussions were based on prevalence data for patients with cardiac problems and depression. Clinical leads then defined stages of the cardiac pathway and how psychological care could be integrated within this. The principle was to provide the right level of care at the right time — "least intervention first time".

The views of patients and carers were incorporated in designing an integrated psychological/physical care pathway that was acceptable and accessible. This needed to be offered at the point of delivery within a multi-disciplinary team, supported by effective communication. A clinical lead role was taken in the cardiac and IAPT service, supported by the project manager.

Clinical staff were involved in shaping how the pathway was delivered and encouraged to raise issues and observations. Joint team meetings and staff attending each other's professional meetings helped to make the pathway work.

Benefits

Preliminary findings for 25 patients who have completed treatment so far show statistically significant reductions in anxiety and depression at:

- step 2 — psycho education and telephone support;
- step 3 — one to one cognitive behavioural therapy.

A cardiac nurse commented:

"If my patient doesn't engage with rehabilitation there is now the option of Heart2Heart' — before I felt they fell into a black hole."

Patient comment:

"After my heart attack I was feeling chest pain — I had a heavy heart — I kept going into A&E and hospital but they said I was fine. Then I saw the Heart2Heart therapist and realised I was depressed. I've got a long way to go but I can get out of the house now and am thinking about going back to work".

Financial implications

The £60,000 cost for the first year will be mainstreamed from April 2013. The economic evaluation of the pathway is not complete, however national evidence would support savings per patient of £1,670.

Contact

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FINALIST

Service redesign through clinical leadership, staff, patient and public involvement

Sandwell and West Birmingham Hospitals Trust

The initiative

We serve a diverse urban population with high deprivation and poorer than average health. Many of our acute services were duplicated in the two hospitals. Through service redesign and reconfiguration we are securing sustainable services that provide safe, high quality care, improved patient experience, meet national standards, service demand and enable future innovation.

Two recent reconfigurations involved maternity (early 2011) and stroke services (March 2013). Both redesigns followed concerns about the sustainability of providing care on two sites.

In maternity, a review by the Royal College of Obstetricians and Gynaecologists suggested multi site working was unsustainable, a view endorsed by a new clinical director and head of midwifery. For stroke services a peer review recognised improvements but recommended exploring reconfiguration of acute stroke and TIA services to one site to ensure sustainability. The clinical team supported this view.

Formal redesign projects were established and overseen by joint project steering groups, led by Sandwell PCT. These groups undertook comprehensive engagement and consultation with staff, service users and stakeholders. The aim was to describe the need for change, and explore and shortlist options for improvement.

The overview and scrutiny committees and other key stakeholders were consulted as soon as reconfiguration was a possibility. Papers were taken to a public board meeting and service users and staff engaged in pre-consultation activity to select the options for public consultation. Options were presented through formal public consultation engagement with staff. Clinical leads played a key role, presenting evidence of why services needed to change and likely improvement to outcomes from single site working and new pathways of care.

For stroke services the consultation feedback demonstrated clear public understanding of the need to change and a preference for all services to be located on one site. For maternity services the inclusion of a standalone birth centre in Sandwell was developed from pre-consultation engagement.

Benefits

Delivery of maternity care has radically changed through:

- redefining pathways for high and low risk women;
- introducing single site high risk services;
- focusing on midwifery led care for normal births with two purpose built midwifery led birth centres — one co-located and one standalone on a new site;
- improving safety and quality of care, patient experience and facilities.

We now have the highest normal birth rate in the country: 54% of women in 2011/12 (now 60%). In 2013, our maternity service won the Promoting Natural Birth category at the Royal College of Midwives' national awards and was upgraded to Level 2 for CNST maternity standards.

Stroke and TIA services are now provided in one hospital along clear pathways in a stroke unit with a newly refurbished combined hyperacute stroke ward and a rehabilitation ward.

Experience from stroke reconfiguration in London and Royal College of Physician Guidelines informed the service redesign. An early supported discharge (ESD) team was introduced for Sandwell residents (to be extended to West Birmingham residents) and has facilitated early discharge for 30% of stroke patients with return to work for 40% of ESD patients under retirement age.

Financial implications

Our reconfigurations have been driven by clinical quality and safety concerns and have been used as an opportunity to review staffing levels in line with national standards and best practice. As such, they have not released significant savings.

Contact

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FINALIST

Mind the funding gap: rethinking community substance misuse services in Surrey

Surrey and Borders Partnership FT

The initiative

In March 2011 our three NHS community drug and alcohol services were told that there would be a £892,000 funding gap. With inevitable workforce reductions, including psychiatry, psychology and nursing, service managers were forced to rethink the way the service was organised if quality and capacity were to be maintained.

In doing so there was an opportunity to consolidate and improve services in line with best practice. The following measures were considered to create a more recovery focused service:

- reallocating resources more equitably across the county and aligned to population need;
- standardising processes around prescribing;
- increasing nurse prescribing with support from medics to increase flexibility and reduce spend on ad hoc psychiatry sessions;

- embedding evidence based cognitive behavioural therapy approaches;
- empowering service users to drive their own recovery;
- growing partnerships with trust mental health teams and non statutory organisations to deliver therapy services and support groups previously offered in house.

Benefits

With individual plans for a structured recovery, the service is now more responsive to individual needs. People are prepared for discharge from the outset and the service is avoiding "warehousing" people.

Service users now have a more active role by undertaking training to co-facilitate SMART self help groups as part of their recovery. They undergo the same CRB checks and confidentiality agreements as trust staff, supporting returns to work and enabling some peer support groups to be self running.

Data analysis is enabling outcomes to be recorded more accurately. Trends in key performance indicators can be spotted early and acted upon before the end of the reporting period. Previously errors in the recording of dates could make it appear that people had dropped out of treatment. This is now being tracked and corrected.

We continue to see around 1,400 people per year and quality has been maintained if not improved:

- our figures for successful discharge were 69% in 2010/11 and 71% in 2012/13;
- our latest feedback survey of around 70 service users showed 76% rated their relationship with their key worker as above average;
- despite losing 17 full time posts (21%) only four people were made redundant.

Financial implications

The funding gap was due to a loss of subsidised dispensing from the primary care trust, pay inflation, non pay increases and a £650,000 actual disinvestment by commissioners. The changes would be made gradually — with a 50% reduction by September 2011 and the full amount cut by April 2013. But the timings were still aggressive: the bulk of the redesign had to be operational within six months. The changes were implemented on time and in budget, gaining the confidence of our commissioners.

Having clear data has since helped secure reinvestments totalling around £350,000 in 2012/13 to drive improvements in specific areas.

Contact

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FINALIST

Transforming care at the Bristol Adult Cystic Fibrosis Centre

University Hospitals Bristol Trust

The initiative

Advances in medical treatment mean that CF is no longer a childhood illness. The current average life expectancy of a person with CF is around 34 years, the average life expectancy for a child born today with CF is expected to be in to the 50s. Bristol Adult Cystic Fibrosis Centre (BACFC) manages around 180 patients a year and numbers are increasing by around 10% year on year. It is a tertiary service delivering care to patients across Bristol, Bath, Gloucestershire, Somerset and Wiltshire.

An internal service review, prompted by patient feedback and case studies, revealed an opportunity to extend the multidisciplinary approach and embrace patients with different backgrounds, needs and life goals. We set ourselves the following aims:

- to improve the quality and quantity of information made available to patients and support life choices;
- to work with colleagues in obstetrics to develop a shared pregnancy pathway for CF patients;
- to integrate the clinical information available for each patient;
- to consider the physical and psychosocial needs of patients with end stage disease, including consideration of lung transplantation.

This in turn created an opportunity to bring members of our multidisciplinary team together to:

- assess the current strengths, weaknesses, opportunities and threats of our service;
- shape a vision for the future of the service and formulate solutions;
- design and develop a plan of activities to improve the service;
- implement the solutions;
- evaluate and sustain the changes made.

Our focus was to ensure people with CF have the information they need to make the right choices for them and are supported throughout. This included the key area of supporting choices around parenthood in CF.

Additionally, we worked on creating a new end of life patient care "pathway", including consideration of transplantation, aimed at improving the level of information given and the communication with patients, depending on individual circumstances, in order to better reflect the increased physical and psychosocial needs of patients at this time.

Benefits

Outcomes of the service redesign included:

- redesign of clinics to increase consultant input, as well as new inhaled therapies clinic supported by physiotherapy non medical prescribers, and new nurse led clinics to support the home intravenous antibiotic service;
- design and construction of a comprehensive clinical database. The database facilitates handover and integrates information regarding results, interventions and medications;
- development of the website, Planning for Parenthood (www.cfinfo.org), for patients and their partners who are thinking of having children;
- shared pregnancy pathway developed with colleagues in obstetrics, including joint obstetric clinics; approval for a mother and baby room in our CF ward, with cot and bed for partner
- patient pathway to support patients with end stage disease, including considering transplantation.

Financial implications

We raised funding for the Planning for Parenthood website through successful application for an educational grant from Gilead Sciences UK. Additionally, funding was raised for equipment for the mother and baby room in our CF ward through local charities supporting patients with CF (Comfort Fund and LoveCreate).

Contact

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WINNER

The "WWL Way" — using a partnership approach to achieve demonstrable improvements in culture, staff engagement and performance

Wrightington, Wigan and Leigh FT

The initiative

The WWL way uses skills from a trio of partners, adding both value and rigor to our local staff engagement initiatives.

"Staff Involvement Delivers" offers a range of longstanding partnership initiatives between managers and staff side encouraging honest and open employee dialogue. The "Listening into Action" (LiA) framework provides a compelling approach releasing organisational energy, creativity and idea.

Our "Unipart" partners provide us with discipline and sustainability, maintaining engagement and improvement through visual performance management and enhanced team communication.

Each of these partnerships complements to deliver systematic improvements and create a culture in which employees feel empowered to engage in, and offer up, service improvements through their own initiative. This cultural change is significant and evidence based through both internal pulse checks and the national staff survey.

Benefits

Internally during 2012/13 we have seen an average 29.6% improvement across our ten pulse check questions, including:

- 35% more staff feeling communication from management is effective;
- 34% improvement in day to day frustrations being quickly resolved;
- 32% more staff feeling senior managers encourage new ideas;
- 26% more staff feeling involved in changes in their area;
- 29% more staff believing we provide the very best services to patients;
- 25% more staff having satisfaction that the trust values their work.

In addition, service improvements across QIPP as well as patient experience and performance, can be directly and indirectly tracked to our engagement approach during 2012/13.

Quality and patient experience:
notable improvements in "real time" patient survey data;
improved performance in relation to care quality and waiting time metrics;
service quality gains within our decontamination services;
reduced cancellations within theatres;
improved physical environment by addressing six environmental eyesores identified by our staff.

Innovation:
redefined trust values make the behaviours and leadership style our staff base expects, explicit to our employees;
we currently have over 30 pioneer teams engaged in Unipart or LiA initiatives delivering local change and responding to staff suggestions.

Prevention:
engaged staff are collaborating across the health and social care economy to deliver integrated care in the community and reduce hospital admissions, readmissions and length of stay for patients with long term conditions.

Productivity:
a reduction in delays in theatres;
a 0.8% organisation wide reduction in sickness absence,
a £1.3m reduction in temporary staffing expenditure;
introduction of protected time for staff training, alongside a new easy to use mandatory training system designed round the needs of staff in order to help release staff time to care.

To sustain this improvement we will use the skills and expertise acquired from these partnerships to ensure it becomes embedded as "the way we do things around here", tracking metrics monthly via staff pulse checks and real time patient data. From the demonstrable progress we have made in 2012/13, we have been able to develop and approve permanent and sizeable internal resources to sustain engagement activities into the future.

Contact

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Award sponsored by

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mip managers in partnership

Judges' comments

- *Clear connection being made between partnership and staff engagement, service delivery and quality of care.*
- *Strong indication of leadership commitment to staff engagement – we welcome the involvement of the trust chief executive in presenting the submission.*
- *Good measures to demonstrate positive improvements over time.*
- *Evidence of impact on patient care and strong commitment to involve patients and staff in developing and improving care pathways.*
- *Real evidence of achieving measurable outcomes and contributing to the QIPP agenda.*

FINALIST

Together we can (TWC)

Birmingham Women's FT

The initiative

TWC was launched at a time of significant organisational change affecting almost 20% of staff directly and against the backdrop of a new leadership team and national uncertainty.

As a locally developed engagement programme, TWC has been designed and developed with the aim of empowering staff to use their knowledge and expertise to:

- improve communications;
- design better ways of doing things;
- problem solve.

Since its launch in 2011 an additional aim has been added, which is to improve staff health and well-being. During 2012/13, through the clinical ambitions workstream, the trust evaluated staff views about how services should be developed. Throughout this process there has been high degree of staff involvement.

This has informed our new five year strategy. With change comes fear, uncertainty and doubt (FUD); to ensure that FUD doesn't lead to service paralysis we have continued to operate a regular "board to ward" approach. This has included regular formal and informal director walkabouts involving the governors, and following through with post walkabout feedback and action plans.

Through TWC a multidisciplinary group developed and presented a proposal for locally owned trust values, underpinning those within the NHS constitution. The board adopted the proposal and these have been rolled out across the organisation through:

- branding;
- visual marketing;
- inclusion in staff policies and contracts.

To further embed our values we now aligning our 2013/14 staff recognition scheme with our local values. A staff booklet has been produced that contains information on these values, the trust and local departmental objectives as well as the chief executive's pledge to staff and patients. Staff are encouraged to write their own personal objectives within this booklet.

TWC helps employee relations to remain positive, with regular meetings of both the joint negotiation and the local negotiation committees and, more recently, through the equality and diversity group. Closer partnership working is now a feature of both change management programmes and the process for developing new and reviewing existing policies and procedures.

Our recent staff survey results showed significant improvements. Our staff rated the trust as a place to work or receive treatment in higher than the scores in our three local trusts and also Liverpool Women's.

There has been a noticeable reduction in sickness absence over the past four months; in part due to the outcomes of the 2013 Health and Wellbeing Fair, which was organised by one of the TWC sub groups.

Another outcome has been the introduction of new nursing and midwifery uniforms. This simple change is helping patients and staff to identify staff roles more quickly. To maintain enthusiasm and commitment to TWC we hold regular "Big Conversation" events.

The next event is organised for autumn 2013. This event will be an opportunity to further engage staff while celebrating the successes so far and mapping out staff priorities for 2014/15.

Contact

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FINALIST

Using clinical expertise and staff knowledge to improve patient outcomes and reduce costs

Bridgewater Community Healthcare Trust

The initiative

In January 2013, Bridgewater launched a culture change initiative Transforming Services for One Bridgewater. This bottom up approach harnesses the energy, commitment, and ideas of clinical network leads (CNLs) and staff and is making a rapid and measurable impact on the quality of community services delivered to over one million people across the organisation.

As a newly formed organisation, it was imperative that we respected the different organisational cultures and ways of working. By engaging front line teams and combining talents to create a shared vision and commitment to change, we recognised that by designing our services differently we could:

- improve quality;
- enhance patient experience;
- increase productivity;
- deliver our CIP/QIPP programme in a completely engaged and innovative way.

It was acknowledged that a programme of this scale had to be led by front line clinicians. Clinical networks were established in 2012 and provide the ideal vehicle for staff to review provision, design higher quality and more resilient services fit for the changing health and social care landscape.

Eight workstreams were identified initially; clinical staff were asked how they would improve quality considering the value of partnerships, high clinical standards and engaging patient partners while not forgetting the NHS constitution principles.

A robust governance process was established which included strategic and operational team meetings, with trade union representation. Regular updates also went to the trust's corporate partnership forum and trust board. Launched by the CEO and engaging over three hundred staff via two road shows, eight phase one projects began:

- district nursing;
- musculoskeletal services;
- podiatry
- wheelchairs;
- palliative care;
- falls;
- children's therapies;
- offender health.

In January 2013 work on the first milestone began — the "as is" position. At this stage, there was suspicion from staff, as CIPs and QIPP appeared synonymous with doing more for less. Using a sustainable engagement programme, staff cynicism and suspicion were quickly diminished as staff were engaged and encouraged in taking ownership in the process.

Highly experienced staff defined and set the gold standard for their services, with projects rapidly gaining momentum. The eight phase-one projects have recently completed the second key milestone in their two year project plan — describing the "to be" design for each service.

Front line clinicians and support staff, not managers, have designed the service models in each of the eight services with

projected savings at £2m over two years.

A second road show was held in May 2013 to report back on progress and listen to staff experiences. This critical insight was incorporated and set the direction for phase two projects that are about to commence. A key outcome between phase one and two is the transformation in ownership, as staff take control in identifying the challenges and finding solutions and opportunities for change and improvement.

Contact

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FINALIST

Staff working group and staff board member

Nottingham CityCare Partnership

The initiative

As a staff led organisation CityCare ensure staff are at the centre of the decision-making processes. A staff board member ensures staff views are taken into account at all times and a monthly staff board report allows ideas or concerns to be quickly escalated to decision makers for response.

The staff working group meets monthly and has opportunity to talk with and question an executive board member. The group is supported by a non-executive director to give further oversight and challenge where necessary.

Work with trade unions has been enhanced through joint working. Since forming a staff side partnership committee CityCare has worked collaboratively with unions on policy. Unions have been keen to understand and engage in the commercial aspect of social enterprise to ensure that CityCare remains a competitive and sustainable organisation.

Joint working has been undertaken with the staff working group and both groups are included in all significant developments and change processes from the outset. Current projects on integration and around staff benefits schemes involve management, the working group and unions.

The staff working group sets their own work programme and targets and review progress regularly. The staff board member and non-executive lead work with them in doing this. They are ultimately responsible to those who have elected them and elections are held annually on a rolling programme to ensure accountability and vibrancy.

The engagement structure that CityCare have created allows staff to champion issues that they face daily. For example, two staff members have created a pathway for morbidly obese patients as an alternative to bariatric surgery. They were able to quickly demonstrate the success of their work at board level and gain organisational approval to develop the service further. Through grass roots developments such as these, CityCare are able to involve staff in delivering better care and identifying QIPP developments.

The staff working group has been responsible for the annual staff survey, putting together an action plan where a group member is paired with a board member to implement actions arising. The group also links with community based care groups for close working with patients and carers and have been sponsors of Nottingham-wide awards for young people to further engage with the local community.

A "bright ideas" intranet forum allows individual staff members to ask questions and make comments direct to the working group and senior management where a quick response is required.

Contact

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FINALIST

Developing partnership arrangements between employers and trade unions in clinical commissioning groups in Suffolk

Ipswich and East Suffolk Clinical Commissioning Group and NHS West Suffolk Clinical Commissioning Group

The initiative

In preparation for the establishment of clinical commissioning groups in Suffolk and the transfer of NHS Suffolk staff to these new employers, a workstream was initiated to embed partnership working and develop it to meet the needs of the parties within the CCGs.

Trade union membership was relatively low within NHS Suffolk with few representatives, poor staff engagement and low morale. A major organisational restructuring was undertaken and transition itself was also a major challenge. Improving staff engagement and developing partnership arrangements were seen as a priority to help meet these twin challenges.

With the support of the chief executive and the board, the HR director and trade union full time officers, primarily from MiP and UNISON, worked together to improve trade union density and recruit new representatives of staff through a series of open days. This was highly successful as more representatives were elected and staff felt more confident and engaged in dealing with these challenges. Restructuring and transition were delivered successfully and compulsory redundancies were avoided.

In addition the organisation was able to develop a set of enduring values through engagement with staff and the board. In preparation for transition, new partnership and trade union recognition agreements were developed. They built on existing mechanisms that worked well but drew on the experience of successful partnership working elsewhere to enhance the agreements.

Although all unions recognised nationally with members within the CCG may claim recognition, partnership working is primarily undertaken with MiP, UNISON and the BMA all of whom have local representatives.

Staff engagement within the Suffolk CCGs has grown enormously and this has resulted in strengthened employee relations with our trade unions. An effective staff partnership forum is now in operation and outcomes of meetings are now shared with staff. Staff feel empowered and motivated and are now the driving force behind driving change through.

Two hundred ideas for improved working were generated at the last organisation-wide away day. These ideas were captured into six workstreams:

- communications;
- staff welfare;
- IM&T;
- community engagement;
- leadership;
- staff development.

Each is led by a member of staff and they meet monthly with the HR lead. Ideas are discussed and where appropriate implemented. Over the past six months two thirds of ideas have been implemented and where appropriate have been

discussed with staff side colleagues through the partnership forum.

Staff engagement has enabled sickness levels to remain at an all time low, less that 1%. In addition all staff have started the 2013/14 year with a set of objectives and a personal development plan that have all been signed off by the executive management team.

Contact

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FINALIST

Demonstrating the positive impact of staff engagement to achieve service transformation within a challenging environment and circumstances

North East London FT

The initiative

Following a business transfer in September 2011, North East London FT (NELFT) acquired a demoralised health visiting workforce within the London Borough of Waltham Forest. Staff turnover and sickness levels were high and recruitment of new staff proved difficult because of the negative reputation the health visiting service had.

On transfer, staff were highly critical and distrustful of previous management actions, claiming the previous scale of disestablishment of health visiting posts had led to unmanageable workloads, with high caseloads of children under five where families live within highly deprived socio-economic circumstances.

On transfer, NELFT management set out to re-engage with health visiting teams. However, they quickly recognised that the level of crisis staff were experiencing was leading to a sense of paralysis within teams and inability to develop services.

Enabling health visiting staff to feel able to express their concerns and to know they would receive an effective response became a high priority for NELFT management. Ideas and solutions evolved through listening events with staff and led to six transformation workstreams led by staff, supported by management:

- recruitment and retention;
- role clarification;
- staff and team development;
- structured preceptorship programme;
- enhanced caseload management;
- standardisation of operational procedures.

Contribution to the workstreams and decision making was open to all health visiting staff, who rapidly took on ownership to develop project plans, with clear timeframes, and reported back progress to the wider workforce at staff forum meetings.

Excellent relations and partnership working with local and national trade union representatives have greatly added value to the staff engagement process, leading to staff empowerment, recognition of their role in decision making processes and better patient care and outcomes for children and families.

Assessing the positive impact of the staff engagement process has been measured by undertaking staff and team satisfaction levels in September 2012 and again in April 2013. All staff were invited to complete a questionnaire. Results demonstrate a positive shift in all areas except the ability to meet conflicting demands on staff time at work. This will change with the marked workforce increase scheduled from September 2013.

Responses to the questions: "How enthusiastic do you feel about coming to work?" and "What does feeling valued at work look like?" demonstrate significant positive impacts. While initially this project focused within one borough, early successes led to the processes being replicated wider across teams within all four NELFT boroughs.

Contact

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FINALIST

Improving services through effective staff engagement

Oxleas FT

The initiative

At Oxleas, we have built a culture of excellent staff engagement demonstrated by consistently high results in the NHS staff survey. In 2012, our staff had the highest levels of job satisfaction and the highest proportion able to contribute to improvements in the country.

The creation of this culture at Oxleas, which underpins the NHS constitution and values our staff while ensuring shared values, has taken years. It is the result of a long-standing commitment to our staff and recognition that excellent patient care will not occur unless staff are fully involved and enjoy being part of the organisation.

Our partnership working structure is the application of this culture. We have a partnership agreement that sets out the values and behaviours that underpin our relationship with our trade unions, BME and LGBT networks. This has helped us move up over 100 places in the annual Stonewall survey.

There is an expectation of openness between all parties. Trust is critical for effective staff engagement and maintaining this level of trust requires constant attention from all. The acceptance that things sometimes go wrong but can be rectified with dialogue is an important part of this trust. Our partnership forum is the mechanism by which we achieve this.

To underpin our commitment to genuine staff engagement, we appointed a head of partnership working. The post is an advocate for all staff irrespective of union membership. Working closely with HR, she supports staff through organisational change, runs focus groups and supports organisational developments. She reports directly to the chief executive and has open access to senior managers. Due to the success of this role, a second post has been created.

As part of our response to the Francis Report, the team provides formal reports on the morale of frontline staff to the board and trust staff partnership forum every six months. The principles of partnership working and clear expectations of our line managers are a key part of our culture. We award a prize to the manager who best promotes staff engagement at our Staff Recognition Awards at our annual members' meeting.

The chief executive and executive team are visible across our services and regularly meet with staff governors to discuss how we can improve further. This is supported by line managers

who regularly share information and encourage raising of ideas and concerns. Improvements arising from this include:

- implementation of trust-wide Clozapine clinics that improve the experience of patients on long term medication;
- development of a wound formulary for district nurses;
- improved pulmonary rehabilitation services for prisoners;
- school nursing text messaging;
- improved information for adults with learning disabilities;
- patient co-design work within mental health wards.

Contact

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FINALIST

The Christie 2020 vision

The Christie FT

The initiative

The Christie is a high performing trust where patient care is at the centre of all we do. We are committed to delivering top quality cancer care, accessible to all, alongside excellent education and world class research.

In developing our 2020 vision we understood that our staff are key to the delivery of our ambition to become one of the top five integrated cancer centres in the world. Our staff understand our vision and values because they have been involved in developing them.

Our staff survey results demonstrate that staff are confident in expressing concerns and receiving good feedback. The board of directors and council of governors undertake informal walkabouts across the trust, speaking to staff, listening to any concerns or suggestions. The trust meets regularly with trade union colleagues both formally and informally.

Staff side are represented at the 2020 Staff Vision Forum. Policies are reviewed in partnership and staff side are involved in task and finish groups for specific projects. Our 2020 Staff Vision Forum developed our Christie commitment. Built around our mission — We Care, We Discover, We Teach, our commitment describes the behaviours that we expect from our staff together with our pledges to support and develop our staff.

The pledges have been localised from the staff pledges described in the NHS Constitution. We are consistently one of the top performing trusts in the national in patient survey with patients demonstrating confidence in our services and reporting high quality care.

In our staff survey 93% of staff would recommend the trust as a place to be treated (highest national score was 94%). Our 2012 staff survey results demonstrated improvements across a number of key scores. The majority of scores were above average, no score was below. Staff ability to contribute to improvements at work rose by 9% to 76%.

We have recently revised our induction programme to include a video developed in house by the HR team and members of the 2020 Staff Vision Forum. The video includes contributions from patients and staff describing the excellent care we provide, the importance of our research and real examples of staff development.

Contact

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FINALIST

Putting staff at the heart of a revolution in patient experience

Walsall Healthcare Trust

The initiative

Walsall Healthcare Trust's pathfinder project, Putting People First, put staff at all levels at the heart of the drive to improve patient experience. We worked in partnership with TMI to identify four key areas for improvement through observation, shadowing of staff, focus groups and staff interview.

The key areas were:

- A&E reception;
- the GP admissions and discharge processes;
- one of our surgical wards;
- patient information in the community.

These were areas where we believed improvements could be made with small but meaningful differences in process and behaviour. Staff engaged immediately, and voluntary face-to-face working sessions were well attended by:

- a range of clinical and non clinical staff;
- members of the trust board;
- middle management;
- patient representatives;
- representatives from the CCG.

This broad mix of people worked on a shared agenda. Sessions were focused on patient experience. A number of lightbulb moments included a realisation that although we work in close proximity we sometimes miss the opportunity to work as a team.

A range of improvements came out of the working sessions and were trialled within a month to keep the momentum going. For example, changes in the GP admissions process included a new patient leaflet and GP proforma, improved signage, a redecorated waiting room, a twilight nurse who waits with patients throughout and reduced waiting times.

A broad range of metrics, both quantitative and qualitative, was used to identify what was working well and what wasn't. During the trial period, teams continued to suggest new ideas for improvement, many of which they implemented autonomously.

Following the trial, the ward involved reported a significantly improved staff experience of the GP admission process and its highest result in the Friends & Family Test (FFT) of patient feedback in several months. Improvements recorded in other areas included:

- significantly improved FFT scores in A&E;
- more patients being discharged from hospital before 1pm;
- improved staff communication;
- a focus on patient information;
- improved information for district nurses to ensure a seamless service between the hospital and community.

Comments from staff included:

"During this trial I feel we have been able to give the care we always strived to give."

"Staff morale has definitely improved".

With regard to the future, lessons learned include the need for senior management to recognise the overwhelming sense of duty of care and good intention among staff and the simple steps they are willing to take to improve the patient experience.

Contact

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WINNER

Using radical recruitment strategies to recruit to hard to fill vacancies, achieve long term succession planning, while supporting the nationwide unemployment agenda

Sandwell and West Birmingham Hospitals Trust

The initiative

The trust experiences great difficulties in attracting and recruiting local people into its workforce. Local recruitment deficits occur through low economic growth fuelling the continuing "out migration" of the job qualified. This leaves high levels of unqualified unemployed people and low achievers as our employment resource, resulting in hard to fill vacancies across many occupational areas.

Staff records show that 70% of employees live more than five miles from the workplace. Over the next five years the trust expects 55% of its ageing workforce to reach retirement age. It also regularly suffers an unregistered workforce turnover of 9.5–12%, creating 270 job vacancies annually.

Workforce sustainability is therefore a key objective and it was essential that the trust's recruitment, retention and development strategies were innovative, tailored to local recruitment and addressed succession planning.

Plans were put into place to create a local recruitment centre — The Learning Works — where local people could visit to access NHS Jobs, undergo skills and job assessments, job seeking/interviewing skills and self marketing techniques and sign posted to additionally identified learning. The Learning Works needed to embrace local job initiatives, fusing national policy with the wider economic regeneration plans across the Birmingham and Black Country boundaries.

Expertise drawn from existing learning and development (L&D) staff was used inform all levels of management about the philosophy behind strategies and policy. They also supported the managers in converting qualified staff vacancies to accommodate unqualified people to be developed as a "home grown" qualified member of their team.

Negotiations with the local council ensued, forming a partnership of the largest employers in the area. This partnership enabled local premises to be secured at preferential rates to house The Learning Works. It was Initially launched and manned by L&D staff who have since been collaboratively working with staff from community, neighbourhood projects and Jobcentre Plus.

Benefits

The philosophy of pump primed investment has proven to be an extremely cost effective way of recruiting. Rerouting low achievers, who fail short listing criteria, through pre-apprenticeship development has lead to those recruits gaining successful outcomes in apprenticeship and substantive posts.

Departments investing resources to support the development of inexperienced recruits have done so by using the underspent salary (difference between banded salary and the training allowance paid) to support development and back fill activities, ensuring qualitative development and guaranteed buddy coaching.

This technique quality checks each component of patient

well being providing superior care levels. The care quality aspect, together with the opportunity to use the allocated salary in a creative way highly motivates managers to review and covert "qualified" vacancies into apprenticeships.

Managers' feedback and word of mouth recommendations have advocated the benefits of shaping an unqualified recruit to fit the role — as opposed to retraining pre-trained staff who bring their own values, habits and attitudes.

Financial implications

The finance used to create and operate The Learning Works for its first year was generated through development activities undertaken by the L&D team, using trust salaried substantive staff operating on a rota basis.

A full time coordinator pulls the programmes together and L&D administration staff are shared across the L&D base and The Learning Works, supporting all entities. Below is an example of those costs, based on a dedicated staff model:

- 1 wte Band 6 — centre coordinator £41,684;
- 1 wte Band 6 — trainer/assessor £41,684;
- 1 wte Band 4 — admin supervisor/assessor £25,499;
- receptionist £3,750;
- 12 months rates, rent and utilities £55,000;
- Total £167,617

We also sublet floor space to community groups and other funded enterprises who complement our business and some costs have already been recouped. Prime funding derives from the Skills Funding Agency — supporting apprenticeships, with additional funding available through Jobcentre Plus wage Incentive.

Contact

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Judges' comments

- *Recognising the role of the hospital as a large employer in the community and the impact of employment levels on health. Offering new ways into employment and progression through multi-agency partnership. Pre-employment schemes leading to work experience to apprenticeship.*
- *An innovative model with a clear plan for adoption and spreading throughout the region and potentially nationally.*

HIGHLY COMMENDED

Young blood: apprenticeships in biomedical science

East Kent University Hospitals FT

The initiative

East Kent Hospitals University FT is a large multi-sited trust employing over 7,000 staff serving a local population of around 720,500. In 2011/12 during the strategic workforce planning round, data analysis of the workforce showed that we were under represented in the age profile of 18–24.

Strengthened arrangements for apprenticeships had been piloted in HR in 2011/12. It was decided to build on the approach. HRBPs were asked to work with divisional managers to identify suitable opportunities for the development of apprentices. We wanted to support more front line services.

During this process the need to support entry level appointments in support of the modernising scientific careers was identified. Our head biomedical scientist, haemophilia and education lead for biomedical sciences and the L&D manager did some research and explored what was already available. Their research led them to the conclusion that a locally developed and delivered option was the preferred way forward.

This was proposed and accepted by the pathology board, as it was not only consistent with the strategic aims of the organisation but also an excellent opportunity of providing an alternative pathway for young people to access a career in pathological sciences. We approached Canterbury College and they agreed to develop an apprenticeship programme with us that met both the needs of the service and the academic requirements.

Various stakeholders, including heads of departments, college tutors, and the L&D team were involved in the content. We decided 10 level 3s would be offered as this would be able to be supported from within the current workforce. The college did not have a readily available programme and so had to recruit a tutor with skills in this area.

The college did the initial advert and long listing, there was a huge demand and 194 people applied. 80 were invited to a joint assessment hosted by the college and 20 were interviewed by trust managers and filled the 10 places.

Local managers were given an overview of what their role and responsibilities were in relation to the apprentices and how they, the college and L&D manager had to work together to support the young people. Young people were appointed in March 2013.

Benefits

We have improved workforce profiling and provided a recognised pathway for those young people who wish to progress to obtaining a full degree in biomedical science. Apprentices receive a funded training programme with two educational awards at the end. They also acquire a scientific skill that is transferable to other hospitals and scientific establishments.

We have introduced many automated procedures using technology and innovation. By training the apprentices to work within protocols using the technology we have high quality reproducible results being generated. This frees up registered biomedical scientists and clinical scientists to focus on more complex patients and diagnosis. This has resulted in improved result turnaround times for patient diagnosis.

The trust has improved its 18–24 age profile from 16% of recruits in 2011/12 to 24% of recruits in 2012/13 as per strategic plan. There has been job enrichment for those lab workers and managers involved with enhanced coaching and mentoring skills.

The scheme raises the profile among young people of health care scientists who make up 5% of the NHS workforce but are responsible for around 80% of patient diagnosis.

Financial implications

This approach has required less than £5,000 cash investment. Based on the national salary scale for apprentices of approximately £100 per week, we could have two apprentices per current vacant laboratory technician post at band 2. We therefore have decreased our unit cost within the labs in which the apprentices are working by increasing numbers but maintaining pay bill.

Within the age range 16–18 all training provided by the college to apprentices is fully funded. For any young person aged 19+ a contribution of up to 50% is required from the trust. Of the 10 apprentices employed two required this funding amounting to £4,850.

Contact

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FINALIST

East London apprenticeships

Barts Health Trust

The initiative

Barts Health Trust employs 15,000 staff, the largest single employer in East London, which is highly deprived, has low levels of employment and skills, and high health needs. The public health vision includes themes on making every contact count, workforce health and wellbeing, and the broader determinants of health.

A key aspect of this approach was to focus on health inequalities, based on an analysis of both health and socioeconomic factors in Hackney, Newham, Redbridge, Tower Hamlets and Waltham Forest, a catchment area with in excess of one million residents. The analysis showed that there was a significant gap in clinical outcomes between this area and London and England averages.

Underpinning these inequalities are significant employment and skills deficits that have upstream impacts on community health. On top of significant structural long term unemployment, there was a major issue with youth unemployment with over 12,000 unemployed young people in the area.

The trust took the decision to include the community works for health approach as part its public health programme. Once the public health programme was in place in October 2012, a review was undertaken of the programmes inherited from the legacy trusts, Barts and the London, Newham University and Whipps Cross University. This indicated that there was scope for extending good practice across all six main sites and to provide a service to three boroughs in particular — Newham, Tower Hamlets and Waltham Forest.

At the same time, with a new human resource team in place, there was the opportunity to build community employment imperatives into the resourcing team and to link to skills development approaches. To coordinate this, a community employment steering group was established. The group has terms of reference that are focused on setting targets, agreeing the programme and overcoming difficulties.

An extensive round of stakeholder involvement took place, aimed at establishing a supply line of suitably qualified and job ready candidates for the employment and apprenticeship programme. These included Jobcentre Plus, local authorities and organisations from the community and voluntary sector.

Benefits

- 84 local people were placed into employment (30 in apprenticeships and 54 into substantive band 1 to 3 roles).
- 170 work placements were provided, including 47 by those on health related benefits.
- 335 local people received information, advice and guidance.
- 30 new apprentices were recruited to roles in theatres, pathology labs, sexual health, audiology, central appointments, renal outpatients and public health.

After this trial period, an ambitious programme was developed based on a workforce analysis of existing vacancies and turnover rates. This provided a basis for setting targets of 75% of b1 to b3 vacancies filled by community sourced candidates and to create 150 apprenticeships roles, divided 50:50 between clinical and non clinical areas.

Since April 2013, apprenticeships have been created in facilities management, informatics and corporate administration. A distinctive career route is being piloted in HCA roles, with 10 participants being placed in an extended induction in outpatient locations for six months, to be followed by 12 months training in the level 3 nursing diploma.

Financial implications

The development of the programme considered the financial savings entailed by appointing apprentices instead of band 2 or 3 roles. While these savings did not overwrite the imperatives of the programme in terms of community benefits or workforce development, it should be noted that the savings to the trust in the first 12 months of the programme amount to over £300,000.

As the programme scales up, there is clear scope for this saving to be replicated and expanded. The expansion of capacity and capability in this area has meant that significant investment has been secured in terms of covering training costs and in some cases financial rewards for employing apprentices. In 2012/13 this amounted to over £200,000. While this income cannot be guaranteed in 2013/14, so far £40,000 has been secured in terms of income to deliver training and employment in 2013/14.

These savings and income mean that the management of the community works for health programme is delivered at no net cost to the trust.

Contact

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FINALIST

The Birmingham Youthspace youth board ppi recruitment programme

Birmingham & Solihull Mental Health FT

The initiative

The mental health act (2007) states that mental health trusts have a duty to provide an environment suitable for the age of their patients and there is evidence that adolescent only wards improve quality of care.

Sixteen and seventeen year old females from Birmingham often have to stay in hospitals many miles from home, as there is insufficient local provision. In order to respond to this issue Birmingham & Solihull Mental Health FT have recently opened a ward for these young females in need of inpatient care.

The development team were keen to ensure young people were integral to the development of the project and commissioned the Youthspace youth board to enable this. The youth board were asked to develop a recruitment strategy and a two day induction programme to ensure all clinical staff had appropriate understanding and engagement skills to work with young people. Additionally the youth board were asked to create a digital tour of the ward including a summary of the roles of the different staff members for new patients and their carers and design a patient information booklet as part of the introduction for new inpatients.

The youth board initially designed a recruitment morning for prospective staff during which they showcased the role of the youth board and had an opportunity to talk with candidates in an informal setting. The morning also included a care planning activity task where each candidate worked one to one with a youth board member to develop a care plan. During this the youth board members assessed the candidate competencies and demonstrated the importance of the youth board to the design and delivery of the service.

Interviews for clinical psychologist posts required candidates to complete a role play exercise and formulation of a case which was role played by a youth board member who was an amateur actress. The role play was a observed by the interview panel which included youth board members.

Following this the youth board facilitated two days of induction for the new ward staff that included:

- a showcase of youth board projects;
- team building activities;
- tasks to help young patients understand why some items are restricted and expectations on the ward;
- planning and scripting a digital tour of the ward and taking staff photos for a ward welcome board.

Benefits

This programme involved a great deal of new learning by all involved and a major challenge identified was the lack of adequate planning time for the range of activities. The recognition that this was a greatly empowering and appropriate initiative for both staff and youth board members was evident in the tremendously positive feedback engendered by the project.

Staff feedback included:

"The pre interview tasks were extremely well organised and the feedback from this was professionally delivered and very relevant to the a recruitment process";

"The induction training increased my awareness of how to adapt my practice to young people";

"Great to have input from those that have experienced an admission";

"The interview process was very positive in identifying suitable candidates".

Youth board feedback included:

"Has definitely increased my confidence and I would feel more confident doing this sort of thing again. I think it was also quite therapeutic to be involved and has helped my resilience";

"It has helped me mentally, emotionally, educationally and it' even challenged some of my own views on things and helped me learn things about myself that I never knew before!";

"It has made me believe in myself a bit more and made me confident with my ability in my job".

Financial implications

The Youthspace youth board includes two employed members under apprenticeships and between 30 and 40 volunteers who choose to get involved in projects that they may have an interest in. Basic expenses were paid and the digital tour film was funded at cost from the service staff training funding provision.

Contact

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FINALIST

Band 6 apprentice programme

East London FT

The initiative

The band 6 clinical practice lead role is often considered the most challenging of all. Staff moving from a band 5 staff nurse into the role often describe feeling unprepared, overwhelmed and struggle to meet the demands of being a lead clinician and junior manager. With this in mind, along with the need to develop potential and retain quality staff, an apprentice band 6 programme was developed.

This was a 20 day programme, staggered over a nine month period and broken into three key components.

Clinical

This includes; two days recovery training which focuses on recovery in practice, the art of engagement and developing recovery care plans, physical health training, women's needs, rapid tranquilisation, CPA, family work, risk. Understanding the relationship between the ward and the world are also part of the clinical element of this programme.

Leadership:

This includes a five day leadership programme which looks at leading self, leading others, influencing and developing others. A "Clear as Mud" component looks at how nurse leaders work through the myriad of problems they face and uses experiential learning to explore their relationship with staff and others. A number of sessions explore leadership style, personal strengths and the ability to lead and follow.

Management:

This introduces the apprentices to the bigger picture and an understanding of governance, commissioning, the role of the executive board and the national picture. There is also core staff management training.

Benefits

Throughout the course, there are structured support groups, action, learning sets and recovery reflection groups to support the learning. After each component there are a number of individual assessments focusing on how each person can use the learning in practice and how they can meet the desired competencies.

Each apprentice is allocated a mentor/coach who will support, challenge, assess and be his or her critical friend throughout the course. They will also be given some project work to complete, which they will present to the executive board, service and clinical directors and borough lead nurse at the end of the programme. Successful completion of the programme will result in them being apprentice band 6s and they will be supported in securing substantive band 6 posts within a year of completion. The majority of the sessions are facilitated by staff working for the trust, using the wealth of experience and expertise we have within our organisation.

Financial implications

The training is provided in house so there is no cost to the organisation. The programme and sessions are led and presented by senior professional staff within the trust. Apprentices have the opportunity to supervise a member of staff, shadow other senior professionals and hold the duty senior nurse bleep under supervision. They also have a two week placement of their choice. We feel we have expertise and apprentices can benefit from having trainers who know the organisation and are applying their skills in settings familiar to the apprentices.

Contact

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FINALIST

Recruiting, retaining and rejuvenating health visiting in North East London FT

North East London FT

The initiative

Following a business transfer in September 2011, North East London FT (NELFT) acquired a demoralised health visiting workforce within the London Borough of Waltham Forest.

On transfer, staff turnover and sickness levels were high and recruitment of new staff proved extremely challenging because of the negative reputation the service had. The high vacancy levels within the health visiting service were assessed to be of significant clinical and quality risk, which led to the decision to cover vacant posts with temporary agency staff.

While this mitigated against clinical and quality risks, the financial risk to the organisation quickly became apparent. For NELFT the Government's Call to Action (C2A) investment target to recruit an additional 99 wte health visitors came at a time when the trust already had a very high level of vacancies.

With high vacancy and turnover rates, an ageing workforce (50% aged over 50) and an over reliance on agency staff, creative and innovative ideas were needed to achieve the ambitious target. A project group involving staff, staff side members and management was established to explore and problem-solve issues of health visitor workforce recruitment as well as retaining the existing workforce and rejuvenating the service.

The group developed a project plan to focus on a key question "Why would a health visitor want to work within NELFT?" Following health visitor meetings with a recruitment consultancy, the concept theme of "Open Up Possibilities" emerged from a comment made by a health visitor: "You just don't know what you're going to find behind the door".

The concept design represents opening up possibilities for both children and their families, and health visitor career development. Three health visitors are featured talking about their experiences working within NELFT.

A detailed recruitment, retention, and rejuvenation project plan was developed in collaboration with members of the health visiting teams, staff side union representatives and human resources. Using proactive approaches, such as Saturday recruitment days, NELFT have been highly successful in attracting health visitor applications and appointment of new staff.

Benefits

To date eight wte health visitors have been recruited into post, with a further 30 wte currently going through pre employment checking processes. Further interviews are scheduled with

13 candidates confirmed. In addition, through significantly increasing the number of health visitor students supported in community placements we are expecting to recruit a further 26 health visitors by January 2014. A similar number of students will be supported in 2014/15.

Service user experience is a key priority for NELFT and through the development of the project group the health visitor members have engaged and involved local parents in the design of what a good/excellent health visitor service would look like.

Financial implications

£30,000 was allocated to the project to cover set up costs for developing and implementing the recruitment campaign, create web designs, links to social media sites, promotional materials/ leaflets, stands at university open days and job fairs. Based on the trajectory for increased recruitment figures, direct saving on agency spend is expected to be around £800,000 per annum.

Indirect savings will be realised through reduced sickness among health visiting staff due to a reduction in workload and the resulting saving in management time. Increase in health visitor service productivity as a result of reduced unplanned absenteeism will achieve increased workforce efficiencies and client directed activities. Following implementation of flexible working and flexible retirement policies NELFT has also experienced a reduction in health visitor turnover with only two staff leaving the organisation since January 2013.

Contact

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FINALIST

Development of a qualified nurse preceptorship programme facilitated through the Nursebank flexible workforce team

Nottinghamshire Healthcare Trust

The initiative

The local services nurse bank began in April 2012 and on average receives 3,500 shift requests per month with a third of these being for qualified staff. The aim of the "Starting Out" programme is to provide clinical areas with a newly qualified member of staff to fill short term vacancies that are otherwise difficult to fill, while affording the nurse an opportunity to complete a period of preceptorship.

This approach provides greater continuity of care, which is highly valued by service users and staff, as opposed to the transitory arrangements of temporary staffing solutions. The intended outcomes for the newly qualified nurse are to complete a preceptorship period and attain the competencies for a band 5 staff nurse making them more employable.

The starting out participants are supported to seek substantive employment with the trust or continue bank work. This provides a mechanism to prevent attrition and retain developed staff. The intended outcomes for the trust are the availability of a standardised, well understood, quality assured and monitored approach to employment of newly qualified nurses.

Benefits

The programme was initially piloted with a cohort of nine who qualified in January 2013, the pilot was very successful and became a standing programme extended to nurses returning to practice and those in need of upskilling after changing area.

The programme provides a standardised approach to supporting newly qualified nurses. The feedback from the placements has been extremely positive in that it has allowed them to cover short and long term vacancies with a regular member of qualified staff who can be moulded to the needs and functioning of the ward.

The programme provides better quality care for patients, is more cost effective and provides greater continuity than the usual temporary staffing solutions. It has allowed the opportunity to assess competency and thus decide on future employability.

Financial implications

The programme has required minimal financial support due to the nurse bank already having responsibility for completing the recruitment process for bank members. The recruitment process incurs some costs in relation to CRB checks and the time taken to complete the process which is not recouped should the preceptee withdraw from the programme. The development sessions are scheduled for two hours every six weeks and this does have an additional cost to the service as it is not provided to regular bank staff nurses.

The cost savings of this programme are immediate as the preceptee's are paid at bottom point band 5 in line with their experience whereas the regular bank nurses, who would be required to cover these vacancies, are paid at midpoint band 5. This is a saving of £1.86 per basic hour, £2.45 for a Saturday and nights and £2.98 Sunday and bank holiday per hour per preceptee.

For the initial cohort of nine preceptees this will be saving of £2,718 per month or £32,643 per year in basic wages without taking in to consideration unsocial hours, pension and national insurance contribution savings.

Contact

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FINALIST

Implementing the care support worker development programme at Portsmouth Hospital Trust to improve workforce planning

Portsmouth Hospitals Trust

The initiative

We implemented the care support worker development programme (CSWDP) as we recognised that there was a group of individuals applying to our managed service provider to work as healthcare assistants (HCAs) who weren't passing the recruitment checks or didn't have acute hospital experience.

These individuals did have the right values and beliefs, so we looked at ways we could bring them in and provide them with the right support and training. We also found that, due to the demand for care support workers (CSWs), we had to go out to agencies to fill shifts. This was an expensive option, so we used the CSWDP to grow the available bank workforce, which we believed would give us better quality workers.

The clinical team agreed to implement the CSWDP. Once recruited, the CSWs are required to undertake a five day tutor led classroom training course to achieve the necessary theoretical standard. This is followed by a five day period of ward based supervised practice.

A six month period of paid and supervised work within the trust follows. During this time, trainees form part of the

workforce and are expected to function as a junior care support worker. The programme takes approximately 720 hours, which is roughly 30 hours a week over six months. Band 5 or 6 nurses, or more senior CSWs, act as the CSWs' mentor. When we first introduced the programme to the ward managers, there was some scepticism about the CSWs, but they have proven to be a real asset to the team.

The CSWs were put on a basic band 2 pay, which meant we would gain a substantial saving, compared with using the experienced band staff and agency staff. Improving our workforce planning is very important and we knew that, through implementing the CSWDP, we would be able to fill vacant shifts, as well as having the opportunity to grow the available temporary workforce.

The CSWDP also means we have consistent staff on the wards, which we believe is essential to improving quality and productivity. Recruiting for values from the local health economy has helped create jobs and skilled individuals.

Benefits

The CSWDP has proven to be extremely successful — we've had a 100% success rate and 37 CSWs had completed the programme by May 2013, all of which are working approximately 30 hours a week.

The programme allows us to tap into a pool of resources that we would not otherwise have had access to, with the majority of CSW shifts now being filled by our managed service provider, significantly reducing the reliance of agencies. Many of the CSWs continue to work with the managed service provider and the trust once they have completed their training, and we encourage the ward managers to move the CSWs into a normal CSW pay band so we can continue to book them, to increase our self fill.

The programme incurs lower cost with lower risk than direct recruitment, as the CSWs compliance and governance is monitored and managed by the managed service provider. Indications are that the programme has had a positive impact on care delivery. Each trainee stays on their host ward for the full six months, resulting in good continuation of care, which is difficult to achieve through temporary workers.

Financial implications

Our managed service provider recruits the CSWs directly and pays for their classroom training; this gives us a substantial saving on recruitment costs. The managed service provider's CSWs are much more cost effective than hiring agency workers to fill shifts. Their CSWs have filled 22,402 hours in 2012–13 and we have saved £42,000 through using them.

Contact

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FINALIST

Mixed skill workforce driving successful clinical trials in a district general hospital

United Lincolnshire Hospitals Trust

The initiative

United Lincolnshire Hospitals Trust provides acute hospital services from district general hospitals at Lincoln (County Hospital) and Boston (Pilgrim Hospital) and from hospitals in Grantham, Louth, Skegness and Spalding. It employs over 7,500 staff and treats 180,000 accident and emergency patients, nearly half a million outpatients and almost 100,000 inpatients each year.

Though the trust has large patient populations and employs a large number of staff, in the past it was not supporting clinical trials thus missing out on the contribution to quality improvement that trials can bring.

In general, consultants working in district general hospitals do not have protected time to do research. Clinicians were keen to support multi centre clinical trials but due to a lack of protected time and mixed skill clinical workforce, the trust was not able to support them.

The trust negotiated and attracted funding from the National Institute of Health Research (NIHR) to set up the workforce to provide support to consultants. The Lincolnshire Clinical Research Facility (LCRF) appointed two senior managers to train research nurses (band 6) to take consent where it was possible and provide most of the trial related support.

Band 4 staff members were trained specifically to help consultants:

- complete all governance/ethics and regulatory requirements;
- maintain clinical trials site file and update and apply for amendment;
- facilitate observational and genetic studies;
- take, centrifuge and process blood samples.

A senior clinical trial pharmacist was appointed to train and develop trial pharmacy workforce. In addition, band 2 assistants were specifically trained to help band 4 and research nurses. The department had always had difficulty in recruiting research nurses so we started a nurse/radiographer student placement programme in order to train, prepare and attract future research workforce. Further clinical nurses were seconded and trained after discussion with the trust chief nurse.

Benefits

Due to having a trained mixed skill workforce, our consultants are now able to support trials even though they still do not have protected time. We are now recruiting consultants, and some contact the unit in advance of applying to find out how active we are.

In some cases, the trial findings are implemented, helping patients and the trust. We are among the top recruiters in the country for some trials. A few years ago, the trust was supporting only 12 studies and now there are around 200 ongoing. The trust funding has gone up to £1.5m from £4,500 and the department has become fully self funded.

The trust was able to set up specialised clinical services in stroke and angioplasty services where research was essential criteria. This has helped meet our objective in making clinical trials and treatments available to Lincolnshire patients.

The trust consultants and nurses have developed good links with teaching universities. Quality and productivity have improved many fold without investment by the trust.

Financial implications

This initiative was set up using existing limited staff resource and without any financial support from the trust. All funding was attracted from external sources. The main source of our funding is from the NIHR networks.

Due to running and implementation of clinical trials, the trust is saving quite lot of money. For example in the case of a CLOT stroke trial, it is estimated that from implementation in 2010, it has saved £267,804. In addition, Tandem, SPIRIT 2 and AML16 trials have saved £526,621.

Contact

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