

HST

MEDICAL
PUBLICATION
OF THE YEAR
2012



2012 AWARDS

BEST PRACTICE REPORT

Inspiration and innovation

With over 1,000 entries and more than 120 individual organisations shortlisted, an HSJ Award remains the most fiercely fought over accolade in British healthcare.

Selected from those entries, the winners and finalists are the sharpest of cutting-edge thinking. They 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.

The report explores what our finalists set out to achieve, the methods they chose and outlines the benefits that their initiative produced. Crucially, in an era of efficiency, the reports set out any savings achieved by each project.

The HSJ awards tend to track, and sometimes even run ahead of, changes in the healthcare system. Months before they assume full control, clinical commissioning groups make up all five shortlisted entries in the commissioning category, while the provider trust category is dominated by organisations delivering community-based services.

Despite the instability created by the reorganisation of the commissioning landscape, widespread reconfiguration of the hospital sector and the looming shadow of the *Francis Report*, the NHS and its partners continue to innovate and excel across almost every aspect of healthcare.

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*



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WINNER

Warrington Clinical Commissioning Group

The initiative

Warrington Clinical Commissioning Group was formed in February 2011 and we are now seeking wave 1 authorisation. Twenty eight practices were involved in the development of the CCG, commissioning for a population of 208,000 with full delegated authority for £250m budgets since 1st April 2011. The CCG is co-terminus with Warrington Borough Council.

The CCG clinical forum includes hospital and mental health consultants, GPs, practice nurses, dentists and pharmacists who discuss, debate and advise on commissioning plans. GP board members attend neighbourhood boards to actively engage with local population.

We have strong, robust relationships with all key partners in the town. This has enabled us to address a very challenging financial situation and deal with difficult issues while still maintaining goodwill and a shared vision. Over 65 of our 109 GPs have a named role within commissioning delivery. There are governance mechanisms that allow each partner to hold the others to account.

We looked at the entirety of spend, using the NHS *Atlas of Variation* to identify outcomes, pathways and services where we were an outlier, in terms of:

- Activity;
- Expenditure;
- Quality;
- Outcomes;
- Value, and/or equity.

Using this information we undertook a systematic review of services. Each review group was led by a GP clinical lead with input from relevant secondary care colleagues. Every review group had patient membership.

The reviews analysed data from several sources on activity, expenditure, outcomes and quality and we used these to demonstrate the need for service reform and the shape of those reforms.

Reforms are now being implemented under the Oversight of the Health Summit. The reform programmes resulted in an overall reduction in activity based on the 2010/11 baseline, suggesting that in the programme areas the CCG has been successful at managing activity growth.

Benefits

Warrington CCG, supported by its member practices, delivered a turnaround programme in 2010/12. It has continued moving towards authorisation in 2012/13 by leading system wide transformation of healthcare to improve health outcomes for the people of Warrington and achieve system wide efficiencies.

We practice a business delivery process underpinned by a programme approach to drive reform. This ensures that we maintain:

- A focus of management and supporting resources on the objectives and purpose of the organisation; improving the healthcare system and delivering financial sustainability;
- Delivery of prioritised outcomes, such as patient safety in an environment of expenditure reductions;
- Development of proposals in a way that ensures appropriate decision making;
- Decisions at optimal points in the process to drive delivery;
- Actual and timely implementation of decisions made;



- Minimal use of resource on inappropriate/ unnecessary activity, such as on the development of reform proposals that are not viable or capable of implementation.

Warrington CCG Healthcare Reform Process takes reform, innovation and efficiency proposals from initiation, through case for change development to programme delivery. This process plays a key role in generating ideas for reform and identifying opportunities for innovation and efficiency, both via the market and pathway and service redesign and consolidation.

The Respiratory Long Term Conditions Programme, delivered in 2011/12, is an example. The programme resulted from our service review process. The reform recommendations were taken forward as a pilot to ensure that the reform delivers the required performance and benefits it aims to achieve. The following outcomes were a result of the whole system change:

- Pro active management via correct targeting of cohorts of patients to reduce incidences of acute episodes of disease;
- Maximising coordination with, for example, smoking cessation and IV therapy;
- Increased core hours of community service;
- Provision of community based alternative to short (0-1 day) acute LOS, using referral criteria to ensure compliance;
- A centralised telephone contact line for patients;
- A single point of triage for advice, intervention, sign posting, support, access to pulmonary rehabilitation;
- Protected daily slots for urgent access via the triage contact point.

Financial implications

The CCG has worked within its existing resource allocation to deliver current performance. As part of implementation, use of the CCG's delegated authority to lead contract management as part of the 2012/13 contract cycle, was integral.

Contact

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Judges

Philip DaSilva, co-director, NHS QIPP

Jill Matthews, cluster lead — Primary Care Quality and Safety Ambition, NHS Midlands and East

Andy McKeon, managing director, health, Audit Commission

David Peat, partner, David Peat Solutions and former chief executive, East Lancashire PCT

Elizabeth Wade, head of commissioning policy and membership, NHS Confederation

Commissioning organisation of the year

FINALIST

NHS Bassetlaw Clinical Commissioning Group

The initiative

Bassetlaw CCG was established 18 months ago and has used this time to develop itself in advance of the authorisation process.

The leadership team was keen from the beginning to ensure a real clinical focus to decision making. The CCG has produced health profiles at both practice and CCG level to improve commissioning decisions and services. Our commissioning plans are built upon information from public health, clinical input and consultation with partners including local authorities, patient groups and providers.

We have a comprehensive primary care strategy as well as a clear relationship with the LMC regarding roles and responsibilities. We have worked with practices to improve services, and have reduced GP referrals to secondary care from 3rd quartile nationally to upper quartile by improving clinical engagement at practice level.

The senior team of the PCT has worked with the clinical leadership to develop an approach where staff are empowered with a challenge to be pragmatic, flexible and progressive.

The clinical leadership team has been appointed on a combination of election and appointment to ensure that they have peer support and the high level of competence needed to deliver change. All the new leaders undertook 360° assessment and had a personal development plan based on their objectives.

Benefits

We worked with Doncaster CCG and patient groups to jointly develop service solutions to gaps and sustainability issues associated with local paediatric and maternity services. The plans were supported by the CCG, the hospital board and the cluster are now embedded within the contract for 2012/13.

We led the development of a new approach to urgent care based on senior decision making early in the pathway, improved communication exchange of information and strong multiagency working. This new model has already delivered a 40% reduction in inappropriate emergency admissions.

We worked with the acute trust to ensure that stroke services meet standards set in national best practice guidance. This work was in response to a review of outlier mortality rates by the CCG's Quality and Patient Safety Committee. This has resulted in the trust now achieving stroke targets for our patients.

We worked with clinicians to deliver a prescribing saving of £1.7m in 11/12 (the target was £1m). Quality and cost issues were discussed in public meetings. In particular cephalosporins and quinolone antibiotics have reduced considerably (7%) resulting in a reduction in *Clostridium difficile* cases locally.

Financial implications

The relationships between the clinical leaders and the management team means that clinical time is only used where it is necessary and adds value. In this way, clinicians' time is protected for patient care and costs are reduced.

Engagement with practices led to significant reduction in prescribing spend and in contracts with hospital providers. Through the savings made from prescribing and contract budgets, we have been able to invest in specific improvements in primary and secondary care, including paediatrics, maternity services, urgent care, training and dementia care.

Contact

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FINALIST

NHS Blackpool Clinical Commissioning Group

The initiative

NHS Blackpool CCG was established in April 2011 and is currently undergoing authorisation in wave 1. We face significant health challenges which drive both our short and long term strategic planning. Life expectancy is the worst in the country for males and almost the worst for females. Blackpool people spend a much smaller proportion of their life in good health than average, and levels of deprivation within the town are extremely high.

Using the health data in our JSNA we have worked closely with our health and wellbeing board, identifying the primary causes of poor life expectancy and commissioning targeted interventions that will have the most impact. Our excess deaths lie predominantly in the 15 to 55 age group with the main issues being alcohol, mental health problems, accidents, and cardiovascular disease. We are targeting interventions that can have the most impact, making significant improvements in identification and treatment of cardiovascular disease, atrial fibrillation, COPD and diabetes.

We have commissioned Blackpool wide projects to identify and treat undiagnosed hypertension, to screen all over 65s and those with any chronic disease for atrial fibrillation, to reduce harm and hospital admission due to alcohol misuse and to optimise management of CVD.

We are more than two years into an urgent care redesign and non elective admission reduction programme, using our combined predictive model for identifying high risk patients. We have developed and implemented a single point of access for all mental health services.

Benefits

Strong clinical leadership of the commissioning agenda has had demonstrable benefits for patients in end of life care where we have seen a 41% increase in people being rapidly discharged to their preferred place of death. We have also reduced the incidence of healthcare acquired infections and the number of falls leading to significant harm. We have identified and treated an extra 224 people who were not known to be suffering from atrial fibrillation, hugely reducing their risk of stroke.

We have commissioned a primary care DVT service which, in its first year has assessed more than twice as many patients at significantly less cost than the previous service. We have commissioned alcohol liaison nurses in our local acute trust link patients with alcohol problems into treatment services.

Financial implications

NHS Blackpool CCG inherited a strong financial position from the PCT, with significant surplus and a culture of robust financial governance that we aim to continue. The availability of non recurrent money over the previous two financial years has enabled us to invest to "pump prime" schemes.

Our non elective admissions reduction scheme required £1m initial investment, largely to fund increased capacity in primary and community services. This scheme is now providing savings.

Blackpool sees more than eight million visitors each year, many of whom are elderly and need to access healthcare during their stay. We started a recharge system for residents of other areas using our new unscheduled care services. Income generated by this is almost £300,000 per annum.

Contact

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FINALIST

NHS Nene Clinical Commissioning Group

The initiative

NHS Nene Clinical Commissioning Group (CCG) is estimated to be the fifth largest in the country, covering most of Northamptonshire's districts. It was originally formed in 2007 as Nene Commissioning. Seventy Nene GP practices support the health needs of a registered population of 628,659. This population is expected to rise to 710,400 by 2019.

We have increasingly assumed responsibility for commissioning over the last 12 months. We have championed integrated approaches to care planning and delivery. The Northamptonshire Integrated Care Partnership (NICP), led by Nene, transformed services for elderly, reducing excess bed days by 26%, and for patients at the end of their life, with a 9.32% reduction in deaths occurring in hospital.

We have negotiating contracts with Kettering General FT, Northampton General Hospital Trust and Northamptonshire Healthcare FT for 2012/13. These contracts reflect the priorities for change that our practices identified. We have engaged with more than 10,000 members of the public including 300 delegates at our *Shaping Nene* launch conference.

Benefits

Every clinician and practice manager can help shape the continual development of our clinically and locality led organisation and we are large enough to pool our resources, "devolve risk" and have real commissioning "clout" with providers. For example Nene CCG played a leading role in delivering £26.5m NHS Northamptonshire QIPP savings in 2011/12.

A new community elderly care service, developed with input from all relevant stakeholders including patients, GPs and health and social care representatives. The service aims to ensure older people receive care at home or in a community bed, where possible and clinically appropriate.

Between April 2011 and March 2012, the service ensured 1830 frail older people received community based, rather than hospital based, care, prevented 4,285 excess bed days a year, 312 readmissions from specialist care beds, and 306 emergency admissions a year for patients with class two cellulitis.

The new end of life service provides a 24/7 central point of contact where care is coordinated, and access to services including district nursing, Hospice at Home, Macmillan nurses, Age UK and Cynthia Spencer Hospice.

The end of life service aims to improve patient choice and reduce the proportion of people dying in hospital by 9.7% by 2013. Between April 2011 and January 2012 there was a 9.32% reduction in proportion of deaths occurring in hospital.

The care home advice pharmacist scheme visited 44 care homes, undertaking 1,660 medication reviews, and making 5,451 suggestions based on these medication reviews. In this period, 1,225 drugs were stopped, 1,450 drugs were changed and 134 new drugs started, improving patient care and saving £188,300.

Financial implications

The total budget for NHS Nene CCG for the 2012–13 financial year is £623.8m. Examples of significant savings include:

- Recurrent annual savings on End of Life care of £1,697,000 per annum;
- The care home advice pharmacist service has so far delivered savings of £188,300.

Contact

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FINALIST

NHS Nottingham City Clinical Commissioning Group

The initiative

The driving force of the CCG is the executive committee, which includes nine clinicians. Each has taken lead clinical responsibility for at least one key commissioning area.

The leadership team, with GPs, commissioning colleagues, patients and partners, worked collaboratively to shape our three year commissioning strategy. The focus is on three key outcomes:

- Improving outcomes for patients with long term conditions;
- Reducing cancer mortality;
- Improving the mental health and wellbeing of the population, with a focus on dementia.

A patient engagement toolkit for commissioners, backed by a training programme, has been produced and rolled out across the CCG. This supports commissioners through the engagement process for individuals and organisational stakeholders including the voluntary sector and local authority.

Benefits

While cost improvements are critical to managing tighter NHS budgets, the CCG has placed emphasis on ensuring that service change is also quality driven and improves the patient experience. The following two case studies provide examples.

The crisis response service was developed in response to a growing body of evidence suggesting that such services ensured that fewer people were unnecessarily admitted to hospital or residential care, resulting in better outcomes for individuals and greater efficiency in the system.

The pilot project received 1,091 referrals in its first year. Of these 972 patients (89%) were referred to try to prevent an admission to hospital and 119 patients (11%) to prevent admission to a care home. Savings are estimated at £1.5m for the CCG with additional savings for social care. The service has now been mainstreamed and is piloting clinical support out of hours.

Back pain affects approximately one third of the UK adult population each year — with the total annual NHS cost in excess of £480m. Evaluation highlighted that many patients referred to hospital for orthopaedic treatment could be more effectively treated using primary care interventions. The acute trust had long waits in its spinal department, where conversion rates to surgery were particularly low at 25%.

The launch of a new back pain pathway was attended by more than 90 primary care staff and included presentations from consultants, physiotherapists, and the Nottingham back pain team. More than 50% of orthopaedic patients are now directed to appropriate community based services. This has translated into a reduction in the number of first outpatient appointments and an improvement in the conversion rate. The reduction in spinal appointments alone will save almost £100,000 per year.

Financial implications

The CCG is responsible for the healthcare of 342,000 registered patients, having received delegated authority for commissioning and a budget of £420m from the PCT board in April 2011 — more than 70% of the PCT's revenue resource limit formally transferred to the CCG for day to day control. A financial plan is in place to deliver the CCG's commissioning strategy with in built flexibility to cope with multiple funding scenarios.

Contact

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WINNER

Liverpool Heart and Chest Hospital FT

The initiative

Getting the best out of life is what we offer the communities we serve. We work on prevention in addition to caring for patients and families living with disease. We deliver evidence based practice, and are working to eliminate unnecessary variation but we personalise care to the needs of every patient and their family.

We needed to create a compelling picture of the future, that our staff believed in. This was particularly important in light of the dire economic situation, which may have resulted in our staff becoming demotivated and disengaged just at the time when we needed them most. This led to the creation of our Patient Experience Vision.

The executive team developed a vision articulating how the patient experience could be excellent. The team used a six step approach to the development of the vision, breaking down the steps of the patient journey, to demonstrate the importance of each of these stages for patients and for our staff.

Following this initial draft, it was made real by staff, patients and families who defined and refined it. To bring the story to life this vision was written up as a patient story to paint the picture of how the patient experience could be. It was important at this time to have a strong organisational development plan that encompassed an innovative leadership programme that developed 90%+ of staff who lead others.

Our accommodation was reviewed to ensure that our hospital was fit for purpose to deliver new models of care and day case procedures that were fitting with our Patient Experience Vision.

We have been working to deliver the six steps model of our patient vision for three years. This became the standard by which all our activities, clinical and non clinical, were measured. The vision energised staff, gave them permission to challenge care that did not meet our ambitious standards and focused investment of resources.

Staff performance is measured by their contribution to the vision. Investment in our estate is determined by the vision. Our Electronic Patient Record programme has the vision at its heart and the board uses an innovative set of metrics to monitor progress.

As our work progressed, we adopted the phrase “majoring on the minor”, borrowed from Mayo, this phrase captured exactly what would make the difference between good and great care. Truly understanding the priorities of patients led to innovations that had not been of priority to healthcare workers. For example, the provision of warm blankets in the theatre forward wait area, significantly reduced patient anxiety.

Benefits

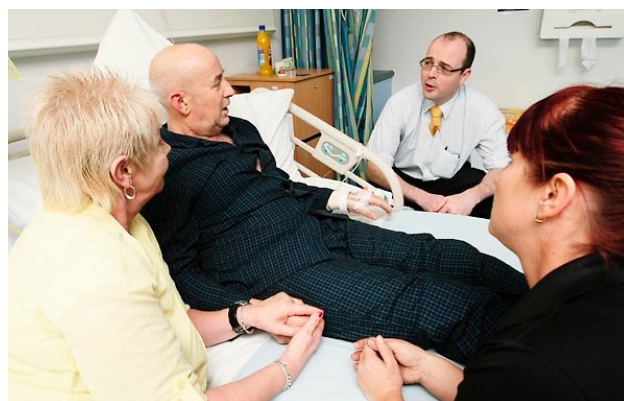
Improvement in patient experience

We were top nationally in five questions including:

- How would you rate how well the doctors and nurses worked together?
- Overall, how would you rate the care you received?

We are significantly better than the national average in 51/69 of the questions asked and worse in none.

In 2009 we scored 91.3. In 2011 we scored 92.46. We have also



increased the gap between 1st and 2nd place to 0.8 points.

Improvement in staff engagement

Our score has now increased to 3.85, which is an increase on our 2010 score of 3.78, and puts us in the top three in the North West. This is against a trend in which 69% of North West trusts reported a lower overall staff engagement score when compared with 2010.

Reduced costs of care

We have reduced the costs of care through reducing waste and through better organisation. For example, we have improved the flow of inpatients through radiology by individualising care; we give patients much more choice over mealtimes so that their relatives can support them, this has led to much better nutrition care and less food waste.

Improved safety

Falls in the hospital have significantly reduced. This was in part due to the innovations we have implemented about open access visiting and carers being encouraged to support patients. We are developing a culture where it is recognised that it is we that are the “visitors” in patients’ lives — not their relatives.

Financial implications

Over three years, less than £100,000 has been invested in project costs. The benefits to patient experience have been delivered by focusing and harnessing the talents of our staff, partners, patients and families. Their motivation to do the best for patients and the hospital has released significant resource (time) that has been deployed to dramatic effect.

For example, it has enabled us to exceed expectations on a newly developed service. The integrated care model for CVD for a population of 180,000 has significantly reduced emergency admissions for heart care and reduced spend by c£1m a year.

Contact

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Judges

Helen Bevan, *chief of service transformation*,
NHS Institute for Innovation and Improvement

Nick Chapman, *chief executive*, NHS Direct

David Colin-Thomé, *consultant*, DCT Consulting

David Flory, *deputy chief executive*, National Health Service

Professor Mayur Lakhani, *general practitioner and chair*,
The National Council for Palliative Care

Mil Milojevic, *director*, Allocate Software

Paul Streets, *director of public and patient experience and engagement*,
Department of Health

Award sponsored by



Provider trust of the year

HIGHLY COMMENDED

Torbay and Southern Devon Health and Care Trust

The initiative

In April 2011, under an agreement with NHS Devon, the trust assumed responsibility for NHS community services in Southern Devon — including 800 staff and nine community hospitals.

The benefits of integrated care are felt by patients/service users and carers, by the staff delivering and managing care and by external partners who have links with our services. Our model uses zone (cluster) based working which brings together health and social care specialists in one office, under a single manager, thereby enabling care services to be developed around the particular needs of the local community.

The implementation of the health and social care coordinator provides patients/service users/carers/GPs and other partners with a single point of contact for the entire range of care services, vastly reducing duplication and bureaucracy. People need to tell their “story” just once to gain assessment and access to the entire range of care services and support.

The continued development of intermediate care services means that people can return home more quickly and safely than ever before, and are therefore enabled to recover in the comfort and security of their own home with the support of NHS care professionals.

We are founding members of the Clinical Cabinet, a unique group linking professional, clinical, commissioning and management expertise to redesign local community, acute, social, and learning disabilities services. The group works to identify opportunities for improving care pathways for the patient, enabling staff to look beyond organisational boundaries and share skill and knowledge.

Benefits

While the objective of integrated care is not financial efficiency, it does deliver good value for money and enable a less management heavy infrastructure.

It is recognised that many of the organisational benefits of integration are experienced outside our own trust. For example, by providing effective health and social care within the community we support people to remain more independent, staying at home when they would otherwise require a hospital stay. This allows acute hospital partners to turn over beds more swiftly, ensuring operational effectiveness.

For the GP community, we enable a far quicker and more responsive referral system, through which a GP can gain quick and immediate access to the local health and social care system.

For our own organisation, the knowledge of individuals' health and social care needs and the needs of the community, brought about through our joined up approach, enables us to develop services which are relevant and accessible.

Financial implications

Due to its integrated model, the trust has both NHS and local authority funding streams. Operational budgets are managed at an organisational and zone level, enabling resources to be deployed locally to achieve maximum effectiveness for communities. Our collaborative work with commissioners and providers will enable us to monitor the impact of developments in care across the whole health and social care community.

Contact

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FINALIST

Birmingham Community Healthcare Trust

The initiative

Birmingham Community Healthcare Trust is the largest provider of community and specialist services in England with a turnover of £255m in 2011/12. Services are delivered by 5,000 dedicated staff operating from over 400 sites and are available to the 1.1 million population of Birmingham and, in the case of our specialist dental and rehabilitation services, to the 5.5 million population of the wider West Midlands region.

The breadth of our provision puts us in a unique position because it enables us to identify where patients would benefit from one or more of our services so that we can develop bespoke, personalised packages of care to meet individual needs holistically.

In response to the national Transforming Community Services programme, the trust acquired £91m of services during 2010/11 with the transfer of over 2,000 staff. With commissioners, the trust established 29 key benefits to be realised from establishing a citywide community provider organisation.

The benefits link to six organisational objectives:

- 1 Delivering consistently high quality of care
- 2 Improve patients' experience of care
- 3 To meet all statutory, financial targets and efficiency requirements
- 4 Delivering care as close to home as possible
- 5 Responsiveness of services to commissioners;
- 6 To ensure fit for purpose workforce, estates and information systems.

In line with a review of the commissioning arrangements across Birmingham it was agreed to move towards one commissioning organisation by April 2011. In parallel, the three Birmingham PCTs reviewed arrangements for the provision of community services.

Our clinical strategy is based upon the use of an integrated services model that places the patient at the centre of service delivery; thus supporting its vision of accessible and responsive, person centred health services for people throughout their lifetime.

We have introduced an innovative approach to adult community services with the implementation of a single telephone point of access for urgent and non urgent referrals. Referrers can access professional to professional advice and signposting to ensure care is delivered in the most appropriate place in each case, reducing the number of unnecessary admissions to secondary care.

Urgent care is delivered by a rapid response service, providing advanced assessment within two hours for patients who can remain at home and require urgent interventions. Integrated multidisciplinary teams, operating on a locality basis, provide district nursing and therapeutic care for patients requiring long term condition management and treatment at home.

Benefits

The transfer of health visiting and school nursing has enabled standardisation of access to services for children and families across Birmingham. Improvements range from more primary visits in the first 15 days after birth to a rise in numbers receiving school leaver immunisations.

Community dental services transfers from five neighbouring PCTs have enabled provision of more clinics, more people treated closer to home, lower waiting times and reduction in inappropriate referrals.

Providing citywide services has also extended opportunities to develop working practices with health and social care partners.

Provider trust of the year

The Learning Disability Service has undertaken a transformation initiative, working in partnership with NHS West Midlands on a national programme to develop a community tariff based on delivery of care pathways. The redesign of current pathways established a number of projects, including successful development of a referral management centre and single point of access.

Rehabilitation Services has launched a series of clinical business units. Successes include the Gait Lab's development of a service for Britain's Paralympians, now being marketed to other providers, and the prosthesis service introducing a prescription matrix to reduce the cost of prosthesis while maintaining quality of technical specification.

Financial implications

Our QIPP continues to improve health outcomes for the population while accommodating rising demands within a fixed resource envelope. This is challenging and can only be achieved through robust programme and performance management, and timely intervention if projects are at risk of non delivery or adversely affecting quality and safety.

The newly established performance programme management office plays an integral role in the performance management and the successful delivery of the QIPP and benefit realisation programmes. The return on investment is clearly demonstrated through the development of a single evidence base of quality improvements and efficiency savings.

Contact

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FINALIST

Derbyshire Community Health Services Trust (DCHS)

The initiatives

The DCHS Way

Our internal culture guides our way of working from patient care to appraisals. It aims to engender common working standards and culture across the trust, being clear about what people can expect from their leaders and what the organisation expects from them in return. It is delivered through structured appraisal, monitoring behaviours against standards and with uniform KPIs setting a minimum expectation around attendance and professional development.

Single Point of Access (SPA)

Single point of access is aimed at relieving service pressure during winter. It brings together DCHS as lead agency, working with local acute, ambulance, local authority and CCGs, initially within North East Derbyshire. It was piloted in winter 2011/12 to manage patient flow of frail elderly population from 37 GP practices, using clinical and service navigation to avoid unnecessary acute admission. It demonstrated positive results benefiting patients and providers — as a result it has become a permanent service in Chesterfield, North East Derbyshire and Bolsover.

Jonah

In response to local health priorities and aging population, we set up Jonah to synchronise discharge planning and transfer, to improve quality of care for patients and to reduce length of stay in community hospitals. Jonah is a QFI programme using a simple database which records a planned date of discharge within 24 hours of admission. All tasks are geared towards achieving that target date. It was initially rolled out across all

our inpatient facilities and has since been rolled out in day services with plans to roll it out to community teams.

Improvement leaders programme (ILP)

ILP is delivered by a home grown faculty of clinical staff in real life clinical positions, with over 200 staff taking part so far in 10 cohorts. Staff are released from their normal duties for time dedicated to ILP. It promotes an organic growth of service improvement champions throughout our services developing their confidence and skills.

Benefits

DCHS Way

Since April 2011 we have seen: increased staff engagement; increased in appraisal completion from 80% to 90%; the organisation working together to deliver a £6.4m cost improvement programme.

SPA

83 patients were referred through the clinical navigation process during the pilot, of those 78 patients avoided an inappropriate acute hospital admission.

Jonah

Benefits to patients/service users: effective, safe care planned around patient need rather than service availability; reduced risks associated with prolonged length of stay; timely mental health assessment and appropriate placement.

Benefits to staff include: improved communication; reduced lengths of stay and occupancy levels, effectively releasing time to care; improved recruitment to mental health wards.

ILP

Our 10 cohorts have generated savings of £1.25m. Key successes include: slashing a 100+ waiting list for speech and language therapy sessions to zero for children needing follow up appointments; maximising the booking systems to manage appointments for podiatric surgery, and meeting coding deadlines has led to increased activity and freed up more than £100,000 for the service.

Financial implications

SPA cost £200,000 to set up, admission costs avoided were £840,000 plus A&E, and ambulance conveyance costs. Cost of admissions to community hospitals was £580,000, with an estimated CCG saving of £60,000 and return on investment of 30%

Jonah's set up costs included purchasing the QFI Jonah discharge software, project coordinator costs and staff training. Significant reductions in length of stay have enabled improvements in quality of care and reduction in bed stock. Length of stay was reduced by 50% in the first two months of implementation resulting in the return of £2.5m to commissioners.

Contact

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FINALIST

Nottingham CityCare Partnership

The initiatives

Carers Federation

The Carers Federation is a programme to extend our offer and improve access, not only to patients, but also to a group of difficult to reach carers whose own health needs are often not a priority for them. The clinics will initially target carers and their families who access services at the Carers Federation, including often forgotten young carers. This bespoke offer will exploit

Provider trust of the year

new technologies and the ability to deliver remotely. The model will provide a holistic approach with carers receiving a health and wellbeing pack.

Boots

We extended choice and access by reinvesting our surplus to rent an entire clinic within Boots Nottingham City Centre store. Feedback from our patients tells us they like the venue and they welcome the extended opening at weekends.

Crisis Response

The Crisis Response team provides interventions allowing a medically stable person to be supported and treated at home, avoiding unnecessary expensive hospital admissions:

- 1,091 patients were referred;
- 89% were seen within four hours;
- 89% were referred to prevent hospital admission;
- 11% were referred to avoid admission to a care home;
- 13% were required no further services.

Care Home Framework Agreement

The Care Home Framework Agreement is CityCare's strategy for growth and demand/capacity management. We identified gaps within the provision of care home placements. We have commissioned palliative care beds for people who do not wish to die in hospital and where their home is also not an option. We adopted a business process of engaging providers with the flexibility we need through a Framework Agreement. This will give CityCare the ability to flex to support commissioners in a timely manner as the at home and hospital demand rises.

Benefits

Carers Federation

The benefits of this initiative include health promotion in addition to core community services. For example, how to recognise and respond to potential pressure ulcers. We will also be trialling remote consultations for carers.

Boots

Patients get access to high quality settings at a venue and time that suits them, even if that is a weekend. There is potential for greater collaboration with Boots around long term conditions — eg diabetic checks and medicines reviews. With foot fall through the store of 100,000 people per week there are health promotion opportunities.

Crisis Response

The Crisis Response service has been able to demonstrate improvements in patient outcomes.

Care Home Framework Agreement

Each year we procure temporary winter pressure beds, and recent acute activity has shown all organisations have to be able to flex to meet demand. Our framework agreement allows us to have a range of beds to call off from step up, intermediate care to palliative. This approach has allowed us to take out of area patients to support local acute and social care.

Financial implications

Crisis Response has saved £1.5m of NHS and £310,000 of social care funding. A grass roots review of the HR, Workforce and Organisational Development Directorate has delivered savings of 40% on the budget.

A new lease car scheme maximising salary sacrifice benefits has saved money as has a new payroll provider. We increased our turnover by gaining new business worth £2,500,000 in 2011/12. We were successful in a bid for social enterprise investment funding to support transformation.

Contact

For more information on this initiative please contact lyn.bacon@nottinghamcitycare.nhs.uk

FINALIST

Tees, Esk and Wear Valleys FT (TEWV)

The initiatives

In 2007 we became the first mental health trust in the UK to adopt a quality improvement system based on the Toyota Production System and adapted for health care by Virginia Mason in Seattle. TEWV QIS is about improving the way we do things by identifying and removing wasteful activities and focusing on those that add value to our customers. Our aim was to embed a culture of continuous improvement across the trust.

It was important that TEWV QIS was led from the top and the board give a longterm commitment to embedding the system in the organisation. A dedicated team was established to lead the work and to train other staff. All our directors and most of our senior managers were trained as "certified leaders" and they are leading improvement activities and helping embed TEWV QIS. We also developed an abridged version of the training programme (QIS for leaders) and a programme for medics and these are both being rolled out across the organisation and over 200 medics and 100 leaders have been or are being trained. Improvement activities include:

- Rapid process improvement workshops (RPIWs) — week long, intensive workshops which empower staff to develop and implement change (85 held);
- 3P events — a radical approach to design. Examples include redesigning a learning disabilities inpatient unit and development of the trust electronic patient record (12 held);
- Kaizen (improvement) events — shorter, one to two day events (16 held);
- Rapid pathway development workshops — based on principles of RPIWs, devised by the trust to facilitate the development of care pathways (11 held);
- Share and spread programmes — an initiative developed by the trust to ensure we are able to successfully replicate best practice in all areas of the trust (24 held).

Benefits

In the last five years we have:

- Piloted in one of our adult wards and subsequently rolled out across adult and older people's wards our purposeful inpatient admission project (PIPA). This has reduced average lengths of stay across adult and older peoples' assessment and treatment wards (from 49 in 2009/10 to 37 in 2011/12) and significantly reduced the levels of violence and aggression on the wards (reduced by 80% over two years);
- Bed numbers were also reduced by almost a third (499 to 328). This resulted in efficiency savings of approximately £7m and meant we could reconfigure and reinvest in community services and develop new services;
- Developed clinical pathways including psychosis, dementia and falls;
- Reduced referral to treatment time in children and young people's services from 162 days to 35 days;
- Increased specialist mental health support for older people in care homes. This halved the number of admissions to mental health hospitals.

Financial implications

Investment to date (TEWV QIS) in training staff, running improvement events and funding a dedicated team has been approximately £500,000.

Contact

For more information on this initiative please contact tewv.enquiries@nhs.net

WINNER

Right person, right place, today!

Hilary Neve and Liz Brimacombe

St Levan Surgery

Background

Demand for general practice consultations has risen from an average of 3.9 per patient per year in 1995 to 5.5 in 2008. As more people with chronic health problems live longer, the complexity of those consultations has also increased.

In 2008, struggling to cope with this demand and to meet national requirements, St Levan Surgery radically redesigned its appointment system. We wanted to improve the service we offered patients and enable doctors to spend more time with the patients who needed them most.

Under the new system, patients no longer need to book appointments days or weeks ahead. Instead, every patient requesting a doctor's appointment or advice receives a telephone call from a GP, usually within an hour — and, if needed, a GP appointment on the day and time of their choice.

The process

The initiative required a team that was willing to rethink how they delivered care to patients. We held away days for partners and staff to plan the change. We sent a letter to all patients explaining the new system and employed additional doctors for a two week period so we would have empty surgeries on launch day. Once launched we closely monitored demand, workload and patient satisfaction.

How it works:

- The receptionist takes the patient's details and adds them to the doctor's screen;
- The GP calls the patient back, usually within an hour, prioritising those with more urgent symptoms;
- Patient and doctor agree a management plan and book an appointment if needed. Most patients choose to be seen the same day — but can book for a day and doctor of their choice;
- Where patients don't need an appointment, GPs give advice, signpost to other healthcare services, organise investigations and arrange follow up — often by phone.

All patients can speak to a GP the same day, whatever time of day they ring, leaving no unmet patient needs for the out of hours services. Special arrangements are made for people with language, hearing and other difficulties.

Evidence shows our A&E attendances are 38% less than expected for our practice demographic and an average of 20% lower for practices using a similar approach. Patient satisfaction is greatly improved.

Advice to other organisations

The approach has now been adapted for use in over 40 other general practices in a range of settings. It is simple to implement and could very easily be applied in other general practices throughout the UK. The benefits appear to be replicated across the practices using this system.

Benefits of the initiative

- Patients choose their appointment time.
- GPs speak to all patients, so urgent symptoms are identified promptly.
- No unnecessary visits to the surgery — this is particularly valuable for working people, carers, and people with mobility problems.
- Doctors spend longer with patients with greatest need.



- 67% patients are seen on same day, more than half of patients receive a call within 30 minutes.
- Quality of care has improved: we book appointment length according to patients' needs.

Only about 30% of phone consultations result in a doctor's appointment. Doctors usually see the patients they have spoken to by phone — this provides better continuity. The initial phone call enables doctors to gather information so they are fully prepared for patient appointments. Phone calls are spread out across the day — there is no longer a queue of patients outside the front door and a deluge of calls at 8.30 from patients.

Financial implications

The set up cost was minimal, consisting of:

- Doctor cover for an away afternoon;
- Additional locum sessions in the two weeks prior to launch;
- Postage and printing for letters to all patient households;
- Time for monitoring and evaluation;
- Staff training.

The financial benefits are to other services:

- Reduced pressure on out of hours health services as all patients have GP contact on the day they call. There are no unmet needs for other services to deal with;
- 20% average reduction in A&E attendances, estimated as £4 saving per registered patient per year: this means a saving of over £25,000 a year.

Future plans

We intend to share our experiences:

- Locally, through workshops in Plymouth and offering support and advice to practices in Devon.
- Nationally as a member of Patient Access, a social enterprise set up to promote this initiative and support other practices who are interested in using this approach.

Contact

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Judges

Sir Stephen, Bubb, *chief executive, ACEVO*

Penny Pereira, *assistant director, The Health Foundation*

Rebecca Rosen, *senior fellow in health policy, Nuffield Trust*

Richard Taunt, *deputy director, NHS Policy and Strategy Unit, Department of Health*

HIGHLY COMMENDED

Anticipatory care through General Practice Provider Organisations

Ian Greaves

Gnosall Surgery

The initiative

The initiative was a service to review the health and social care inputs for the top 300 high risk and expensive patients in a primary care setting.

The principles of anticipatory care and personalisation within a personal health budget pilot were used to create care and treatment plans to empower self help and care planning.

300 patients were identified from Secondary Uses Service data provided by the clinical commissioning group along with those identified from long term condition databases and the 75 birthday card system described in the Staywell 75+ beacon service.

A paid volunteer was employed to visit, befriend and perform structured case analysis on these patients to prepare information for the case review. The senior partner returned from retirement to review six cases in a session. Consultations with the patient and family identified needs and created care plans. Each health care input was reviewed against outcomes. This optimised the patient journey and set out an agreed risk management especially to avoid non elective admissions. A treatment plan set details of care inputs.

Written confirmation of the plans were given to the patient and they were asked to performance manage these. The original paper based system was transferred to iPads to enable improved communication, patient reported outcomes (PROMS) and performance management by the family. These pads were linked to EMIS general practice software.

The patient-held record notified the family if the service failed. All Stafford and Cannock area practices are forming two General Practice Provider Organisations (GPPOs). This structure enables community service commissioning. AQP, integration with existing trusts and direct service procurement provides income and converts savings to income. The QIPP is £4 for every £1 spent.

Benefits

The pilot was fully evaluated for process and financial metrics by teams from Stafford CCG, SHA, NICE and the joint commissioning unit at Staffordshire County Council.

The pilot showed a QIPP where hospital activity was reduced. The budget for an 8,000 list size was £8m (50% below national average) but the use of resources changed from £300,000 overuse in 2010–12 to £1.4m under plan for 2011–12.

The transfer of control to the family is matched to the responsibility for service use including emergency call out. Non-elective admissions were reduced by 20% and A&E attendances by 310 in a year.

The holistic assessment included social care inputs and generated frequent discussions around the tension between health, which is free, and means tested social care. Innovative alternatives to social care ranging from personal assistant to alternative accommodation to care homes were developed as spin offs. These reduced costs and inheritance loss.

Financial implications

Total input costs were £42,200. If the service was commissioned through the GPPOs then for Stafford (170,000 patients) the costs would be £900,000. The total service including pad rentals could be commissioned for £1m Cannock (165,000) patients would cost similar amounts.

This should produce at least £8m QIPP. The provider structure allows release of savings to service delivery. The anticipatory care plan accompanied the patient into hospital at admission. The excess beds days for complex cases was reduced from an average of 21 to nine, as it was easier to upgrade a care plan than create a new one in A&E. The majority of patients could be safely discharged back to home, reducing long term care costs.

Contact

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FINALIST

Community Elderly Care Service Bharath Lakkappa and Peter Watson NHS Nene Clinical Commissioning Group

The initiative

In Northamptonshire, the population is ageing and the number of people aged 65 and above is expected to be one in five by the year 2019, including another 5,000 people aged over 85.

This change in the local demographic will put additional pressure onto the health service. NHS Nene Clinical Commissioning Group worked with partners in health and social care to ensure frail elderly patients receive their care in the most appropriate setting, and help reduce the number of avoidable hospital admissions among this vulnerable group.

The Community Elderly Care Service (CECS) was developed and commissioned by Nene Commissioning with agreement from all members of the Northamptonshire Integrated Care Partnership (NICP), which is made up of representatives of all parts of the local health service including hospitals, GPs, community health services and local authorities.

CECS was developed with input from all relevant stakeholders including patients, GPs, and representatives from all sections of health and social care. The aim was to ensure older people receive their care either in the comfort of their own home or in a community bed. The service has an annual budget of £3.7m that is managed by Nene.

Under the CECS scheme, patients have access to a dedicated community team including nurses, pharmacists, intermediate care, social care staff and consultants who specialise in working with the elderly.

GPs or hospitals refer patients to the intermediate care team (ICT) who then assess them. The ICT have direct access to consultant geriatricians and psycho geriatricians for a comprehensive medical/psychiatric assessment and planning. Once assessed the patients are cared for either in their own home, or in a CECS community bed, depending on the patient's need.

Benefits

The service launched in December 2010, between the start of April 2011 and the end of March 2012 the service ensured 1,830 frail older people received community based care and avoided having to be admitted to hospital.

In addition it has prevented:

- 4,285 excess bed days a year for frail, elderly patients;
- 306 emergency admissions a year for patients with class two cellulitis eligible for home and antibiotic therapy;
- 312 readmissions from specialist care centre beds

The service has also improved integration between different parts of health and social care services, improved speed of access to quality care for frail elderly patients, and provided a daily pharmacist review for those in the specialist care centre beds.

Acute and primary care innovation

Financial implications

The service costs approximately £3.7m for 2012/13, but is expected to make a net saving of around £2.2m over the year.

Contact

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FINALIST

Innovative integrated care for acute and primary care in North West London — for people with diabetes and people aged 75 years and older

Jonathon Valabhji and Scott Hamilton
NHS North West London,
Integrated Care Pilot (ICP)

The initiative

The aim of the North West London ICP was to:

- Improve outcomes for patients;
- Create access to improved care outside hospital;
- Reduce unnecessary hospital admissions;
- Enable effective working of professionals across provider boundaries;
- Deliver annual £14m efficiency savings.

The ICP addresses major issues that normally prevent the delivery of widespread integrated care. These are:

- A governance structure so all organisations share and work to the same objectives;
- Financial incentives and work within agreed guidelines;
- Information technology that supports integrated care;
- Sufficient scale — including two hospitals, community services, 100 GP practices and five local authorities.

The ICP covers the care of people with diabetes and those aged over 75, representing 10% of the population and 28% of budget in North West London.

The planning and coordination of care across patient settings is by multidisciplinary groups (MDGs). MDGs include primary, community, mental, social, voluntary and acute representatives covering around 50,000 patients. This shared accountability fairly rewards clinicians and organisations for the costs of providing care. It includes an agreed system whereby commissioners and providers share the financial gain if the pilot exceeds its objectives.

Clinicians have worked within agreed clinical guidelines with aligned incentives; a governance structure has ensured set objectives are maintained and a funding model has fairly rewarded partners for the costs of providing care; an IT system has supported integrated care, linking with stakeholders' strategies

All care providers reviewed patient information and proactively risk stratified patients. The IT tool generated care plans including work lists for providers where care plans can be shared.

Benefits

The key change for GPs and consultants is that they are jointly accountable for performance and working in multidisciplinary groups including primary, community, mental, social, voluntary and acute representatives. The IT tool has helped them to:

- Proactively plan care by identifying high risk patients using population segmentation and risk stratification;
- Coordinate and plan care for patients (sharing these plans across settings) and monitor progress;

- View patient medical information from multiple settings;
- Spread best practice by tracking and evaluating the performance across GPs and MDGs;
- Provide patients with access to their care plans to encourage a greater understanding of their own health issues.

MDGs have been able to spend available money to increase out of hospital care capacity. Examples of this spending include:

- Starting a 24 hour turnaround email service;
- Increasing the capacity of a falls service;
- Funding an additional diabetes specialist nurse;
- Providing additional diabetes education;
- Piloting a programme for A&E consultants to call GPs before patients are admitted.

Improved case management reduced duplication of clinical investigations resulting in less disruption to patients' lives by ensuring that everyone involved in their care has been "in the loop".

Financial implications

The initiative required an investment of £2.5m in:

Out of hospital resources

The ICP allocates £40 (previously £80) for each elderly patient and £20 (previously £40) for each patient with diabetes. This funds additional care planning and case management, the time of clinicians to engage in multidisciplinary working and the deployment of more primary, social and community care.

Hospital care

This included the need for A&E to flag patients that are part of the ICP and can be entered into the information tool to enable planning for care outside of A&E.

The ICP has also required a £1.8m investment in infrastructure, including the operational team, IT operations and evaluation.

If the ICP prevents one emergency admission a month for each participating GP this will save the local health service £14m a year.

This entry was also a finalist in the **Enhancing care with data and information management category*

Contact

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FINALIST

Implementation of a care bundle to improve mortality for community acquired pneumonia

Trish Winn
North West London Hospitals Trust

The initiative

The aim of the initiative was to develop a care bundle for the management and treatment of patients with community acquired pneumonia.

National guidelines by the British Thoracic Society have highlighted that pneumonia has the highest mortality rates of all medical conditions. Community acquired pneumonia is a survivable condition and mortality rates can be reduced with the implementation of five to six key interventions. North West London Hospitals Trust has already made reductions in mortality rates through the implementation of care bundles for COPD and heart failure using a sticker design. This project

Acute and primary care innovation

aimed to take this process further in developing a care bundle for community acquired pneumonia

The initiative involved the development and implementation of a care bundle using evidence based research. The care bundle identified key interventions proven to reduce mortality rates. These were:

- Confirmation of diagnosis with an X ray;
- Assessment using CURB 65 score;
- Assessment of oximetry;
- Antibiotic therapy given within four hours of diagnosis;
- Assessment of patient acuity using NEWScore.

The data was collected weekly and entered on to a web reporting tool. This gave evidence of compliance and was fed back to staff weekly.

Quality improvement methodology was used to implement the process and ensure sustainability. This process included the use of staff feedback and communication, the use of process mapping to identify gaps and "plan, do, study, act" cycles to change the process and embed the process.

Benefits

The CURB 65 score indicates the severity of the patient's condition with one being mild and five denoting the most severe. Findings showed that 80% of patients had a CURB 65 of 3 and above this was at variance with national data which showed that 70% had a CURB 65 score of 1–2. The average age of patients was 83.

There was a reduction in mortality from 26% to 18% across the evaluation period. There was also a reduction of length of stay from 10 to nine days.

This work has led to the development of further care bundles and has contributed to the development of quality metrics for medical conditions. The trust is working on the following care bundles:

- Caesarean section;
- Asthma;
- Pyelonephritis;
- Pulmonary embolism;
- Alcohol withdrawal;
- Upper gastro-intestinal bleed.

Financial implications

The project team received £50,000 to develop this initiative. This was used for training and educating staff, developing the care bundle and printing information leaflets for patients. The cost of the care bundle now it is in place is £700 a year.

The initiative contributed to the reduction in overall length of stay leading to releasing savings of £200,000. In addition, it was calculated that 49 lives had been saved due to this initiative.

Contact

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FINALIST

Hospital Alcohol Liaison Project (HALP)

Mary Ninkovic and Christine Greer

Peterborough and Stamford Hospitals FT and Drinksense

The initiative

Peterborough has had a high rate of alcohol attributable hospital admissions. There is strong national evidence in support of alcohol liaison work in hospitals. A local project,

HALP, delivered by a third sector provider Drinksense, operating in Peterborough City Hospital (PCH) in 2011/12 has demonstrated the impact such work can achieve in relation to health outcomes and reduced hospital admissions.

We contracted with Drinksense to place alcohol liaison workers (1 wte) in Peterborough City Hospital. The workers engaged with over 20 wards, departments and clinics, building referral pathways and confidence in the service.

Continuing local commitment to HALP in primary care, PCH and other service providers has brought transformational opportunities to develop the alcohol pathway and, particularly, increase impact with high intensity service users.

Benefits

We analysed the data on a pilot year in which 373 people were referred to the service. We were able to track patients who had a history of multiple admissions and saw very promising changes in their admission rates after the intervention.

By reviewing data at a patient level, we were able to estimate savings with greater accuracy than the available national models and provide compelling evidence of costs avoided and improved health outcomes.

Patient stories support the impacts indicated by the data:

- There are patients who have been alcohol free and have engaged with community based treatment and support services following the HALP intervention who are likely otherwise to have been repeatedly admitted to hospital;
- There are patients who, as a result of the HALP intervention have been able to appropriately engage with the treatments on offer (for example, one is now fit for liver transplant and is awaiting a donor organ; another has had a transjugular intrahepatic portosystemic shunt (TIPSS) which enables better liver function and will reduce the need for future admissions).

Financial implications

The project's impact is upon costs avoided. We compared admissions and cost of admissions of 60 patients for 10 months of 2010/11 with 10 months of 2011/12. Of the 60, 25 had a pattern of hospital admissions over the two years. 16 showed a reduced cost of admission in 2011/12 (the year of the intervention) compared with 2010/11, equating to a saving of £31,268.

Of nine patients showing an increase in costs of admission between the two years:

- Seven incurred all costs before referral for the HALP intervention (ie there were no further admissions following the intervention);
- One had a second HALP intervention during a second admission (net increase £132) and none since;
- The final patient had had 11 admissions over two years at a total cost of £26,869. In 2011/12 this individual had two admissions prior to HALP (total cost £8,371) followed by three further admissions (total cost £6,091), each with a further HALP intervention.

There have been no further admissions since the most recent intervention in November. While a longer view will be necessary for confidence, the indication is that after HALP intervention the number and rate of readmission has reduced, possibly halted, with an associated annual saving of between £2,000 and £14,000 for this patient alone.

Contact

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FINALIST

Outpatient and home parenteral antibiotic therapy and anti-coagulation service.

Selina Hogue and Barbara Partington
South Devon Healthcare FT

The initiative

The outpatient and home parenteral antibiotic therapy (OHPAT) and anti-coagulation initiative was implemented to facilitate rapid discharge from acute hospital care and to mitigate patient admission by providing care within the patients' own home or in an outpatient setting.

The aims of this service were to:

- Provide the best care for patients;
- Prevent admissions and reduce length of stay by treating patients at home or in outpatient settings;
- Reduce the patient's risks of acquiring healthcare associated infection;
- Provide integrated care between acute and primary care;
- Support a 10% reduction in nursing home admissions.

In order to develop the service it was necessary to involve the stakeholders and patient representatives. Audits were undertaken to identify numbers admitted into hospital with deep vein thrombosis (DVT) and pulmonary embolus (PE).

Delivering home or outpatient intravenous antibiotics involved auditing numbers of patients with cellulitis admitted to A&E and the emergency assessment unit. From this data a business case was developed and funding obtained for 5 wte specialist nurses to provide a seven day OHPAT and anti-coagulation service.

In order for the initiative to be successful, new ways of working had to be implemented. It was necessary to influence change among professionals and the patients in an acute setting to encourage referrals. Small episodes of change were used to pilot new processes and pathways, which in turn showed successful outcomes and gained the team credibility.

Educational programmes were developed to support the nurses in new roles, along with new policies, supported by a consultant haematologist and a microbiologist. Patient group directives (PGDs) were developed to allow nurses the autonomy to prescribe warfarin and fragmin.

Benefits

Combining an OHPAT and anti-coagulation service run by the same team of specialist nurses, working seven days a week running a "virtual ward", is an excellent formula for a dedicated, enthusiastic and knowledgeable workforce.

There were no *Clostridium difficile* infections in patients. There have been no postoperative thromboembolic complications. The readmission rate for patients with infection after OHPAT was 4%.

Improvements have been made to the referral process by the development of the enhanced recovery programme that ensures patients with sepsis and UTI's are highlighted in the A&E and assessment wards and referred to OHPAT for earlier discharge.

Financial implications

The initiative saved 1,697 bed days in 2011, additionally, deep vein thrombosis and pulmonary embolus management saved approximately 1,750, perioperative 558 and atrial fibrillation 1,440 bed days. The total bed days saved for one year was approximately 5,445. Our average cost per bed day is £127.

The project has resulted in financial savings of around £500,000 in 2011.

Contact

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FINALIST

Patient journey maps

Harry Madhar and Christopher Davies
Walsall Healthcare Trust

The initiative

The initiative was designed to support patients in understanding the entire journey of care that they would go through for specific procedures. Instead of giving patients pages of information we decided to create a patient road map. This highly visual, easy to understand map outlined the journey that the patient would go through, from referral by a healthcare professional through to treatment. Each stage of the patient's journey had with it specific information on what the patient could expect eg tests, location and which staff would see them.

The map was created following work with patients who identified that one of the main issues they had with treatment was that they were not informed enough on what would happen to them during various stages of their admission process.

Initially we worked with the cardiology, trauma and orthopaedics departments to identify the main steps that a patient would undertake to be seen and treated for chest pain and hip/knee replacements. We then redeveloped this information using existing documentation applying the principles of road signs.

These were then put into a pictorial flow, starting at referral through to discharge. Each step was clearly defined using numbers. This map was retested with staff from the departments to make sure that it was accurate and easy to understand.

It was then shared with patients to see what their views were and identify any areas that they did not understand or had concerns with. These were then incorporated into the new map. For example patients identified that clear language must be used — no abbreviations and not too much medical jargon.

They also found it helpful to know the timings between steps and said that the use of symbols was excellent as it was a language that they were familiar with.

Benefits

The main benefits are:

- Reducing patient anxiety, as they understand the specific steps that they will need to go through for their procedure;
- Helping patients to plan for the procedure;
- Acting as a common currency across all sectors of health. This aids integration and better partnership working;
- Supporting achievement of national performance targets, as times to be seen are clearly identified on the map.

The map also has an important role in showing other teams how the care they provide impacts on other services that the patient will use during their journey.

Financial implications

The main financial resource was the time of the improvement team in designing and developing the maps, and wider staff in meeting to ensure that the map was accurate and clear. The departments have absorbed printing costs.

Contact

For more information on this initiative please contact
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WINNER

A pan London approach to improve quality, access and patient experience in general practice

Gary Williams and Howard Freeman

NHS London

Background

There is wide variation in performance and gaps in the quality of care in general practice across London. Lead GPs, NHS London, London PCTs and London-wide local medical committees (LMCs) began a major new initiative to tackle variation in quality in August 2010. The pan London General Practice Outcome Standards and Framework (GPOSandF) is central to London's strategy to achieve excellence in general practice provision

Evidence from The King's Fund inquiry is that general practice needs to own the quality agenda and take on professional leadership for quality improvement for performance to improve. It recommends publishing information about practice performance so that clinicians have the data they need to prioritise areas for improvement and sharing this transparently with the public and professional peers.

The process

The GPOSandF is the first time a region has brought together a set of standards that provide a comprehensive overview of general practice provision. In collaboration with stakeholders, including the public, King's Fund and Imperial College London, a pan London performance framework and set of outcome standards have been agreed. These represent the core contribution of general practice to delivering the NHS outcomes framework and are:

- Patient focused;
- Outcome focused;
- Evidence based;
- Measurable now;
- Achievable.

To engage a broad spectrum of GPs in using this information to improve their service, general practices were given first sight of the data so they could report errors and improve practice.

Commissioners and general practice now have access to a restricted web tool that alerts to risk, highlights excellence and identifies practices in the middle range of performance where there is greatest potential to improve. The capital's 1,600 practices have been graded into four quality categories.

The leadership for this work has come from GPs. The standards represent a professionally led view of quality and provide a comprehensive overview of the services provided by general practice. The clinically agreed thresholds for identifying and escalating risks apply proper statistical variation analysis.

The outcome standards are presented to the public on the *myhealthlondon* website in a simplified format. The website includes tools to support GPs and CCGs in garnering insight, feedback and engagement with the public in broader areas of health and social care in London.

Advice to other organisations

The London approach is evidence based and builds on best practice. It is relevant to all primary care commissioners and general practices and could be adopted elsewhere. The model has huge potential to reduce variation in primary care in other regions and nationally.

The website is highly adaptable and transferable, it could be scaled and rolled out nationally.



Benefits of the initiative

For the first time patients can easily compare the quality of care they receive from their practice with other practices in London in areas like childhood vaccinations and cytology.

General practices have a tool designed for them to have full awareness of the health outcomes they deliver, which they can benchmark against other practices across London with similar practice characteristics, such as list size and deprivation.

Eight hundred practices (50%) in London validated their data and benefited from training on the use of such tools in delivering the best possible patient care. This significantly improved the quality and robustness of the data published.

There have been over 75,000 visits by the public to *myhealthlondon*.

Financial implications

All development work has been done in house by NHS London. The restricted access alert tool for general practice and commissioners was developed by a London GP and cost £26,000.

The cost of the digital package was around £120,000. This included a tool so the public can compare outcomes, a webpage and intranet page for every GP practice in London (over 1,600 in total) and a set of tools for patient engagement (online surveys and forums).

Future plans

Assurance is now being sought from clusters that:

- They have identified those practices where there are risks to the quality and safety of the service patients are receiving by triangulating local intelligence with the general practice outcome standards assessment ratings.
- The necessary steps are being taken, as outlined in the performance framework to support general practice to improve and to address under-performing practices.

Contact

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Judges

Sir Andrew, Cash, chief executive, Sheffield Teaching Hospitals FT

Tim Kelsey, national director for patients and information, NHS Commissioning Board

HIGHLY COMMENDED

Live prostate cancer surgery results — online, accessible, clearly defined results, reported by patients and designed for patients

Alan Doherty and Jenny Hudson
Birmingham Prostate Clinic

The initiative

There is overwhelming agreement that surgeons should publish more outcome data. However, this often involves taking a snapshot of a small patient group and publishing a study in a journal, which does very little to help patients evaluate different treatments.

In prostate cancer surgery (prostatectomy), after cancer clearance, the two outcomes patients are most concerned about are incontinence and erectile dysfunction following surgery. The purpose of the initiative was to offer all patients the opportunity to take part and publish their results online (anonymously). The results are reported by patients during follow up consultations in the 12 months post surgery, building over time an accurate and evidence based picture of outcomes from surgery.

The aim was to help patients evaluate the advantages and disadvantages of surgery, and to help the surgeon evaluate the techniques he uses and better understand the factors that contribute to good continence and erectile recovery.

We worked with a medical illustration and data specialist who created a new, purpose built database located on the Birmingham Prostate Clinic's website.

The database enabled data received during a follow up consultation to immediately be published online. Each new entry is immediately applied to the overall measurements. For example, the results centre shows 83% of patients are currently reporting erectile function at 12 months.

New results are automatically applied to the percentage so the results centre provides a wholly up to date reflection of outcomes.

Patient anonymity is assured because each patient is given his or her own unique number. They then report their continence and erectile function at three months, six months, nine months and one year. Erectile function and continence is categorised in terms of traffic lights — green for functional, amber for some degree of function and red for incontinence or no erectile function at all.

Benefits

A patient who has had a prostatectomy at the Birmingham Prostate Clinic can track their own progress and compare it with others. This is important because erectile function and sometimes continence can be poor at three months and men can find this difficult. Patients can now see how 'the reds' on the graphs frequently turn amber and green throughout the 12 months.

From the perspective of the patient who has prostate cancer and is evaluating different types of treatments, they can see patient outcomes very clearly and importantly; these are outcomes from the individual surgeon, not nationally reported outcomes, collated from many different surgeons.

From the surgeon's point of view, the data can be streamed to show difference in age and different surgical approaches (eg nerve sparing intended to preserve erectile function or non nerve sparing). This enables the surgeon to better evaluate techniques and understand his surgical outcomes.

Financial implications

The initiative involved two days a week for five weeks spent by one of our full time administrators plus about £2,000 for the services of the data specialist. The ongoing costs of maintaining the database are fairly low and the system has been set up to integrate easily into clinical practice.

Contact

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FINALIST

Ambulance Service Cardiovascular Quality Initiative

Niro Siriwardena and Anne Spaight
East Midlands Ambulance Service Trust,
National Ambulance Clinical Quality and
Research Groups and University of Lincoln

The initiative

The Ambulance Service Cardiovascular Quality Initiative (ASCQI) is a quality improvement (QI) project involving all twelve English ambulance trusts. The aim of the initiative was to improve delivery of prehospital cardiovascular care by ensuring all patients presenting with acute myocardial infarction (AMI) or stroke receive "critical to quality" care.

Best clinical practice for AMI and stroke is defined in the *National Service Framework for Coronary Heart Disease* and the *National Stroke Strategy*. This has been translated into guidance by the joint royal colleges ambulance liaison committee and developed into "critical to quality" clinical actions (or indicators) by the national ambulance services clinical quality group.

The indicators are:

Stroke

- S1 Face Arms Speech Test
- S2 Blood glucose recorded
- S3 Blood pressure recorded
- S1+S2+S3 = Stroke care bundle

AMI

- M1 Aspirin
- M2 GTN
- M3 Initial pain score
- M4 Final pain score
- M5 Analgesia given
- M1+M2+M3+M4+M5 = AMI Care bundle

National ambulance clinical performance indicators showed significant variation and poor delivery of the care bundles nationally:

- 57.4% (range 33%–80%) for AMI;
- 85.2% (range 54%–98%) for stroke.

Our objectives were to reduce variation and improve the delivery of the care bundles nationally to at least 70% for AMI and more than 90% for stroke by April 2012.

Chief executives in all English ambulance trusts signed an agreement to collect and share quantitative and qualitative data in accordance with relevant data protection and information legislation. Participating trusts used a standardised data collection tool and submitted data to a central point for analysis and feedback.

Frontline clinicians were appointed as QI fellows and formed QI teams. Using a variety of QI methods and patient involvement, QI teams identified barriers and facilitators, and devised changes to improve the care delivery.

Small pilots of change were implemented using "plan,

do, study, act” cycles and implemented more widely once data showed a sustained improvement. Learning was shared through the national quality improvement collaborative network that we developed.

We used annotated statistical process control (SPC) charts to measure performance over time and funnel plots to measure differences in performance between services.

A six month baseline was established for each trust as a comparator to data collected throughout the project. These charts helped to distinguish common cause from special cause variation and to establish the effects of specific interventions.

Benefits

National benchmarking has demonstrated an overall improvement and a reduction in variation across trusts. Performance for AMI increased to 78.8% (range 54.5%–100%) and for stroke to 96% (range 92%–100%). This equates to 4,833 more AMI patients and 6,367 more stroke patients receiving the entire care bundle.

To illustrate the benefits, 1,065 more AMI patients are now being given aspirin. The *International Study of Infarct Survival* (ISIS-2) found patients who received aspirin within the first five hours of onset of cardiac chest pain had a 13% reduced risk of mortality, compared with those who were given aspirin between 5–12 hours after onset. With 1,065 more AMI patients now being given aspirin, we estimate 138 patients’ lives per year are being saved.

We calculated 4,266 more stroke patients are having their blood glucose levels assessed by ambulance clinicians before arrival at hospital.

Non diabetic patients who have a stroke can experience stress induced high blood glucose levels. Early detection is important, as prompt delivery of insulin therapy can reduce the risk of mortality and morbidity. We calculated 4,266 more stroke patients are having their blood glucose levels assessed by ambulance clinicians before arrival at hospital.

Information gathered from patient interviews is also being used to develop patient reported experience and outcome measures.

Financial implications

A successful bid to the The Health Foundation provided ambulance services with £380,000 to support ASCQI. However, not all costs incurred were covered by these funds.

Staff and service users invested an estimated total of 23,678 hours in the initiative; 17,224 hours were funded, the remaining unfunded hours equate to £99,304. The remaining costs of £151,598 included expertise, materials training, ICT, conferences and meetings, travel and subsistence.

It is difficult to calculate cost benefit and return on investment for each element of the care bundles, because of a general lack of evidence relating to prehospital care and how it directly benefits patient outcomes.

Nevertheless based on the administration of aspirin to 277 patients over the two years of this initiative, we have calculated the cost “per life saved” to be £1,372 per patient.

It is difficult to determine the time frame for return on investment. The data suggests continued and sustained improvement. We can only surmise that investing in improving delivery of “critical to quality” care will continue to reduce morbidity, saving long term health costs.

Contact

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FINALIST

Innovative integrated care for acute and primary care in North West London — for people with diabetes and people aged 75 years and older

Benn Keaveney and Andrew Steeden

**NHS North West London,
Integrated Care Pilot (ICP)**

The initiative

Data and information management is key to the delivery of integrated care at patient level. It requires:

- A patient level business intelligence solution, providing information that informs decisions about care delivery and patient pathways;
- Sharing of essential patient level clinical and scheduling information;
- The coordination of standardised care plan delivery across multiple clinicians and organisations along the patient pathway.

The aim of North West London ICP has been to improve outcomes for patients; create access to better, more integrated care outside hospital, reduce unnecessary hospital admissions and enable effective working of professionals across provider boundaries.

The ICP information tool is a secure web based portal that allows healthcare professionals to plan and deliver care as part of a multidisciplinary group (MDG). For the information governance, all providers and individual GPs have continued to be controllers of their data and NHS Kensington and Chelsea will act as a sole data processor.

The data and information work on the ICP has been clinically led. For risk stratification and the sharing of data from GP and SUS systems, the basis of consent has been the existing consent that GPs have to view their patient information and Section 251 coverage of SUS data.

GPs have been required to take explicit patient consent at the time of creating their care plan. This consent has enabled sharing of information across all relevant providers and has been recorded in the ICP information tool. Patients have been given a leaflet explaining how their information will be shared along with the privacy safeguards.

Information governance (IG) compliance has been ensured by access controls. All providers have signed an establishment and IT managed service agreements that detail what provider shares what data and the relevant security assurances around data transfer.

The IG function at NHS Kensington and Chelsea and their Caldicott Guardian and Senior Information Responsible Owner has provided the official IG support for the pilot.

Benefits

The key change for GPs and consultants is that they are jointly accountable for performance and working in multidisciplinary groups including primary, community, mental, social, voluntary and acute representatives.

The IT tool has helped them to:

- Proactively plan care by identifying high risk patients using population segmentation and risk stratification;
- Coordinate and plan care for patients (sharing these plans across settings) and monitor progress;
- View patient medical information from multiple settings;
- Spread best practice by tracking and evaluating the performance across GPs and MDGs;

- Provide patients with access to their care plans to encourage a greater understanding of their own health issues.

MDGs have been able to spend available money to increase out of hospital care capacity. Examples of this spending include:

- Starting a 24 hour turnaround email service;
- Increasing the capacity of a falls service;
- Funding an additional diabetes specialist nurse;
- Providing additional diabetes education;
- Piloting a programme for A&E consultants to call GPs before patients are admitted.

Financial implications

The initiative required an investment of £2.5m in:

Out of hospital resources

The ICP allocates £40 (previously £80) for each elderly patient and £20 (previously £40) for each patient with diabetes. This funds additional care planning and case management, the time of clinicians to engage in multidisciplinary working and the deployment of more primary, social and community care.

Hospital care

This included the need for A&E to flag patients that are part of the ICP and can be entered into the information tool to enable planning for care outside of A&E.

The ICP has also required a £1.8m investment in infrastructure, including the operational team, IT operations and evaluation.

If the ICP prevents one emergency admission a month for each participating GP this will save the local health service £14m a year.

This entry was also a finalist in the **Acute and primary care innovation category*

Contact

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FINALIST

CaptureStroke

Karen Portas, Michael Bell, Peter Mercer and Gavin Kipling

North of England Cardiovascular Network and Digital Spark

The initiative

The CaptureStroke programme was intended to address the significant duplication of effort in collecting crucial stroke audit data. The system also aimed to:

- Increase data quality and accuracy;
- Enable data collection;
- Provide real time insights into stroke care provision that would enable real service delivery change.

System development was driven entirely by clinical need. The programme team worked with stroke clinical teams to deliver a system that would fit as seamlessly as possible into the existing process and be very easy to use.

It began with a discovery engagement that focused on the challenges around data collection, team interaction, processes and communications involved in stroke care. The discovery engagement also looked to define key aspirational requirements of the programme, effectively giving clinical teams an opportunity to define their highest value requirement. All requirements were ranked and translated into a benefits-led delivery roadmap.

In the development phase iterative prototypes of the CaptureStroke system were reviewed daily across the selected

four pilot sites over a six month period.

The programme was managed between interaction design specialists, Digital Spark, North East clinical teams, North of England Cardiovascular Network and NHS North East. It has resulted in an online system that is now in place at 14 hospitals.

Benefits

CaptureStroke delivery was subject to an early stage benefits review. This was undertaken two months into system implementation. All four pilot sites showed that predicted benefits were being delivered, including proven increases in data quality and accuracy specifically related to audit submissions. The result of this exercise triggered the CaptureStroke North East region rollout.

A recently commissioned independent survey of benefits of the CaptureStroke programme by NHS North East found:

- Increased data quality;
- Increased data accuracy;
- Reduced duplication of effort in recording data;
- Improved communications and collaboration within stroke teams between consultants, nursing teams and MDT;
- Facilitation of reduced risk by sharing patient information across care settings;

Financial implications

The development of the system, from an NHS standpoint, was funded through money from the NHS North East Good Ideas Fund and North of England Cardiovascular Network funding. This funding was matched with input from Digital Spark.

The NHS cost to develop and implement CaptureStroke, including requirements gathering, iterative development and in four hospitals before rolling out to the remaining eight acute admitting hospitals in the North East was £318,000.

The system has provided savings by reducing time wasted in duplicated data collection and reporting processes. Further returns on investment are expected through improvements to patient pathways.

Contact

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FINALIST

Coordinate My Care

Julia Riley, Eileen Sutton and Michael Thick

The Royal Marsden FT Hospital and McKesson UK

The initiative

Coordinate My Care (CMC) is a service dedicated to preserving dignity and autonomy at the end of life. It was set up in response to the *End Of Life Care (EoLC) Strategy* (Department of Health, 2008) which aims to improve care for patients during the last year and ultimately at the end of their life.

EoLC in London was disjointed with poor transfer of information between key services. Patient preferences were poorly defined, with high rates of unnecessary admissions to acute services.

In partnership with McKesson, we created a single view electronic system that allows health and social care professionals who may come into contact with a patient to access a single source of real time clinical information to guide decision making according to patient wishes.

The project's care pathways enable health professionals from primary, secondary and community care to put the patient at the centre of health care delivery at this most sensitive time. EoLC training is coupled with familiarisation with the electronic system in order to promote higher standards of end of life care.

The initiative was developed with significant stakeholder engagement, including patient/carer representation. As part of the project plan we work with a locality to identify the professionals who need to be trained and the tipping points for each professional group that need to be reached before each system can go live.

This ensures localities are well informed as to what CMC is and the benefits it provides, it also ensure CMC embeds well within localities.

Benefits

The wishes and preferences of a patient are available to all legitimate care providers. A 111 or out of hours call by a patient is flagged as CMC and reviewed by a clinician, bypassing the usual triage process. Paramedics responding to 999 calls have information available to make appropriate clinical decisions without necessarily transferring to hospital.

An initial assessment has found that where CMC patients expressed a preference, 73% achieved their preferred place of death (PPD). Of the total deaths, 76% of patients have died outside hospital (home 42%, care home 19%, hospice 14%).

A range of care providers can update the patient record in real time. This ensures that health and social care providers receive the same information. Unclear information is fed back to clinicians to clarify patient records.

The initiative provides real time data to support commissioning. It also provides auditable outcome measures that support a governance infrastructure. The clinical governance framework ensures that patient records are as accurate as possible.

Financial implications

The IT implementation of the service cost £344,917. Staff costs were three trainers, one part time project manager, two part time clinicians and one project developer.

Significant cost savings will be made as a result decreasing the number of hospital admissions, as there is a potential net saving of £958 per person who dies in the community. In addition each unnecessary ambulance transfer to hospital that is avoided saves £500.

Contact

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FINALIST

Driving zero pressure ulcers with Datix developments

Doretta Knowles and Sally-Ann Cooper
Barts Health Trust

The initiative

The aim of the initiative was to provide organisational access to live, reliable, multifunctional information regarding scale, trends and details of inpatient pressure ulcer occurrences.

This involved revision of Datix pressure ulcer reporting codes to:

- Incorporate current evidence based clinical guidance for classification of pressure ulcer harm;

- Create additional Datix codes to redirect capture of non pressure ulcer incidents;
- Discontinue obsolete codes.

The revised Datix codes were assimilated into trust policies and endorsed via the training portfolio.

Five new generic reporting codes were introduced to Datix in April 2011:

- 1 Pressure ulcer — admitted;
- 2 Pressure ulcer — acquired during Whipps Cross Hospital (WCH) care;
- 3 Pressure ulcer — deterioration during WCH care;
- 4 Pressure ulcer — discharged from WCH;
- 5 Wound not pressure ulcer related.

Additional sub generic codes were also provided to enable specific reporting of pressure ulcers by EPUAP (2005) grade severity 1–4. Non pressure ulcer wounds were defined as hospital acquired or admitted, trauma, chronic ulcer or end of life skin changes, moisture ulcer and gangrenous limb or body part.

Each classification of pressure ulcer grade was matched with a Datix harm level of no, low, moderate or severe harm.

Grade 3 and 4 ulcers

Defined as severe harm serious incidents.

Grade 4 ulcers

Defined as severe harm local never events.

Admitted grade 3 and four ulcers

Required dual safeguarding incident reporting.

The new Datix code structure was designed by tissue viability and information systems specialists. Governance teams, Nurse specialists and ward teams and senior nurses were engaged in the consultation process.

In addition we developed pressure ulcer data extraction and validation processes to inform corporate governance and clinical report streams.

The impact of the revised code was evaluated via a monthly quality report cycle. Developments were reviewed annually within the context of a zero pressure ulcer campaign.

Benefits

Pressure ulcers are now the most frequently reported incidents in the trust, and there is an embedded organisational culture of vigilant detection and disclosure.

There has been a 24% increase in the total number of reported pressure ulcer incidents, while the mean average of pressure ulcers admitted has remained stable.

New hospital occurrences have shown a significant decrease in Grade 3 severe harm ulcers, with no new Grade 4 ulcer occurrences.

The triggering of serious incident escalations via Datix is more streamlined. The tissue viability service receive automatic e-mail alerts from Datix with each reported incident; enabling targeted, rapid clinical support responses for patients and clinicians.

Financial implications

No additional financial resources were needed. Teams used existing resources to produce improved clinical outcomes.

Additional treatment costs were paid by commissioners because the trust was able to demonstrate a genuine reduction in the number of inpatient pressure ulcer occurrences using reliable information derived from Datix pressure ulcer capture.

Contact

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WINNER

Ferndene — a purpose built mental health facility for children and young people, including those with a learning disability

John Carson and Jane Gibson

Northumberland, Tyne and Wear FT

Background

The purpose of the initiative was to provide a new inpatient centre, Ferndene, which combines learning disability and mental health care for children and young people. The design's driver was to create a safe and secure space for young people that was also nurturing and homely, where patients can successfully come together to share amenities.

The impact on the environment was also carefully considered with the decision taken that the development would push the boundaries of sustainability, not only from a design perspective but also from the environmental aspect and its impact on the wildlife that inhabits the local area.

The trust worked closely with the architects to ensure that Ferndene sat comfortably within its rural location. The environmental design maximises natural daylight and ventilation and improves the immediate microclimate. Mechanical services traditionally associated with hospital buildings were minimised which led to energy saving measures.

The process

A young people's design group were engaged in many aspects of the design and build process. Monthly visits facilitated by hospital staff and Skills for People, a user led voluntary organisation, allowed the young people to have their voices heard, to feel involved and to effect change.

It became apparent early in the project that there were colonies of bats residing in the existing buildings. There were differing species, some which lived in cavities and those that live in roof voids. Events were timed to remove the roof when the bats had vacated their roosts and headed to the woods to mate. Bat boxes were erected as well as a purpose built roost, which was further enhanced by the provision of a thermostatically controlled solar power heated bat box to provide a heated maternity roost.

Advice to other organisations

The new facility was designed to achieve an excellent BREEAM score — difficult to achieve in a mental health care facility. Some of the more innovative pieces of mechanical and electrical elements that have been incorporated are solar panels, air to air heat pumps and photovoltaics.

Benefits of the initiative

High quality, patient centred services have led to improved levels of user and carer satisfaction as demonstrated through care quality commission (CQC) visits, and an outstanding Ofsted report.

Ferndene has helped strengthen links with the local community in the town of Prudhoe, in a variety of ways:

- Pupils from the local secondary school were involved in design issues;
- The new facilities have been instrumental in developing



relationships with the Prudhoe youth forum — an advisory group that listens to young people and acts upon their ideas;

- Working with the local Youth Works team, providing opportunities for young people to get involved in various activities and projects;
- The use of the facilities for weekly exercise sessions for members of the public and the young people at Ferndene;
- Sunderland Football Club providing a 12 week football skills course.

The increased size of the sports hall, specifically requested by the young people, is drawing the local community into Ferndene. All of these activities are enabling the service to break down barriers and tackle stigma.

Financial implications

Combining facilities and services created a more effective use of resources as spaces and sessions are jointly accessed by young people from all wards simultaneously.

Joining together services in specifically designed environments has reduced the use of out of area placements, and admissions of young people to adult wards have dramatically decreased. Bringing together highly skilled professionals provided teaching and learning opportunities and led to the development of in-house training packages, designed to meet the specific needs of the workforce without having to pay external fees.

The implementation of a core nursing shift pattern was designed to reduce multiple shift systems and wasteful working practices. Environmental measures are envisaged to make savings in respect of the running costs of the building and of the carbon footprint.

Contact

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Judges

Paul Haigh, *chief operating officer, City and Hackney Clinical Commissioning Group*

James Mackenzie, *programme manager, NHS Sustainable Development Unit*

Peninah Murage, *health intelligence lead, London Regional Public Health Group, Department of Health*

Stephen Welfare, *deputy chief executive and director of workforce, NHS Midlands and East of England*

Award sponsored by

NHS
**Sustainable
Development Unit**

FINALIST

Carbon reduction — an holistic approach

Fiona Daly and Matthew Tulley

Barts Health Trust

The initiative

The purpose of the initiative was to reduce our building energy carbon emissions by 10% over a three year period, embedding sustainability and carbon consideration into our core working practices, while developing innovative ways to address our indirect carbon emissions such as those from waste and water and begin our journey to influence behavioural change through our clinical practices.

The strategy was endorsed by the trust board. Objectives were set covering all aspects of sustainable practice, from building energy to IT to behavioural change. There are 12 categories in all.

We have invested £1.6m in efficiency projects, implemented two key projects around waste and water, reduced our water consumption and diverted all our waste away from landfill while measuring the carbon emissions from our waste service.

We also evaluated our supply chain emissions and are currently working with our suppliers to raise awareness and reduce these. In order to encourage sustainable staff travel we have invested in improved cycle facilities and linked this with our health and wellbeing strategy.

Most recently we have formed partnerships with GE and Global Action Plan to implement a behavioural change programme.

Benefits

The key benefits of the initiative have been a significant reduction in our impact on the environment through:

- Reduced carbon emissions — down by 35% (22,900 tonnes);
- Sending zero waste to landfill — 1,200 tonnes diverted;
- Reduced water consumption, down by 30% (one million m³);
- Improved bio diversity;
- Engagement with staff and patients.

This, coupled with significant operational cost reductions, has meant the organisation has been able to drive its vision of a low carbon future while redirecting resources back into patient care. Staff and patient engagement have meant the organisation has started to improve the knowledge of its workforce and community and has been able to start its journey towards delivering low carbon patient pathways.

We have also been able to share our knowledge and experiences across the NHS in London and nationwide, benefiting and learning with others through shared experience, to implement best practice NHS wide.

Financial implications

The investment in the efficiency projects was £1.6m over a three year period. This resulted in savings of over £900,000 per annum and 6831 tonnes of CO₂. In addition the trust has avoided £82,000 in carbon reduction commitment tax costs. The return on investment is 1.7 years without carbon tax and 1.6 years with.

The water project had no initial set up cost, and is run on a share save system. The project has saved £300,000 to date.

The waste project cost £15,000 to set up and has annual savings of £250,000.

Contact

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FINALIST

Transformation to a sustainable

healthcare organisation at

Bradford Teaching Hospitals FT

Ian Hinitt and Ian Buckle

Bradford Teaching Hospitals FT

The initiative

Our sustainable development implementation plan has been operational for three years and involves all the main non clinical departments of the trust in working groups. We are now mainstreaming sustainability in the trust by developing a corporate led response involving clinical departments.

The trust brought in an outside consultancy Hyder Consulting to provide expert advice during the early stages. They directed the trust on the scope of the sustainable strategy and gave a structure through the implementation plan for the work of the steering group and the working groups. Board level support extends to having the chairman of the trust as the chair of the sustainable development steering group.

Sustainable development is included in the mandate of the deputy director of estates, and led to the employment of a full time environment and sustainability manager in 2009. The sustainability projects are constantly evolving with a range of buildings projects, the latest being 100kW of solar photovoltaic panels at both sites.

Engagement has encouraged support from clinicians: an energy saving audit initiated by anaesthetists led to a joint article being published in the *Journal of the Royal College of Anaesthetists* on the role clinicians can play in energy saving.

The sustainability manager developed an energy intelligence system that brings together utilities, financial and operational data and gives directors instant, web based access to benchmarks, KPIs and summarised sustainability performance reports.

Benefits

The concerted effort to improve sustainability has produced significant results at the trust. For the Carbon Trust carbon management programme the trust committed to a 20% carbon reduction target by 2015 on 2007/08 levels. The target covers goals for waste, water, refrigerants, transport, procurement and a 24% target for buildings emissions. By 2011/12 BTHFT had achieved a 17.5% carbon reduction on buildings emissions and outstanding progress in other areas.

The sustainable strategy for waste involves a zero to waste landfill policy coupled with a shift in clinical waste disposal from incineration to less carbon intensive heat treatment. Implementation of the policy has required the introduction of colour coded bins and training for clinical and non clinical staff including e-learning. By 2011/12 the trust had halved the amount of clinical waste being sent for incineration and achieved zero to landfill for domestic waste through the mixed recycling at source initiative and recycling by the waste contractor.

Staff engagement has harnessed a motivation already present in our clinical staff to limit their environmental impact. Our renal department, anaesthetists, cardiologists and theatre management have developed their own sustainability initiatives.

Financial implications

The trust has been very active in seeking funding for sustainability projects. Since 2007 BTHFT has secured £4.1m in

Department of Health and Salix funding for carbon reduction projects including:

- Total de-steaming of one site and partial de-steaming of another;
- Installation of combined heat and power units at both sites;
- Reduction in energy demand through installation of low energy interior and external lighting, building insulation and variable speed drives.
- Salix funding requires a payback of five years, but low energy lighting has a payback of 2.5 years, our energy intelligence system under one year.
- Metering improvements have been made with the introduction of automatic meter reading, half hourly meters and sub metering. The trust has used Salix funding plus its own capital funding to finance the installation of 60kW solar photovoltaics with another 40kW at the design stage.
- By reducing consumption of gas and electricity the trust has saved £406,170 at current unit prices since 2007/08. Taking into account a carbon price of £12 per tonne CO₂, BTHFT has saved £30,648 on its carbon reduction commitment liability.

Contact

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FINALIST

DCHS Good Corporate Citizen programme
Mark Armstrong-Read
Derbyshire Community Health Services Trust

The initiative

The Good Corporate Citizen and Carbon Management Programmes (GCC/CMP) were set up to tackle the specific issue of reducing carbon emissions by the trust by 25% by 2014. The initiative has been running for two years. The GCC/CMP programmes are wide ranging, including:

Communications

We set up the website www.wethinkgreen.co.uk; produced posters; appointed green champions.

Travel

We set up joint working group with councils, introduced telephone conferencing, provided £20,000 of safety/efficient driver training and doubled cycle mileage rate.

Buildings/facilities

We achieved Environmental Management Standard ISO14001; replaced inefficient buildings; installed a 50KW solar array; replaced boilers, windows and inefficient lighting.

Procurement and waste

We introduced a sustainable procurement policy with whole life costing and stringent supplier checks; replaced inkjet printers with centralised multi function devices; reduced landfill waste; increased recycling; participated in gas fuelled vehicle technology trials.

Benefits

The nature of the initiative means it doesn't involve direct patient care. However, more efficient back office services provide savings that can be diverted to patient care.

Under the Patient Environment Action Team (PEAT) programme, every inpatient healthcare facility in England is

assessed across areas of environment, food and privacy and dignity. The trust has 13 community hospitals assessed in the three areas and achieved "excellent" in 36 of these, with the other three being "Good".

Financial implications

Much of the work we do in GCC is part of our everyday work; one area where we do have specific measurement of costs and savings is in the area of carbon reduction.

We have spent over £650,000 on capital projects for carbon reduction in the last three years. Installation of solar panels, new boilers, replacement lighting, and green travel initiatives have resulted in recurring 12% reduction in CO₂ equating to 1,424 tonnes per year and 22% reduction in costs equating to £780,000.

Our implementation of a teleconference system has resulted in 150 calls with over 500 participants per month. Since starting in October 2009 this has saved an estimated 250,000 miles, 62 tonnes CO₂ and over 100,000 hours of time. These savings in CO₂ put us on track to meet our target of a 25% reduction by 2014. Our financial savings are well ahead of 2014 target of 25%.

Contact

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FINALIST

Liverpool NHS Good Corporate Citizen
Sarah Dewar and Andy Hull
Liverpool PCT and Liverpool CCG

The initiative

The initiative aims for the Liverpool NHS to be a good corporate citizen (GCC) through wide collaboration to meet legal and NHS obligations for carbon emissions and act as local leaders for improving health and wellbeing through sustainable development.

It encompasses a broad strategic and engagement model that reaches across the GCC spectrum. It aims for the NHS locally to help lead Liverpool's regeneration towards a more sustainable footing that improves social, economic and environmental conditions to reduce health inequalities.

The key in this framework is ensuring that the NHS locally is improving its own performance in terms of resource use and carbon emissions, sustainable models of practice and supply chains.

NHS collaboration locally aims to improve our progress and bring economies of scale to the programme. We formed The Carbon Collective from seven trusts and achieved carbon trust accreditation in September 2011. We wrote sustainability requirements into main provider contracts and formed North Mersey QIPP programme involving 12 trusts.

Using best practice social marketing, we developed Simple Actions, a joint behaviour change campaign with staff from 12 trusts to enable sharing of resources, economies of scale, increased capacity and consistency.

We adopted a travel plan, partnered the transport authority and support active travel promotion. We are reviewing taxi/courier use among seven trusts with potential to reduce costs/emissions.

With Liverpool City Council and Mersey Forest we developed a green infrastructure strategy implementation which includes 38 community green space wellbeing projects.

Benefits

Trusts in the North Mersey are now actively collaborating on sustainable development. It is too early to have direct figures from the collaborative approach however it is delivering results over and above those of individual trust activities.

The Simple Actions campaign has seen a significant increase in communications with staff and nearly 1,000 Simple Actions ideas were submitted at the start of the campaign.

Sustainability is now part of the Level 3 QIPP programme, has significant partner buy in and is enshrined in local contracts. There is far greater ownership, understanding and activity among the Carbon Collective Trusts and across different disciplines.

The Carbon Management Plan projects are being introduced across the trusts both individually and collectively. They are beginning the essential process of reducing the impact of escalating fuel costs and fossil fuel dependency, increasing NHS resilience.

Wider engagement brings additional resources for sustainability. For example we secured health as a core goal of the local transport plan and our collaboration around active travel supported the successful £25m local sustainable transport fund bid.

Financial implications

For the internal NHS work, savings on energy spend of around £4m pa are identified in the collective carbon management plans, amounting to approximately 37% of energy spend. Of this, £450,000 of savings pa could be achieved through behaviour change. There has been an investment of £70,000 in developing and delivering the shared communications campaign and delivering phases 1 and 2.

Contact

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FINALIST

Carbon management — providing healthcare that won't cost the earth

Fran Silcocks

Sandwell and West Birmingham Hospitals Trust

The initiative

Sandwell and West Birmingham Hospitals Trust is committed to improving environmental performance. In 2008 the trust established a Carbon Management Plan (CMP) that defines a number of projects that act as a route map towards achieving our target of a 15% reduction in carbon by 2014. Area specific targets have been also set for a 15% reduction in energy use and 10% reductions in water, waste and travel.

The initiative is part of an ongoing sustainability programme, where a number of sustainability related projects are in the pipeline at any given time.

To help measure the impact of the CMP, projects are listed with estimated energy, carbon and cost saving. Priority is given to those projects with the shortest payback and greatest potential in terms of energy and carbon reduction. Awareness campaigns are estimated to save £21,000 and 209 tonnes of carbon per annum and annual staff surveys are being run to gauge energy efficiency awareness.

Governance is a key part of the process and, since January 2010, we have had in place a sustainability working group (SWG) made up of members from across the trust who work to

a sustainability action plan.

Engagement is also vital and so we have developed a trust board approved sustainability and environment policy. We have 100 sustainability champions and over 100 sustainability supporters to help promote sustainability and awareness, and regularly update staff and stakeholders through events and campaigns run throughout the year.

Sustainability is also presented as part of trust mandatory training.

Benefits

Replacing boilers with more energy efficient models has saved circa £86,000 and 694 tonnes of carbon per annum after the initial payback period.

IT powersave software has saved £29,000 and 326 tonnes of carbon per annum after initial payback period.

Estates rationalisation work at City Hospital saves circa £226,000 and 1,980 tonnes of carbon per annum.

Waste recycling scheme at City Hospital has driven general waste production down by 20.3 tonne in the first nine months since implementation. This saved the trust £1,800 in waste disposal costs while also preventing waste going to landfill. Cardboard onsite segregation for recycling has also been introduced, saving money and driving efficiency.

Food waste digesters at Sandwell site are estimated to save circa £16,000 per annum in direct energy and water savings and 29.4 tonnes of carbon.

The trust recycles ink cartridges and the money generated goes into our sustainability trust fund, funding small scale local sustainability champion projects.

Financial implications

A business case was put to trust board with details of the CMP, including projected savings in carbon, energy and funds for each project. The CMP was approved by the trust board in 2008.

Each year, a paper is submitted to trust board for sustainability/energy efficiency funding through SIRG. In 2010/11 and 2011/12, funding of £500,000 was secured through SIRG to support our CMP projects on an invest to save basis. Return on investment varies from project to project, from one year up to a maximum of five years for larger investments.

Contact

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FINALIST

Sustainable community healthcare

Nigel Burchett and Will Clark

Sussex Community Trust

The initiative

In March 2012 the board of Sussex Community Trust (SCT) signed off phase 2 of the trust's five year Sustainable Development Management Plan (SDMP), which commits SCT to becoming the leading community services provider for sustainability in the UK.

The first phase achieved significant outcomes; phase 2 is broader in both scope and ambition. The trust's carbon footprint has been recalculated (following the integration that led to SCT's formation) and a new, improved reporting system has been created.

The trust treats sustainability as a journey and is already looking beyond 2015. It is now working on a longer term

strategy that will see it become the UK's first carbon neutral healthcare provider. It has also initiated a collaborative project to implement the NHS Route Map at a local level.

Key aspects of the new plan include:

- Calculating a new SCT wide carbon footprint baseline for SCT (2010/2011) – 7,890 tonnes CO₂e;
- Setting new targets to build on what has been achieved so far;
- Establishing a new GCC action plan to take us to "excellent" scores across the board by 2015;
- Broadening and strengthening the trust's sustainability team to support delivery of the SDMP;
- Implementing a new waste management policy and waste contracts to deliver zero waste to landfill and reduce infectious waste generation;
- A new trust wide energy spend to save programme, which includes a 50kW photovoltaic system at the trust's headquarters;
- Developing a new three year environmental communications plan — including a staff attitudes survey and a new carbon champions training programme;
- Developing a new, ambitious business travel plan to tackle travel emissions and encourage active travel;
- Creating a new KPI dashboard and reporting system to track progress;
- Repeating the external validation exercise and widening the scope to include the GCC scores and evidence.

Benefits

During phase 1 (2010–2012) the programme delivered a carbon dioxide saving of more than 1,000 tonnes and cost savings of over £150,000. This phase focused on the trust's Brighton and Hove operation only. For phase 2 the trust's footprint baseline has been expanded to cover its entire operation.

Delivery of the new three year plan will result in an absolute Approximately saving of 1,180 tonnes per annum. It will also reduce the amount of general waste sent to landfill to zero. A new waste contract has been put in place and this objective was a central element of the selection criteria. The trust's new waste management system will mean that more than 90% of general waste will be recycled, with the remainder being sent for refuse derived fuel.

SCT's sustainability team has started to undertake sustainability and carbon management work for other trusts, meaning that good practice can be shared and results replicated.

Financial implications

The trust employed a full time sustainability manager (band 8A) to develop and deliver SDMP. We also invested capital resources in a spend to save programme. During the first phase the programme delivered net savings in excess of £150,000. The phase 2 SDMP includes a fully loaded cost and savings schedule, which shows that the programme will continue to deliver new savings in excess of £100,000 per annum. This includes the cost of a full time band 6 energy and environment officer who will assist in undertaking income generating work for other trusts.

The spend to save programme for 2012/2013 includes a number of longer term carbon saving initiatives, since many of the quick wins were captured during the first phase. An example of this is the 50kW photovoltaic system being erected at Brighton General Hospital, which will pay back in 10 years and save 20 tonnes CO₂ per annum.

Contact

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FINALIST

Carbon reduction programme

Yorkshire Ambulance Service Trust

The initiative

The purpose of the initiative was to reduce the carbon footprint of the Yorkshire Ambulance Service (YAS) and reduce our emissions impact on the local and global environment. By identifying where our carbon emissions are, we can work to reduce our electricity, gas, water and fuel use. Driven by the national NHS movement to reduce carbon footprints by 10% by 2015 we took up the challenge to reduce our carbon footprint by 30% by this date.

Many of the challenges identified in our carbon management plan are not applicable to any other part of the NHS as 60% of the carbon footprint for the ambulance service is from vehicular movement. To tackle this we are:

- Making ambulances more aerodynamic;
- Using methanol/hydrogen fuel cells to reduce engine running times while on standby;
- Looking at the viability of hybrid/electric vehicles within the emergency fleet;
- Reducing vehicle weights;
- Leading a project with suppliers and manufacturers to produce a green ambulance that is fit for purpose.

We asked staff to join a carbon champion scheme to get staff buy in across the organisation. We now have 82 carbon champions across the region.

We are also undertaking estates upgrades including boiler upgrades, efficient lighting installation, plant shut down, and ensuring that all appliances installed are efficient.

Eco driver training has been rolled out to all the patient transport staff across the trust and any new A&E staff.

We are working with the Hotspots team across Yorkshire to reduce fuel poverty, which will have a knock on effect on our services and reduce the number of call outs.

We are presently looking at renewable technology installation across the estate.

Benefits

We have implemented a waste recycling programme to reduce the amount of waste to landfill, achieving a 54% reduction to date.

Our awareness campaigns are encouraging staff to turn off, reduce, reuse and feedback any amendments to the service that they have and is helping to reduce our carbon footprint.

We have adapted our fleet strategy according to our requirements and we are trialling a variety of new technologies in order to ensure that the technologies work and are applicable to our vehicles prior to roll out.

Through our eco driver training we are working to reduce accidents, which has a knock effect on servicing and vehicle efficiency/availability. An intelligent deployment programme will also reduce the carbon footprint of our service.

Financial implications

Through awareness campaigns and estates upgrades, there has been a £200,000 reduction in energy use last year. With some internal investment in 2012 we will be installing solar panels at our HQ within the year.

Contact

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WINNER

Joint initiative between three local authorities and the mental health trust to set up a service to work with young people at risk of entering care or custody due to aggressive or antisocial behaviour.

Simone Fox and Keith Shipman

**The Merton, Kingston and Sutton
Multi Systemic Therapy Team**

Background

In 2008, the South West London and St George's mental health trust worked in close collaboration with partners in the local authority including education, youth justice and social care across two London boroughs, to set up an initial pilot project. The project board overseeing the running of the service consists of managers from social care, education, youth justice and health across boroughs.

The process

The Merton, Kingston and Sutton Multisystemic Therapy (MST) team works with the families of young people aged 11–17 who are at risk of going into care or custody because of antisocial or aggressive behaviour. The aim of MST is to reduce the numbers of young people entering care/custody, to improve outcomes in education/ employment and to reduce offending.

MST is now in the NICE guidelines for personality disorder and it is anticipated that it will be included in the new guidelines for conduct disorder.

The team was initially recruited as part of the national research pilot. Relationships were formed with stakeholders and there has been a steady stream of referrals to date. The team has now completed recruitment of families for the research trial.

The partnership's strengths are the cross borough and health trust arrangements which reduce overall costs, strengthen quality assurance and governance arrangements and increase the effective targeting of resources where they will have the greatest impact. The intention is to build on the intervention's success, consolidating MST within the two boroughs and to expand the programme to other boroughs within the South West London region.

Advice to other organisations

MST is a well validated evidence based intervention that originated in the US. The team was set up in 2008 as part of a national randomised control trial comparing MST to "usual services". Due to some initial excellent outcomes, the Department for Education and Department of Health with support from the Youth Justice Board are part funding new additional sites across the UK.

Benefits of the initiative

The aim of MST is to help families to manage their child's behavioural difficulties with the aim of keeping that young person in the home or education.

The MST team has discharged 90 families from 2008 to June



2012. The average length of treatment was 133 days. Of those discharged, 92% of youth were living at home at point of discharge, 69% were attending school or working and 84% had not offended.

Ten families have been followed up 5–21 months post discharge to take part in two doctoral research theses looking at the sustainability of the intervention from a service user perspective.

Feedback from parents and young people has been extremely positive, with many parents indicating that without this intervention their child would be in care. Young people have also stated that relationships at home have improved, with better communication and patterns of interaction between family members.

The intervention has meant that many young people who were at high risk of care at the time of referral are now able to live at home. This has huge cost savings implications.

Financial implications

MST costs £6–8,000 per family. The average cost for a child looked after in foster care ranges from £25,000 to £70,000 per year, and a child looked after in secure accommodation can cost up to £200,000 per year. These costs increase as the young person gets older. The cost efficiencies of a successful MST project are clearly demonstrable.

Initial funding was secured from a successful bid application to the Department of Health in 2008. In 2011 the project board secured additional funding from the Department for Education to expand the service to cover additional boroughs including Sutton and Richmond.

In addition to this funding, the local boroughs have committed resources to the project. Local commissioners are now considering how MST will be funded as a mainstream service.

Contact

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Award sponsored by



Judges:

Karen Livingstone, *director of strategic partnerships, NHS Midlands and East*
Dr Martin, McShane, *director of QIPP and commissioning, NHS Lincolnshire*
Baroness Glenys Thornton, *former parliamentary under-secretary of state, Department of Health*

HIGHLY COMMENDED

Towards work in forensic mental health improving practice and tackling stigma

Jean McQueen and Elaine Hunter

Ayr Clinic (Partnerships in Care) and the Scottish Government

The initiative

This initiative consists of joint working between health boards, the Scottish Government and Partnerships in Care. The focus is on improving the vocational rehabilitation process, tackling stigma and dispelling myths surrounding those with forensic mental health issues in the work place.

This was undertaken through consultation with service users, exploration of evidence for practice and evaluation of current practice across 14 health boards. The project consisted of three concurrent parts:

- 1 Exploration and capture of the views of forensic mental health service users; focusing on how services promote the aspiration to work, the development of skills for work and the vocational rehabilitation process. This provides an insight into users' views on the barriers and enablers to accessing work.
- 2 Investigation of the research based evidence in this area in order to develop best practice based on current high level research evidence.
- 3 Examining practice nationally throughout 14 health boards within Scotland investigating current practice, comparing this with the views of service users and the current evidence base.

The project was led by an AHP consultant seconded to the project. It also involved designing and delivering training on various aspects of vocational rehabilitation such as models of practice and management, partnership working and mental health and criminal offence disclosure.

Benefits

This initiative has resulted in changes to practice in the field ensuring that service provision in vocational rehabilitation throughout Scotland is based on the best available evidence. Qualitative evaluations have been undertaken with service users, their comments include:

- "I don't think I ever thought I'd be employable again, without the support and encouragement I probably would have stayed in hospital if I could" (Service user who had just been offered paid employment)
- "For me its about doing something useful, its given me a lot of confidence." (Service users first experience of paid employment)
- "I would say try and get into the working environment as soon as possible, it lifts your self esteem, lifts your confidence." (Participant in low secure mental health unit involved in voluntary work placement).

Financial implications

This initiative was supported by the Scottish Government with funding for an AHP consultant for one year. While financial savings have not been formally assessed there are implied savings in terms of service users being less reliant on benefits. There is also emerging evidence that those with mental health issues who are employed use fewer mental health services.

Contact

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FINALIST

Blackpool Night Safe Haven

Stephen Morton and David Rigby

NHS Blackpool

The initiative

Blackpool town centre plays host to a vast number of holidaymakers and locals who come to use the late night bars and clubs. In many cases they come with the sole intention of getting drunk.

Much of the emergency services time on weekend evenings is spent dealing with alcohol fuelled violence, injury, sickness and crime. Consequently a lot of time is spent taking people to A&E, and escorting them while there. Saturday evenings and early Sunday have been identified as peak times for anti social behaviour (ASB), violent crime and hospital A&E attendance.

The initiative involved offering a visible safe haven in the town centre. The objective was to reduce demands on emergency services and the number of hospital admissions.

The Night Safe Haven offers vulnerable individuals a safe space in the town centre. It also offers potential perpetrators of violence time and support with the availability of free water for rehydration. The service brings partner agencies together to provide a one stop shop for those experiencing difficulties on a night out.

The facility provided by Blackpool Council incorporates a mobile police station, St John Ambulance, North West Ambulance Service, NHS Nurses. The Safe Haven provides an area of rest for those in need and advice in relation to alcohol/drug use and sexual health. Those who require rest and recuperation are cared for by the service and provided with access to water, foil blankets, condoms and safe disposable footwear.

Benefits

During the first 12 months of service the Night Safe Haven avoided 956 hospital attendances (numbers seen by Night Safe Haven who would have previously been transported to hospital by an emergency service).

In addition to this almost 3,200 others were seen by the service to receive advice on alcohol or drugs, sexual health, collect harm reduction items, or simply use a quiet area of rest. All of these have had an impact on reducing the demand on emergency services.

An analysis of reported incidents of ASB in the vicinity during the first year of the Night Safe Haven initiative shows an encouraging reduction in levels of police reported ASB and violence. Since the launch of the Night Safe Haven the number of assaults presenting at A&E has decreased.

Financial implications

The initiative required an investment from the PCT of £64,000 to pay salaries for staff in addition to the police officer time. The costs of vehicle maintenance were met by the council who share the vehicle with daytime sexual health services and youth provision.

The investment has been recovered by the savings in demand for other services. The 956 ambulance journeys to Blackpool Victoria Hospital and A&E treatment would have cost in the region of £160,000, suggesting a reduction in spending of approximately £100,000 during the first operational year.

Contact

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FINALIST

The Healthy Urban Team, wider determinants of health

Claire Lowman and Stephen Hewitt

The Healthy Urban Team, Bristol

The initiative

The Healthy Urban Team (HUT) is a small team of public health professionals who work alongside council, community sector and other partner organisations to help make the city a healthier place to live. HUT's overall purpose is to help ensure that Bristol is a healthy city with reduced health inequalities.

HUT is a multidisciplinary team, comprised of specialists from different fields and organisations, principally NHS Bristol, Bristol City Council and the WHO Collaborating Centre at the University of West of England. The key areas within HUT's remit are:

- Transport;
- Town planning;
- Physical activity;
- Food policy;
- The urban realm;
- Climate change and resource depletion.

HUT's role is to initiate new ideas, contribute to policy and practice, and test and evaluate methods and tools.

The work has a large number of threads including:

- Commenting on planning applications and infrastructure proposals;
- Contributing to the development of major strategic plans;
- Working with local community groups and neighbourhood forums to assess the health impacts of planning proposals for their locality;
- Helping to support community initiatives;
- Working with leading academics and experts on evidence and knowledge transfer;
- Carrying out research and disseminating latest information through partners and partnership organisations;
- Working with service providers on improving services, for example, food provision in local hospitals;
- Providing public health expertise and perspective on policy issues.
- Contributing to the development of Bristol's Health and Wellbeing Strategy and Joint Strategic Needs Assessment.

Benefits

Examples of the benefits HUT's of work include:

Health and planning protocol

Bristol City Council and NHS Bristol signed an agreement in May 2011 that ensures that NHS Bristol is consulted on all major new planning applications. The purpose is to ensure that future development will facilitate healthier lifestyles.

West of England health and transport forum

The West of England Partnership and four PCTs signed a memorandum of understanding in 2010 to encourage coordination and cooperation. The forum's objectives are to ensure that the transport system is designed to enhance health.

Food policy

Who Feeds Bristol is a research report commissioned by NHS Bristol. It provides an overview of the current food system. Bristol Food Policy Council (FPC) was established in 2011 with a brief to take forward the findings of *Who Feeds Bristol*.

Health impact assessments

Health impact assessments (HIA) are now carried out on planning applications for all new major developments. As an

example, a recent HIA on the redevelopment of a sports facility showed that local residents would have inadequate access. As a result, the planning application was amended.

Financial implications

NHS Bristol, with Bristol City Council providing in-kind support, has provided funding for most of HUT's activities. The main investment is in posts and expertise, rather than projects. This means that, to date, HUT has been able to avoid the challenges posed by time limited funding sources and has been able to invest time and energy in developing long term initiatives that focus on policy as well as practice.

Much of HUT's work is strategic and focuses on long term change. This means that savings that may accrue from improved population health that will not be visible for many years to come and, even then, will be difficult to attribute to these interventions. The partner organisations involved are happy to support this work because of its potential to reduce health inequalities by addressing the wider determinants of health.

Contact

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FINALIST

Working in partnership to improve health and wellbeing of vulnerable people in Christchurch

Jan Childs and Rev. Sandra Prudom

Christchurch Locality Commissioning Group (CCG)

The initiative

The aim of the initiative was to strengthen links and build trust with colleagues in local government and with third sector agencies to improve the health and wellbeing of people who live in Christchurch. The initiative aimed to:

- Establish a Christchurch health network to include members of Christchurch borough council, Christchurch community partnership, safer neighbourhood teams, patients, carers, the local NHS and other statutory, voluntary and third sector agencies;
- Engage with the health network to identify needs and aspirations and obtain feedback on health priorities, strategies and plans;
- Promote "assets" of third sector and voluntary agencies and the community's ability to address the needs of individuals and the community;
- Identify joint projects and joint funding opportunities to achieve the overall aim of improving health and well being of people in Christchurch;
- Engage with the health network to improve and monitor services.

The locality commissioning group launched the concept of a Christchurch health network to patients, Christchurch borough council, Christchurch community partnership, safer neighbourhood teams, third sector agencies, NHS and community care providers.

Specific outcome based activities were discussed with the NHS Dorset commissioning lead for Christchurch, focusing on key areas in the plan. This included developing a coordinated approach with local government and pro active NHS case management teams, to provide low level support for patients

with long term conditions and vulnerable older people. Information and consultation events were arranged including:

- Personal health budgets;
- Developing a locality commissioning service for Christchurch;
- Developing a shared vision for community services in Christchurch;
- Developing dementia services in Dorset;
- Christchurch locality commissioning priorities;
- Day care and vocational services;
- Joint strategic needs assessment/public health priorities;
- Respiratory care pathway.

Feedback from workshops at these events was given to the commissioning group and to the health and care action group led by the chief executive of Christchurch borough council.

The practice manager attended meetings of local community groups and third sector agencies, inviting them to an event to “sell” their assets to local NHS and social care commissioners.

Benefits

Membership of the network has reached 175. Trust has been built, and good relationships formed between partners. GPs attend events to hear first hand what people think about services and their care.

Benefits of the initiative include effective involvement of local government — a councillor with portfolio for health and care sits on the GP commissioning group, as does the council's strategic planning director. Commissioning priorities are fed back to the health and wellbeing board. All network members have been given the opportunity to contribute to commissioning decisions and to the Joint Strategic Needs Assessment (JSNA).

GPs now have better knowledge of third sector agencies providing support for their patients

Financial implications

The practice manager obtained funding for one session per week, initially from NHS Dorset from Stour surgery's freed up resources and in the last year from the locality commissioning group (approximately £5,000 per year).

Savings can be expected from the reduction in emergency admissions across the locality 2011/12. Local care pathways will also reduce secondary care consultation costs.

Contact

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FINALIST

Mental health link worker between housing and mental health

Martin Applegate

The Gateshead Housing Company and Gateshead Primary Care Mental Health Team

The initiative

As part of ongoing monitoring of Anti Social Behaviour (ASB), The Gateshead Housing Company (TGHC) became aware of common occurrences of mental ill health in such casework. It was apparent that significant numbers of either perpetrators or victims had some form of mental ill health.

In order confirm this, TGHC had initial discussions with Gateshead social services mental health section to establish if their client data could be accessed. This enabled the company to undertake an exercise to see if there was a correlation

between ASB and mental ill health.

The data held by social services was accessed and a direct correlation was found. Discussion then began with Gateshead Council and the PCT on how improved services could be provided for this client group. Funding was provided by the PCT and development of the mental health housing link worker placement began.

The mental health link worker (MHLW) is seconded to work with the Gateshead housing company, based within the neighbourhood relations team to provide a seamless link between the two agencies.

The joint working arrangements support the company's commitment to early intervention and targeting resources towards vulnerable service users. They also support our partnership approach to identifying and supporting people with mental health issues and are linked to safer Gateshead priorities. The MHLW key objectives are to:

- Raise awareness of mental health across housing management;
- Provide a referral and signposting function to housing staff and council tenants;
- Provide advice on all known neighbourhood relations team cases with mental health issues identified;
- Attend joint visits with neighbourhood relations officers and estate officers;
- Provide specialist and timely advice to neighbourhood relations officers and estate officers.

Benefits

During the period April 2011/12 there were 128 referrals made to the MHLW. The MHLW carried out the following actions:

- 6 were given advice by the MHLW and referred to the carers association for appropriate support;
- 3 were given advice by the MHLW and referred to their GP;
- 10 related specifically to alcohol induced behaviour and were referred to the brief intervention alcohol worker for advice and support;
- 2 were offered advice by the MHLW and were referred to the learning disabilities team;
- 6 have been referred to the social services adult care team for support;
- 13 were given advice by the MHLW and referred to the primary care team;
- 14 were given advice by the MHLW and referred to the secondary care team;
- 4 received advice and support from the MHLW and were rehoused due to the impact of ASB issues linked to their wellbeing;
- 22 received advice and support from the MHLW and now feel able to manage their mental health without ongoing support;
- 37 continue to receive support from the MHLW.

Of the 95 referrals relating specifically to ASB cases, 59 have since been resolved and closed, this equates to 62% of the overall referrals relating to ASB cases.

Six customers were rehoused following intervention and advice from the Mental Health Link Worker. Four of these customers were complainants and two were alleged perpetrators.

Financial implications

The annual cost of the part time joint working arrangements is £20,876, this cost is funded by the South Tyneside FT.

Although legal action has been taken against two customers referred to the MHLW during this period, we avoided taking legal action against three customers and limited the action taken against one customer. This reduction in legal action

provides a cost saving of £544 relating to officer time, £6,872 cost associated with eviction action and £2,675 costs associated with homeless prevention. This amounts to a potential saving of £30,274 relating to the three cases.

While injunction action was taken against one customer, this prevented further legal action giving us a potential saving of £8,252 in this case.

Five customers were issued with a formal warning in relation to the conduct of their tenancy and following this their ASB case has been closed due to a significant improvement in their behaviour and management of their tenancy. This removed the need to pursue further legal action, giving TGHC a potential saving of £50,145 broken down as £544 costs associated with officer time pursuing legal action, £6,872 costs associated with eviction action, and £2,675 costs associated with homeless prevention totalling £50,458 for five cases less the cost of issuing five formal warnings at a cost of £312.

Contact

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FINALIST

Integrating Sure Start Children's Centres within health

Siobhann Leviton and Sian Larrington
Norfolk Community Health and Care Trust

The initiative

The *Kennedy Report* made 39 wide ranging recommendations focused on integration that are likely to be considered in the government's spending review. In 2009 the *Healthy Child Programme* for birth to five years and 5–19 years was published. It provides a framework for provision of preventative health services to all children through an integrated model of delivery bringing together health visiting, midwifery, Children's Centre staff, school nursing and general practice.

This model has required a new approach to leadership as different professionals come together with their own philosophies, structures, accountabilities and professional languages; this starts with a robust and integrated leadership team.

Services are aligned to centre clusters, and extends the current provision of universal services within Norfolk Community Health and Care Trust — Sure Start Children's Centres, health visiting and school nursing. The extended provision includes specialist children's services — paediatric nursing, speech and language therapy, and infant mental health services.

The initiative involved:

- Dedicated subject matter expertise within teams;
- Visionary leadership;
- Assistant director level sponsorship;
- Effective consultation with staff groups, partner agencies and client groups;
- Strong engagement with the more vulnerable and targeted community members who have become strong advocates for the model within their communities;
- Robustly challenging historical and established professional working practices

The project was driven by evidence based research and a requirement to deliver improved outcomes thereby providing rationale for any challenge to change. It involved developing and building on local networks and partnerships to enable the delivery of wraparound services closer to the child and their families' home.

Benefits

Benefits of the initiative are improved outcomes for children and their families, particularly those with early predictions of poorest outcomes based on the national *Every Child Matters* outcomes:

Be healthy

- Improved inoculation rates;
- Increased breastfeeding rates;
- Increase in parents receiving smoking cessation support;
- Evidence of improved diets for the under fives;
- Increase access to maternity services through increased integration and joint work;
- Increase in migrant families accessing maternity and postnatal health services.

Staying safe

- Reduction in re-referrals to child protection teams;
- Social work staff in the integrated teams provide an assessment for those with complex social needs and provide services to support families in need;
- Integrated safeguarding processes;
- Implementation of the Solihull Approach Programme ensures all staff provide consistent interventions.

Enjoy and achieve

- An integrated two year review;
- Improved early years foundation stage scores.

Financial implications

The Sure Start grant is a dedicated budget for this initiative and currently stands at approximately £6m.

The *Rowntree Foundation Study* estimates that child poverty is costing the UK exchequer £2bn a year in extra benefits paid to adults who grew up in poverty and are now out of work. Child poverty is also diminishing UK GDP by at least £11bn through reduced earnings of those in work, £3bn of which would have gone to the exchequer in taxation.

Contact

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FINALIST

Reducing health and social care inequalities for older people through integrated working

Carolyn Hanna and Helen Bartlett
South Essex Partnership University FT

The initiative

In Southend, between 2001 and 2009, the regional population of people over 65 grew by 44%. Many of these people live alone. We also know that 45% of the Southend population live in the most deprived wards in Essex. The increasing older population is linked to a rise in A&E admissions and a growing demand for social care services over the past five years.

Southend-on-Sea Borough Council, together with partners in the PCT and community services, needed to meet this demand with limited resources. The solution involved changing the way services were accessed, delivered and commissioned — moving to an integrated model of care. It also involved a fundamental shift in focus: from crisis to prevention.

The main aim of the initiative was to support people to enjoy a good quality of life and to remain as independent as possible for as long as possible.

We launched our integrated model of care for intermediate care in October 2011. A major innovation in the delivery of this model is a SPOR (Single Point of Referral). The SPOR is made

up of staff employed by Southend Borough Council and SEPT (South Essex Partnership Trust).

This multidisciplinary team of staff, based at Southend Hospital, assess and plan care. This model is mirrored in the community with weekly meetings to review cases and plan care that is short term, goal based and supports independence. After intermediate care is complete, the SPOR team liaises with the local authority's brokerage team to develop long term care based on Self Directed Support (SDS).

To enable the team to operate efficiently, a common assessment process and shared information system for assessments and care plans was introduced with remote access for the community teams. Every patient is allocated a key person with whom to plan care and discuss their needs.

Benefits

There has been a 30% increase in referrals from GPs to support patients in the community from October 2011 to February 2012. Compared with the same period last year, the service capacity has increased by 10% (with the same resources) and the split between community and residential care has moved to a greater number of people being supported in their own home, rather than going into residential care.

Financial implications

Existing resources were used; teams were brought together from what were previously separated pathways. An additional investment of £250,000 funded extra therapy, social work and office accommodation.

Expected savings for the programme in 2011/12 are £3.8m. This will come from avoiding hospital admissions and treating people in the community. It will also come from prevention or early intervention — which maintains independence and avoids costly interventions that would occur without the prevention services in place.

For social care, reablement is an important factor to support this type of prevention strategy. It is also recognised that frail older people with complex needs will need health and social care support that is flexible and responsive.

This initiative is not only about savings; this model of care has increased the effectiveness of existing resources by reducing duplicate working and in appropriate placement of cases into services. This has increased the capacity of existing services by over 50%. Outcomes for those services have also improved, with an increase in the number of people being independent, after the service, of 10% over the past six months.

Contact

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FINALIST

Measure Up — a whole system approach to supporting unpaid carers

Gail Rogers and James Drummond

Torbay and Southern Devon Health and Care Trust

The initiative

Measure Up, the interagency carers strategy for Torbay, is a rolling three year strategy and action plan driven by joint working between Torbay Council and the NHS. Since 2000 we have had long term development of carers services, building effective partnerships with carers, carers groups, the voluntary sector and statutory agencies.

Research shows that the majority of carers are reluctant to seek support or don't identify themselves as carers. Our initiative has shown that a joint proactive response from health and social care can be successful in meeting carers' needs and in changing the culture in health and social care. The Measure Up strategy has six aims with implementation through a series of three year action plans with targets.

Each edition of Measure Up (current 4th strategy 2012–14) is derived from ongoing assessment of local needs and an evidence base of what works. The Measure Up approach combines:

- Direct access services — information, advice and emotional support available to all carers through primary and secondary health and social care services;
- Prevention of breakdown of carers' mental and physical health;
- Targeting specific groups of carers — those who are hard to reach or excluded;
- Development of flexible breaks services and "enabling" capacity.

In practice this has involved:

- Building an infrastructure of direct access support — carers' support workers, Signposts carers information service, Torbay carers register;
- Developing services for "hard to reach" groups of carers including in mental health, young adult carers (16–25) and older carers of adults with learning disability;
- Commissioning flexible breaks and enabling services with the independent/voluntary sector;
- Developing a new form of carers assessment in partnership with primary care that includes physical and mental health.

Benefits

Benefits of the initiative include:

- Development of effective networks of "direct access" carers support services (eg carers support workers in all GP surgeries) with reliable evidence of impact on carer well being;
- Identification of previously "hidden" carers;
- Joint working between GPs and social care. The style of intervention enabled patients and carers to accept services which otherwise they would have refused;
- Reducing barriers between services, making referral and signposting easier between GPs, voluntary sector services, secondary services and in transition from children's to adult services;
- Direct carer involvement in service development resulted in new ideas for service design. In addition, carers as volunteers provide major resources to the organisation.

Financial implications

Since 2003, Torbay Council and PCT have operated a joint budget for development of carers services, using Department of Health carers grant and specific PCT funding to resource the Measure Up strategy.

New services have been developed at low cost by incorporating them into the core structures of carers support. For example the overall cost of provision of Torbay carers register has remained the same for five years even though the numbers of carers receiving its services has doubled and additional services have been developed. Currently 3,300 carers are receiving this service.

Contact

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WINNER

Electronic requesting and reporting of laboratory medicine and radiology services with positive patient identification (PPID) driven specimen labelling at the bedside

Paul Altmann and Payam Mohaghegh

Oxford University Hospitals Trust

Background

A 2009 survey of 120 trusts found 365,608 laboratory specimens mislabelled. In 46 cases this mislabelling contributed to death, or a significant delay in patient treatment.

International studies found a mislabelling rate of 1:165, and wrong-blood-in-tube of 1:1986. A key study showed failure to follow up inpatient results in 20% to 62% of cases. Emergency department result follow up failed in 1% to 75%.

The aim of the initiative was to improve the entire process of requesting and reporting for radiology and laboratory medicine by designing and implementing an electronic order communication system that uses PPID at the bedside.

The process

We set up separate workflows for doctors, nurses and phlebotomists; however, all use the PPID approach for lab samples.

The key piece of technology for this initiative was the Workstation On Wheels (WOW). This consists of a laptop which has full SMARTcard based access to EPR, a wireless specimen label printer, a barcode scanner to read the patient wristband, and trays containing specimen tubes, specimen bags, and, all the phlebotomy kit.

The doctor or nurse takes the WOW to the patient's bedside and the patient wristband is scanned, this opens the patient record. After checking the patient demographic, requests are typed and signed in EPR. This triggers the system calculated appropriate number of labels to be produced. The information on the labels indicates the number of tubes required and the type of tubes/container required.

The biggest change has been for the phlebotomy staff, whose workflow has changed from a totally paper based flow to a completely paperless one. Staff have adapted to this new PPID way of working very well, and are championing the new ways of working.

The radiology workflow has also been transformed from paper based to a paperless one.

Advice to other organisations

EPR Order Comms with PPID went live across the whole of the Nuffield Orthopaedic Centre in September 2011, and at emergency department (ED) and maternity departments of the John Radcliffe Hospital and Horton Hospital in December 2011. The roll-out across rest of the Oxford University Hospitals sites is continuing.

We have shared our various project collaterals (testsheets, data collection worksheet, workflows) with several trusts already (Wirral University Teaching Hospital, Imperial College, Southend University Hospital, and South London Healthcare Trust.)

Benefits of the initiative

On peak days more than 1,500 laboratory and 400 radiology requests are placed from NOC/ED/Maternity. Under the new system the problems associated with paper requesting (data quality, transcriptions errors) are removed for these orders.

99.7% of laboratory results (sample size 7,136) and 99.4% for radiology reports (sample size 6,870) are posted to the patient



record. The results not posted are tracked via a daily exception report.

Radiology requests received by department on the same day referral were made improved from 15% to 100%. Radiology referrals received with no referral date or signature improved from 10% of referrals to 0% of referrals.

Approximately 50% of laboratory and radiology results are endorsed by requestors from their EPR inbox online.

The software design contains clinical pathway based caesets, structured order screens, and mandatory fields.

Requestors can track the status of their laboratory and radiology requests, including the radiology appointment time.

Financial implications

Commercial interface costs paid by trust were £60,000. The other project costs were covered as part of the NHS Connecting for Health contract with BT.

The estimated on-going annual cost saving is of £1,187,053. This estimate consists of a cash releasing element of £97,145 and a non cash releasing element of £1,089,909.

Future plans

We have held Lessons Learned workshops with BT/Cerner, the Lessons Learned logs are shared with other trusts via the NHS Southern Programme for IT, and BT/Cerner are using them at their other deployment sites in UK and worldwide.

The Cerner Order Comms Special Interest Group meets every six weeks, and learning is shared between various NHS sites. The group has representatives from trusts in the South of England and across London.

Contact

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Judges

Sir John Oldham, national clinical lead, QIPP, long term conditions and urgent care, Department of Health

Paul Rice, director; telehealth lead at health innovation and education cluster, NHS Yorkshire and the Humber

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

HIGHLY COMMENDED

Alcohol relapse prevention project Cathy Barrett and Graham Mallinson d2 Digital by Design and NHS Bolton

The initiative

High rates of alcohol related relapse have been identified globally, nationally and locally. Research data shows that within the first year after detoxification (detox), relapse rates vary from 80–90%.

As part of the Health Foundation Shine 2011 project d2 Digital won a grant to trial a new alcohol relapse prevention project in conjunction with the Bolton NHS and alcohol services.

The main objectives of the initiative were to:

- Increase engagement with alcohol aftercare services
Community Alcohol Team (CAT) from 42% to 75%;
- Reduce re-referral rate in the CAT service by 4%.

This programme consists of a supportive interaction between an individual and the service through mobile phones. This involves:

- Client engagement with the aftercare programme — a reminder system with integrated response request mechanism;
- Daily motivational texts with personalised feedback (answers trigger the most suitable feedback from profile/database alerting service on the client's performance and in the case of emergency);
- Options for an individual to engage directly with the service in the case of relapse or cravings.

There is a dedicated web based platform that allows service key workers and managers to monitor client performance on a daily basis. It provides an area where feedback and motivational encouragement text messages can be inserted for every client individually; allowing SMS to be highly personalised and relevant to an individual. The platform also provides rigorous reporting indicating not only client engagement but also service keyworker engagement.

Benefits

So far the project has shown following results (based on the 11 month data):

- Average engagement rate with CAT, 83% (baseline 42%);
- Average engagement rate with Alcohol and Drugs Service (ADS), 69.5% (baseline 17%);
- Project participant re-referral reduced by 400%.
- In addition ADS have logged 11% DNA rates with project participants. DNA rates for all clients currently managed by ADS is 57%.

The project provides workers with better data about their client's progress. They are able to see if there are patterns in their responses and explore these at the client's next appointment.

The service providers (CAT and ADS) have benefited by seeing an improvement in outcomes ie in the number of clients successfully completing their aftercare courses. This improvement in efficiency does not lead to savings as such, since the demand for services continues to outstrip the supply. However, it does mean they are able to help more people due to the reduction in re-referrals.

There have also been some unforeseen and unexpected benefits. For instance the key workers have reported that the process of working with clients to develop individually tailored messages for the message bank contributes to the therapeutic process and improved information about clients' triggers, which can be of great value in providing support.

Financial implications

Initial funding of £75,000 was received as an award from The Health Foundation Shine 2011 programme.

The estimated cost savings range (based on 10 people) varies from £5,000–£150,000 (detox only) and £143,260–£474,150 based on treatment complexity and additional services. All these estimates are based on the client case history data.

Contact

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HIGHLY COMMENDED

Wireless working for out of hours care John Blakey and Kelly Benning Nottingham University Hospitals Trust

The initiative

Seventy five percent of the year falls outside 9am to 5pm, Monday to Friday. During this "out of hours" period, services are stretched and patients are at highest risk. Care in hospital is provided by a small team of doctors, nurse coordinators and health care assistants. This team covers work in all specialties, often across a large area.

Coordination and communication between wards and team members has been a major issue locally and nationally. Standard pager and landline telephone systems are prone to:

- Delays while pagers are answered;
- Information decay through repeated retelling;
- Information loss without robust means of recovery.
- Handover between shifts has been repeatedly highlighted as an area of concern.

We introduced a wireless IT system to manage workflow out of hours, replacing the pager system. Our objectives were to improve the quality and speed of communication between doctors and nurses, reduce information loss, and improve user satisfaction. We also aimed to capture data on every task requested, (including type, priority, location, and duration) to understand the actual workload and reorganise resources.

These intended improvements in efficiency, safety, staff satisfaction, information governance and cost are in line with recent initiatives and statements from government and learned institutions.

The development and deployment of the system involved extensive collaboration between clinical staff, NHS IT, Cisco Systems, and NerveCentre Software.

We undertook a phased approach over four weeks, firstly introducing task requesting and allocation elements, then data transfer to team members, and finally refining data collection. Deployment was trialled at one acute site before roll out to a second.

A nurse requests a task (eg patient clerking) giving standardised information through the NerveCentre interface on the ward PC. Once submitted, the request is automatically allocated a priority based on predefined rules and sent to a coordinator's handheld tablet device.

Coordinators see at a glance all information entered, including the priority, location and task type. When they select a task, a list of staff and their current workloads is shown. They choose the most suitable team member and information is sent to their mobile phone.

The recipient accepts the task to the work list on their phone and will indicate it as complete when undertaken.

Cumulative data is collected centrally and pre specified reports are automatically generated. Evaluation and refinement of the system required further collaboration with university academics and the Association of Chartered Certified Accountants (ACCA).

Benefits

Questionnaires and interviews show wireless working was well received with particular praise for improvements in task flow efficiency and information governance. The coordinators spend vastly greater time engaged in direct patient care, with a 55% increase in clinical activity.

Doctors appreciated their personalised record of work (for educational portfolio) and being able to respond to the explicit urgency of tasks rather than simply a bleep. To illustrate this, 26% of cardiac arrest calls were historically to obtain help with patients who had not arrested. This proportion fell significantly to 11% with the new system.

Systematic review of over 1,100 clinical incidents showed a significant reduction in the proportion attributable to out of hours response or handover. Fewer incidents and greater efficiency appeared to contribute to shorter length of stay: on medical wards the average fell from 6.5 days to 5.67 days over comparable three month periods one year apart.

The major benefit is the capture of the actual work undertaken out of hours. Simple recent examples would include:

- Targeted alerts to ward managers when their staff recurrently request tasks that should have been accomplished during the day (eg warfarin dosing);
- Alerts to pharmacists of drug card rewrites undertaken out of hours so they may be checked at the next opportunity;
- Assessing the efficiency and accuracy of new junior doctors and designing related teaching.

We have used data from the system to begin to objectively reorganise staffing. Clinical support worker shifts have been altered, as has junior doctor allocation: one third of junior doctors were covering surgical wards but these generated less than 6% of the work.

In the near future we will use the available data to further alter staffing, in particular to recognise that there is not a uniform amount or urgency of tasks through the year in all specialities

Financial implications

The trust had a Cisco Medical Grade Network in place. Additional work on this network, the NerveCentre software, Blackberry devices, and tablet PCs cost £118,000.

By better understanding the work undertaken by clinical support workers we were able to alter their shift patterns, saving £98,000 per year. The ACCA report estimates the increased clinical work undertaken by coordinators to be worth £300,000 annually, and the reduction in length of stay to save the trust £292,000 annually. The reduction in clinical incidents (48 per year) saves the trust £96,000 annually that would have been spent on reporting, investigation, additional clinical work, and legal fees.

In addition, the new system has also led to four long term vacancies for coordinators being filled, and has therefore reduced the total cost of nursing coordinators. The success of the system has led to academic grant applications that support work in developing the system and realising its reporting and educational potential.

Contact

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FINALIST

Real time patient records support high quality care

David Thompson and Andy Jago
Cornwall Partnership FT

The initiative

In this initiative, electronic records, accessible 24/7, 365 days a year, were introduced to support the delivery of high quality patient care. Across the trust's mental health and learning disability services paper records and a variety of online systems were replaced with a single electronic patient record system called RiO.

RiO has the capacity to document care plans, risk, demographics and history in a single location for each patient. When combined with a variety of technological solutions the system enabled a radical change in the trust's working practices.

An internal team was established deliver the implementation. The trust's performance management team and clinical leadership ensured new systems and practices achieved the reporting and performance management standards required nationally.

A programme of communication and engagement with staff in clinical areas ensured involvement and ownership from the outset. This was reinforced through training, floor walking and support resources available on the trust's intranet. Training and additional support in the weeks following going live ensured new practices and ways of working became fully embedded. Over 1,600 staff made the transition to the new patient records tool.

Significant investment in new IT equipment encouraged the adoption of the electronic system. Laptops, the installation of Wi-Fi and remote access through "sim" technology provided additional staff incentives to embrace the new records tool.

Clinical governance is achieved through transparent access while complaints and serious incidents are easily investigated and referenced to data on the patient experience.

An ambitious programme of clinical audit was established to embed quality practices. Clinical leaders, including the trust's chief executive participated in the review of records, feeding back to individual clinicians where quality improvements could be made.

Historical paper records were replaced with an online archive. This increased the security and governance of patient information.

Benefits

Care quality has been improved through access to the latest clinical information, particularly for patients in crisis out of hours. Countywide, teams are able to work flexibly and innovatively. Patient case notes can be simultaneously viewed and discussed, allowing multidisciplinary professionals to come together remotely to discuss a patient's care.

The use of online diaries allows clinical time to be scheduled more effectively. This is especially important in Cornwall because we have remote and disparate communities. A significant reduction (18–20%) in non-productive travel has been achieved; this has released time to care for the benefit of patients.

Information and record loss is minimised. Data governance and security of data is ensured through robust log in and access audits.

The removal of paper record archives and files has released space in offices and clinical areas.

Financial implications

Investment in mobile working has increased the clinical time spent with patients. Travel times and costs have been cut. The use of online diaries ensures the best use of clinical time and accommodation.

Over £500,000 has been invested to purchase additional laptops and mobile technology. Additional resources including Wi-Fi access, printers, laptops and scanners have supported the transition and implementation enabling clinical staff to fully exploit the benefits of the electronic records.

Contact

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FINALIST

Improve patient outcomes and organisation efficiency with EMIS Web

Shaun O'Hanlon and Matt Murphy
EMIS

The initiative

EMIS Web is an integrated healthcare system for GPs, extended care, community and secondary care. The system provides patient information to frontline staff whenever and wherever they need it, saving time and delivering efficiency savings. It was developed to support new ways of working, to fulfil local healthcare objectives and to enable the emerging clinical commissioning groups (CCGs) to deliver the national policy for healthcare.

Sharing patient information is vital if CCGs are to deliver more efficient care outside institutional settings to an increasingly elderly population with multiple health needs. It enables different healthcare teams to work more efficiently and deliver integrated care.

For example, in Cumbria securely sharing the patients' GP medical records has freed up 15 to 20% of clinical time for community healthcare teams. In South Liverpool record sharing between different healthcare teams using EMIS Web has enabled the anti coagulation service to deliver 13,831 consultations closer to patients' homes and at a reduced cost.

The system has real time data sharing capabilities that can be embedded at the core of daily operations.

Benefits

There is evidence that EMIS Web has improved patient care, service delivery, productivity and cost effectiveness.

MMR vaccination rates in Tower Hamlets rose from 80% to 95% following use of EMIS Web search and reports functionality.

Having information available where and when it's needed means clinicians can spend more time on patient care, and less on chasing information.

Direct access to patient's medical records via EMIS Web is allowing acute medical unit pharmacists in North Mersey to see an additional 140 patients a month.

Sports medicine consultants caring for one million patients in the North East and London have reduced dispatch of discharge letters to GPs from 10 days to 24 hours.

In Cumbria the respiratory team are saving time since using EMIS Web to share patient records saving at least two hours of admin time each day.

Financial implications

Liverpool PCT used EMIS Web to redesign their extended healthcare services, to provide clinics such as joint injections in

a community setting rather than in hospital. The joint injections service is now delivered at a tenth of the cost of providing it in hospital (£45 per injection instead of £450).

Contact

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FINALIST

Community glaucoma overtaken by the i-van

Nerinda Evans and John Havard
Ipswich and East Suffolk CCG

The initiative

The purpose of this initiative was to improve the standard of glaucoma care by the systematic and regular assessment of patients using a mobile lorry called the i-van.

As the population ages, more and more patients are developing this chronic and potentially blinding condition. Our research has shown that secondary care treatment is falling short of good clinical practice.

The i-van is in accord with the policy of bringing care closer to home and uses technology to ensure that the highest standards are met. Each case is reviewed by a consultant ophthalmologist who has the full set of clinical parameters to assess along with historic data provided with the software.

We started this work in February 2006 and got as far as designing our own i-van. Then we learned of Newmedica through the NICE glaucoma lead from Moorfields and decided to contract with them to adopt our way of working in Suffolk. The crucial difference is that this was a primary care initiative, not Newmedica contracting with acute trusts to help them manage their glaucoma load.

The first steps of the initiative involved proving there was a problem. Hospital departments tend to feel they provide a gold standard service and that they need to be delivering chronic as well as acute care. We demonstrated that patients whom the consultant had said should be reviewed every six months were sometimes not being assessed for fifteen months.

This was not a failure to give appointments but a failure to get all the tests done — usually the delays were on visual fields since this test takes over half an hour and the machines are always being used.

The original i-van proposal floundered because the local consultants did not want to do the remote assessments. Linking up with Newmedica meant that there was a pool of specialists that could be used if the local ophthalmologists did not want to take part. The data shows us that over 80% of hospital patients do not need to see the consultant but can be safely monitored in the community.

Benefits

The i-van experience is designed to be efficient and friendly for the patient. Each mobile clinic unit houses all the equipment needed for glaucoma testing:

- Visual acuity (letters) chart;
- Humphrey visual field test;
- Slit lamp microscope;
- Pachymeter;
- Goldmann tonometer.

There is also an optical camera to provide digital images of the back of the eye. An important feature of the community service

Improving care with technology

is that all records are kept electronically, so there are computers in the unit, although records are actually stored securely on an off site server.

The clinic is specially designed for glaucoma and the entire appointment should last around an hour. In that hour, all the tests are undertaken in rotation. There is no waiting between one test and the next as the clinic is streamlined for a speedy appointment.

The consultant reviewing the case has the full set of information from every visit to make the best decisions. The Newmedica computer programme makes it easy to look back at previous results and so to spot trends early.

Financial implications

Ipswich and East Suffolk CCG has predicted 3,500 appointments in the first year for stable/low risk patients but not likely to exceed 5,000 over three years. The numbers requiring follow up will increase due to both a 7% year on year increase but also changes in the local demographic. The new service is a cost effective way of delivering this growth.

The service is commissioned at 85% of the 2012/13 tariff of £67 + Market Forces Factor (MFF) at £2.92 as the contracted value fixed for three years. The savings are based on reduction on flat tariff costs and saved follow up appointments, as all tests are done in one session. The total expected savings over three years is expected to be £1.04m. Trusts are incentivised to keep follow ups low as commissioners currently do not pay for follow ups over the capped new to follow up ratio of 2.75 (currently 4.59). Patient associated costs are also considerably reduced on travel as we have found local sites without parking charges.

The national tariff is likely to remain constant for the next couple of years as it has just risen due to the increased complexity of follow ups retained within the acute environment.

Contact

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FINALIST

Improving care with the on line pressure ulcer path: prevent and treat, step by step

Lyn McIntyre, Jacqui Fletcher and Jeremy Peters
NHS Midlands and East

The initiative

The initiative involved developing an online pressure ulcer path to support trusts to achieve the ambition to eliminate avoidable grade 2, 3 and 4 pressure ulcers by December 2012 across NHS Midlands and East.

The path takes the user through the steps they need to take to help prevent and treat pressure ulcers. Patient safety is improved as all the relevant information and guidance is presented in such a way that staff at any level can understand it. All the documentation and tools have been created to be used alongside local policies and procedures.

The reduction and prevention of pressure ulcers is one of the key national quality indicators and the 2012/13 NHS Outcomes Framework identifies the incidence of newly acquired category 2, 3 and 4 pressure ulcers as an improvement area. The pressure ulcer path enhances current practice and provides the basis of a consistent approach to prevention and treatment across the NHS Midlands and East cluster.

The guidance has been created by an expert working group and ensures all areas of pressure ulcer prevention and treatment

are covered, not only in the best practice standards but also in all other relevant documentation. The path introduces the SSKIN bundles for prevention and treatment, a new approach not previously used in the care of pressure ulcers. With the simple SSKIN model, clinicians can be confident that all the important areas of care are being addressed — skin, surface, movement, incontinence and moisture, and nutrition and hydration.

The path is a clickable journey that can be found at www.stopthepressure.com/path. The public can also access the path from a PC, so are better informed as to current endorsed best practice and understand the care they or their family member should expect on admission to their local hospital.

Benefits

By using the online path, staff can access information relevant to their patient to ensure they can recognise and subsequently take any preventative measure to reduce the risk of the patient developing a pressure ulcer.

It takes them through the pathway for preventing and treating pressure ulcers, giving instant access to all the mandatory forms and guidelines. Forms and information can also be printed off as reference materials for the healthcare professional to use.

The benefits will be monitored using the NHS safety thermometer a measurement tool. This approach is supported by a pressure ulcer intensive support team. The data will be used to ensure patient care improves and avoidable pressure ulcers are eliminated across the NHS Midlands and East cluster.

Early figures suggest this is already making a difference, but the evidence of the improvement in patient care will be the total elimination of avoidable pressure ulcers.

Financial implications

There were some initial costs in setting up the software for the online tool but these were kept to a minimum as it was developed through a partnership between the East of England pressure ulcer expert working group, the NHS Midlands and East communications team, and Norfolk and Suffolk FT's support service.

Contact

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FINALIST

Stroke telemedicine

Kath Pasco, Seamus Watson and David Watts
NHS South of England

The initiative

People who have had a stroke require urgent access to a senior stroke medical specialist to diagnose stroke and start treatment. Timely access to treatment reduces a patient's disability, the risk of having a second stroke and death. Access to a senior stroke practitioner is usually not available 24/7 because most district general hospitals only have two stroke consultants.

The purpose of this initiative is to provide access to stroke consultants 24/7 through the use of technology and a county wide cooperative approach. It supports the attainment of the standards set out in the national stroke strategy, enhances quality and reduces variability, delivering care close to a patient's home.

It also significantly reduces expenditure both in acute care

Improving care with technology

and in rehabilitation and residential care.

The project required a great deal of cooperation and flexibility within the stroke community. Stroke consultants met and agreed on a county wide cooperative approach to delivering acute stroke care.

Once agreed major technical hurdles had to be overcome to enable consultants to access IT systems across five general hospitals. Stroke telemedicine enables the consultant, remotely, to have a two-way conversation with the patient and treating team in A&E. Both the consultant and the treating team can see and talk to each other and the consultant can see excellent quality brain images to aid diagnosis and commence treatment.

This initiative also required a countywide approach to clinical governance to help ensure it was supported by good quality training, audits and reviews.

Benefits

This initiative has significantly increased the number of patients who receive urgent stroke care. Patients have less disability, spend less time in hospital and are more likely to be discharged home and resume normal activities. There is a reduced need for residential or nursing home care because patients have made better recovery following stroke.

It has delivered access to stroke consultants 24/7 and the ability to start treatment even when consultants are not on site. It has raised the profile of stroke patients and treatment significantly. It provides acute care across five general hospitals; rather than the hospitals trying to meet patients' needs 24/7 in house.

This has also raised wider issues for other professionals who deliver acute care in A&E concerning the need to consider working cooperatively to meet the needs of patients overnight and at weekends.

Financial implications

Approximately £150,000 was needed for the IT equipment.

There have been savings from a reduction in length of stay from about 24 to 14 days, with an average cost of an acute hospital stay of £500 a day. Further savings have come from a reduced need for residential or nursing home care at a cost of £600–£800 per week.

In addition, people who make a good recovery after a stroke are more likely to maintain employment and rely less on benefits to subsidise their incomes.

Contact

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FINALIST

The virtual dementia house

Eileen Richardson

The Dementia Services Development Centre (DSDC), University of Stirling

The initiative

Growing numbers of people are developing dementia: about 800,000 are already affected in the UK, and that number is set to exceed 1.7 million within 40 years. It is recognised that it is imperative that more people are supported to live well for longer in their own homes, and that care homes and even hospitals are designed take their specific needs into account.

The virtual dementia house (<http://dementia.stir.ac.uk/>)

virtualhome) is an evidence based interactive online resource that illustrates key aspects of dementia friendly design. The layouts of seven individual rooms are presented, and as viewers scroll across each room, information is displayed explaining how the features benefit a person with dementia.

It shows how living spaces — whether they are people's own homes or care home settings — can be adapted to support the particular spatial and sensory needs of people with dementia. Making simple and inexpensive adaptations to the dwelling space of a person with dementia can mean independent living for longer. For instance, increasing the light levels may have more beneficial effect than medication.

The resource involved the input of people with dementia and their carers, the DSDC's team of health and care practitioners, researchers, librarians and support staff, and associates of the centre including an architect, a landscape architect, lighting engineer, and a web editor.

Each room features key design points that compensate for the cognitive impairments that are a common feature of dementia. The presentation of the virtual rooms is deliberately straightforward so that even people with poor internet connectivity or slow computers can access the information. Indeed, in the first three days after the resource was launched, 3,000 people from around the world visited the site, and new visitors discover it every day.

Benefits

Until now, the DSDC team was frustrated by the difficulties of disseminating their research on dementia friendly design. The centre's headquarters, the Iris Murdoch Building on the University of Stirling campus, includes a suite of demonstration rooms for design and technology, but access to it can pose problems. The virtual dementia house makes the information easily available to everyone, wherever they are.

There is a great deal of evidence to show that sympathetic design and dedicated technology significantly benefits people with dementia, and those who care for them. Eliminating contrast in floor covering, for instance, or employing clear signposting, can reduce distress and discomfort among people with dementia. Carers find that dementia friendly design adaptations make their role easier; and having a therapeutic environment in which to live significantly supports patient dignity, and allows people to remain independent for longer.

Financial implications

The creation of the virtual dementia house was funded by a £15,000 grant from the Nominet Trust, which provides investment for projects that generate social impact. £10,000 of this was used for collating information relevant to the project, for the architects and designers, and for making prototypes of the rooms and testing them. £4,000 was spent on administrative support, and £1,000 went towards the resource launch.

The virtual dementia house is free to access, and the DSDC expects no return on its investment beyond an increased awareness of its dementia friendly design consultancy and audit services. But the resource will make significant savings for health and social care providers who put its principles into practice. Supporting people with dementia to live as happily and independently as possible, for as long as possible, not only benefits the individual and their carers, but also yields savings for the public purse.

Contact

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WINNER

Host Families Scheme (HF)

Phil Byrne, Alexis Bowers and Nick Kamera

Hertfordshire Partnership FT (HPFT)

Background

HPFT has recruited families who are willing to take into their homes service users as an alternative to them being admitted to an acute ward. The Crisis Assessment and Treatment Team (CATT) will provide home treatment to the service users.

Without the host families, the service users would not have been able to stay in the community due to an unstable home environment.

The process

HF aims to:

- Create choices for users, carers and clinicians, within the acute care pathway;
- Provide a community based, acute care alternative to hospitalisation;
- Offer opportunities for increased early discharge from acute wards;
- Extend the choice of options for users and carers and so promote increased engagement during the acute episode;
- Provide a normalising and non stigmatising environment for acute treatment;
- Increase in-house options for treating acute mental illness and reduce out of area treatments;
- Act as a community based complement to existing acute care provision;
- Provide for a strengthening of the recovery based approach within acute care;
- Promote greater social inclusion during the acute phase of recovery;
- Reduce stigma and discrimination among the public;
- Provide greater opportunities for acute treatment in the least restrictive environment.
- Provide the trust with an opportunity to demonstrate innovative capability in developing new models of recovery based approaches to acute care and treatment in the community.

A similar scheme is in operation in Lille. HPFT invited a host family from France to a recovery conference to discuss host families and launch it in HPFT. A host families steering committee was formed with representatives from all HPFT's key stakeholders. The host families were recruited and service users on acute wards placed with them.

Care is provided by CATT in the host families' homes. Currently there are four host families — we are in the process of recruiting more host families across the county

Advice to other organisations

Host Families is new to the UK, however — as stated above — it has been tried with success in other countries, including France. It could be readily adopted by other trusts.

Benefits of the initiative

The scheme has many advantages including:

- Maintaining living and social skills and community connections during an acute episode;
- Providing a non-stigmatising and normalising environment;
- Promoting and maintaining self management;
- Provides community education/normalisation among host families and their social and community networks;



- Reducing pressure on inpatient beds;
- Reducing out of area treatments.

Qualitative evaluation was conducted by fellow service users (whose mental state is currently stable) through the HPFT's Peer Experience Listening project. The service users who have been placed in host families have given positive feedback and they said that it enhanced their experience of the mental health services. They felt much better being in a host family than being on the acute ward.

Financial implications

Host families is being funded from the acute budget, the host families project staff are existing HPFT employees.

Host families are paid £600 per week whereas it can cost more than double that for the same service user to be cared for in an acute inpatient bed.

Future plans

Service users and carers now have a choice as to where the service user can be treated — whether in an acute ward or a host family. We are recruiting more host families to add to the existing alternatives to acute care delivery.

Host families champions that have been set up on the acute wards to promote host families to service users on acute wards. We hope that in the future more and more service users will be cared for in the community rather than being admitted to an acute ward, and there will be an increased satisfaction and positive experience of acute care from service users and carers who use our services.

Contact

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Judges

Harry Cayton, *chief executive,*
Professional Standards Authority for Health and Social Care

Paddy Cooney, *interim director,* Mental Health Network, NHS Confederation

Jan Hutchinson, *director of programmes and performance,*
Centre for Mental Health

Jonathan West, *consultant psychiatrist and clinical director,*
Oxleas FT

HIGHLY COMMENDED

myhealthlocker — service user held electronic personal health records

Mike Denis and Jiri Janeck

South London and Maudsley FT

The initiative

The eMPOWERMENT programme is a joint venture between South London and Maudsley FT (SLaM), the Institute of Psychiatry at King's College London and primary care practices in Lambeth.

In line with the Department of Health's Information strategy to improve access to service user health information, the programme has led the development of an electronic Personal Health Records (ePHR) system known as myhealthlocker. It works with Microsoft® HealthVault™, a privacy and security enhanced online service which allows service users to gather, store and share health information.

Myhealthlocker connects service users with their data from SLaM and their local GP, as well as provide the opportunity to feedback through patient rated outcomes straight to SLaM's electronic medical record system.

This not only provides service users access to their health information but also offers the environment and opportunity to contribute directly to their own health experience through a record created and owned by them. This will enable users to be better informed, understand their choices and become a more empowered partner in their care.

The design and development of myhealthlocker has been a collaborative process between service users, clinicians, local GPs and private sector partners. Initial development involved setting up stakeholder forums, governance mechanisms, pilot sites and identifying technology partners to support the initiative.

Additionally the programme interfaced with a study undertaken at the Institute of Psychiatry, to investigate access to and use of technology (Ennis et al, 2011). A literature review was also undertaken to review existing implementations of ePHRs and assess lessons learned to date (Ennis et al, 2011).

Using this information the team began consultations with service users and clinicians to introduce the concept of ePHRs. This included understanding what features, design and functionality would be beneficial and how to overcome potential barriers that users may face in trying to access the system.

Our technology partners then supported development of the IT infrastructure and integration of data from local GPs and SLaM's electronic medical record system into myhealthlocker. Alongside this process, reference groups of users and clinicians were consulted for feedback, which has led and refined developments to the application.

Benefits

To date the project has:

- Delivered an integrated electronic personal health record system that service users can use to access their health data from SLaM and their GP. Users can also provide feedback through patient rated outcomes to their care team and researchers;
- Enabled service users and their family/carers to move from passive recipients to engaged partners in their health experience.

Financial implications

The project has been funded through SLaM's transformation programme with additional support from SLaM charitable trustees and the South London Health Innovation and Education Cluster (HIEC). To date the total cost has been £100,000.

A full economic analysis into the cost benefit of the initiative is being conducted. Indications of the potential benefits of this innovation can be found in other examples where healthcare providers have adopted ePHRs.

In addition there is potentially significant financial value in the information provided. This includes an unprecedented rich source of data regarding population health.

Contact

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FINALIST

Best evidence summaries of topics in mental health

Julian Walker and Jonathan Piotrowski

Avon and Wiltshire Mental Health Partnership Trust

The initiative

BEST in Mental Health (BESTinMH) is a clinical question answering service developed as a tool for clinicians within the Avon and Wiltshire Mental Health Partnership Trust (AWP). The project has the aim of overcoming some of the practical barriers that are faced in the day-to-day uptake of evidence based practice and knowledge mobilisation/transfer.

In response to intervention based clinical questions in any area of mental health, BESTinMH will identify, appraise and summarise high quality research evidence from systematic reviews, randomised controlled trials (RCTs) and clinical guidelines.

The initiative bridges the gap between research and clinical practice. It was developed through partnership working with AWP, the Cochrane Collaboration Group for Depression, Anxiety and Neurosis (CCDAN) and the University of Bristol.

These partners have ensured that the project is highly relevant to clinical services, while upholding the principles of high quality research evidence. The initiative has involved the development and integration of a new service into an existing NHS secondary care mental health trust through engagement with clinical and management staff. This has required working towards a cultural shift within the organisation, through the delivery of focused workshops and talks, and engaging clinical and managerial staff in discussion around evidence based medicine, and its relevance to their practice.

The project has a team of information specialists that conduct literature searches, and a pool of technical authors who appraise the evidence. Systems have been developed that allow the electronic submission of clinical questions to the project from anywhere within the trust, at any time. A database of the clinical questions addressed and the resulting evidence summaries has been created. This has been accessed about six times a day over the last year, demonstrating that it is a relevant, clinically useful, resource.

In addition, the intranet resources that have been created for the project provide information on the principles of evidence based practice, and signposting to other relevant organisations.

Benefits

The benefit of this initiative can be seen at a number of levels. On an individual level, an ongoing evaluation of the service has found that clinicians feel as though the service gives them the confidence to know that they are working in an up to date evidence based way. Engagement has encouraged a culture of constructive critical thinking — questioning the best possible

treatment and finding the evidence to support clinical decisions.

The evidence summary gave the support that the clinician needed to develop an active life programme. Building on this, a large scale multicentre RCT is in development. The BESTinMH project offers a tangible link between research and practice, not only bringing research to clinical decision makers, but also vice versa, providing a means by which clinicians can become engaged with research.

Financial implications

An initial grant of £110,000 was awarded to the project as part of the NIHR Cochrane engagement scheme. This award was used in the first year of the project in order to instigate and develop the service.

This initiative is now funded through the research and development department of AWP, and as such is cost neutral to the trust as a whole. The aim of the initiative is not to specifically reduce costs. Rather it works to increase quality in the trust through ensuring that the clinical decisions that are made with the support of the project are based upon high quality, reliable evidence.

The cost of the project should also be seen as offset by the cost of the time that conducting a similar task would take a clinician. This, of course, varies dependent upon profession, and the differing abilities of each individual, and ultimately the length of time that these tasks will take.

Contact

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FINALIST

Youthspace — a comprehensive strategy for youth mental health

Vicky Fowler, Tim Newbold and Claire Rigby
Birmingham and Solihull Mental Health FT

The initiative

The prevalence of mental disorders in young people is higher than in any other age group, yet the majority are unlikely to receive any appropriate treatment at illness onset.

Working in close partnership with The Princes Trust, the Youthspace strategy for youth mental health is a response to this in line with current Department of Health and public mental health policy and research suggesting that youth mental health is a risk category “best buy” for strategic prioritising.

In a unique response to current policy (*No Health without Mental Health 2011*) we have integrated:

- Clinical service redesign (Youth Access Team);
- Service user involvement (Youthboard);
- A schools educational programme (Schoolspace);
- Youth and professional media resources (youthspace.me website films and social media);
- Academic evaluation and dissemination Collaborations for Leadership in Applied Health Research and Care (CLAHRC) Birmingham and Black Country);
- Dedicated partnership working (The Princes Trust — Fairbridge)
- Targeted public mental health campaigns (*Don't turn your back on Psychosis*)

The overarching aim is to reduce delay in accessing appropriate mental health treatment for young people.

Over the past three years we have:

- Identified and targeted major sources of delay for young people in accessing appropriate treatment across

Birmingham (CLAHRC);

- Developed and supported a Youthboard of young service users and volunteers to advise and direct all elements of our work including clinical service redesign, creation of a youth friendly website, films and other social media (Youthspace.me) alongside other educational projects that reduce stigma and increase awareness;
- Worked with primary care, Child and Adolescent Mental Health Service and Youthboard to create an effective and appropriate youth clinical service to meet local needs, reduce delays, improve transitions between services and adopt a preventative triaged intervention model;
- Carried out an educational randomised controlled trial in secondary schools across Birmingham to reduce stigma in young people;
- Consolidated an effective working partnership with The Princes Trust — officially launched in May 2012;
- Created a high impact 18 month public health psychosis campaign in South Birmingham to reduce treatment delay associated with psychosis in young people;
- Applied an iterative evaluation and knowledge transfer strategy with evidence based research through our CLAHRC involvement;
- Used health behaviour change and public health planning models throughout.

Benefits

The impact of Youthspace strategy in the local healthcare economy has been very high, with evaluations, feedback and reports all demonstrating improvements to access of health education and intervention for young people.

In the initial five months of the new youth clinical service operation in South Birmingham, 207 referrals were received with improvements to attendance rates and assessment times and very positive feedback from service users and GPs

Financial implications

The initiative has been developed without any dedicated developmental investment but has benefited from involvement with the NIHR funded CLAHRC programme. The clinical service redesign is being carried out within the context of necessary cost savings faced by all NHS organisations.

The programme is informed by the *Early Intervention in Psychosis* Department of Health strategy, which has been found to have significant cost savings and benefits including reduced suicide, increased employment and long term cost and health benefits.

The savings in cost and investment resulting from the energy and effort of dedicated volunteers has enabled the range of activities to be quite ambitious.

Contact

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FINALIST

Innovative radio programmes tackle mental health stigma

Richard Laugharne, Rosie Dunkley and
Rohit Shankar

Cornwall Partnership FT

The initiative

The aim of the initiative was to bring mental health out into the open through a series of programmes run by Cornwall

Innovation in mental health

Partnership FT and BBC Radio Cornwall. The programmes gave the public free access to mental health professionals; using the phone-in format to get people thinking and talking about mental health.

Common and topical conditions were identified as the basis for the first programmes. Internet resources and social media were exploited to maximise the coverage.

Hosted by BBC Radio Cornwall's Laurence Reed, the programmes engaged in a live on air debate on a featured mental health condition. Over the course of a year, 12 programmes were broadcast, broaching usually shunned subjects like psychosis, self-harm and mental health during pregnancy.

Each month a case study made the subject real for the listener, providing an insight into the trials and tribulations of living with a mental illness. The trust's clinically trained staff were available on and off air to take calls and debate the featured topic.

Radio Cornwall producers ensured callers and case studies were treated with empathy while the programme host ensured common public perceptions were raised, challenged and debated in a lively and informative manner. The dynamic approach adopted led to discussions on mental health which were unusually frank.

To ensure the programmes achieved their aim, their success was evaluated using callers' feedback.

Benefits

Engaging with the public through this medium gave trained mental health staff the opportunity to talk to 100,000 people each month.

Across Cornwall more people are talking about mental health and stigma is being openly challenged. Some callers to the programme have also gone on to seek help formally, citing the radio programme as the catalyst.

Financial implications

Limited financial resources were required. A small grant allowed clinicians to receive tailored media training. The trust released staff and encouraged their participation. All other costs have been met from within existing budgets.

Contact

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FINALIST

Kent wide personality disorder service

Ruth Hirons and Deidre Correa

Kent and Medway NHS and Social Care Partnership Trust

The initiative

The aim of the initiative was to treat the large numbers of patients with severe personality disorder in secondary mental health care in Kent. The aim was:

- To reduce admission rates and to enable patients to progress to employment, courses or voluntary work;
- To improve their sense of well being;
- To enable all patients to take full responsibility for their own therapy;
- To create a flattened hierarchy where decision making is shared jointly — eg patients interview potential new staff and vote on admission and discharge of patients from the service;

- To establish two hubs to offer therapy to 24 members, three days per week for a year.

Before and after the hub patients attend a weekly outreach therapy group in West Kent. One hundred and seventy patients attend this service at any one time in the hub and outreach groups, and most are in the service for up to four years.

On completing the programme patients can participate in our professional training programme, becoming experts by experience and teaching others.

We asked our experts by experience to participate in this and asked current patients to join our project panel. A patient group interviewed all shortlisted applicants for the East Kent hub.

Many patients have been referred for the East Kent hub and teams have been asked to select their most needy. Patients in the West Kent hub will visit and help the East establish a democratic community working to explore their difficulties and to overcome them together while cooking, eating, shopping and dividing up all the tasks of the day.

Benefits

Benefits of the initiative include:

- Reduced self harm;
- Fewer hospital admissions;
- Increased sense of well being, autonomy and ability to manage relationships.
- Increased self regulation in patients with severe personality disorders;
- A shift in the culture of the trust from hopelessness and despair in relation to personality disorder to empowerment and optimism.

Measures showing improvements include PDQ4, CORE, GAF, IIP-32 and outcome interviews with patients leaving the service. These interviews were very positive with evidence of global benefits backed by questionnaires.

Benefits for mental health services include support, consultation and help with the most difficult patients in acute care.

In addition, teaching delivered by the service manager to a wide range of health care professional groups over seven years has led to increased professional skills with personality disorder in teams throughout Kent.

Financial implications

The budget for the West Kent hub and outreach service is £454,361, this includes travel costs, art materials, food and:

- Band 7 — 2.4 wte;
 - Band 8b — 3.0 wte;
 - Band 4 — 1 wte;
 - Band 3 — 0.4 wte;
 - Medical consultant psychotherapist — 1 wte;
- The budget for new East Kent hub is £412,600, this includes:
- Band 8b — 1 wte;
 - Band 7 — 3.6 wte;
 - Consultant psychiatrist — 0.3 wte.

There will be travel costs and an old trust building is being renovated to house the service.

We hope to reduce out of area placements from East Kent by taking patients into the hub programme, which will result in financial savings. Saving will also arise from the diversion of patients with severe personality disorders into our service from hospital and the reduction in their use of services after completing treatment.

Contact

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FINALIST

The Woodland Retreat — a sanctuary to enhance mental health recovery, treatment and rehabilitation

Hayley Hurndall and Joanne Huddart
Pennine Care FT

The initiative

As part of its inpatient Child and Adolescent Mental Health Service (CAMHS), Pennine Care has developed a state of the art treehouse and nature area to complement the existing inpatient units that provide treatment to young people with complex mental health needs.

The Woodland Retreat introduces young people from the Hope and Horizon units to relaxation and learning, enhancing the units' therapeutic approach. It was developed in response to feedback from patients.

During an engagement exercise, the young people said they wanted a place that was totally different from the clinical surroundings of the ward. The team supported the young people to write a letter to the King's Fund to bid for funding as part of the *Enhancing the Healing Environment* programme. Once funding had been secured, the team set about designing and developing the unit, with young people at the centre.

The Woodland Retreat is set in the natural woodland next to the Hope and Horizon units. It includes a 40 metre wooden treehouse, complete with decked area, barbeque and allotment. The space has been designed with the needs of the young patients in mind to ensure that it is safe and secure. It has a living sedum roof, LED low energy lighting, self composting toilet, veggie plot, bird box webcam and a pond to attract wildlife.

Benefits

The Hope and Horizon units offer assessment and treatment to young people aged between 13 and 18, for a range of complex conditions including schizophrenia, depression, self-harm and eating disorders.

The Woodland Retreat provides our patients with a truly unique experience in a natural setting. It complements the patients' treatment by helping to reduce stress and tension. Treating young people that have a mental illness can be challenging, often involving difficult behaviour. Many of the young people who access our services have had poor life experiences and the retreat will help to build their confidence and make them feel valued.

A great benefit of the Woodland Retreat is that families now have a friendly place where they can come and spend time with patients outside of the ward setting. Previously they would have been restricted to the hospital grounds or canteen and this has helped to improve the quality time families spend together.

Financial implications

Launched in 2002, the King's Fund's *Enhancing the Healing Environment* programme encourages teams to work in partnership with service users and carers to improve the care environment. Since 2003, the programme has been funded by the Department of Health. To celebrate 10 years of the programme, the King's Fund launched a capital scheme where providers could bid for funding to support a development project. Pennine Care submitted a successful bid for £100,000.

Pennine Care provided an additional £78,000 through capital investment to realise the development.

Contact

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FINALIST

Buddy App — therapy services in a digital world

James Seward and Aisling Treanor
South London and Maudsley FT and
Buddy Enterprises

The initiative

Buddy is a simple SMS and web based tool that enables people with mental health conditions to better understand their condition and take control of the service they receive. Buddy replaces traditional paper diaries with SMS.

Service users create a daily diary — which they text in — recording their activities and rating their mood. A web application allows them to view previous entries, and see the patterns between their lifestyle and their mental health, empowering them to understand what helps them feel good and what makes them feel worse. The service also allows them to collaborate with their therapist to set goals, using their data as a way to improve communication and understanding.

Buddy uses technology to improve a proven clinical approach (mood diaries) and intervention (behavioural activation). It does this by using "just enough technology". It is not a smartphone app, which is not accessible to all users. Instead, we have focused on a simple and ubiquitous technology, SMS, which makes the service more available, easier to use, and cheaper.

Buddy was developed as a collaborative project with South London and Maudsley FT (SLaM) and their service users. It aimed to exploit digital tools to improve user engagement and satisfaction, help services achieve better outcomes and improve service efficiency by reducing did not attend (DNA) rates.

It took us 12 months of prototyping and development to understand the real problem and simplify the solution. The work with users helped us to focus our solution on the future instead of the past, on wellbeing instead of illness, and on self management instead of social networks.

Benefits

Buddy bridges the divide between formal/professional healthcare, and informal/community care. These two worlds are historically separate, but Buddy feels and works like a consumer application, and is therefore not stigmatising. However, it also plugs into the healthcare system, where real people, with human insight and human experience, support the technology.

We saw clinicians and managers as key beneficiaries of the innovation too — and we have spent a lot of time working with them to ensure it fits with their service practices and makes their life easier. Buddy has been designed to bring benefits for users, for therapists, and for managers.

Financial implications

Buddy App was developed with £36,000 investment from NHS London's Regional Innovation Fund (RIF) which was used to design, build and test three versions of the tool over a 12–18 month period to arrive at the current completed product which is now ready to be used in multiple NHS settings.

The product retails at between £20 and £40 per service user (based on the volume of licenses purchased by the service provider). The return on this investment can be more than offset in service efficiency terms by reducing DNA rates alone.

Contact

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WINNER

Effective partnership between geriatricians and GPs in nursing homes reduces emergency hospital admissions

Radcliffe Lisk and Keefai Yeong

Ashford and St Peter's Trust

Background

Nursing home residents tend to be very frail older people with complex pathology and care needs. Many experience multiple admissions to hospital, often with long stays.

This initiative aimed at reducing the number of emergency admissions to our trust from nursing homes by working in partnership with staff in the homes and local GPs. The aim was to help provide more bespoke care for this patient group, keeping them out of hospital wherever possible. The project was also part of a trust wide response to the emergency admission cap introduced through the National Operating Framework 2010/11.

An initial audit of 1,954 nursing home residents admitted to our trust (April 2006 to March 2009), showed a total length of stay of 20,074 bed days or 6,691 days per year. Of these, 82 residents had multiple admissions (4 or more) equating to 3,073 bed days or 37.48 days per patient, costing a total of £798,980 over the three years (each 24 hour stay on a ward costs approximately £260). These patients became our focus.

The process

The initiative began with a three month trial focusing on the three nursing homes with the most multiple admissions (≥ 4).

Consultant geriatricians visited the nursing home managers and GPs to discuss how they thought we could help them reduce hospital admissions. They suggested the following interventions, which were adopted:

- Medical advisory meetings with GPs — the consultant allocated to meet with the GP and the nursing home manager monthly at the nursing home to discuss residents and evaluate those that needed medical input — a two hour meeting;
- Availability of telephone advice (Monday to Friday 9am–5pm) from a hospital consultant;
- Medihome — a private healthcare company — to provide intravenous antibiotics and fluids to these nursing homes;
- End of life care — to liaise with GPs regarding residents about end of life care and facilitate advance care planning.

In addition with the intention of reducing length of stay the trust IT department set up an email alert system to inform the consultant geriatricians whenever a resident from one of these three nursing homes was admitted to hospital. On receipt of that alert, geriatricians review the resident and liaise with the nursing home manager and GP to expedite discharge.

Advice to other organisations

The focus of long term care has shifted over the years from hospital long stay wards directed by geriatricians to private nursing homes where medical care is provided by GPs.

Residents of nursing homes often have multiple diseases with significant mental and physical impairment. Many GPs do not have specialist training in managing these patients.

The results of the initiative can be used to improve practice



in other trusts as it has demonstrated that effective partnership between geriatricians and GPs in nursing homes reduces emergency hospital admissions.

Benefits of the initiative

The nursing home project had a significant impact (52% reduction) on emergency admissions from these three nursing homes despite overall rising emergency admissions. There was also a reduction of 57 bed days. In view of this initial success, the project was extended to six nursing homes from October 2010 for a period of four months.

The extended project had a significant impact on admissions from nursing homes. There was also a reduction of 250 bed days compared with the year before. Due to this success, the project was extended to 12 nursing homes in March 2011 and has shown a 30% reduction in the last 12 months

Financial implications

During the project, the consultants involved did this work out of goodwill and were not paid. However, to effectively cost the project we used the national average for a consultant's time.

Costs:

- Consultant — £146 per hour.
- Medihome — £165 per day

Based on these figures, the total cost for the first part of the project was £2384.

Potential savings:

- Cost of prevented admission — £523
- Cost of one bed day — £260.

Given a 52% reduction in admissions and a reduction of 57 bed days compared with similar period in 2010, this easily offset the cost.

For part two of the project, the total cost was calculated at £5784 (six nursing homes for four months) Given a 43% reduction in admissions and a reduction of 250 bed days compared with similar period in 2010, this also easily offset the cost. Potential cost saving for this period is calculated at £74,383.

Contact

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Judges

Dr Naresh Kanumilli, long term conditions lead,
South Manchester Clinical Commissioning Group
Becky Reeve, head of professional relations, diabetes, Sanofi

Award sponsored by



Managing long term conditions

HIGHLY COMMENDED

Tailored care (integrated care with enabling assistive technologies)

Tuan Nguyen and Ann Nolan

Liverpool Community Health

The initiative

The purpose of the initiative was to support patients with long term conditions (LTCs) to self care and stay out of hospital, giving them and their carers control over their own lives.

A GP based in Anfield worked with Liverpool Community Health colleagues to devise a new clinical model for patients with LTCs called Pro Active Care (PAC). This model brought the patient, the GP, the community matron, medicines management and a health trainer from the voluntary sector together in a 12 week programme of integrated care around the patient, with a strong emphasis on self care and education.

Meanwhile, a telehealth project using Philips Motiva was being implemented, but with disease specific focus (heart failure patients initially).

The tailored care programme brought these two things together to achieve greater results than they could separately. Telehealth was built into the PAC clinical model as a core part of the redesign of the service around the patient.

As patients were being educated in their conditions and self managing, telehealth was introduced seamlessly (rather than an "add on") and community matrons embraced the technology as an enabler to their new way of working around the individual.

Benefits

A 73% drop in emergency admissions for acute coronary syndrome and 38% reduction in number of bed days (both compared with the same period the previous year).

The number of patients reporting no problems walking about rose from 20% at the start of the project, to 60% by the end.

At the end of PAC, patients self reported an average score of 65 on their "health today" (0–100 scale – 0=worst possible health, 100=best possible health) — a significant improvement from the average baseline of 38 before intervention.

One patient went from 17 emergency admissions for COPD in a single year to none in the following year.

The telehealth implementation was independently evaluated by John Moores University with strong recommendations from patients and staff satisfaction.

Financial implications

Through explicit development with our Liverpool PSS voluntary sector partners, the role of health trainer was embedded in the model. This, coupled with a reorganisation of clinical time in line with the new adult nursing commissioning specification, has meant that the PAC model has been close to cost neutral.

Small amounts of GP backfill and admin resource (4 hours and 2 hours per week respectively during the 12 week PAC model) were required, amounting to £5,000 for 15 patients. Telehealth costs for 15 patients were £30,000 inclusive of community matron recruitment and review time.

If each patient in the cohort is assumed to save two admissions each in a year, the saving from the initiative is £45,000.

Contact

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FINALIST

First Diabetes bridges gap between primary and secondary care

Gino DiStefano and Kyran Farrell

First Diabetes, a partnership between Derby Hospitals FT and First Provider

The initiative

Bridging the gap between primary and secondary care through the development of integrated care pathways, in particular for patients with long term conditions is a key national priority.

First Diabetes is a new partnership between primary and secondary care commissioned by the PCT with a single programme budget and joint clinical decision making and clinical governance.

The initiative aimed to achieve a comprehensive, integrated diabetes service that was jointly owned by both primary and secondary care. This would enable the programme budget to be spent on the areas of patient care that needed it most thereby reducing duplication and ensuring a consistently high standard of care. We were committed to introduce care planning as an essential component of our service in order to develop patient empowerment.

The partnership evolved out of a conversation between the lead GP and a local consultant as to how to improve the diabetes service. Clinicians from primary and secondary care together with a patient met to define the clinical pathway. These meetings built up trust between organisations that had previously had a strained relationship due to the competitive nature of payment by results and tariff.

A board of directors was set up as First Diabetes was registered as a company limited by shares (one director from the hospital and one from primary care).

A clinical board was also created to run the service. This was co-chaired by a GP and a diabetes consultant with equal representation from primary and secondary care. Patients are also represented on the clinical board and have formed a parallel patient advisory board.

Throughout this process, great attention has been paid to develop trusting and open relationships between clinicians from primary and secondary care and also between clinicians and managers. This has enabled us to move quickly to implement effective change.

Benefits

Significant improvements in diabetes care have been shown including a 38% increase in the percentage of patients with an HbA1c <7% and a 26% increase in the percentage of patients with an HbA1c <8%.

There has also been an 18% improvement in the percentage of patients reducing their BP to <145/85 and a 53% improvement in the percentage of patients achieving a cholesterol target of <5mmol/L.

Within the first year, 91 patients referred for better blood sugar control had lowered their HbA1c with 39 patients achieving 1% or greater improvement. 73 patients were discharged back to their GP. Over 1000 patients have been screened for diabetes with 15 new diagnoses made. Over 200 patients have attended group education courses.

All this has been done within the budget previously assigned to the same patients when seen in secondary care. Significant improvement in relationships is now leading to further integrated organisations being formed and talks about rolling this model out to other long term conditions. Patient satisfaction has consistently been high in our surveys.

Managing long term conditions

Financial implications

This new organisation was established as a joint venture company as it needed to be jointly owned and run by primary and secondary care.

A single programme budget has been established for patients allowing the service to invest in screening and prevention programmes. Investment was also made into education programmes for patients who were newly diagnosed.

Savings were achieved through shared patient records giving all clinical professionals access to the same information, so eliminating duplication. Also as routine care now provided in the community there has been a significant reduction in follow up consultations.

Payment by results and the national tariff have created a financial barrier between primary and secondary care. This has the potential to generate conflict between good clinical decisions and financial implications of decisions. A joint venture company owned by both parts of the health care community has the opportunity to make the correct clinical decisions and mitigate any consequent financial risk across the whole health economy, ultimately resulting in best care and best value.

Contact

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FINALIST

Reducing lower limb amputations for people with diabetes on the Isle of Wight

David Shields and Ma'en Al-Mrayat
Isle of Wight Trust

The initiative

Figures published in 2000 showed that the Isle of Wight had one of the highest amputation rates in the country while admission for diabetic foot/leg disease is the single largest component of hospital bed use by people with diabetes. The evidence base suggested that the absence of an organised screening programme for vascular and neurological impairment was increasing the risk of chronic ulceration and amputation in the lower limb by 50% or more.

The purpose of this initiative was to reduce preventable amputation and neuropathic ulceration in patients with diabetes by using specialist podiatrists to carry out tailored lower limb vascular and neurological assessments.

The assessments were delivered in primary care which allowed:

- Targeted early intervention;
- Enhanced self management;
- Efficiency savings.

The project plan and business case was developed as a result of joint working between:

- GPs;
- Community podiatry;
- Commissioning;
- The local diabetes network group which included patients.

This included guideline development, a workforce development programme and service development

We created a guideline as part of the GP electronic record which, as well as identifying risks of complications that could lead to amputation, enabled information to be shared with the practice staff, community staff, secondary care and the patient.

Benefits

Recent national figures produced by Yorkshire and Humber Public Health Observatory have shown Isle of Wight now has one of the lowest amputation rates in the country. Neighbouring trusts have a far higher rate with one neighbouring trust being over four times the IOW rate.

The initiative has prevented admissions, saved theatre time, surgical time and greatly reduced major limb amputations. It has improved productivity for GPs and consultant diabetologists; freeing them up from the task of assessing their patients as all of this is now done by an allied health professional. This allows them concentrate to on blood sugar control and other complications associated with diabetes.

This aspect is particularly significant as the Isle of Wight has only a small district general hospital and patients often have to travel to the mainland for specialist care when such complications occur.

Financial implications

The initiative required 1.5 wte podiatrists at a cost of £80,000 for 6,800 patients. This means the initiative cost less than £12 per patient per year.

As a result of the initiative we have moved from having a very high amputation rate 10 years ago to one of the lowest in the country in spite of having a high elderly diabetic population. With each amputation estimated to cost £68,000 this has led to substantial savings and improved the quality of life for these patients.

Contact

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FINALIST

End of life service

Lesley James and Ursula Holt
NHS Nene Clinical Commissioning Group

The initiative

Ensuring a peaceful and dignified death and improving choice for patients about their place of death are key concerns for commissioners of end of life services.

Research shows that around 70% of people would prefer to die in their own home, but the reality is that around 60% still die in hospital. The NHS Nene Clinical Commissioning Group end of life service aims to reduce the proportion of people dying in hospital by 9.7% by 2013.

Nene CCG, working with local GPs, acute and community based clinicians and professionals from carer and voluntary agencies, led the redesign of the local services which now provides:

- A 24/7 central point of contact where care is coordinated;
- A nurse led rapid response service providing domiciliary-based care within an hour of referral;
- End of life link nurses in both acute hospitals to support end of life discussions with patients and their family, and facilitate timely safe discharge home where this is the patient's expressed wish.

The initiative is likely to meet its target as between the first of April 2011 and the end of January 2012, there was a 9.32% reduction in the proportion of deaths occurring in hospital. There has also been a 26% reduction in excess hospital bed days experienced by those at the end of their life, compared with the previous year.

Managing long term conditions

Benefits

In addition to quantitative improvements in patient choice, and financial savings, patient experience interviews show positive results.

The husband of a patient was positive about the end of life service that enabled his wife to die at home, receiving coordinated support from services including Hospice at Home, District Nursing, Age UK, Cynthia Spencer Hospice and Macmillan.

Janet, who died from terminal cancer in October 2011, went into Cynthia Spencer Hospice in July 2011 but husband James wanted her home and underwent training to use hoists. When Janet came home she started with two carers visiting twice a day and a twice-weekly visit from the District Nurse.

As Janet's condition worsened, visits increased with three carer visits a day and regular visits from hospice at home, GP and district nurse. Janet died peacefully at home. James said: "I had support from all services — I think more people should die at home. I had support I needed — there wasn't anyone else I needed because they were all here."

Financial implications

As a three year business case, the service aims are to reduce the proportion of people dying in hospital by 9.7% by 2013, and costs were calculated assuming an incremental approach to implementation.

In addition to improving patient choice over preferred place of death, the new service is also expected to deliver significant savings. Over the course of the business case, the total cost of operating the above end of life community services is £3,096,000, thus generating a total net saving of £532,000 over the three years.

However the sustainable recurrent savings for each year beyond year three is £1,697,000 per annum and recurrent annual costs forecast at £1,335,000 realising sustainable savings of £362,000 per annum.

This entry was also a finalist in the **Primary care and community service redesign category*

Contact

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FINALIST

Care navigators based in primary care

Caroline Leveaux and Jemma Curry

Royal Borough of Kensington and Chelsea

The initiative

A mapping exercise in Kensington and Chelsea as part of the dementia strategy, indicated that while there are many different organisations offering a range of services to people with long term conditions, many people are not aware of what is on offer or how to access it.

This informed work by a group of GPs, secondary care clinicians and commissioners to develop a care navigator role with three components:

- To support people and carers with long term conditions or challenges in primary care;
- To improve access to support from the local authority and third sector — whether they qualify for benefits and personalised budgets or not;
- To provide the GP commissioner with live feedback on service quality.

Navigators were placed with GPs, one in an area of high social need and diversity, one in the south where there is a high concentration of older people living alone.

The navigators take referrals from GPs or others in the practice, usually in response to a rise in unplanned use of care. The navigator sees the patient in the surgery or at home depending on preference.

The navigator works with the patient to identify a plan, then refers or guides them to find services. The initial package is for up to six weeks, but is adapted to need.

Each navigator has an active caseload of 40 to 50 at any one time. Navigators maintain data for monitoring by commissioners as evidence of how to maximise the effectiveness of the intervention.

The navigators are employed by Age Concern, managed locally within the practice and have provision of a mentor through secondary care.

Benefits

An evaluation of the impact of the service was carried out at the end of year one. Comparing the six months before and after navigator intervention demonstrated a significant reduction in:

- Use of GP appointments;
- GP out of hours;
- A&E admissions;
- Inpatient admissions;

The navigators also submitted case studies that demonstrated the impact that they were having on complex cases. Navigators were able to provide a bridge between health and social care, coordinating multidisciplinary action and alerting the relevant professionals when patients' needs increased.

Financial implications

A navigator with all costs including host costs, GP costs and mentoring comes to £50,000. At a caseload of 140 per year this amounts to £360 per patient.

This can be compared with cost of:

- £108 for a single A&E attendance and investigation;
- £350 for a single night admission for investigation;
- £48 for a single DNA on a hearing test.

A typical case was analysed at a potential saving of just over £10,000 in a year for an elderly man who had become isolated and frail.

Contact

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FINALIST

Supporting Swindon people to live their lives, their way

Kim Hogan and Jan Trethewey

SEQOL

The initiative

With rising admissions of people with respiratory and heart disease we developed an operating framework that reduces admissions by giving people choice and control over their care at home. The initiative was focused on supporting people in the way they want to live their lives.

We devised the Patient Life Plan — a personal, dynamic document owned by the patient and revisited by patient and practitioners. The plan is available to the hospital, ambulance and out of hours services so they can work with the patient,

Managing long term conditions

and it identifies high use of any particular service eg hospital, so more appropriate ways of managing conditions can be sought. It provides a single point of access, so clients only have to tell their story to one professional.

Community matrons became senior clinicians and developed competencies to work on reablement and rehabilitation. We also created multidisciplinary integrated teams who worked physically side by side so communication was fast and effective.

We established a SEQOL integrated discharge team at the hospital to ensure there were no delays to discharge. Our GPs/nurses trained ambulance crews in how to determine when hospital admissions are not appropriate.

We have also begun enabling and empowering patients in their own homes through understanding their own bodies, monitoring changes and self medicating, using tools including telehealth, virtual wards and IV therapy.

Benefits

The percentage of patients discharged without needing an individual care package is 75%, against 58% nationally.

SEQOL's integrated discharge team removes delays to discharge. As a result there are no unnecessary stays in beds, and so no penalties for the council.

Community matrons work directly with disability nurses to help disabled people access mainstream services.

There has been a year-on-year reduction in the standardised admission ratio for non electives between 2009/10 and 2011/12. Admissions dropped from 23,296 to 20,486 changing the ratio from 112.7 to 97.2. In addition 3.5% fewer people died in an acute hospital, saving £84,000.

Case history

Len is in his 50s, has severe heart disease and diabetes. His wife gave up work to care for him, and in 2009/10 he was admitted to hospital 50 times and saw his GP weekly. Working with the community team, GP and cardiologists, he now uses telehealth to manage his care.

Les had just one hospital admission since March 2010 and sees his GP three times a year. His wife has been able to return to work. In 2009/10 Les's hospital admissions/GP visits cost around £121,920. Since March 2010 they were £4,552.

Financial implications

The cost of the reablement and telehealth initiative was £275,000, which came from PCT commissioners. Other initiatives to manage long term conditions were delivered through workforce realignments.

Contact

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FINALIST

Implementing the "super six" model and community diabetes service across

South East Hampshire

Partha Kar Jane Egerton

Southern Health FT and

Portsmouth Hospitals Trust

The initiative

The initiative aimed to provide a multidisciplinary, community based specialist approach for the care of newly diagnosed

people with diabetes (PWD) and those requiring follow up in primary care, unless they fall into the "super six" categories. It optimises knowledge and self management of diabetes through clinician and patient education programmes.

Instigated by a local GP with a special interest in diabetes, it was jointly developed by local commissioners and providers to tackle three key issues:

- Inefficiencies and patient dissatisfaction with the traditional pathway of long term follow ups for PWD conducted in secondary care clinics;
- Unacceptable variation in the quality of care in primary and community settings. This was believed to be contributing to higher than expected diabetic emergency admissions and complication rates;
- Disconnect between care services, which resulted in an absence of structured care plans or duplication of effort.

Drawing on national service frameworks, care was shifted from secondary care. A key aim was to discharge 90% of PWD from secondary based follow up back into primary care. This required a local enhanced service, appropriate specialist support and structured education programmes.

It was agreed the service would provide triage for secondary care referrals to ensure appropriateness and return those inappropriate with clinical advice. This included people newly diagnosed with type two diabetes.

Baseline assessments were undertaken by consultants. These identified patients for discharge to primary care and those who were more appropriate to be retained by the secondary care team through the "super six" clinics: pregnancy, renal dialysis, insulin pumps, acute type one diabetes, type one education and adolescents.

Practice meetings with a diabetologist and specialist nurse jointly reviewed patients identified for discharge. This instigated support for practices, identified care management issues and education requirements of clinicians.

To strengthen engagement and promote partnership working and joint problem solving, open access arrangements for advice and support via telephone or email were put in place with clear and rapid response times.

Benefits

The initiative has enabled discharge of 642 (90%) of patients from secondary care since November 2011. Another 57 patients now receive more appropriate secondary based care in "super six clinics".

New secondary care referrals have fallen from around 15 to two per month and 31 GP practice education visits have been undertaken with follow up visits booked.

Since beginning in 2007 it has enhanced the skills and knowledge of PWD and clinicians:

- 2,263 PWD have undertaken DESMOND training;
- 227 clinicians have undertaken MERIT training;
- 1,354 individual practice referrals seen;
- 30 clinicians have undertaken Conversation Map training.

Patient feedback is overwhelmingly positive. Patients report feeling empowered and in control of their diabetes. They report that the training is equally useful for their carers who accompany them.

Relationships with clinicians and other staff are consistently positive. Feedback reflects the value placed on gaining a rapid response to queries. MERIT training and update sessions are continually oversubscribed.

Emergency admissions are expected to reduce and health improvement outcomes are expected to improve in the longer term, both will be monitored.

Financial implications

The service has led to the decommissioning of a large proportion of secondary based care, with revenue shifted to support the primary care model. Ongoing running costs for the team cover staffing (including consultant diabetologist input) and training and education costs. These currently stand at £194,000 per year. The team remains within budget.

Through discharging 642 patients from secondary care it is estimated that, at a cost of around £90 per follow up appointment, this is saving of around £54,000 a year. The fall in new outpatient referrals also represents a reduction of from around 180 referrals a year to 24. With a new appointment costing around £200, this represents a recurrent saving of at least £31,200 a year.

The service generates some income through private provider teaching of the Programmes of Learning in care homes.

Due to the long term nature of diabetes complications and interventions such as limb amputations and visual problems, it is not expected that local rates will fall for a number of years. This will be monitored through admissions data to secondary care.

Contact

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FINALIST

TLC for LTCs — innovative telehealth project improves care and generates savings

Alison Lewin and Sara Roscoe

Tameside and Glossop shadow CCG

The initiative

NHS Tameside and Glossop's investment in telehealth was a key QIPP project, part of the long term conditions QIPP programme. There are currently 7,644 patients in Tameside and Glossop included on primary care disease registers with a diagnosis of COPD and/or heart failure. There were 1,300 emergency admissions (960 patients) for patients with heart failure and/or COPD in 2010/11.

The key aims of the initiative were:

- To use new technology to support the care of patients with COPD and heart failure;
- To enable patients to improve self management of their long term condition;
- To assess the effectiveness of remote monitoring;
- To evaluate the impact on patients and the pilot team;
- To determine the impact on admission rates and uptake of secondary care services from this group.

Telehealth was introduced as a pilot in December 2010, with the service rolled out across the area in two months.

Sixty patients used Tunstall's *mymedic* units, which allowed patients to monitor their blood pressure, oxygen levels, weight and temperature, and also asks a series of health related questions on a daily basis. Results are automatically transmitted to the icp triagemanager software for review and processing by the long term conditions team, based at the health centre in Ashton-under-Lyne.

The key to the project's success has been the collaborative effort of the trust and Tunstall to deliver a fully managed service that meets the needs of its users and integrates with social care.

The community health provider and commissioning teams incorporated telehealth into local COPD management

pathways, working with clinical teams to put in place operational processes such as patient recruitment, assessment, service redesign and technical/clinical triage.

This collaborative process began with an intensive period of engagement with local stakeholders and has resulted in telehealth being embedded into everyday working practices of local clinicians.

The pilot was evaluated and results presented to the CCG board in August 2011 which led to the agreement to expand the service to 265 units. The service remains ongoing as a result of the findings of our pilot.

Benefits

Patients recruited to the telehealth pilot have had, on average, less demand for secondary care, believed to be due to close monitoring and self management. Telehealth also supports rapid discharge following a hospital admission, thereby reducing length of stay.

Data demonstrates:

- Admissions reduced by 35%;
- A&E attendances reduced by 40%;
- Outpatient attendances reduced by 20%;
- Length of stay reduced by 70%.
- Results of patient satisfaction questionnaire:
- 95% of patients would recommend telehealth to family and friends;
- 88% said equipment was easy to use;
- 83% of patients reported improved quality of life as result of telehealth;
- 69% cite telehealth as specific reason for avoidance of a hospital admission;
- 67% of patients reported a positive impact from telehealth for their partner/family;

Results of the staff satisfaction questionnaire:

- 100% of staff questioned stated that they would recommend telehealth to their patients;
- 100% of staff believe that information obtained via telehealth will contribute to better patient care;
- 93% of staff questioned about the service said that they believe telehealth would empower patients and promote self care;
- 85% believe that telehealth can help them provide better care.

Financial implications

The five year projections for the service with 265 units is:

- Non-recurrent costs — £275,102;
- Recurrent costs — £834,871;
- Savings — £4,438,527;
- Net savings — £3,328,555.

Savings are based on a conservative assumption of a 40% reduction in emergency admissions. Calculations incorporate reduced length of stay for any patients who are admitted and also ongoing delivery of the pulmonary rehabilitation service and oxygen assessment by TandGCH at no additional recurrent cost.

We track activity at a patient level, so for each patient using telehealth equipment, we can track the before and after telehealth picture in terms of cost and hospital activity. This is a continual monitoring process, and data is provided to GP practices to demonstrate the impact on commissioning budgets.

Contact

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WINNER

A model of integrated, person centred healthcare for homeless people

Nigel Hewett and Alex Bax

The London Pathway

Background

At University College London Hospital (UCLH) it was found that homeless patients attended A&E six times more often than the housed population, were admitted four times as often and stayed three times as long, with total costs five times that of housed people. This was associated with an average age of death for homeless people of 40.5 years.

Homeless patients gave negative feedback about their experiences and some staff revealed negative attitudes to homeless patients.

The key characteristic of homeless patients with complex needs was tri-morbidity — the combination of physical ill health with mental ill health and drug or alcohol abuse. A pilot intervention was introduced in May 2009 that combined a hospital nurse with a community GP to provide regular ward rounds, visiting each homeless patient on every ward.

The aim of the intervention was to improve patient experience. The objectives were to provide compassionate patient centred care, integrated case management across hospital and community and more efficient care with reduced duration of hospital stay.

The process

Before introducing the initiative, UCLH commissioned a GP and nurse team to undertake a needs assessment informed by literature and data reviews. They consulted patients, hospital and community staff working with homeless people and built their support and involvement. The findings convinced UCLH to introduce a pilot Pathway service.

The service consisted of a homeless health (nurse) practitioner (HHP), and a community GP. Subsequently we have added a care navigator — a person with experience of homelessness. The HHP accepts referrals and visits all homeless patients within a day of admission, the care navigator supports and mentors homeless patients during their hospital stay. The GP attends the hospital for four half day sessions a week and leads a weekly multi agency care planning meeting involving hospital teams, mental health and community housing, social care, drug and alcohol and voluntary sector workers with the aim of coordinating and planning controlled discharges for homeless patients.

Benefits of the initiative

A database has been maintained for all referrals to the team, showing time elapsed from admission to referral, duration of admissions and numbers of repeat admissions. There has been a 30% drop in bed days occupied by homeless patients, equivalent to a reduction of 1,000 bed days for UCLH. Allowing for the costs of the intervention, this quality improvement was highly cost effective. Longer term follow up is suggesting a reduction in readmission rates.

Other benefits are:



- Patient experience has been transformed;
- Hospital staff are much more positive about working with this challenging patient group,
- Community agencies have commented on improved and positive relationships and better care coordination.

Financial implications

Various grants were provided by the hospital charity and by external funders to fund the needs assessment and launch the Pathway service. Direct costs of the initiative in a hospital are:

- The cost of one full time HHP — a band 7 nurse;
- Four half-day sessions of a consultant GP;
- A part time care navigator.

These are estimated to total £142,000 pa.

In addition, support is given by core staff of the newly established London Pathway charity and the costs of this are estimated at £21,000 pa.

There has been a sustained reduction of around 1,000 bed days pa. At a base minimum bed day cost of £185 this equates to a gross saving of around £185,000 pa. At UCLH a more reasonable estimated bed day cost (including medical costs) is around £350 per day equating to a gross saving of £350,000 per annum and a net saving of just under £200,000. It took eighteen months to achieve this level of savings in UCLH, and we have seen the reduction of bed days maintained for two full years.

Future plans

We are sharing our model with other hospitals, and participate in the recruitment of their medical staff ensuring they share our vision. They are trained and supported by our experienced staff.

We have formed the UK's first dedicated homeless health charity to raise our service's profile and the links between homelessness and health.

We are working to establish Medical Respite Centres to offer patients a short-term supportive community, providing medical and other services. We have published a feasibility study and are selecting delivery partners to work with us.

Contact

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Award sponsored by



Judges

Dr Charles Alessi, chair, National Association of Primary Care

Kim Guest, head of sales, O2 Health

Ben Page, chief executive, Ipsos MORI

Michael von Bertele, chief executive officer, Picker Institute Europe

HIGHLY COMMENDED

Next Steps — goal based outcomes

Elaine Williams and Fiona Pender

Cheshire and Wirral Partnership FT

The initiative

Improving quality of care and patient centredness in the NHS is top of the agenda — there must be *no decision about me, without me* (Department of Health, 2010). The emphasis is on collecting meaningful outcome data from service user perspectives. However, thus far the involvement of young people in Child and Adolescent Mental Health Services (CAMHS) has been minimal (Moran et al, 2012).

This initiative was developed following a commitment from Cheshire and Wirral Partnership FT (CWP) to involve young service users in making choices about their care, setting meaningful goals for intervention and making a user defined recovery. There was also an intention to use information gathered from service users to improve the quality of care for young people with mental health difficulties.

Goal based outcomes (GBO) is a nationally recognised outcomes tool which measures whether young people and families have reached their therapeutic goals with CAMHS. CWP decided to pilot the use of a GBO across three, Tier 3, CAMHS teams and one Tier 4 (inpatient) ward and evaluate young service users' experience of using it.

Adherence to the GBO model was reviewed through clinical audit, as well as using a structured process to involve young people and gather feedback about their experiences of using GBOs. This information will be used to make improvements to the GBO process, and will in turn improve on the experiences and outcomes for young people using GBOs.

Initial findings from young people's feedback led to the development of the Next Step resource model to facilitate young people setting and reviewing goals in CAMHS. This new resource model will act as both a clinical tool in sessions while keeping the outcome measurement principles attached to the original GBO.

Benefits

Qualitative and quantitative feedback from young service users on their experiences of using the GBO measure was collected over a nine month period. The young service users understood why it was being used and were able to set goals in collaboration with their therapist.

They liked the process of choosing their own goals for treatment and found that it helped them stay focused. Some of the young people said that they found it difficult to set goals and some clinicians also reflected this difficulty in the focus groups. A few young people felt that goal setting was restrictive and some clinicians were concerned about goals being too simplified.

This feedback was used to develop the Next Step resource, a pack of cards that enable therapeutic goals to be set and reviewed. The resource enhances the setting of user defined goals at the start of CAMHS treatment and enables therapeutic engagement through its young person friendly design. Setting better goals and reviewing them regularly improves quality and efficiency of care.

Financial implications

The price was £15,925 + VAT for:

- Consultation;
- Design/development,
- Production of 100 copies,
- Two staff training workshops.

Support from a graphic design company was used to develop this initiative through the use of end of year monies. After the

completion of research focusing on the experience of using the resource, the aim is to market it to other companies as a source of income generation for the trust.

Contact

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HIGHLY COMMENDED

Health Chat

Amanda Huddleston and Eleanor Hill

Stockport FT

The initiative

Three years ago the community public health provider and commissioners locally agreed that in order to achieve better public health there needed to be a collective systematic approach to improving the poor health outcomes of the Stockport population.

Collectively the public and voluntary sector workforces are the greatest resource in achieving this. Health Chat was designed to help reduce health inequalities and embed public health into frontline practice. It is a package designed by staff that puts the patient at the forefront of the process.

The strategic approach to delivery focused initially upon building workforce capacity in the community, then secondary care followed by local authority and voluntary sector.

To achieve the strategic vision, the Health Chats programme was developed using an evidence based approach. The primary aim was to enable front line staff to undertake health chats with clients. In order to achieve this, staff attended a two and a half hour training session that focused on the practical aspects of delivering public health related messages.

The programme teaches nurses and other frontline staff to provide opportunistic health and lifestyle advice, giving staff advice on how to quickly assess patient motivation. This is key to supporting positive change and compliance. Patients are then signposted to appropriate specialist services.

Benefits

The benefits of this patient-centred approach include:

- 40% improvement in staff wellbeing due to personal behaviour change;
- 73% increase in staff knowledge and confidence;
- Increased lifestyle referrals;
- 25% reduction in patients failing to attend lifestyle sessions.

The Essential Public Health training package has been acknowledged as an exemplar model and has received acknowledgement in recent NICE, King's Fund and RCN publications. As a result of this national publicity there has also been an opportunity to generate income.

Financial implications

Health Chat had no development costs. It was the product of an MSc research project and came about following a training redesign. This has saved £58,000 in staff training time.

Since 2009 the sale of training packages has generated income of £73,000. This has supported the development of additional training in Stockport and contributed to reducing the NHS deficit.

Contact

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FINALIST

Working together to improve the lives of local palliative care patients

Sarah Martin-Merchant and Annie Macleod
Bedfordshire Partnership for Excellence in Palliative Support hosted by Sue Ryder

The initiative

Bedfordshire Partnership for Excellence in Palliative Support (PEPS) is an integrated partnership of 15 organisations from the health, social care and voluntary sector coming together to form a central coordination centre, hosted by Sue Ryder.

PEPS facilitates the delivery of face to face assessments and care, access to hospice beds, planned acute and community palliative interventions as well as being responsive to patient need and providing access to respite and carer breaks.

It supports the local implementation of the national quality standards for EPaCCS (Electronic Palliative Care Coordination Systems), as well as putting into practice the End of Life (EoL) QIPP programme.

Although the care delivered by services was good, prior to PEPS, services tended to work in isolation and there was confusion on who to call at different times of the day. Palliative care registers were in place within general practice but these were inconsistent and there was no central register for palliative and EoL care.

The operational group (with provider and carer representation across county) was set up and developed an operational policy, which went into detail about how the service would work on the ground with links through to the coordination centre and register. All providers signed a memorandum of understanding to confirm their commitment to working in partnership to deliver the new service. The operational group meetings are ongoing, led by Sue Ryder as lead partner.

Benefits

Within five months of launching the service we have:

- Supported more than 400 patients — improving overall experience of care and support for patients, families and carers;
- Conducted over 309 home visits by our palliative care support workers;
- Supported different types of families with varying problems.

Over 60% of patients using the service have been able to die at home, their place of choice. Only 10% have died in hospital, and the remainder within a hospice

Patients' care and experience has improved, as care is timely, responsive and flexible and geared around meeting the needs of the patient with their preferred place of care. This enables best quality of life, continued service with piece of mind and minimises the need for emergency hospital admissions.

It also meets needs of professionals through access to services, expert advice and attendance to perform face to face assessments and joint visits when required, as well as quick access to hospice beds and direct access to a hospital bed for the provision of palliative interventions.

Financial implications

The costs to set up PEPS was approximately £42,000 — this included IT, telephone equipment, recruitment training, legal and evaluation. Annual running costs are about £240,000.

We are working with Sheffield University School of Health and Related Research (SchHARR) to develop a methodology for assessing the economic impact of PEPS. The full results will not be known until the evaluation is complete, but early analysis of

data indicates a possible reduction in emergency admissions and length of stay.

Contact

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FINALIST

Delivering enhanced recovery to every patient

Kathleen Cooper and Thomas Satyadas
Central Manchester University Hospitals FT

The initiative

The Enhanced Recovery Programme (ERP) involves applying a collection of interventions to the pre, intra and postoperative care of patients undergoing surgery. The overall aim is to help patients recover more rapidly after an operation. The core principles of ERP include:

- Improving patients' general health before they come into hospital for their surgery;
- Empowering patients to play an active role in their recovery;
- Ensuring optimal intraoperative care including effective, opiate sparing analgesia, reducing nausea/vomiting and providing accurate fluid replacement;
- Ensuring early feeding / nutrition and active planned mobilisation;
- Ensuring patients have telephone follow up after being discharged.

The ERP pathways were initially developed for gynaecology, orthopaedics, colorectal and urology. This involved:

- The development of patient information, in order to improve patients' knowledge and their ability to participate in their own recovery;
- Production of a patient information DVD that is useful for all patients but specifically those who find written information difficult to understand;
- Introducing carbohydrate loading into the four specialities, with plans to provide this element to all surgical patients;
- Opening a new surgical admission lounge that facilitates on the day admission of patients having major surgery.

We have also worked collaboratively with the laboratory services and developed a preoperative clinic to provide a clinic service for patients who require blood products to be cross matched on the day of surgery. We intend to develop pathways for all adult surgical services in the future.

Benefits

The benefits of ERP include a better patient experience and reduced length of hospital stay, which in turn results in a number of financial benefits.

The benefits from the four key specialities are:

- Gynaecology — reduction in length of stay from 4.5 to 2.3 days. Patient experience study results indicating significant improvements in patient preoperative to postoperative quality of life scores;
- Orthopaedics — reduction in length of stay for hip and knee replacement patients from 7–8 to 3–4 days;
- Colorectal — reduction in length of stay for bowel surgery patients from 12 to seven days;
- Urology — pathways developed for cystectomy and prostatectomy surgery.

Financial implications

Initially, an application for funding was agreed by the North West Cancer Network to fund an enhanced recovery specialist nurse for a six month period to implement the ERP pathway with patients suffering from cancer in gynaecology, colorectal and urology surgery. The funding equated to £21,500. This funding covered the cost of the enhanced recovery specialist nurse from May to November 2011. The funding was non recurrent but as significant benefits had already been realised the trust has assumed responsibility to fund the post at band 7 level.

In addition the trust has recognised that to implement the roll out of the core Enhanced Recovery principles, an emergency services (band 7) specialist nurse has been appointed and a band 6 specialist nurse post has been agreed and is currently in the recruitment process.

A "snap shot" cost analysis has been undertaken that demonstrated a £700 cost saving per patient based on a comparison between two patients undergoing the same operation before and after the ERP was implemented.

Contact

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FINALIST

A unique multidisciplinary service spanning hospital and community, meeting the complex needs of women with female genital mutilation

Rachael Jones and Naomi Low-Beer
Chelsea and Westminster Hospital FT

The initiative

Female genital mutilation (FGM), also known as female circumcision, involves cutting of the genitalia (clitoris and/or labia) for non medical reasons. In its most severe form (infibulation), the vaginal opening is stitched and becomes covered by scar tissue.

Long term consequences include pain, genito-urinary infections, psychosexual problems and complications during childbirth. National guidelines recommend de-infibulation before conception to improve quality of life and reduce obstetric risk.

In the UK FGM is illegal but an estimated 24,000 children are at risk. Our local population has a high prevalence of women from FGM practising communities, many of whom are "hard to reach" vulnerable women. Department of Health guidelines on FGM highlight the importance of safeguarding children and the need for accessible, sensitive health and education interventions.

Our service aims to:

- Provide holistic, accessible sexual health, gynaecology and maternity services for women with FGM, delivered by an all female multiprofessional team before and during pregnancy;
- Ensure service design is informed by service users;
- Identify the health risks associated with FGM through clinical audits, supported by accurate data capture systems;
- Raise awareness among FGM practising communities of associated health risks, benefits of de-infibulation and UK law on FGM;

- Provide health professional training;
- Implement robust systems to safeguard children.

West London African Women's Service comprises a hospital and a community based service, and provides advice and treatment for women before, during and after pregnancy. The initiative involved developing and improving access to the existing hospital FGM service, coordinated by a specialist FGM midwife and led by an obstetrician with a keen interest in FGM, and creating an innovative open access community FGM service, coordinated by the same specialist FGM midwife, led by a consultant gynaecologist in collaboration with GU medicine physicians, a Somali health advocate, and a sexual health adviser.

Service development and redesign was shaped through input from the Somali health advocate, whose outreach and community work ensured engagement with FGM practising communities both locally and across London. Design was also informed by results of audits of the pre existing hospital FGM service and of a dedicated sexual health service for women with FGM. We identified and trained an all female multiprofessional team, established links with child safeguarding teams, and developed health professional training programmes. Input from pharmacists and theatre staff ensure de-infibulations are undertaken in a sensitive and pain free way. IT staff have been key to implementation of user friendly data capture systems and creation of open access email and telephone referral pathways.

The service has fully operational since October 2011. Within two months it was over booked and an additional monthly session was arranged so that patients did not have to wait.

Benefits

Overall benefits of the service include:

- Engagement with vulnerable women from hard to reach groups;
- Identification of coexistent health risks;
- Training of health professionals;
- Robust systems to safeguard children.

The community service provides a welcoming space with open access referrals and a Somali health advocate. All women are offered screening for sexually transmitted infections (STIs) and blood borne viral infections. A GU medicine team manages infections, institutes contact tracing and family screening for hepatitis B. The gynaecologist and FGM midwife manage gynaecological problems and offer de-infibulations in clinic

The hospital service provides continuity antenatal and postnatal of care, provided by a FGM midwife and specialist obstetrician. FGM data is captured in a maternity database. Women requiring de-infibulation are able to make an informed choice about timing and place. Since the service started in June 2011 84 pregnant women have been seen.

Financial implications

The trust provided £6,400, to fund a monthly session staffed by one consultant, a band 6 midwife, a health care assistant and a language facilitator. A change of practice was submitted to the PCT in Hammersmith and Fulham to ensure payment of FGM de-infibulation as an outpatient procedure.

Savings have been made in gynaecology — principally due to reduced use of day surgery facilities, including anaesthetics. In the medium and long term, we anticipate savings in maternity, as increased numbers of de-infibulations performed in community before pregnancy will result in a reduction in numbers of these procedures performed in the more costly hospital labour ward maternity setting.

Sexual health screening in the community clinic results in earlier diagnosis of these infections and reduces the costs associated with health complications — eg cirrhosis and liver cancer due to hepatitis B.

Contact

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FINALIST

Patient centred integrated discharge and choice policy including innovative tools to enable seamless transition between providers that enhances patient experience, improves patient care and flow with efficient use of resources

Juliet Apps and Sarah Maycock
East Kent Hospitals University FT

The initiative

The aim of this initiative was to improve the flow of urgent and emergency patient pathways and to foster and sustain a culture of continuous improvement.

The objectives were to:

- Have a consistent patient centred discharge planning process on all sites with metrics, professional standards and improved patient outcomes reported and evidenced;
- Ensure that patients, relatives/carers are involved in their discharge plan from the beginning of their hospital stay;
- Ensure timely engagement of appropriate health and social care professionals at the correct stage of the patient journey;
- Ensure all staff involved in the patient pathway are aware of their role when discharging patients, including understanding the consequences of inaction;
- Ensure that admissions are managed within the trust's funded bed base;
- Implement discharge processes that smooth the patient journey;
- Work with community and social care partners to review delayed transfers of care and redefine whole systems pathways, to reduce delays and readmissions.

The initiative began with a diagnostic that compiled data relevant to patient flow and provided evidence regarding barriers to flow. All stakeholders participated in workshops organised to agree a collaborative approach. Flow charts were developed describing the ideal end state for discharge processes including key steps and timescales. Aim statements and metrics for improved performance were identified, with balancing metrics to monitor/manage any adverse impact.

The next step was to develop action plans to identify and resolve process and function issues which impact on seamless patient flow. Electronic referrals were introduced in a phased approach to test their effectiveness, PDSA cycles (Ticket Home) were used in association with Productive Ward. A communication strategy was developed to support engagement and understanding. Performance monitoring reports were developed for wards (live and retrospective) so service improvement could be visually displayed.

Predictive bed modelling was introduced to show anticipated daily admission and discharge profiles. The policy was widely distributed, and meetings to explain the changes supported this. A dedicated web page was established as a

single reference point for all discharge related information and tools.

Benefits

Improved patient flow has contributed to a reduced LOS, which supported improved clinical outcomes, optimised patient experience and delivered cost improvements across the trust. Evidence of improved quality of care is demonstrated by:

- A reduction in hospital acquired infections from 96 Clostridium difficile and six MRSA infections in 2010/11, to 40 Clostridium difficile and four MRSA infections 2011/12;
- Improved elective crude mortality, from 0.08 in 2010/11 to 0.06 2011/12 0.06;
- Improved non-elective crude mortality, from 3.33 in 2010/11 to 2.8 in 2011/12;
- During first six weeks, 150 patients were treated in their own homes through the hospital at home virtual ward initiative.

Improved efficiency is demonstrated by:

- Shifting patients from a longer to shorter LOS with a 28% reduction in number patients with LOS greater than 14 days;
- A change in admissions profile towards a shorter LOS — a higher proportion of total urgent and emergency patients were seen in ambulatory care and short stay (10%) with only a slight increase in overall admissions.
- 50% less delayed discharges (reduced by 12 patients a week)
- A reduction in the trust's average LOS by 0.6 days from 3.87 in 2010/11 to 3.27 in 2011/12.

Financial implications

No financial resources were required to develop the Integrated Discharge and Choice Policy and associated tool kit. The main human resource element was provided by the dedicated project managers promoting new ways of working.

Improvements made around discharge planning and reduction in LOS have underpinned the division's ability to make service efficiency changes that release bed capacity. This has delivered a 13% reduction in beds (54 funded, 115 unfunded), releasing £4.77m (£1.62m cash reduction, £3.15m cost avoidance).

Contact

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FINALIST

Crisis Response Falls Team

Mark Gregory, Peter Mason and Ashley Knights
East Midlands Ambulance Service Trust

The initiative

The trust was approached by Northamptonshire County Council with a proposal to make use of re-enablement funding. The key feature of this funding was to provide social care that had tangible health outcomes through working in partnership.

The initiative involved collaborative working between the ambulance service, health services and social care.

It began with a scoping session and workshops to identify the best method of achieving the goals of an enhanced falls service. It was decided that what was required was the creation of a specially trained crew consisting of a paramedic and an emergency care assistant with knowledge of all falls pathways

and a range of lifting techniques and advanced assessment tools. The intention was that this would result in:

- A reduction of the time a faller is left in the fallen position;
- A reduction in the number of manual handling lifts;
- Fewer conveyances to acute hospitals through conveyance to alternative providers such as Specialist Care Centres (SCCs);
- Fewer conveyances to any healthcare centre through the application of falls assessments and appropriate examinations;
- A reduction in repeat callers by staff making patient centred referrals, ensuring appropriate care/care packages are implemented;
- A reduction in repeat fallers;
- Better quality of life for those that fall through the support mechanisms that are put in place.

The initial response is followed by a visit from the specialist crisis response (falls) team (CRT). The CRT works collaboratively with the ambulance crisis response falls team and the intermediate care team to conduct assessments of the patient, the environment and intrinsic and extrinsic factors that may have contributed to the fall.

Early identification of factors that may have caused the fall is important from a patient safety perspective. Once completed the collective team offer a wide range of suggestions to help reduce the chances of a repeat fall.

Benefits

We targeted an 8% reduction in the number of fallers that are conveyed to A&E, which would deliver a non conveyance rate of 46.6%. This would equate to 5,693 conveyances to A&E of the predicted 12,216 fallers. Using the cost of dispatch at £182.80 and the A&E attendance cost of £117, the total expenditure would be £1,706,761 and a further £1,192,404 spent on dispatches that do not convey. This means that a saving of £546,698 can be achieved when comparing the current years information.

There is an additional saving through the change to the resource dispatched, equating to £32,429.

In addition, any level of reduction will have a positive impact on the acute hospitals. Fewer people conveyed to A&E means capacity is given back to the system with the additional effect of less strain on the acute wards through fewer A&E attendances.

Financial implications

The initiative began in November 2011 and will run until March 2013. The cost of this has been £305,000, which has paid for:

- Two ambulances;
- A full range of lifting equipment, some of which is unique to these vehicles within the trust;
- Two teams to operate these vehicles for eight hours a day, seven days per week.

Funding also paid for the provision of higher education for the team members via the University of Northampton, all of who gained 10 credits at level 4.

Since the start of the initiative non conveyance rates have been 60% — a reduction of 14.6%, significantly above the target of 8%.

This equates to 4,886 conveyances to A&E. Using the projected cost of dispatch at £182.80 and the A&E attendance cost of £117 the total expenditure would be £1,464,823 with a further £1,339,924 spent on dispatches that do not convey. This equates to a saving of £673,545 against the previous spend.

Contact

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FINALIST

Helping to empower loved ones and patients (HELP)

Chris Pearson and Paul Downes

Salford Royal FT

The initiative

Patients and their families know the patient better than anyone. Despite this, no systems existed, outside of convention, to provide this group with a voice if they felt that significant preventable harm was imminent.

The HELP project aimed to provide the patient and their loved ones with an alternate option to discussing their concerns with those immediately providing care.

A key aim of the initiative was to set up a system that would reduce anxiety and provide piece of mind to patients and families. The system instituted was designed to give every patient a three step pathway to the medical and nurse directors and ensure that all patients had access to an independent review should they feel they were at risk of harm.

In the event that the first responder could not address the concerns raised, the patient's consultant and/or clinical director would intervene within 24 hours of the initial call.

The initiative was initially confined to two wards areas, following successful implementation it was rolled out to a whole speciality. It was amended in line with feedback received and the trust's assurance framework was used to ensure involvement across the organisation. The initiative was implemented throughout the trust in January 2012.

Education awareness was essential and existing committees/ staff meetings were used to inform and raise awareness. Audit of HELP began early in the process to ensure that it was meeting its objectives. Staff and patients are audited on a monthly basis to ensure awareness of the initiative. In addition, each call received is reviewed to assess the necessity for wider learning and predict the outcome of patient care had the system not been activated.

Benefits

One benefit of the initiative has been a change in culture within the organisation whereby staff are aware of HELP and how it can prevent a possible serious untoward incident. This has alerted staff to the fact that although they believe the care to be safe and of high quality, the patient and their families are usually the best just of what is safe when it comes to their care.

Within the last four months 14 help calls were received. The most common factor across the calls was communication. Each call's potential for harm is RAG rated and 12 of the calls were allocated green with two being amber.

The amber events related to a patient who had been informed that they required an urgent CT scan because of a blood clot to their arm and a patient who had been discharged with inappropriate medication. As a result of the HELP system both events were resolved, and neither led to patient harm.

Financial implications

The initiative was driven within existing resources over a one year period with the assistance of clinical leads from each organisational division.

Contact

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WINNER

The Ipswich Touch Test and Foot of the Bed Form — simple tools to increase foot examinations and prevent hospital acquired foot ulceration in people with diabetes

Gerry Rayman

Ipswich Hospital Trust

Background

People with diabetes and loss of protective sensation (neuropathy) are at risk of foot ulcers while in hospital. These are costly, increase hospital stays, cause considerable suffering and may lead to amputation. They can be prevented by identifying and targeting protective measures to those at risk.

All patients with diabetes should therefore have their feet examined — NICE CG 119. However, nationally this occurs in only 25% (27% in our trust), yet one in thirty suffers a hospital acquired ulcer (National Diabetes Inpatient Audit: NaDIA 2009, 2010). Admitting doctor's excuses include being too busy, and unable to find the screening instruments. Even when screened the patient's risk is confined to the notes and seldom conveyed to those responsible for foot protection.

The aim of this initiative was to reduce hospital acquired foot lesions in people with diabetes by simplifying the foot examination procedure so non-medical staff could undertake it: thereby increasing the number of people with diabetes receiving preventative foot protection.

In this way responsibility would be transferred from doctors those best placed to protect the feet — nurses and care assistants

The process

We needed a quick, simple test, easily taught to large numbers. Patella hammers, tuning forks, and monofilaments did not fulfil these criteria. Our innovation, the Ipswich Touch Test (IpTT) involves testing sensation by lightly touching the tips of the 1st, 3rd, and 5th toes of each foot: the inability to feel at two or more signifying neuropathy. This is quick to perform, easily taught, has no cost and is always at hand.

We demonstrated its validity to detect sensory loss by comparing it with the recognised standard, the monofilament, in 265 individuals.

To support implementation, summarise an individual's risk, and direct care, we designed the Foot of the Bed Form containing:

- Instructions for the IpTT and a chart to document findings;
- A risk factor assessment chart;
- A referral pathway for those at risk.

We developed an implementation programme including a DVD demonstrating the IpTT and a powerful patient story to inspire staff. We regularly audited uptake and used the results to celebrate success and stimulate competitiveness by posting individual ward's performances on the hospital's web.

Benefits of the initiative

The implementation programme was well received by care assistants and nurses and once the tools were in use their enthusiasm was obvious. They were surprised to find so many people with "at risk" feet and felt empowered to quickly act and involve others when necessary.

This engagement was reflected by an increase in examinations from 27% prior to implementation to 55%, 75%, 80% and 79% at 3, 4, 5 and 10 months. Currently more than 85% of people with diabetes receive a foot assessment.

The reliability of the nurse's assessments was evaluated during these audits by comparison with specialist nurses results and found to be excellent (kappa score 0.97).

Hospital acquired diabetic foot lesions have fallen by 62% following introduction of the IpTT:

- 2009 — Prior to IPTT
Number = 34;
- 2010 — First year
Number = 22;
- 2011 — Second year
Number = 13.

Financial implications

The IpTT has been adopted as a CQIN worth £60,00 by the PCT to evidence that we are examining the feet of people with diabetes. As described above, more than 85% of our patients now have a foot examination and heel ulcer rates have significantly fallen.

We very much hope that the national initiative will show similar falls in hospital acquired diabetic foot lesions, which could result in a very significant reduction in diabetic foot disease with a significant saving in bed days and expenditure.

The only costs incurred have been printing of the 'foot of the bed forms', production of the implementation DVD by the hospital medical illustration department and staff time in implementation and auditing the take up and ulcer rate. We have not formally costed these activities as these are relatively small and some are part of our clinical responsibilities in delivering and improving clinical care. At the most this will be in the region of £1,000–£2,000.

In terms of cost saving, the fall in heel ulceration rate of 21 cases per year represents a saving of over £100,000, which if multiplied over several hundred trusts across England would be very substantial.

Future plans

Following national presentations, more than 70 trusts have asked for the tool. With support from NHS Diabetes and Sanofi Diabetes we are providing an implementation pack and audit tool to these trusts.

Diabetes UK has adopted the IpTT as part of their *Putting Feet First* campaign; renaming it the *Touch the Toes Test*. This follows our recent study showing that relatives can accurately detect neuropathy, and its use raises awareness and empowers patients to seek preventative care.

Contact

For more information on this initiative please contact gerry.rayman@ipswichhospital.nhs.uk

Judges

Jules Acton, director of engagement and membership, National Voices
Kate Beaumont, nurse director, The Learning Clinic and director, QGi Ltd
Jill Finney, deputy chief executive, Care Quality Commission
Dr Elaine Maxwell, assistant director, patient safety, The Health Foundation



HIGHLY COMMENDED

Reducing adverse perinatal outcome through standardised peer review of stillbirths and neonatal deaths

Jason Gardosi and Fiona Cross-Sudworth
West Midlands Perinatal Institute

The initiative

The West Midlands has one of the highest perinatal mortality rates in the UK. The largest proportion are stillbirths, the rate of which has changed little across the NHS in the last two decades, in part because many were considered unexplained.

One of the key remits of the Perinatal Institute is to understand the causes and implement strategies for the prevention of adverse outcome. To help fulfil this, we undertook a series of confidential case reviews into different aspects of perinatal death. The aim of a confidential enquiry is to examine cases in a blame free environment, assess the standard of care and identify causes and contributing factors. Such enquiries aim in particular to identify system issues, based on the fact that most adverse outcomes relate to system rather than individual errors.

However, while past national confidential enquiries ended in the publication of a report, and appear to have had little if any effect on mortality rates, we wanted to engage with the respective clinicians and commissioners to ensure that the learning points from the case reviews are implemented.

We developed proformas and recruited a “bank” of volunteer panel members — senior clinicians including obstetricians, midwives, health visitors, neonatologists and neonatal nurses (155 from around the West Midlands).

Case notes fitting the selection criteria were collected anonymised, and sent to panel members for review before the panel meeting. The panels were multidisciplinary, usually including two members from each profession. Typically four or five cases would be reviewed in one afternoon.

A summary of the conclusions of the review were written up and circulated to panel members for approval. The outcome was revealed to the unit who had managed the case, and compared with the results of their own in house assessment.

One hundred and seventy two cases were assessed over a five year period, commissioned by SHA, PCTs or individual trusts, and included:

- Perinatal deaths in areas of high mortality;
- Antepartum deaths with foetal growth restriction;
- Intrapartum related deaths;
- Perinatal deaths to migrant mothers;
- Neonatal deaths for the Birmingham safeguarding children's board.

A key finding of the confidential enquiries was the wide variation of ways in which maternity units review their deaths and often fail to learn from them:

- 42% of the deaths had no record of any review;
- In the intrapartum enquiry, only 24% of key concerns expressed by the independent panels were identified as such also by the in house reviews.

To address this, we developed a web-based application to assist with a methodological review of all factors surrounding a perinatal death. Risk factors, key points and taxonomy (care issues) are auto generated and lead to a systematic action plan.

Benefits

The panels identified many instances of substandard care, with recurrent themes including:

- Poor medical and/or social risk assessment at the beginning of pregnancy, often resulting in the wrong care pathway;

- Poorly formulated management plans;
- Inadequate antenatal surveillance, including non detection of foetal growth restriction as a frequent risk factor and antecedent of poor outcome.

Many neonatal deaths also had upstream causes originating from the beginning or before pregnancy, and were missed. Overall, between 50% and 85% of normally formed perinatal deaths were considered by the independent panels to have been potentially avoidable.

The findings raised awareness among commissioners as well as providers, and helped sprout a number of initiatives, including:

- Agreement to monitor a set of key performance indicators; these highlighted gaps and resulted in improved performance — eg in early health and social risk assessment;
- Increased regard to the importance of foetal growth assessment, which resulted in a Birmingham wide adoption of better protocols and referral pathways;
- This in turn contributed to a significant drop in perinatal mortality rates associated with foetal growth restriction in late pregnancy.

Financial implications

Confidential enquiries are labour intensive and can only review a proportion of deaths. If learning points are implemented, they can potentially save considerable costs through prevention of morbidity and mortality. The Clinical Negligence Scheme for Trusts stipulates the need for external peer review. The most cost effective process is to implement at unit level, an open, blame free, structured review process so that a local learning process is translated into the relevant action points to aid prevention. This can then be combined with an external peer review / quality assurance programme.

Contact

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FINALIST

THINK DRINK — putting hydration at the forefront of patient care

Karen Braid and Julie Marshman
Great Western Hospitals FT

The initiative

Hydration is a key component of the national QIPP safe care programme. Adequate hydration is as vital to hospital care as medication. Poor hydration leads to increased risk of infection, delayed wound healing, decreased muscle strength, depression and premature death; resulting in increased and prolonged hospital admissions and increased costs.

Last year the Care Quality Commission raised concerns about how fluid intake was being monitored and documented at the trust. In response to this the trust chose to trial The Hydrant, a hands free drinks system that solves the problem of not being able to reach or hold drinks, enabling patients to drink without assistance at any time day or night. It was first trialled on a medical ward for elderly patients where staff received intense training and education. An awareness campaign was then launched and the programme has spread across five wards.

Wards were given a resource folder with strict instructions about monitoring and recording fluid intake and assessing patient suitability for The Hydrant. Collaborative working with

local universities has ensured the programme is included in student nurse training.

Posters and leaflets are displayed around the hospital targeting staff and the public. Urine colour charts are displayed in toilets and small cards highlighting the symptoms of dehydration are shared with staff and patients.

A survey was used to assess patient experience. A staff questionnaire allowed us to assess the practical implications and measure staff understanding and awareness.

Benefits

Early results from the three month trial have been extremely positive. 43 patients and 30 members of staff completed questionnaires. The patient survey showed the overwhelming majority of patients (88%) thought The Hydrant helped them drink more and 84% thought it was easy to use. 88% of patients thought it helped them to maintain their independence and 84% said they would consider using it at home.

Involving patients in managing their hydration makes them more aware of their hydration needs. 97% of staff felt patients had benefitted and drunk more as a result of The Hydrant. 70% of staff felt it saved time helping patients to drink or replenish their water jugs and 97% felt confident in using the product and thought it was easy to clean. The consistent measurement system allows staff to quickly monitor a patient's fluid intake, reducing the risk of errors.

Financial implications

An IV cannula drip costs £6.34, but this excludes the cost of nursing staff, infection and patient pain/dignity. A Hydrant costs £6, plus £1 per day for replacement drinking hoses. 300 hydrants and accessories were purchased for £5,000. A return on investment is expected in two years, once the programme is further expanded.

Contact

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FINALIST

Improving patient safety from sepsis — from recognition to reducing mortality

Rudi Matull and Andrew Thompson
Musgrove Park Hospital

The initiative

The Musgrove Park Hospital (MPH) acute care sepsis initiative began in 2009, following a Serious Untoward Incident investigation after a patient presenting with severe sepsis was not recognised and optimally managed on the medical admission unit (MAU). The aims of the initiative were:

- To promptly recognise acutely unwell patients with likely sepsis on their arrival to MPH;
- To initiate early treatment;
- To improve patient safety and outcomes.

The objectives were to recognise 95% of patients presenting with probable sepsis within 30 minutes, and to complete a bundle of treatment and investigations within one hour of sepsis being recognised.

The primary outcome measure was an inpatient reduction in mortality of 15% with secondary outcome measures of reduced length of stay, excellent patient experience and an improvement in intensive care unit (ICU) outcomes (APACHE-II on admission, length of stay and mortality).

Benefits

Since the initiative there have been significant improvements in patient safety. There have been no serious untoward incidents on MAU. Patient treated with the proforma have all rated their care as excellent in satisfaction surveys. The percentage of patients transferred to ICU from MAU has decreased year on year.

Data from the proforma (1,571 patients) shows that the median time to antibiotic administration is consistently near one hour in all three admitting areas. (In February 2009 the median time for patients (n=44) with pneumonia was two hours.)

The International Classification of Diseases (ICD) primary diagnosis codes from the proforma sample have been used to identify the appropriate sepsis ICD codes for the hospital as a whole, and these used to analyse Dr Foster data. There are fewer deaths than expected from October 2009 onwards with a 1.4% reduction in sepsis related mortality (up to September 2011) compared with 2006 to 2008. The hospital standardised mortality ratio of septicaemia has reduced from a relative risk of 100 in August 2009 to 50 in August 2011.

The work has highlighted the need to have the correct key individuals established at the beginning to successfully engage the staff and drive the changes through. The acute care sepsis work stream is part of the Improvement Network (IN) at MPH, aiming to spread the Safer Patient Initiative (SPI) philosophy. There is now more integration between A&E, the medical and surgical admitting units and ICU, and this improved communication has extended to other areas in common.

Financial implications

Time was provided for the lead clinician to support the acute care sepsis working group. Otherwise the data analysis and meetings have been done within the working time and job descriptions of the representative members.

There have been some administrative costs associated with the proforma, but otherwise there are no additional costs. The costs of treating sepsis are the same, it is the early recognition and timely delivery of this care that has changed.

Cost savings have not yet been analysed, as the focus has been on reducing mortality. However MAU to ICU admissions have consistently reduced over the last two years from 1.03% to 0.85%, which will have an associated cost saving, and the length of stay data is currently being validated. Given a £275 estimated cost per bed day, if there is also a reduction in the length of stay for patients receiving early recognition and treatment of sepsis, as is anticipated, then there will be considerable cost savings.

Contact

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FINALIST

The pressure ulcer reduction collaborative

Chris Pearson and Natalie Curvis
Salford Royal FT

The initiative

At Salford Royal we identified that harm acquired from pressure ulcers was an area ripe for improvement. The initiative looked at changing the culture to become a hospital where acquired pressure ulcers were deemed avoidable and an unnecessary burden to patients. The key areas of focus were accurate reporting, prevention and management of pressure ulcers.

The Institute for Healthcare Improvement Breakthrough Series Collaborative structure was used as a framework for

the project. The steering group is made up of the divisional directors of nursing, quality improvement team members and tissue viability nurses from the hospital and community.

Initial work began in early 2011 to understand organisational pressure ulcer data and to begin to build will for change. In April 2011 the first learning session took place. Fifteen teams (from across wards, critical care and theatres) were invited to take part. Teams learnt about improvement methodology and best practice from across the globe. Initial change ideas included:

- Reliable intentional rounding;
- The SSKIN bundle;
- Patient and staff education and communication.

Further learning sessions took place in June, December and April 2012. Ideas from the sessions have now spread across the collaborative teams. These include the "stop the line" concept and "stand up time". New ideas around the prevention of device related ulcers are currently being tested and introduced.

The collaborative began in April 2011 with the aim of a 50% reduction in grade two hospital acquired pressure ulcers and elimination of grade 3 and 4 hospital acquired pressure ulcers by the end of November 2011. On 1st May 2012 we set a target of 100 days without pressure ulcers for each of the collaborative ward teams. At the end of May 2012 the collaborative teams had achieved elimination of acquired grade 3 and 4 pressure ulcers and the wards involved in the collaborative report a 45% reduction in grade two acquired pressure ulcers.

Benefits

The 45% reduction in grade two ulcers and elimination of grade 3 and 4 pressure ulcers provides a key benefit to patients as they receive improved quality of care and reductions in complications.

Improved systems of reporting and management of reporting includes verification of all ulcers by the tissue viability team. All pressure ulcers are also photographed within 48 hours. This provides us with more reliable data on which to base our improvement efforts.

The work has led to a culture change where grade 3 and 4 ulcers are viewed as "never events". The collaborative has also shown that improvements in pressure ulcers can be achieved at a large scale across an organisation. Previously best practice work on pressure ulcer reduction in the UK has focused upon a small number of wards.

There are also implications around the reporting of device related ulcers. Our data suggests that device related ulcers were previously under reported.

Financial implications

The initiative is part of the larger quality improvement strategy of the trust. Because of this, quality improvement lead time has been allocated to the project, however this has not resulted in any additional spend for the trust. Likewise learning session costs have been kept to a minimum by using internal resources. Staff who attend the learning sessions have managed this within their budgets and staffing allocations.

The Department of Health's pressure ulcer productivity calculator shows an estimated saving of £433,000 which represents nursing workforce time, bed occupancy and treatment costs. The calculator gives the mean cost of a grade 3 pressure ulcer as £10,000 and a grade 4 pressure ulcer as £14,000. Since 30th November 2011 the collaborative areas have eliminated these grades of ulcer.

Contact

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FINALIST

Stockport electronic Master Patient Index (eMPI) allocation system

Roger Dent and Tina Roebuck
Stockport FT

The initiative

The eMPI (electronic Master Patient Index) is a patient focused scheduling tool, developed by Stockport district nurses to enhance patient experience and patient safety. The system aims to improve the care of housebound patients by:

- Increasing patient choice of the time of district nurse visit;
- Improving patient safety by reducing the number of missed visits;
- Eliminating medication errors due to allocation errors.

There is a clear trend of increasing numbers of complex patients receiving care in their own home. Based on our local projections this is set to continue. Many of our patients who receive care in their home report that they are visited by so many different services that they often feel a lack of control over aspects such as their disease management, social and daily life.

We want to help reduce these inequalities and strive to improve the patient experience no matter where they receive care. The two main areas that led us to wanting to develop this project were:

- 1 A recent patient survey highlighted that there is room for improvement regarding the time given to patients;
- 2 Our customer care team have highlighted a recent trend in the number of complaints from patients relating to missed visits.

In essence the eMPI ensures that patients are provided with care by the right nurse, with the right skills at the right time. In addition the system provided:

- Continuity of patient care;
- Business continuity;
- Improved data quality;
- Quick access to data for audit;
- Prospective data for effective workforce planning;
- Reduction in use of bank staff with associated cost benefits.

Benefits

eMPI "went live" in February 2011. 3,500 patient visits have been scheduled using the system, to date there have been no missed visits. Staff report that the new system is better for patients and saves them around two hours of clerical time each per week.

There are three major benefits to our patients:

- 1 We have virtually eliminated the risk of a missed visit / medication error;
- 2 Patients are now able to negotiate (where possible) their time of visit;
- 3 Staff have more time to care rather than sit at a computer.

Financial implications

The pilot project was completed in house using existing staff. For the larger roll out we commissioned a software designer to develop a more robust system at a cost of £8,000.

The tool has a search engine style facility that finds any spare capacity in the system and allocates a 'neighbouring nurse'. This has reduced our demand on bank staff by around 25%, saving about £50,000).

Contact

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FINALIST

Creating a dementia friendly acute hospital

Karen Bowley and Daryl Leung

Royal Wolverhampton Hospitals Trust

The initiative

The National Dementia Strategy highlighted the shortcomings of acute hospital care for patients with dementia, pointing out the poor clinical outcomes and impact on costs.

In this initiative we developed a care bundle designed for people with dementia in acute hospitals. The bundle is a process for identifying interventions which, when delivered in a consistent way, improve care. It focuses on:

- Nutrition;
- Hydration;
- Communication;
- Environment (including safe personal space).

There is now a ward caring for frail patients with complex needs. An outreach team within the hospital provides advice and support to other wards. The dedicated ward is designed with the needs of people with dementia. There is a communal area for dining and regular activities and a therapeutic garden and an ensuite facility for carers. A training programme for volunteers specialised in dementia to support staff has been undertaken.

Benefits

Benefits include:

- Higher staff motivation — sickness level on the ward is 1.6% below trust target;
- Closer working relationships with social services, primary and community health services and nursing homes;
- Relatives are more engaged in the planning and caring for their relatives where this is their wish;
- A reduction in the number of falls;
- A reduction in chest and urinary infections.

In addition, the number of those returning to an admission address has increased significantly.

This work has had a fundamental impact on the whole trust. The attitude and culture of care toward those with dementia has changed entirely. Staff understand the disabling impact of dementia and are now confident in providing care.

At the heart of the initiative is the need for teamwork and empowering of those providing care. This has resulted in greater ownership and suggestions for changing to working practice. The methodology has been adopted in other initiatives throughout the trust as an effective means of bringing about change and improvement

Financial implications

From the outset it was realised that there was a need to review and adjust staffing levels in the ward designed to accommodate those with most complex needs. In addition a small MD outreach team has been created to work across the hospital. The total additional cost per annum was approximately £350,000 pa

The evaluation process included a cost benefit analysis. This identified savings from lower staff sickness levels, turnover, reduction in injury from falls, infections, complaints handling etc. However, the most significant single saving was in the increase in number of patients discharged to the admission address rather than to nursing and residential care. This was estimated to be in the region of £300,000.

Contact

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FINALIST

The turnaround project

Judy Gillow and Gail Byrne

University Hospital Southampton FT

The initiative

The purpose of this initiative was to reduce hospital acquired pressure ulcers and falls through intentional rounding. It was a Department of Health pilot with two acute trusts using rapid spread and social mobilisation methodologies, based on evidence from high impact actions. Our trust was chosen because of our proven track record in reducing MRSA and *Clostridium difficile*.

The model was to introduce intentional rounding to 30 wards in 30 days achieving rapid spread. The initiative evolved from a growing recognition that we needed a step change to reduce pressure ulcers and falls. An action plan had been developed for phased implementation but when approached by the Department of Health to undertake this pilot we were ripe for rapid spread.

An implementation group was established and we introduced the approach by combining both high impact actions into one approach introducing a new care bundle and form but taking out two existing forms. Wards were provided with a supporting pack including guidelines, audit to measure results and patient information. The approach was supported from learning from root cause analysis investigations.

The project started with an immersion event with a patient story to capture hearts and minds, secure local ownership with transformational leadership. Wards were rewarded for success, which culminated in full accreditation, partial accreditation or exemplar. Of the six wards awarded with exemplar status, four have not had an avoidable pressure ulcer or fall.

Benefits

The initiative has produced a reduction in pressure ulcers and falls:

For grade 3 and 4:

Outturn in 2009/10 was 108; in 2010/11, 78; in 2011/12, 32;

A reduction of 75%.

For Grade 2:

Outturn in 10/11 was 473; 11/12 in 297;

A reduction of 62%.

High harm falls have been reduced by 30% although other initiatives have been introduced that may have contributed to this improvement, including the introduction of multifactorial assessment and medication review.

Since the project began in 2010 it has seen a change in culture that embraced robust reporting and intervention.

Financial implications

The project required:

- Executive sponsorship;
- An implementation lead;
- An information analyst;
- Support from the implementation team.

This was delivered within existing resources.

The cost of a grade 3 and 4 pressure ulcers has been evidenced as equating to £10,000 which would equate to a cost saving of £760,000. 50% reduction in high harm falls at a cost of £15,000 per fall equates an annual cost saving of over £250,000

Contact

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WINNER

Community ultrasound for prisons

Teresa Caddick and Michelle Lord

GP Care

Background

Eastwood Park Prison has about 300 female inmates at any one time but an annual throughput of circa 2,500. Healthcare provision for is the responsibility of South Gloucestershire PCT. A survey in 2008 concluded that the prison's inmates have about 200 ultrasound scans a year of which about 60% are maternity related.

At present inmates have to be transported, with appropriate security, to secondary care facilities for ultrasound scans. This is highly disruptive for the secondary care facilities whose normal patient flow can be significantly interrupted and comes at a very high cost to the PCT.

The purpose of this initiative was to significantly improve the patient pathway by offering a less disruptive, more convenient and cost effective method of service delivery.

The process

The scope of the initial proposal was to offer the following scans

- Maternity, pre 18 weeks — viability and dating;
- Maternity, post 18 weeks — abnormalities and scan tracking;
- Deep vein thrombosis;
- Gynaecology;
- General abdominal including renal, gall stones, spleen, pancreas, liver, kidneys and aorta.

GP Care developed an ultrasound service that used high quality portable ultrasound equipment and experienced, HPC accredited ultrasonographers to deliver a service once a week at the prison.

Advice to other organisations

The model has been designed so that it can be easily implemented in any other prison or organisation requiring such a service.

Benefits of the initiative

The primary aim of our community ultrasound service is to provide a cost effective model for prisons to use for their inmates. Sending a sonographer and mobile ultrasound equipment in to a prison, as opposed to sending an inmate (handcuffed to a prison officer, accompanied by a second prison officer) in secure transport to a hospital has clear benefits to all concerned:

- The inmate's respect and dignity are maintained;
- The prison no longer needs to waste prison officer's time;
- The commissioner makes a significant cost saving.

Consultants from many disciplines hold clinics at the prison and refer patients to our service for a variety of conditions. We work with them to develop management plans for the patients and have strong links into secondary care, which enables us to refer patients on where necessary.

Prior to the launch of our service, only one inmate per day could be taken to secondary care, this often meant that inmates would have to wait a significant amount of time for an ultrasound scan. They were also not always properly prepared for the scan, eg did not have a full bladder/had not fasted for 24 hours, and in a number of cases this resulted in more than one visit being required.

With the advent of our service, regular clinics are held at the prison, seeing up to seven patients in one clinic. This has meant that inmates don't have to wait for long and are able to prepare.



Financial implications

The service model has been in operation since 2008.

The service is set with a fixed fee per clinic (each clinic can accommodate up to seven patients). This generates a cost saving of between £150 and £220 per patient against the costs normally incurred for a secondary care visit.

Annual savings to commissioners are circa £33,000. Since the contract started we estimate we have saved the commissioner over £132,000.

Future plans

Another local prison has expressed an interest in the service and is currently in the process of assessing volumes with a view to developing a business case.

Since the service started in 2008, GP Care has expanded the community ultrasound services to include both NHS and private patients across Bristol, North Somerset and South Gloucestershire. This service is hosted in GP practices, closer to patient's homes with easy access for the wide demographic that it covers.

There is a cohort of obstetric patients that currently attend secondary care for their scans, we are working with the local hospital to implement the relevant training for our sonographers to take over the care of these patients; and plan to extend the clinics to accommodate the predicted increase in volume.

GP Care has a large clinical team, including consultant radiologists, sonographers, nurses and health care assistants. We provide quarterly professional development team meetings at which the team discuss current services and work on future opportunities, as well as reviewing interesting cases and disseminating information on best practice.

Contact

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Judges

Sophia Christie, *director, UKPrime Ltd*

Professor Steve Field, *chairman, NHS Future Forum and National Health Inclusion Board*

Charlie Keeney, *director for primary care and commissioning, NHS Institute for Innovation and Improvement*

HIGHLY COMMENDED

Implementation of citywide rapid access to 24 hour community based services including telemonitoring

Lorraine Thomas and Linda Lockwood
Birmingham Community Healthcare NHS Trust

The initiative

Emergency hospital admissions are increasing and while alternative services are available in the community, they were fragmented and not always easy to access particularly out of hours. A new model of care was designed to enable rapid access to a menu of community services supporting flexible, accessible and responsive services close to home.

The new model was developed in partnership with all key stakeholders across the local health/social care economy. It aims to provide a seamless approach, ensuring referrers and patients have timely access, 24/7, to a range of community services as a real alternative to a hospital admission.

The purpose of the new model is to provide:

- Better patient outcomes and to support patients to live independently;
- Improved service user and staff experience;
- Reduction in emergency hospital admissions;
- Facilitation of early discharge;
- Partnership working and integration with key stakeholders across the local health and social economy;
- Increased productivity and more focused use of limited resources.

The new model involved the establishment of:

- A 24/7 single point of access to manage both urgent and non urgent referrals;
- The development of rapid response service within two hours for urgent referrals;
- An integrated multidisciplinary teams managing non urgent referrals for all community services with response time between four and 48 hours.

Improvements requested by patients were incorporated and include:

- Easier access at any time;
- Quicker and more appropriate response;
- One person coordinating care programme;
- One patient record easily accessible and shared;
- Closer working with social and secondary care.

A programme management approach was developed to ensure successful planning, development and implementation. Engagement with service users, clinicians and key stakeholders was embedded throughout and reflected in programme board membership. A series of mapping events was undertaken where stakeholders considered the national/ local evidence, the current local state and shaped the future state. The team was led by senior clinicians across the health economy including a GP, consultant geriatrician and senior nurses and allied health professionals.

The telemonitoring service was expanded once single point of access and rapid response service were established. Set up quickly, it was facilitated by excellent relationships between BCHC and commissioners. The service was clinician led and owned as opposed to technology led.

Benefits

The model has radically changed referral and caseload management, resulting in patients receiving appropriate care, at the appropriate time, delivered by the appropriate person. There is evidence of efficiency and productivity gains for

example reductions in DNAs and waiting times. There has also been an increase in activity and face-to-face contacts following a skill mix review and workforce redesign.

Benefits realised include:

- An increase in ambulatory care sensitive condition activity deemed admission prevention. Current commissioner target is average 302 contacts per month. Division reported average 383 contacts at end of January 2012.
- Rapid response — currently 97% of referrals are responded to within two hours;
- An increase in face-to-face contacts per wte staff within district nursing from 1,114 to 1,228 at the end of the third quarter;
- The integrated care pathways deliver care closer to home for example IV and DVT therapy services.

Telemonitoring has reduced emergency admissions by up to 70%–93% of patients found it assisted them in managing their health.

Financial implications

An investment of £2m was required to transform the infrastructure and workforce. It is projected there will be return on investment within three years.

The model supports development of a community tariff aligning income to activity through identification of cluster-wide QIPP savings — for example reduction in length of stay.

Reduction in emergency admissions attributed to the implementation of telemonitoring resulted in savings of £250,000.

Contact

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HIGHLY COMMENDED

Horizon Blackpool's Integrated Treatment System

Stephen Morton and Nicola Dennison
NHS Blackpool

The initiative

Background

Using programme budgeting marginal analysis, the PCT identified that it was spending on drug and alcohol services without the expected outcomes. Historically, the drug and alcohol services were commissioned separately from multiple providers, incrementally there was duplication in the way services were being delivered.

In addition, clients had raised concerns about fragmented treatment delivery. The services were largely input and process driven and not focused on recovery outcomes.

The aim of the initiative was to move to a patient focused, cost effective, outcome based service, with the intention of delivering a new integrated service model for drugs and alcohol treatment without the turmoil created by retendering services in a limited market.

The work involved:

- Symmetric computer modelling work;
- Service user focus groups;
- Development of new service specifications which were evidence based; development of performance framework focused on outcomes;
- Amalgamation of the drug and alcohol budgets; Pooling the commissioning resources to one team.

Primary care and community service redesign

The new model was presented to the service users. Negotiations took place with providers to establish whether they were prepared to work with the new system or whether it went out to full tender. The providers agreed to work together, and a consortium agreement was established, with CQUIN payments being dependent on the joint delivery of agreed outcomes. Key changes were:

- Developing medical prescribing for methadone clients;
- Moving to an expectation of recovery within a defined timescale;
- Historically, clients who wanted to achieve recovery were being treated alongside the most chaotic clients. They are now receiving treatment in a separate dedicated building, or general practice/community settings;
- Evidence based brief intervention services and training was introduced for frontline staff;
- The criminal justice services had operated on a virtual basis; services were moved under one roof, which improved communication between the different agencies around the client.

Benefits

The initiative improved patient satisfaction:

- 94.4% agreed that they felt heard, understood and respected;
- 93% agreed they felt confident that the service could meet their needs/help them recover from drug/alcohol dependency;
- 97.2% agreed they were satisfied with the service;
- 90.1% agreed their quality of life has been improved by the service.

In 2009/10 the number of clients that were achieving successful treatment completion drug free was 19% and in 2011/12, 48% of clients who left treatment were successfully completed drug free. The re-presentation rate was 10%.

Financial implications

Additional resources were not required to implement the service redesign.

In total £770,000 efficiency savings were achieved through the service redesign. These savings were achieved over a two year period.

Contact

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FINALIST

MyAction Westminster: an innovative community based vascular prevention programme that produces measurably healthier lives

Adrian Brown and Susan Connolly
Imperial College Healthcare Trust

The initiative

In Westminster, there is an average 10 year gap in life expectancy between the most deprived and most affluent areas. This is principally due to cardiovascular disease (CVD) and cancer. Furthermore, there is a high prevalence of black and minority ethnic groups (BME) who have a substantially higher incidence of CVD.

In 2008, per Department of Health guidance (*Putting*

Prevention First), NHS Westminster implemented vascular checks in primary care. To ensure those identified at high risk for heart attack/stroke could access high quality preventive care we initiated the community based MyAction Westminster vascular prevention programme. The programme has a strong evidence base derived from the principles of the Euroaction study conducted by Imperial College.

MyAction's aim and objectives were:

- To deliver a model of excellence in preventive cardiology in the heart of the community;
- To help to reduce the risk of CVD through healthy lifestyle change, management of risk factors, appropriate medication and the promotion of psychological well being;
- To help reduce health inequalities by focusing efforts in areas of social deprivation and high prevalence of BME groups

The MyAction Westminster programme was set up by Imperial College Healthcare Trust in 2009 in four community based hubs, two of which are in the borough's most deprived wards (where there is a high BME prevalence). Each hub includes a multidisciplinary team (MDT) including nurse specialists, dieticians, and physical activity specialists, supported by a clinical psychologist.

Both patient and partner attend an initial assessment that includes assessment of smoking habit, diet, physical activity levels, anthropometric measures, psychosocial measures and medical risk factors. The MDT then use this assessment in conjunction with motivational interviewing and goal setting as behaviour change strategies to help the couple work to reduce their cardiovascular risk.

The 16 week programme includes individualised follow up, a weekly educational workshop and supervised exercise sessions. The programme is flexible with day or evening sessions and is menu based. Transport and interpreters are provided where needed and the teams are trained to deliver culturally appropriate advice.

MyAction patient education materials include a family resource pack and a personal record card to help track goals/progress as well as other educational material in key languages. The patient and partner then have a detailed reassessment at the end of programme and also at one year.

Benefits

To date, over 1,800 patients have been referred with one in two patients coming from BME groups and also from the borough's most deprived wards. 79% of patients referred attended, with 61% completing an end of programme (EOP) assessment. By EOP, the stop smoking rate was ~33%.

- There was a significant increase in adherence to a cardioprotective diet including a doubling of proportions achieving five fruit and vegetables portions a day (to 50%).
- There was an average 2cm reduction in central obesity and 2kg weight loss.
- Only 20% of patients were achieving physical activity targets at baseline but this increased to over 50% by EOP.
- There were also significant improvements in blood pressure and lipids with seven in ten patients achieving their targets by EOP.

The results were similar in BME groups and white patients and also in partners. Analysis of one year follow up data suggests that the majority of these improvements are being maintained at one year.

85% of questionnaires returned rate the programme as very good and 96% feel they have a better knowledge and understanding of their risk of CVD.

Financial implications

The programme was funded as a block contract by NHS Westminster (£1.3m recurrent annual investment) until contract end. This funding covers the entire service cost including leasing of community venues, capital costs, equipment, IT, transport, pathology and staff costs (salaries, training etc).

The opportunity was also used to reconfigure the hospital based cardiac rehabilitation programme into the MyAction community based programme leading to further efficiencies in terms of cost and patient pathway.

Contact

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FINALIST

End of life service

Lesley James and Ursula Holt

NHS Nene Clinical Commissioning Group

The initiative

Ensuring a peaceful and dignified death and improving choice for patients about their place of death are key concerns for commissioners of end of life services.

Following discussions with patients, the public, GPs and staff at NHS Nene Clinical Commissioning Group, ensuring there was more choice for patients at the end of their life was identified as a significant priority and the key focus in developing end of life services in Northamptonshire.

Research shows that around 70% of people would prefer to die in their own home, but the reality is that around 60% still die in hospital. The NHS Nene Clinical Commissioning Group end of life service aims to reduce the proportion of people dying in hospital by 9.7% by 2013.

Nene CCG, working with local GPs, acute and community based clinicians and professionals from carer and voluntary agencies led the redesign of the local services.

To help develop the service, public focus groups were used to obtain views on services required, and discovery interviews used to evaluate services received.

The service now provides:

- A 24/7 central point of contact where care is coordinated;
- A nurse led rapid response service providing domiciliary-based care within an hour of referral;
- End of life link nurses in both acute hospitals to support end of life discussions with patients and their family, and facilitate timely safe discharge home where this is the patient's expressed wish.

The initiative is likely to meet its target as between the first of April 2011 and the end of January 2012, there was a 9.32% reduction in the proportion of deaths occurring in hospital. There has also been a 26% reduction in excess hospital bed days experienced by those at the end of their life, compared with the previous year.

Benefits

In addition to quantitative improvements in patient choice, and financial savings, patient experience interviews show positive results.

The husband of a patient was positive about the end of life service that enabled his wife to die at home, receiving coordinated support from services including Hospice at Home, District Nursing, Age UK, Cynthia Spencer Hospice and

Macmillan.

Janet, who died from terminal cancer in October 2011, went into Cynthia Spencer Hospice in July 2011 but husband James wanted her home and underwent training to use hoists. When Janet came home she started with two carers visiting twice a day and a twice-weekly visit from the District Nurse.

As Janet's condition worsened, visits increased with three carer visits a day and regular visits from hospice at home, GP and district nurse. Janet died peacefully at home. James said: "I had support from all services — I think more people should die at home. I had support I needed – there wasn't anyone else I needed because they were all here."

Financial implications

As a three year business case, the service aims are to reduce the proportion of people dying in hospital by 9.7% by 2013, and costs were calculated assuming an incremental approach to implementation.

In addition to improving patient choice over preferred place of death, the new service is also expected to deliver significant savings. Over the course of the business case, the total cost of operating the above end of life community services is £3,096,000, thus generating a total net saving of £532,000 over the three years.

However the sustainable recurrent savings for each year beyond year three is £1,697,000 per annum and recurrent annual costs forecast at £1,335,000 realising sustainable savings of £362,000 per annum.

This entry was also a finalist in the **Managing long term conditions category*

Contact

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FINALIST

The community child health partnership; a service innovation

Sharon Nicholson, Emily Roberts and Kevin Hewitt

North Bristol Trust

The initiative

Following a 2008 tender for the provision of local children's services, a redesign required to streamline the care pathways between different aspects of the service. This was undertaken by NHS Bristol, NHS South Gloucestershire and Children and Young Peoples Services (CYPS) to commission an integrated service delivering the best outcomes for children, families and carers.

The key aims of the service are:

- To put the child at the centre of the model of care;
- To have service user participation at every level;
- To be outcome focused and innovative;
- To provide equitable and accessible services;
- To integrate Child and Adolescent Mental Health Services (CAMHS) and Community Child Health Services.

In addition clinical teams were to be reconfigured to be co-terminus with CYPS areas.

The service model was developed and customised, with Barnardo's, to meet local needs and keep links with acute sector, while delivering innovative solutions for vulnerable children and families in hard to reach areas.

We needed to meet the commissioner's outcomes by bringing a creative approach to change management and

Primary care and community service redesign

service reconfiguration. We involved stakeholders in our plans/discussions right from start and at every level, establishing and communicating the purpose of the changes through working groups, consultations, meetings, promotions, constructive issues management and seminars.

The trust encouraged a sense of pride in the project; over 400 staff had to be transferred into North Bristol Trust from three different organisations, so staff attitudes to the service were fundamental to success.

The framework targets were challenging with heavy financial penalties on failure; a robust project structure was key to supporting the changes and how they were managed. Multiple work streams were managed, monitored and completed within given timescales.

We continue to strive to meet QIPP annually through redesign, efficiencies and new ways of working. Alongside a single patient record (Care Plus), the IT strategy includes mobile working, voice recognition/digital dictation and electronic subscribing. The trust has now relocated to seven colocated local settings using partner organisations and grants to fund the buildings.

Benefits

Benefits of the project include:

- CAMHS waiting time targets have been exceeded — against a target of 75% they have achieved 95% on eight weeks choice (new) and 90% on 10 week partnership (follow up);
- All key targets have been exceeded with a significant reduction in DNA rates, which has increased capacity and utilisation;
- Waiting times have been reduced from two years to eight weeks with 95% achieving an 18 week care pathway.

The matching of community child health partnership areas to CYP boundaries has generated a partnership approach and commissioning that addresses local needs.

Financial implications

The establishment of a single service has created opportunities for efficiency savings and productivity improvements. The previous contract was with multiple providers and cost £21m pa.

The new £21m contract required the generation of savings in line with the national efficiency targets in the operating framework: the service has delivered savings of £2.2m (10.5%) in years 1–3 of the contract.

Contact

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FINALIST

Hospital@Home — making care closer to home a reality for the citizens of West Cheshire

John Hodgson and Linda Gorst

Partners4Health and NHS West Cheshire Clinical Commissioning Group

The initiative

The purpose of this initiative was to deliver a safe, high quality alternative to admitted care for residents of West Cheshire. The Hospital@Home service was designed to treat patients who

would otherwise be admitted as an emergency with a range of conditions including:

- COPD;
- Community acquired pneumonia;
- Severe urinary tract infections;
- Cellulitis;
- Acute confusion.

NHS West Cheshire Clinical Commissioning Group (CCG) took over delegated responsibility from the primary care trust for a contract with a GP led private provider (Partners4Health) to deliver an urgent care unit.

It was recognised by both Partners4Health and the CCG that it would be possible to deliver better value from this contract and use it to transform service provision by bringing care closer to patients' homes. This was also a key priority identified for local people.

The CCG chair and chief officer, together with the Partners4Health medical director, met with clinical and managerial leads from health and social care. As a result they came to a consensus view that better provision of care in the community could improve patient experience, deliver value for money and improve resilience to unplanned care pressures.

The result was Hospital@Home — delivered within the existing contract value of £1.6m.

In order to develop and implement and Hospital@Home the CCG and Partners4Health:

- Held open and honest conversations with an emphasis on encouraging innovation within urgent care;
- Engaged effectively with the relevant stakeholders for each phase of the development, ensuring that the model was fit for purpose and had gained a high level of buy-in prior to implementation;
- Implemented via a small project team. The team calls on specialist expertise when required;
- Used a project management approach which incorporated clear individual responsibility for delivery.

Because of the success of the initiative, the partner organisations have increased its geographic footprint and built on the initial model.

Benefits

The initiative maximised the value of the existing contract to deliver high quality service provision for our population in patients' own homes. It was founded on the ability of the service to manage acute phase patients in their homes, with initial capacity to accept four patients per day.

The model has achieved very high levels of patient satisfaction. For example all patients responding to a post treatment survey have expressed the wish to be treated in Hospital@Home in the future.

Activity has increased week by week within the service, with around 240 patients accepted in the first four months. Initial modelling suggested that an average three day length of stay would be deliverable and this has been borne out by our experience.

Financial implications

No pump priming was required. Phase 1, 2 and 2 of Hospital@Home will be delivered within the value of an existing contract.

The full year effect savings for phase 1 of the project are £2.9m — this is what we would have spent had these patients been admitted to hospital.

Contact

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WINNER

Putting research at the heart of healthcare

Alison Richardson and Cliff Shearman

University Hospital Southampton FT

Background

By 2011 Southampton had become the third highest recruiting trust to National Institute for Health Research (NIHR) portfolio studies, was applying for re funding for our four major NIHR infrastructure awards, and was attracting significant interest and investment from industry. Yet, in a trust of 7,500 employees with a full range of services and major centres of excellence in several medical disciplines, there remained unevenness in research effort and success across the trust. Outside of the major research funding foci most research was the result of individuals with commitment and passion, with variable amounts of engagement and involvement by the clinical workforce.

The purpose of the initiative was to extend and integrate the support, infrastructure, reward and recognition of research needed to foster the emergence of new investigators and research capacity across our clinical services.

It aimed to strengthen dedicated research support, establish responsibility and capacity among the wider clinical workforce, further integrate research into clinical operations and raise staff and patient awareness of the critical role of research in better healthcare.

The process

Key research successes and developments have been integrated into the CEO's staff engagements and communications, while research KPIs are a standing item of trust board and executive management discussions.

We established R&D leads in our four clinical divisions; these senior research active clinicians coordinate, promote and review research in their divisions; key activities so far have included informal events to discuss upcoming funding calls, workshops to identify opportunities for collaboration and systematic reviews of research activity.

Core R&D support has been expanded to include two research facilitators who work in developing, administering and quality managing research studies. An R&D communications manager and R&D information manager were appointed and our R&D commercial team expanded to support engagement, performance management and commercial research.

Our senior research nurse managers initiated joint nursing appointments between R&D and clinical divisions and secondments from the wider nursing workforce into our 40 strong dedicated research nursing team.

We continued support for joint appointment of consultants between divisions and NIHR research infrastructure.

Advice to other organisations

Our experiences of collaborative working across clinical, management and operational teams have been instructive and will have parallels in other similar organisations. We think other trusts in similar stages of development will find our experiences useful, and we have had active encouragement from our



CLRN management team to share best practice through lead research management and governance meetings and local and national NIHR networks.

Benefits of the initiative

Strong leadership and line of sight from the top has ensured clear, authoritative sponsorship of research activity trust wide, and effective, accountable performance management. Joint appointments for nursing and consultant posts have secured enthusiastic buy-in from clinical directors, while the R&D leads have begun to identify talented clinicians to encourage in becoming investigators, and to coordinate their already active investigators.

Our research facilitators have been central to realising a saving of one week in start up times through a review of sign off procedures. The level and cohesiveness of communication about research has grown. Investigators and patients have the convenience and assurance of using research infrastructure that is fully integrated with hospital services.

Future plans

The initiative has started the process of building on core, dedicated research capacity and key areas of research strength by integrating research into the fabric and work of the wider trust. Having established many of the key posts and initiated activity, we are in a position to expand the range and extent of our efforts.

Contact

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Judges

Helen Campbell, *portfolio manager, Department of Health Research Networks Cancer Research and Clinical Research Facilities, Universities of Exeter and Plymouth*
Liz Philpots, *head of research, Association of Medical Research Charities*
John Sitzia, *chief operating officer, NIHR Clinical Research Network*

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**National Institute for
Health Research**
Clinical Research Network

HIGHLY COMMENDED

Organised curiosity and reflective practitioners, the keys to a research rich environment

Pip Logan and Sarah Kirkwood
Nottingham City Care Partnership

The initiative

This initiative started in June 2011. Before this the organisation did not initiate or hold research grant applications, support its staff to complete postgraduate training in research, employ researchers or have research items on committee meetings. It responded to external research enquiries by recruiting participants.

A group of clinical nurses, physiotherapists and occupational therapists decided that it was essential for a successful NHS provider service that we develop our research culture.

The aim of the initiative was to make Nottingham City Care Partnership a place that academics, industry, patient groups, voluntary sector and clinicians come to when considering community based research. We set out to:

- Increase the research capacity among the workforce;
- Engage directors and senior managers in the research process;
- Secure research money;
- Support patients and staff in taking part in nationally funded research projects;
- Include patient and public involvement in all research projects;
- Use research findings to implement innovation and modernisation.

Clinicians who were involved in complex care and treatment of patients presented to the directors the epidemiology of the local older people and their health care needs. Information was presented on the increase in hospital admissions and the lack of good research evidence for community based health interventions.

Clinicians recognised that although many health care professionals have research as part of their job description they were either too busy with clinical workload or did not have the skills to undertake high quality research. Directors committed money to employ an academic clinician for one day per week to lead research. This role is jointly funded with the university and the local acute hospital. We promoted this role as patients use both hospital and community services.

Benefits

Research became a standing agenda item on the clinical advisory group meeting. This is one of the most important meetings of the organisation as it brings together management and clinical leads enabling a rapid response.

There has been an increase in externally funded research being undertaken within the organisation and in MSc and PhDs being completed by the staff. More patients are taking part in research and interest from national research projects to recruit participants in Nottingham City is increasing.

Patients are enjoying our improved research environment. By having research going on throughout the organisation in the stroke team, smoking cessation team, falls prevention team, care home team and health visiting teams, clinicians feel they are able to contact the leaders in their fields from other organisations to get help or advice on complex health care issues.

Contact

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HIGHLY COMMENDED

Increasing recruitment into NIHR CRN studies
Steve Woby and Tina Kenny
Pennine Acute Hospitals Trust

The initiative

Prior to the initiative, the trust had a small R&D team, consisting of an R&D manager, administrator and six research nurses. The majority of clinical staff did not see research as a priority and recruitment of patients into high quality studies was limited due to the small number of research nurses.

The trust board felt that a new R&D strategy was urgently required that focused explicitly on enhancing recruitment into National Institute for Health Research Clinical Research Network (NIHR CRN) adopted studies. The new R&D strategy had a number of objectives, which included:

- Changing the structure of the R&D department;
- Increasing the infrastructure for R&D;
- Working more proactively with the Comprehensive Local Research Network (CLRN) and topic specific networks;
- Prioritising R&D among the trust's medical staff.

The trust board approved a new R&D strategy and sanctioned the appointment of a head of R&D to act as operational lead for implementing the strategy. Funding was secured to increase the size of the R&D department. An additional 10 members of staff were appointed, seven of who were research nurses. The funding for these posts was secured from the CLRN, commercial research income or trust endowment funds.

The head of R&D liaised closely with the data team at the CLRN to identify those NIHR studies that had the greatest recruitment potential within the trust. Once studies had been identified we approached consultants and invited them to be principal investigators (PIs). Additional training was provided where necessary and consultant job plans were amended where appropriate.

Recruitment targets were set for each study and the studies were performance managed. Performance was reported to the trust board. The trust comprises four separate sites and studies were opened across all four sites to maximise recruitment.

Research reports were reported in the local hospital newsletter. The aim was to highlight the impact that research had on patient care. The trust board felt it was imperative to make the link between patient care and research explicit if it were to shift the research culture of the organisation.

Benefits

The initiative has provided our local population, living in one of the most deprived areas in the UK, with the opportunity to participate in high quality research. High quality research and best care are intertwined and the increased research activity has helped to highlight this among staff. It is well known that there is a strong link between the research activity of an organisation and the quality of care that patients receive.

The trust's ability to recruit patients into high quality research studies has resulted in a number of commercial organisations contacting us with a view to undertaking their trials within our organisation. We are currently the third largest recruiter of patients into NIHR CRN commercial trials within Greater Manchester and have recruited more patients into commercial trials than two of our local large teaching hospitals.

Contact

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FINALIST

A primary care research partnership

Robbie Foy and Claire Seymour

NHS Bradford and Airedale

The initiative

Prior to this partnership, the PCT had a limited research portfolio, with a small number of research active professionals and practices in the local area. There were few studies going on in primary care, no grant applications in progress and poorly developed research management and governance arrangements. Research was seen as an irrelevant activity compared with the core business of planning and delivering healthcare.

The history of collaboration between the NHS and academics has often been problematic. For example, NHS organisations often work to short timescales and need to make pragmatic decisions whereas research works to longer timescales and often generates rather than reduces uncertainty. Furthermore, the translation of research findings into practice can be a slow and haphazard process.

In 2009, NHS Bradford and Airedale joined forces with primary care academics at the University of Leeds to address these issues. We aimed to develop a programme of implementation research that would focus on closing the gap between evidence and practice. Our partnership principles included:

- Embracing the NHS duty to ensure that local populations can participate in and benefit from research;
- Ensuring that research addressed national priorities, was methodologically rigorous and led to patient benefit;
- Realism about timescales while recognising indirect benefits to patient care and the health economy from active engagement with research;
- A mutual commitment to work up research bids, with regular and clear lines of communication between trust and research staff;
- Recognising that primary care teams needed funding, training and support to recruit and retain patients for research.

This initiative depended upon gaining and developing the PCT board's commitment to develop a sustainable and progressive research culture. We also recognised the need to provide support over the lifespan of research studies, ie from initial problem identification and proposal development through to implementing study findings and lessons.

We acknowledged the risk of trying to address too many research priorities at once and hence adopted a focus on implementation research that built upon the expertise of our researcher partners. We undertook an early scoping exercise to identify local healthcare professionals interested in research and healthcare problems where there was evidence of a gap between recommended and actual practice.

The PCT had a research management team and also invested in two research fellow posts at the university with the specific remit of supporting the development and submission of National Institute for Health Research (NIHR) bids.

We aimed to normalise participation in research by both professionals and patients while recognising the set of challenges this entailed. We therefore worked closely with our comprehensive local research network, the primary care research network and others to pilot and implement training, facilitative and funding mechanisms for local general practices and pharmacies.

By ensuring close linkages between our research management team, researchers, primary care providers and commissioners, we hope to close the gap between evidence and practice.

Benefits

The PCT has increased its research grant income from £250,000 to over £3m. We have now embarked on an ambitious programme of work that includes:

- Action to Support Practices Implementing Research Evidence (ASPIRE), an NIHR programme grant to develop and test approaches to implement NICE guidance;
- Two research for patient benefit grants addressing problems in primary care, respectively evaluating a local pay for performance scheme and examining prescribing of opioids for chronic, non cancer pain;
- National Institute for Health Research (NIHR) academic clinical fellowship and clinical lecturer posts in general practice, both of which are critical to generating longer term capacity and leadership;
- Partnership on a European Union grant to understand the organisational learning needs in general practice;
- Recycling a subsequent increase in research capability funding by awarding it to local academics and health professionals to support development of further research grant applications;
- 18 general practices and pharmacies have undertaken training and education enabling them and their patients to become involved in research studies.

Contact

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FINALIST

Making research "everybody's business"

Jules Wendon and Zoe Lelliott

King's College Hospital FT

The initiative

King's College Hospital FT previously had variable levels of research activity across different disciplines. Some departments were research active, but this was due to local commitment, and not part of a corporate approach. Managers had little oversight of research activity in their areas. Principal investigators (PIs) worked individually, with little central support and limited ability to develop staff involved in research. Staff not engaged in research often saw it as at best a distraction, at worst a drain on NHS resources and something to be discouraged. The R&D office was understaffed and reactive. Governance arrangements were centralised and had little involvement of clinical staff.

In recognition of the importance of research in underpinning clinical services, we sought to foster and develop a culture of research excellence. We wished to focus on supporting individual researchers and groups while integrating research activity into clinical management programmes and reporting structures. Our objectives were to:

- Provide additional support and stimulus for individual researchers and research teams;
 - Achieve local accountability for research activity within our clinical departments;
 - Raise the profile of research at all levels within the organisation, up to and including board level;
 - Build research capacity through small funding awards, intended to pump prime larger grant applications;
 - Ensure that patients were kept informed of our involvement research and its impact on clinical care.
- The R&D office was expanded and restructured, creating specialist governance roles and facilitators. The facilitators help researchers

navigate the governance system, provide basic advice, and highlight funding opportunities. We funded statistical support and statistical software, and purchased dedicated research equipment with competitive consumable grants.

We appointed R&D leads in each clinical specialty, with a formal job description and responsibility for overseeing research activity and governance. Research income is devolved, allowing local accountability and creating positive feedback through patient enrolment.

A research committee was established, chaired by the medical director, reporting to the board. We held research events for staff and patients, presented to FT governors and patient members, and used posters to raise awareness. The trust agreed to central funding (£750,000 pa for three years), which was allocated via a competitive and rigorous process for small grants.

We held regular research awareness days, for staff and patients, with stands in communal areas and research presentations. Working closely with the communications team, we have disseminated information on the outcomes of research. We work closely with the trust PPI team to involve the community and patients in setting priorities for research

Benefits

The number of adopted studies has increased year on year since the introduction of the National Institute for Health Research (NIHR) portfolio. Last year there was a 34% increase in the number of studies, and a 10% increase in recruitment, exceeding the trust target. There has also been a shift towards complexity, with 25% of active studies being interventional. Growth has been achieved through better engagement of staff, and transparency of funding flows.

The number of active investigators within the consultant body has increased, with approximately 30% of consultants acting as PI for one or more studies. There has been a concomitant increase in the number of nurses, AHPs and clinical scientists either participating in research, or taking on investigator roles.

There is strong support from all levels within the trust for the long term goal of nurturing new talent within all staff groups, by placing emphasis on career development and job enrichment through participation in research.

Contact

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FINALIST

Increasing research capacity and activity: a hub and spoke approach

Eleanor Bradley and Kim Thompson

South Staffordshire and Shropshire Healthcare FT

The initiative

In 2007, there were only two portfolio studies open across the trust. The aim of the initiative was to:

- Promote the importance of portfolio research among clinical staff, managers, trust board, service users;
- Increase the number of portfolio studies available to service users and carers;
- Enhance awareness among clinicians about R&D support for research, including training for principal investigators (PIs);
- Develop clinical teams with the expertise to deliver Clinical Trials of Investigational Medicinal Products (CTIMPs);
- Promote the clinical relevance of research and increase

recruitment to portfolio studies;

- Increase the number of intervention studies and clinical trials and engage clinicians in developing areas for research;
- Develop research skills among clinicians to turn data into knowledge and increase opportunities for service users to participate in portfolio research.

In order to achieve this and engage staff across the trust, a hub and spoke approach was adopted. Clinical studies officers (CSOs) within "spokes" support active PIs and develop teams. Commercial funding is used to provide support, including equipment and training.

There is routine CSO presence at key meetings, eg medical advisory committees, junior doctor induction. A brief introduction to Good Clinical Practice (GCP) is provided within mandatory risk training.

Meetings between clinical research leads enhance feasibility testing and expressions of interest for commercial work. A MHRA compliance group ensures compliance in all clinical trial work.

There is a secondment programme for clinicians to work with R&D for one day a week to conduct clinically relevant projects. There are also staff workshops to develop project design and data analytic skills and a seminar series with presentations from locally conducted work. Research findings are put on the trust intranet site, and there is academic support to disseminate local research findings through publications

Service user involvement is another key priority. A service user development post was created to: engage with service user groups; provide routine input to service user and carer committees and develop workshops for service users to enhance their research skills

Benefits

The initiative has had a clear impact on recruitment with numbers increasing by 91% from 333 in 2010/11 to 636 in 2011/12. The number of PIs has doubled from four to eight. There has also been a significant impact on the types of research studies being undertaken, with the number of open clinical trials increasing from one to five.

The number of portfolio studies has increased by 27% over the last 12 months, with a 400% increase in the number of interventional studies and the first phase 2 clinical trial for the trust.

The range of work has expanded, with a recent children's study meaning that research is now available to clinical directorates across the whole trust. Clinicians have accessed new motivational interviewing training (the IMPACT study), to be used in practice. Clinicians have accessed a range of training in new assessment tools as well as the nationally recognised GCP training.

We are currently the highest recruiting site in the country for the DNA polymorphisms alcohol study. One of our PIs has received an award from the Heart of England MHRN, and been able to purchase new clinical equipment through commercial research income.

Workshops have been held across the trust to facilitate clinical staff to turn routinely collected data into knowledge for service developments.

Research active staff have developed the skills to critically appraise their practice, and are well placed to conduct high quality evaluation. Evaluation work is regularly presented at board level, with findings used to support decision making about service changes, stimulating a close working partnership with organisational development.

Contact

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FINALIST

Patient and public involvement initiative

Mark Hayward and Ruth Chandler

Sussex Partnership FT

The initiative

Before this initiative, patient and public involvement (PPI) in research decision making at Sussex Partnership FT (SPFT) was an aspiration that depended on the unusual work of a few early adopters. There was no training or payment for lay members, very little awareness of PPI in our research culture and no departmental systems or paid roles to support it.

The purpose of the initiative was to bring about a cultural shift in valuing lived experience expertise as a way to improve the quality and relevance of clinical research.

We wanted to develop an involvement culture that:

- Adds measurable value and quality to design decisions in each research project according to its methodology;
- Introduces a critical friendship model of constructive critique into the style of decision making between clinical and lived experience experts;
- Is founded on a zero tolerance approach towards tokenism;
- Is integrated into local governance decisions for sponsoring research;
- Develops a pathway of career progression for lived experience experts in research;
- Contributes to the auditing of participant experience and decisions taken as a result;
- Contributes to the research agenda;
- Is integrated into core decision making forum about department activities.

Phase 1 of the initiative developed PPI consultancy and collaboration to improve quality and break down unhelpful them/us barriers. We applied for PPI grants from RDS to develop bespoke applications and training was developed with the RDS PPI lead to support LEAF members to become peer researchers/reviewers. Phase 1 remains ongoing in phase 2.

Phase 2 defined the scope and limits of PPI influence in core trust wide decisions, embedded PPI in decision making for each research theme, developed systems for assessing the added value of PPI in different methodologies and for monitoring participant experience.

We did this by proposing to the R&D executive that LEAF sign off become mandatory in sponsorship of locally designed projects. LEAF reserves the right to say no to working with a study and has investigated critical appraisal frameworks to account for such decisions as proportionate if needed.

Three research themes have established PPI groups (mood and anxiety, early intervention psychosis, learning disabilities) and three are embryonic (forensics, dementia and substance misuse).

Involvement logs are kept on funded studies to assess added value and PPI significantly influenced the development of a research register to support service user led choice to participate in research.

Benefits

Phase 2 has provided a platform where the added value of involvement can be evidenced and provide an ethical grounding to our research culture.

Because our PPI works across the research cycle we can make connections between PPI recommendations.

Contact

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FINALIST

Clinical research — a developing theme

Pamela Johnson and Tracey Taylor

Wrightington, Wigan and Leigh FT

The initiative

At the end of year 2009/10 the trust's research activity involved only 2% of National Institute for Health Research (NIHR) portfolio studies and only managed to recruit 30 patients over the 12 month period. The majority of research being registered within the trust was focused in just two areas.

The trust was keen to engage with the Operating Framework for the NHS in England 2009/10, which makes it clear that the NHS must play its part in supporting health research.

The trust strategy was for our patients and healthcare teams to be at the forefront of evolving new treatments that would result in better patient outcomes. We felt that the key was promoting a research organisation to all staff within the trust.

The overall aim was to develop a coordinated, strategic approach to the conduct of high quality, clinical research that aims to improve patient outcomes. Our first strategy was to equip our staff with the knowledge and support they would need to engage in research in a confident and safe manner. To do this we:

- Set out a five year strategy and published a policy for R&D and intellectual property;
- Set out standard operating procedures to aid all members of staff who are actively involved in research;
- Set up regular Good Clinical Practice (GCP) training events, thus allowing increased team flexibility when conducting research involving patients;
- Created an intranet site informing staff on a variety of research subjects, including links to partner agencies. This site has currently had in excess of 48,000 hits;
- Established forums for promoting research and Innovation within the organisation.

The department actively scrutinised the NIHR portfolio for potential research projects, commercial and non commercial, and then approached potential investigators, at the same time offering to support the project with the use of experienced research staff.

We raised staff awareness by presenting at junior doctors teaching sessions, being a member of the steering group for the professional development days held quarterly; aimed at nursing and allied health professionals, promoting research, development and innovation. This proved very successful and continues to raise awareness within the trust on the importance of research and development. Workshops are provided to assist staff in taking their own ideas forward.

Benefits

The initiative has provided a broad platform in which patients and clinical staff are given the opportunity to engage in research. Investigators are supported in furthering their knowledge: their research work is recognised at senior level as an important part of everyday practice.

An increased number of patients are given access to new innovative drugs that are not routinely available.

The trust reputation for engaging in NIHR portfolio trials has been dramatically improved. Invitations from industry partners to put forward expressions of interest have increased and the trust is often pre selected for commercial trials.

Contact

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WINNER

NHSBT operational improvement — application of “lean” to improve quality and productivity

Kevin Price and Dave Edmondson

NHS Blood and Transplant

Background

NHS Blood and Transplant (NHSBT) is a special health authority employing more than 5,000 staff with an operating budget of £439m. It supplies organs, blood components, tissues, stem cells, diagnostic and other services to the NHS in England in Wales.

A strategic review identified that there was significant potential for improved productivity in the supply chain, including blood collection, manufacturing and distribution activities. Unlocking this potential would be essential if NHSBT wanted to meet its commitment to releasing savings to the NHS.

The process

NHSBT's strategic plan emphasises that customers have an expectation of high quality, efficient and effective services. Among a number of initiatives developed in response to these drivers, a blood supply chain operational improvement programme has been developed, embodying a belief in a culture of continuous improvement, underpinned by respect for patients, donors, staff and resources.

Operational improvement is the application of “lean” (based on the Toyota production system) within NHSBT, and focuses on the continuous elimination of waste such as inventory or overproduction, and the creation of value defined by the customer, using principles of pull and flow applied to processes. The operational improvement approach emphasises engagement and empowerment of frontline staff in problem solving and improvement.

Operational improvement is organised around a series of analytical, planning and improvement events, and since 2009, over 160 events have been undertaken with over 750 staff attending on average two events. A comprehensive training programme has been established exposing around 1,200 staff to “lean thinking”, ranging from awareness through to highly trained facilitators. A group of operational improvement champions has been deployed, with the aim of promoting and raising the profile of continuous improvement.

Underpinning operational improvement is a transformational plan of care, describing the tactics for implementation aligned with organisational strategy, and identifying actions to close the gap between current and future states, requirements for staff development and communication, engagement and penetration of lean culture. This is further underpinned by targets associated with staff development, quality, productivity and service delivery.

Benefits of the initiative

To date the initiative has contributed to:

- The implementation of a major new blood safety initiative without additional staff, thus saving £1m a year for our customers;
- Increased standardisation of practices and processes and general improvements in quality and service delivery;

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- An increase of over 70% in blood component manufacturing and testing productivity, which places NHSBT well into the upper quartile of blood services across Europe;
- A reduction in the red cell price from £140 in 2007/08 to £123 in 2012/13;
- Release of over £10m a year back to NHS front line patient care;
- Reduction in absence of 10% saving £515,000 in overtime and agency costs;
- A rationalisation of blood collection planning, removing over 80% of waste activities;
- Planning implementation of a novel blood component to treat bone marrow transplant patients.

Financial implications

In order to successfully kick-start lean in NHSBT, a commercial partnership was established with Simpler to bring expert support and advice into the programme. Payback on this investment was very rapid. Some savings have been partially reinvested to fund a permanent in house capability.

Future plans

We plan to build on our existing lean capability by putting significant numbers of staff through the programme so that experience and understanding of lean will become the norm.

The lean programme will be extended to other areas of NHSBT including Diagnostic Services, Health and Safety, Specialist Services, Communications and back office. .

Contact

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Judges

Elizabeth Bradbury, *director, Advancing Quality Alliance*

Lynn Callard, *interim director of productivity and quality and national lead for the productive care QIPP work stream, NHS Institute for Innovation and Improvement*

Dr Mo Dewji, *national clinical lead — primary care, QIPP Team, Department of Health*

Peter Edwards, *senior partner, Capsticks*

Professor Hugo Mascie-Taylor, *medical director, NHS Confederation*

HIGHLY COMMENDED

Co-creating best practice to increase value — a shared focus on improving quality to identify and reduce unwarranted clinical variations and optimise primary care resources to improve patient outcomes

Helen Rose

Erewash Clinical Commissioning Group

The initiative

The aim of the initiative was to develop and embed a new culture within the CCG and primary care to support the delivery of our local QIPP agenda. This was to be achieved through an undiluted focus on quality. The emphasis was on changing clinical behaviour in the consulting room to improve patient outcome by using resources differently.

The fundamental objective was to reduce significant local variations in clinical practice in three distinct aspects of activity:

- Referrals to secondary care;
- Emergency admissions;
- Prescribing.

These areas were selected because of their potential to enhance patient experience, improve outcomes, ease pressure on secondary care, and deliver financial savings.

All 13 member practices were engaged in debating and creating a plan focusing on quality and the impact of unwarranted clinical variations. Agreed measures included:

Monthly information packs

These include information on referral, admission, prescribing and immunisation rates. They also include patient experience data and the national QIPP Right Care data set. Clinicians compare their performance locally and nationally. This allows them to prioritise, identify and tackle variation in their own practice.

Practice visits

All practices are visited every three months by fellow GPs for peer encouragement and challenge.

Education

There are funded consultant masterclasses in high referral specialties, to understand and increase the confidence of GPs in avoiding inappropriate referrals.

Prescribing support

Practices were given intensive support encouraging good practice in the use of antibiotics, statins and lower cost items (eg glucose testing strips).

Incentivisation.

Practices were provided with incentives in recognition of the extra effort involved in coordinated care plans for high risk long term condition patients.

Benefits

The emphasis on reducing unwarranted clinical variations and making best use of existing primary care services and skills has led to improved clinical engagement and greater efficiency in a number of areas:

- Erewash CCG's QIPP target for 2011/12 was £4.1m. This has been exceeded by £0.5m;
- The CCG's spending on referrals and admissions has been reduced, delivering a saving of £1.2m for the full year;
- The prescribing overspend across the CCG has been reduced by 75% to £200,000 — a reduction of £600,000;
- Secondary care referrals from CCG practices are down 14%. One of the highest referring practices has reduced its rate by 45%;

- Referral rate variance across the 13 practices has fallen more than 51%;
- Hospital admissions are down by 4% annually. Consultants report the quality of referral letters has improved, following the development of collaborative decision making.

Financial implications

The total budgeted cost for the programme for 2011–12 was £152,000:

- £133,000 for incentivising practice use of coordinated care plans for high risk patients;
- £10,000 to provide cover one day a week for the CCG clinical leadership, who is heavily involved in practice visits;
- £9,000 for consultant/other primary care development sessions.

It is expected that the initiative will produce savings of £1.2m, giving an 8 fold return on investment within the 12 month period.

Contact

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HIGHLY COMMENDED

Driving emergency ambulance efficiency to improve clinical quality

Rob Mason

South East Coast Ambulance Service FT

The initiative

The national response time target for ambulance services in England is one of the most demanding in the world, requiring a response within eight minutes, 75% of the time for patients with life threatening symptoms.

This initiative sought to reduce waste and increase efficiency of the workforce so that investment could be made in developments of the service. This was to be achieved by understanding the relationship between supply and demand and embedding resource use metrics into the day to day operations.

This would ensure that ambulance resources, both cars and ambulances, were placed on duty when the public need them, where they need them,

Over 300 trust managers attended one of a number of seminars designed to show how they could contribute to getting the right number of resources in the right place at the right time. Dispatch staff helped to determine the geographic deployment of resources from the network of stations and standby facilities. Over 100,000 algorithms were developed, for each hour of every day of the year for each area, to ensure that the areas where calls are more likely to originate were resourced before less busy areas.

Rotas for 2,100 front line staff, working from 64 locations, were redesigned and implemented to ensure sufficient staff would be on duty to meet the expected demand for each hour of every day of the year. The workforce plan was developed to increase the number of paramedics from 34% of the workforce to over 60% by 2016.

Benefits

Speed of response to patients affects both their satisfaction and their clinical outcomes. This initiative has ensured that rapid response times to patients with life threatening symptoms are delivered consistently each month right across the service area.

Almost half of the workforce now are paramedics, compared

with 35% when the initiative began in 2008, and the trust is on target to increase this to two thirds by 2017. This upskilling of the workforce supports the desire to provide mobile healthcare services rather than the historical transport function associated with traditional ambulance services. This has facilitated more patients being treated at home or in the community, and we are planning to treat more and more patients outside of hospital over the coming years.

Financial implications

During the period 2008 to 2012 demand has increased by 18%, from 508,000 calls attended to over 600,000, while resources have increased by just 6% during the same period. This equates to productivity gains of 12% in four years, with plans for a further 4% in 2012/13, and has resulted in financial savings of over £25m to date, with a further £9m projected for the coming year.

These savings have been instrumental in enabling developments to the service aimed at improving the clinical quality and patient experience. £10m is being invested in creating 360 specialist paramedics, able to deal with an extensive range of general medical problems and acute traumatic injuries. The trust is also investing £40m in make ready centres, where vehicles are stocked, washed and prepared before the start of every shift. There have also been significant investments in a new 999 computer system and mobile data terminals for 300 vehicles, totalling around £6m over seven years.

The initiative was implemented using in house resources, with the addition of a specialist project manager dedicated to the project for two years. Commercially available spreadsheets and databases were used to develop web page reports distributed across the trust's file sharing network.

We estimated that an additional £45m would have been required to provide resources to undertake the additional activity expected up to 2016 at 2008 rates of productivity.

Contact

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FINALIST

Acute gynaecology clinic

Manjeet Shehmar and Racheal Boothe
Birmingham Women's Hospital FT

The initiative

The delivery of services to our acute gynaecology patients was identified as a problem through local clinical audit. Significant numbers of women were being admitted, patients' experiences were poor as they were waiting many hours on the ward to be assessed and they had multiple reattendances.

The problem was set to increase as the trust had committed to increasing its obstetric delivery rate with an expected 11% increase in gynaecology workload through early pregnancy attendances. Our trust provides gynaecology services to an A&E department of another large co-located trust. As part of their rebuild we were asked to set up a system to be able to respond to a doubling of referrals to our gynaecology department.

We recognised the need for senior care delivery rather than supervision and had to find an innovative way to change consultant attitude and methods to deliver this service. The trust was able to agree development of the service as a CQUIN under the QIPP agenda with a target of reducing emergency ward attendances.

The triage of patients was changed so that the most senior

registrar (SR) became the first person to take the call from switchboard. The call was escalated upwards immediately to consultant level if the SR was unavailable. Senior decision making and ultrasound scanning was delivered by a dedicated newly appointed consultant who would run the clinics and lead on the project.

The initial work was required to be cost neutral using existing staffing models. Once we were able to show that the targets were delivered we were able to successfully make a case for investment of further consultant sessions and more support staff.

Benefits

Local audit showed a 66% reduction in ward attendance rate in the first four months of the service. The trust CQUIN target was achieved. Patient experience outcomes were monitored using patient evaluation forms. 84% of patients surveyed felt that their problem had been solved in one appointment, 8% were awaiting further tests before their problem was solved, 8% felt their problem was not solved in one appointment, 89% of women were seen within 48 hours of the referral.

All women were telephoned with an appointment date within 48 hours of the referral. Only 7% of patients were admitted (compared with 61–74% before the clinic was set up). Over 70% of patients were discharged after the first visit, 3% of patients were fast tracked immediately on to the oncology multidisciplinary meeting with suspected cancer, bypassing the longer two week cancer referral system. The service has freed beds to increase elective capacity and freed routine gynaecology outpatient slots for consultations, follow ups and scanning thus contributing to achieving low outpatient waiting targets.

Financial implications

The acute gynaecology clinic delivered the local CQUIN and payment of £53,856. It has also generated income of £87,273.

The clinic was set up without additional resources apart from an examination couch (£5,000). The staff used for the clinic were deployed into this service.

The average net savings for inpatient costs by avoidance of admission were £2,058 per patient. The in patient costs include bed occupancy, in patient procedures, associated staffing costs and trust overheads.

This does not include the potential additional income that could be further generated from the additional bed capacity. Data from other departments (gynaecology outpatients and radiology) show that these patients represent a new source of income, as there has not been reduced activity in other outpatient departments.

Contact

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FINALIST

Collaborative soft facilities management programme

Ian Chambers

Fulham Road Collaborative and Linea Group

The initiative

The Fulham Road Collaborative was formed to maximise efficiencies in the procurement of goods and services across four organisations:

- Chelsea and Westminster Hospital FT — a teaching hospital specialising in HIV, burns and paediatrics;

- Royal Marsden FT — A specialist tertiary centre for oncology;
- Royal Brompton and Harefield FT — a specialist tertiary centre for heart and lung conditions.
- Institute of Cancer Research — a leading National cancer research charity.

The first major project involved tendering the soft facilities management services across the four organisations. The services include cleaning, catering, portering, laundry and linen, reception, helpdesk, security, car parking, pest control and relocation services. The existing provision was due to expire within six months.

The aims and objectives of the initiative were to:

- Develop an ethos that enables organisations with different cultures to work together for mutual benefit;
- Standardise service specifications across the organisations while allowing for required local service and pricing variation;
- Develop a collaborative multidisciplinary programme team and board;
- Liaise with suppliers to terminate / extend contracts;
- Achieve significant savings and efficiencies while maintain existing quality standards.

Linea Consulting was appointed to provide independent expertise and programme direction. The agreement of the four organisations to jointly procure the service was obtained — 10 work streams being procured over seven years.

A multidisciplinary team spanning the four organisations was created and a programme governance policy agreed. Following this, service specifications were standardised across the four organisations to drive efficiencies and reduce costs.

Local pay agreements were renegotiated, achieving savings of £2m a year, and an e-tendering tool implemented. Bidders were presented with a maximum budget to in order to ensure bids are significantly cheaper than the current service.

The contract inflator was changed from RPI to a capped CPI rate and the award of the inflator was tied into achieving annual NHS efficiency targets of 4%.

At the end of the process a £140m contract was awarded to the successful supplier for seven years (£100m over five years).

Benefits

Cost savings

Savings of £44m were delivered. The renegotiated local pay agreement saves £2m over the life of the contract. The contract included a year on year contract efficiency requirement of 4%. Elements of the contract were VAT reclaimable.

Quality

A robust and proactive governance process was implemented to ensure ease of management. Numerous innovations and quality standards were introduced to ensure best practice and maintain the current “Excellent” rated quality standards across the four organisations.

Innovation and prevention

The contractor's in-house microbiologist implemented a targeted, risk based, approach towards infection control within cleaning methods.

A mobile “clean room” was made available.

Inflatable walls were introduced to isolate infectious areas.

Productivity

A bespoke rapid response cleaning team was introduced to improve the efficiency of hospital bed management and flow. A radio system was introduced to improve portering response times and overall efficiency.

Financial implications

The programme was delivered using internal resources. An external consultancy company was engaged to provide independence, expert procurement support and programme management. This enabled the organisations to keep costs to a minimum.

The approach combined with the level of savings (£38m) achieved ensured that the project started to deliver returns immediately following contract commencement.

Contact

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FINALIST

The Wight way of ensuring value for money through quality and productivity

David Turner and Paul Jerram

Isle of Wight CCG

The initiative

The initiative was a joint project between Isle of Wight CCG and Eclipse Solutions to develop and extensively test Eclipse Live software (originally conceived to enhance patient safety) beyond its original concept.

The medicines management team was contacted by Eclipse Solutions in summer 2011 with a view to being the lead of six UK test sites (at no cost to the PCO) in co-developing this system and facilitating UK roll out. The system was in place and operational in trial sites locally by October 2011 and all surgeries signed up by March 2012.

Through Eclipse Live, GPs share patient records with hospital colleagues and community pharmacists while patients can access their own health records.

This software allows remote access to GP healthcare records with a balanced scorecard of performance (cost of referral, admission cost and drug costs) rather than the cost of drugs alone. It can be benchmarking against national performance/ NICE implementation at the touch of a button.

When a patient is switched from one drug to another we can follow patient outcomes, compliance, adherence to the switch as well as monitoring against safety parameters.

Eclipse Live works by combining ePACT, SUS, HES and NHS Comparator data with GP held patient records. Information is uploaded to a website. Access is protected by multiple passwords. No personal patient information is available outside of the GP surgery (without patient permission). A patient number is generated which can be used within the surgery to identify the patient.

Our local hospital/community matrons/district nurses, community pharmacists and specialist nurses are also engaged, with consultants now monitoring patient test results remotely. Consultants tell us that up to 50% of their patients' consultation is taken up with history taking. Much of this can now be saved, freeing up clinician time.

Benefits

Savings on drug spend can be estimated via existing systems but Live identifies down to patient level switches that can then be checked for appropriateness against the patient records. Furthermore once switched, test results, outcomes and safety can all be monitored remotely, generating automatic warnings or clinical review requests (RADAR).

Remote audit has immense potential to reduce cost while

improving patient safety and outcomes. Risk stratification of patients is now the norm. For AF patients stroke risk is stratified via a CHADS 2 tool that takes less than one second to risk stratify a whole surgery. Patients are called for a clinical review as appropriate. Remote screening against numerous safety parameters runs daily with GP warnings of the need for a clinical review sent automatically.

Live is having a big impact on the way our local healthcare works to the benefit of patients. Healthcare has moved into the community with community cafes being held at multiple sites, where patients and other healthcare professionals have remote access to patient healthcare records, improving communication and target setting.

Teleconferencing between healthcare professionals and patient will increase, with reduced need for many patients to travel to the healthcare professional. With access to their graphically represented healthcare records, patients can see the results of achieving their agreed targets. Now our patients can see the decreased HbA1C, or reduced blood pressure that comes from reducing weight.

Financial implications

Cost savings of more than £1m have been demonstrated from the prescribing budget. Work is ongoing to identify reductions in referrals and hospital admissions.

The initiative will also generate income via a series of disease manager tools that we are in the process of developing. Annual licenses will be granted to Pharma (for a fee) who will use the tool for competitive advantage supplying it free of cost back to the NHS. License fees will support the NHS and add to the cost savings from drug budget plus reduction in referral and admission costs resulting from its use.

Contact

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FINALIST

Home for lunch

Joy MacDonald and Ashok Handa
Oxford University Hospitals Trust

The initiative

Patients need to be discharged on time. Research has shown that too early discharge lead to an increase in readmissions. Too late leads to an increase in adverse events, with a 6% risk of an adverse event occurring with each additional day in hospital.

A review of the trust's length of stay and discharge profile highlighted a mismatch between the admission and discharge profiles. The purpose of the initiative was to increase the number of patients discharged in the morning by developing and implementing a trust wide discharge process in which:

- All patients have an estimated date of discharge (EDD) within 24 hours of admission;
- There is improved communication with patients and carers about the discharge process;
- TTOs are written the night prior to discharge where possible;
- Fewer patients refuse to be transferred to the first available community bed;
- More patients go to the transfer lounge or day room the morning of discharge.

Dr Foster was commissioned to benchmark the trust LOS. The data demonstrated that 2,000 bed days could be released per

year if the discharge process was more improved. Specialities with the longest LOS attended a workshop to highlight issues and generate ideas. Four themes were identified:

Patient communication

Patients and carers were informed of what they are expected to do — participate in discharge planning, organise transport, outside clothing, food at home, accepting the first available community bed.

Staff communication

A web site and posters shared best practice with ward round stickers, visual management boards and web resources.

Pharmacy

The service improvement team supported a service redesign using process mapping to identify bottlenecks for the dispensing of TTOs, inpatient medication and controlled drugs.

Benefits

There was a 75% reduction in the rate of refusal for community hospital beds.

The average length of stay (ALOS) for elective surgery has reduced from 3.70 (April 2011) to 3.28 (September 2011), the trust overall LOS has reduced from 2.33 (April 2011) to 2.04 (November 2011). The root cause for the reduction is unknown but could be a combination of factors including improvement in TTO turnaround time, change to pharmacy working hours and Home for Lunch campaign. Use of the transfer lounge has increased.

Financial implications

A service improvement team member supported the process over three months.

This entry was also a finalist in the **Secondary care service redesign category*

Contact

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FINALIST

Delivering quality and productivity through a seven day working model in physiotherapy cardiothoracic services

Brighton Paradza
South Tees Hospitals FT

The initiative

Across NHS centres and beyond, service gaps occur over weekends and holidays interrupting the rehabilitation processes for patients after major heart surgery. The trust's cardiothoracic directorate adopted an idea to transform physiotherapy delivery from a five day only service from Monday to Friday (7.5 hours) to seven day working (9.5 hours) shift patterns per week (from Monday to Sunday) in April 2006.

This was a multidisciplinary initiative involving the trust improvement team, the clinical support services and the cardiothoracic directorate. This initiative was led by the clinical specialist physiotherapist. The objectives were to:

- Deliver better clinical outcomes;
- Improve patients' experience;
- Reduce length of stay;
- Improve the quality of care;
- Improve bed availability through increased capacity;
- Prevent cancellations;
- Achieve cost effectiveness and efficiency savings;

- Reduced staff costs and improve productivity.

Benefits

Clinical effectiveness

Improved clinical outcomes are demonstrated by reduced postoperative LOS — down by 0.603 to two bed days across all cardiothoracic conditions. Patient throughput was improved by 6.74% (n=81) saving 426 bed days. Timely discharges reduced our hospital “hotel” costs — 55% and 27% improvement respectively based on national and local benchmarks.

Productivity

The initiative improved access and patient flow by ensuring continuity of care over weekends and holidays optimised through “twilight working” — early bird (7.30am) and late finish (6pm). It also reduced weekend mediated variation in quality of care.

Staff working

Staffs working lives were improved by a self rostered, flexible working culture. There was positive feedback from therapists delivering 7 day working.

Patient experience

There were high levels of patient satisfaction with the initiative.

Financial implications

There was an initial capitalisation to cover the cost of creating and appointing two physiotherapists posts, taking our staff level to six therapists, at £242,697.

Over a year 7 day working resulted in savings through:

- Replacement of on call service — £24,096;
- Reduction in patient LOS and improved patient throughput saved 426 bed days — £156,232.

Taking into account the initial investment and enhancement costs of £22,464 for six therapists, estimated efficiency savings of £157,864 were achieved over 12 months.

*This entry was also a finalist in the **Secondary care service redesign** category*

Contact

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FINALIST

Dementia intensive support team (DIST) admission avoidance

Irene Lewsey and Gary Blatch
NHS South Essex

The initiative

People with dementia (PWD) are major users of acute beds and A&E services and often have multiple admissions. Acute hospital data identified over 1,000 admissions between April 2010 and January 2011 with dementia as part of their diagnosis. 162 were readmissions of PWD who had been discharged less than 30 days before. The purpose of this dementia QIPP initiative was to reduce inappropriate admissions and facilitate early discharge. The aims and objectives of this initiative were:

- Reduction in acute budget;
- Reduction in ambulance attendances to A&E;
- Reduction in care/residential home placements;
- Reduction in preventable admissions;
- Reduction in length of stay (LOS) if admitted;
- Reduction in readmissions for PWD;
- Increased carer support and assessments;

- Reduction in falls within the acute hospital;
- Raised awareness of the needs for PWD;
- Improved outcomes for PWD and their carers;
- Improved quality of care.

This QIPP initiative investment was agreed for 2011/12. However due to the changes within the PCT the projects did not start until the second quarter. The CCG's in South West Essex have approved funding 2012/13 for an extra six months. This will allow for a full evaluation of the project. However, the savings and improved outcomes for PWD have been recognised and the CCGs in South East Essex have approved funding for a DIST in their acute hospital.

DIST consists of two social workers (Essex and Thurrock), two general nurses from NELFT community services, two mental health nurses from SEPT and two support workers with 0.5 wte admin support.

DIST are based in the A&E department, identifying PWD arriving to hospital via A&E and the medical admission unit (MAU). They endeavour to prevent an admission to a ward if possible by providing dementia friendly packages of care in the community for up to 6 weeks until handing over to other services. Direct referrals are taken from the ambulance crews, and GPs, thus avoiding an unnecessary journey to hospital.

The team link closely with the dementia care home liaison service to ensure a speedy recovery for those PWD who are admitted from a care/residential home.

DIST are able to support the dementia hospital liaison nurse where more intensive support is required on the wards. They are able to support PWD on the wards, by assisting ward staff to ensure that dementia related issues do not lengthen their length of stay. They also provide specialist input to care planning and carry out specialist assessments, liaising with the complex care team in facilitating early discharge.

Benefits

This initiative has enabled system wide QIPP savings to be made. The profile of dementia has been raised. This has enhanced the quality of care and dignity for people with dementia and their carers. Admissions to care homes have decreased for PWD compared with last year, thus allowing people with dementia to return home after a spell in hospital.

This initiative was initially a South West QIPP, now all the CCGs across South Essex have agreed investment into these teams.

Since the start of DIST some localities have started to pilot rapid response teams across health and social care. We envisage that in the future DIST will be part of these teams, thereby incorporating social care, physical health, and mental health.

Financial implications

This initiative started as an eight month QIPP project with a saving target of £600,000 from our acute hospital activity. The PCT invested £220,000 for 8.5 wte staff including two social workers.

Assumptions were made that 241 admissions for people with dementia needed to be avoided and a reduction in 2860 OBD which equates to £892,590 savings this was based on the previous year's activity /cost data from SUS.

In seven months the DIST team had 792 contacts of whom 192 PWD were not admitted. The notional savings based on 10/11 SUS data average cost of PWD admission £3,842 a saving of £616,822. Our data also showed a reduction in ODB costs for PWD £294.053. Therefore there has been a notional saving of £910,875 in seven months.

Contact

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WINNER

The ambulatory heart failure unit

Dargoi Satchi and James Rushton

University Hospital of North Staffordshire
Trust

Background

Conventionally, treatments for worsening heart failure (HF) are administered within secondary care. This leads to removal of patients from their homes, families and communities and results in long inpatient stays at a cost of nearly £1bn to the taxpayer.

The initiative evolved from a requirement to lessen the burden of HF on inpatient beds. In addition the majority of patients with chronic diseases prefer care closer to home. We developed a model replicating inpatient, high quality, specialist care on an outpatient basis to patients with worsening HF.

Key aims of the intervention were:

- Improvement to the patient experience, through transfer of traditionally inpatient care to an outpatient setting;
- Increased number of HF patients actively managed by a HF specialist in line with NICE quality standard recommendations;
- Reduced acute admissions and readmissions for HF;
- Reduced inpatient length of stay for HF;
- Improved mortality rates for HF population.

The process

Resource growth was required with finances being secured via the health foundation supporting the recruitment of two HF nurse specialists, a half time HF nurse manager and three weekly cardiology consultant sessions. The second stage was to develop new clinical protocols, policies, governance arrangements and working practice, facilitating the shift from care on an inpatient to outpatient setting.

The HF clinic receives general support from nurses within the discharge lounge, where a dedicated seating area operates for our patients. Patients receive a nurse led holistic assessment and management plan including:

- Fluid management (including intravenous diuretics);
- Optimisation of HF therapies (including increase or reduction of medication);
- Assessment for HF therapies (including device therapy);
- Palliative care assessment;
- Co-morbidity signposting;
- End of life care planning as appropriate.

Specialist HF consultant advice is available daily. Integration with community and primary care providers ensures a whole system approach to patient care and management.

Advice to other organisations

Our model is replicable throughout the NHS and would lead to similarly achievable outcomes in other health economies.

We feel there is real opportunity to look at how this model could be transferred to other conditions currently reliant on inpatient care — for example, pulmonary embolism.

Benefits of the initiative

Award sponsored by

Lloydspharmacy
Healthcare for life



Interim data demonstrates:

- Costs reduced by £1,600 per patient;
- Length of stay reduced by 7% for our target patient group;
- Lower mortality than standard care — 0% compared with 6.2% in hospital mortality;
- Closure of nine acute trust beds.

Patients have improved quality of life, spending less time spent in hospital and so finding it easier to maintain normal home life.

There were 167 fewer admissions in year one, with overall reductions in the number of days spent on hospital with HF. Nine beds were closed at the end of year. There was also reduced use of social care.

Financial implications

The financial resource required for this service is predominately pay costs; facilities were already available within the trust and did not require any additional investment.

The pilot pay costs were supported via the £75,000 health foundation grant, with the time frame for return on this investment being four months from the project introduction. This is based on the £1,600 per admission avoidance saving, meaning 47 patients needed to be treated through the service to realise a return.

For the future, a locally negotiated tariff has been approved to fund the service, covering the cost and contribution of running the clinic while also reducing the cost of care to commissioners by £381,000. Additionally the closure of nine beds in the acute trust has meant a saving to secondary care of £821,000.

Future plans

We have written a mixed methods research study with the Healthcare Services Research Unit at Keele University. The study has recently been approved by an NHS Research Ethics Committee and has also been accepted as a portfolio study by the Clinical Local Research Network.

Contact

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Judges

Dame Ruth Carnall, *chief executive, NHS London*

Catherine Dixon, *chief executive, NHS Litigation Authority*

Stephen Hay, *chief operating officer, Monitor*

Chris Pearson, *national sales and key account manager, Lloydspharmacy Healthcare Services*

FINALIST

Patient navigation

Josie Wright, Dominic Conlin and Dee Coffey
NHS Croydon Clinical Commissioning Group
with Croydon Health Services

The initiative

Patient journeys are frequently inefficient and include appointments that add no value, for example:

- Test results are missing from the case file when the patient attends;
- Patients attend only to be discharged, following normal test results;
- The appointment results in new tests being ordered, these could have been ordered prior to the appointment.

Telephone appointments can be more efficient and are often preferred by the patient.

The PCT proposed the introduction of patient navigation to Croydon University Hospital with a view to supporting the achievement of the national 18 week referral to treatment access and the provision of a streamlined patient journey.

The lead consultant for urology was particularly engaged with the concept of patient navigation, therefore it was agreed to run the pilot in that specialty. The patient navigator:

- Attends outpatient clinics;
- Reviews outpatient clinic letters, improving their understanding of the specialty;
- Trains in the use of hospital IT applications, enabling them to identify cases that may be suitable for virtual clinic;
- Books virtual clinic sessions with the service lead;
- Books appropriate patients into upcoming virtual clinics;
- Ensures that all information required to make a clinical decision is available at the virtual clinic.

The clinician attends the virtual clinic in the same way that they would attend an actual outpatients clinic. The patient navigator attends with case notes and test results. Typically, the consultant/clinician will review 25 patients in a one hour session. The navigator captures clinical decisions made for each patient. Where appropriate the patient navigator acts upon the clinical decision to:

- Cancel unnecessary appointments;
- Phone patients to confirm their availability for a telephone clinic;
- Book patients into a telephone clinic;
- Inform patients and GPs of the clinical decision/outcome and next steps;
- Ensure new tests are booked;
- Chase delayed results;
- Record all outcomes;
- Support performance monitoring.

Benefits

Per specialty, per month, over 60 unnecessary outpatient appointments have been saved. The majority of patients are individually saved up to three unnecessary outpatient visits — some patients are saved up to six.

GPs who are confident to manage the healthcare of an individual patient use the virtual clinics to enable repatriation of patients back into primary care.

Waiting times have reduced, for example ENT has reduced from 17 weeks to five weeks within five months.

Knowledge and experience gained through patient navigation is being used to inform further service redesign. The intermediate rheumatology service has been decommissioned due to evidence gathered through the patient navigation team.

Financial implications

Initial development of pilot, August 2011 (urology):

An interim project manager was recruited to implement the pilot, and a band 3 administrator as patient navigator. 102 unnecessary appointments were cancelled during August 2011 @ £120 per appointment. Total gross savings were £12,240.

Current running of service across seven specialties

A band 3 administrator (navigator) leads on 1–2 services, two band 5s manage the team and roll out to new specialties. Once processes are established, new specialties are handed to a band 3 administrator, enabling the band 5 manager to progress to the next new specialty while managing staff and targets.

Gross financial savings to PCT for three months, based on national tariff + MFF: £130,244. Actual running costs for three months were £32,880. Nett financial savings to the PCT for three months were £97,364.

Contact

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FINALIST

It needn't be ED — a new ambulatory care service at the Great Western Hospital
Charlotte Cannon and Stacey Cotter
Great Western Hospitals FT

The initiative

The initiative involved the establishment of an ambulatory care unit to treat patients who fulfilled the criteria for ambulatory care based on *Directory of Ambulatory Care for Adults*.

We relocated and expanded the existing acute medical unit (short stay 24–72 hours) expanding the bed base. We retained control of more patients who required a short medical admission where previously they would have been transferred to a specialist medical ward, thus protecting specialist beds.

In the vacated space we created an ambulatory care unit including diagnostics to speed up the assessment and initiation of treatment for those patients who did not require admission but needed consultant intervention or review. The trust staffed both units with a multidisciplinary team led by consultants in acute medicine.

Benefits

Medical admissions have fallen by 9% at a time of rising emergency attendances. Length of stay for patients with an ambulatory condition has fallen by one day. The number of four hour emergency department breaches associated with the availability of a medical bed have fallen significantly.

The number of patient moves between wards has also been dramatically reduced, and mixed sex accommodation has been eliminated through a redesign of space.

The initiative has helped improve ambulance handover times by reducing pressure on the emergency department. More patients are now being seen by the ambulatory team reducing pressure on other parts of the hospital. It has allowed the redesign of the medical bed base to support the refurbishment of other patient areas

Patients are now seen by more senior doctors earlier in their journey which national evidence shows improves outcomes.

Financial implications

The trust began the pilot in November, using the winter pressure funding of £400,000, normally used for opening

Secondary care service redesign

up a short stay unit as part of our escalation policy. Since the ambulatory care service started, the short stay unit has remained closed, despite a 300% increase in days that wards were closed due to infection.

The initiative has produced savings of £1.2m. Transfer of emergency inpatient to day patients has risen from 28% to 31%, this reduces the amount the PCT pays for ambulatory care conditions, equating to £600,000 (April–June 12). The rise in emergency admissions in Q1 for non ambulatory care conditions have been managed within existing resources

It has also supported the removal of 26 extra bed spaces that have routinely been used since 2002, the remaining 12 extra bed spaces will be removed by September 2012.

This ambulatory care service has provided the foundation for delivering £2.8m emergency QIPP.

Contact

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FINALIST

Single Point of Access

Alison Smith and Heman Pathmanandam
Hertfordshire Partnership FT

The initiative

The Single Point of Access (SPA) is part of Hertfordshire Partnership FT's (HPFT) innovative service transformation programme, Leading By Design. It provides an effective screening and clinical triage referral service.

The aims of the initiative are to:

- Deliver a more efficient and consistent countywide response to referrals, eliminating duplication;
- Provide a single referral point for GPs and others;
- Improve and simplify access to advice and services for the 32,000 service users and their carers who contact us each year;
- Ensure that within 12 months all referrals have an outcome within 72 hours — eg an appropriate face-to-face appointment.

HPFT identified that vulnerable people accessed our services in up to 34 different ways and the quality of the response they received varied. This variation was deemed unacceptable.

To understand these variations, trials were run across Hertfordshire and knowledge gained was built into the new service using best practice.

A feasibility study looked at both clinical effectiveness and efficiencies that could be achieved. We involved GPs and service users in the design and trials and held workshops and GP events to ensure that we captured their future needs.

SPA is supported by a thorough training programme which includes; face to face training, written manuals, revised operational policies, clinical algorithms and a disaster recovery protocol, all of which are available to be used as training aids and examples of good practice.

Benefits

The service enables better management of access to services, ensuring positive experience for our service users and the ability to track them through managed care pathways thus eliminating bottlenecks or delays.

The referral process has reduced outcomes for referrals from three weeks to less than seven days, excluding urgent referrals which SPA deal with within four hours to meet 24 hour targets.

Financial implications

In order to implement the first phase of the initiative, an investment of £733,000 was agreed to fund:

- Project management office and trial sites — £398,000;
- Estate costs, including furniture, ergonomic and acoustic equipment — £134,000;
- IT equipment and telephony — £201,000.

With efficiency savings of £500,000 in the first year, the return on investment currently stands at 18 months.

Contact

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FINALIST

Making it better

Mike Maresh and Leila Williams
NHS Greater Manchester

The initiative

The initiative addressed a number of serious quality and safety challenges arising from over-reliance on locum doctors and frequent service/unit closures affecting obstetric and neonatal services. It overcame these problems by investing in community services, reducing inpatient obstetric/paediatric units from 12 to eight (focusing resources and achieving sustainable critical mass) and creating a new third neonatal intensive care unit.

The initiative encountered considerable political and public hostility which was overcome through the establishment of a formal joint decision making process for all 11 PCTs involved, creation of a joint OSC for all Greater Manchester local authorities.

A dedicated project team of clinical experts led by a full time senior director was established to drive the initiative forward. Clinicians across Greater Manchester agreed a safe and sustainable service model in 2003/4. At this stage the issue of how individual units would be affected was not addressed.

In 2005 there was a public engagement exercise to initiate a stakeholder dialogue. This was followed in 2006 by a public consultation exercise with four options for reconfiguration of units. As a result of the consultation exercise, seven options were added and the joint committee of PCTs considered 12 options in public meetings.

The joint scrutiny committee supported the recommended option with three dissenters referring the decision to the Secretary of State for Health. An Independent Reconfiguration Panel supported the PCT decision, which was approved by the Secretary of State in 2007.

The original project team then took on responsibility for coordinating implementation, assisted by a recently retired trust chief executive personally selected by the trust chief executives to act as a high level mediator between the trusts.

Implementation of the changes was led by the trusts affected with the project team facilitating and supporting.

The reconfiguration element of the project was implemented over the period 2007–2012 including:

- Creating eight sustainable inpatient maternity and paediatric units for Greater Manchester;
- Closure of four inpatient maternity and paediatric units at Salford, Bury, Rochdale and Trafford;
- Closure of the tertiary NICU at Salford and opening two additional tertiary NICUs at Bolton and Oldham;
- Substantial refurbishment and expansion of maternity and paediatric units at Oldham, Crumpsall, Central Manchester, South Manchester and Bolton.

Secondary care service redesign

Benefits

The rationalisation of services has delivered guaranteed one to one care in labour, RCOG standards for consultant presence on labour wards and eliminated unplanned service closures. This has ensured safe and sustainable secondary care paediatric, maternity and neonatal services for Greater Manchester. Other benefits of the initiative include:

- Increasing tertiary neonatal services from two units to three with more convenient access for parents;
- Maintaining urgent, day case and outpatient access for all three services in the communities where inpatient units were decommissioned;
- Establishing a successful stand alone midwife led birth centre in Salford;
- Developing the model of paediatric assessment and observation units alongside A&E services;
- Significantly enhancing community children's nursing teams to further reduce admission of children;
- Changing the medical staffing model to consultant led with substantial numbers of resident consultants delivering care on a 24/7 basis in all three specialties;
- Recruitment of 79 additional neonatal nurses to achieve BAPM nursing standards for intensive care and high dependency babies.

Financial implications

This project was driven by clinical concerns over the resilience and safety of services in smaller maternity/paediatric units which were struggling to recruit and retain staff and which were plainly not viable in the long run.

The primary care trusts recognised that these systemic problems required properly funded strategic changes and set aside a total of £32m spread over four years to fund enabling costs, transitional and double running costs, and to pump prime agreed increases in staffing levels.

PCTs have made a recurring commitment in excess of £5m per annum. Major capital costs amounted to £110m funded through approved business cases relying on increased revenue income from additional patient flows.

Not a single member of the hundreds of staff in decommissioned units was made redundant.

Contact

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FINALIST

Home for lunch

Joy MacDonald and Ashok Handa
Oxford Radcliffe Hospitals Trust

The initiative

Patients need to be discharged on time. Research has shown that too early discharge lead to an increase in readmissions. Too late leads to an increase in adverse events, with a 6% risk of an adverse event occurring with each additional day in hospital.

A review of the trust's length of stay and discharge profile highlighted a mismatch between the admission and discharge profiles. The purpose of the initiative was to increase the number of patients discharged in the morning by developing and implementing a trust wide discharge process in which:

- All patients have an estimated date of discharge (EDD) within 24 hours of admission;
- There is improved communication with patients and

carers about the discharge process;

- TTOs are written the night prior to discharge where possible;
- Fewer patients refuse to be transferred to the first available community bed;
- More patients go to the transfer lounge or day room the morning of discharge.

Dr Foster was commissioned to benchmark the trust LOS. The data demonstrated that 2,000 bed days could be released per year if the discharge process was more improved. Specialities with the longest LOS attended a workshop to highlight issues and generate ideas. Four themes were identified:

Patient communication

Patients and carers were informed of what they are expected to do — participate in discharge planning, organise transport, outside clothing, food at home, accepting the first available community bed.

Staff communication

A website and posters shared best practice with ward round stickers, visual management boards and web resources.

Pharmacy

The service improvement team supported a service redesign using process mapping to identify bottlenecks for the dispensing of TTOs, inpatient medication and controlled drugs.

Benefits

There was a 75% reduction in the rate of refusal for community hospital beds.

The average length of stay (ALOS) for elective surgery has reduced from 3.70 (April 2011) to 3.28 (September 2011), the trust overall LOS has reduced from 2.33 (April 2011) to 2.04 (November 2011). The root cause for the reduction is unknown but could be a combination of factors including improvement in TTO turnaround time, change to pharmacy working hours and Home for Lunch campaign. Use of the transfer lounge has increased.

Financial implications

A service improvement team member supported the process over three months.

This entry was also a finalist in the **Quality and productivity category*

Contact

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FINALIST

Delivering secondary care redesign

through seven day working in physiotherapy
cardiothoracic services

Brighton Paradza

The James Cook University Hospital

The initiative

Across NHS centres and beyond, service gaps occur over weekends and holidays interrupting the rehabilitation processes for patients after major heart surgery.

The trust's cardiothoracic directorate adopted an idea to transform physiotherapy delivery from a five day only service from Monday to Friday (7.5 hours) to seven day working (9.5 hours) shift patterns per week (from Monday to Sunday) in April 2006.

This was a multidisciplinary initiative involving the trust improvement team, the clinical support services and the

Secondary care service redesign

cardiothoracic directorate. This initiative was led by the clinical specialist physiotherapist. The objectives were to:

- Deliver better clinical outcomes;
- Improve patients' experience;
- Reduce length of stay;
- Improve the quality of care;
- Improve bed availability through increased capacity;
- Prevent cancellations;
- Achieve cost effectiveness and efficiency savings;
- Reduced staff costs and improve productivity.

Benefits

Clinical effectiveness

Improved clinical outcomes are demonstrated by reduced postoperative LOS — down by 0.603 to two bed days across all cardiothoracic conditions. Patient throughput was improved by 6.74% (n=81) saving 426 bed days. Timely discharges reduced our hospital "hotel" costs — 55% and 27% improvement respectively based on national and local benchmarks.

Productivity

The initiative improved access and patient flow by ensuring continuity of care over weekends and holidays optimised through "twilight working" — early bird (7.30 am) and late finish (6pm). It also reduced weekend mediated variation in quality of care.

Staff working

Staffs working lives were improved by a self rostered, flexible working culture. There was positive feedback from therapists delivering 7 day working.

Patient experience

There were high levels of patient satisfaction with the initiative.

Financial implications

There was an initial capitalisation to cover the cost of creating and appointing two physiotherapists posts, taking our staff level to six therapists, at £242,697.

Over a year 7 day working resulted in savings through:

- Replacement of on call service — £24,096;
- Reduction in patient LOS and improved patient throughput saved 426 bed days — £156,232.

Taking into account the initial investment and enhancement costs of £22,464 for six therapists, estimated efficiency savings of £157,864 were achieved over 12 months.

**This entry was also a finalist in the Quality and productivity category*

Contact

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FINALIST

Partnership approach to recovery at home service

Andrew Burton and Emma Bowyer
University Hospital Southampton FT

The initiative

In 2010 University Hospital Southampton (UHS) formed a partnership with Healthcare at Home (HAH) to trial a new community based, multidisciplinary approach to care called the recovery at home service. The aim of the partnership was to enable patients to receive high quality care and rehabilitation in their own homes, thereby reducing their length of stay in

hospital and releasing cost efficiencies.

The recovery at home model, originally developed in 2004 for orthopaedic care was adapted in order to deliver medicines for patients in their homes rather than having them in hospital. Services delivered include rehabilitation, IV therapy and drug administration, and domiciliary care for patients who still required acute care management and anti coagulation care.

Healthcare at Home and UHS worked closely with clinical staff to develop clinical pathways supported by governance structures that enabled patients to be treated at home.

A multidisciplinary, clinically led team consisting of specialist nurses, physiotherapists, occupational therapists and healthcare assistants provide personalised care and treatment to patients at home 24 hours a day, seven days a week, 365 days a year. In addition, the clinical team offer patient advocacy services by liaising with local charitable and community organisations that refer patients on to appropriate non-clinical services.

The expert care is supported by the HAH care bureau, a multipurpose IT and telehealth system which has multiple service functions including:

- Accepting patient referrals;
- Scheduling home visits for the team;
- Storing relevant patient information;
- Offering around the clock telephone support for the patient.

The care bureau can also provide clinicians with the latest patient information gathered by the HAH team in real time. A rapid response team has been set up in order to react quickly to calls from patients, thereby often preventing the need for emergency admissions to hospital.

Benefits

The recovery at home service has been shown to significantly improve patient satisfaction by giving patients the freedom to receive treatment in the comfort of their own homes. The service has potential to realise significant cost savings by reducing a patient's stay in hospital and freeing up hospital beds.

A study by Wessex Health Innovation Education Cluster yielded the following:

- Savings achievable through releasing a ward's activity to homecare equates to £250,000;
- Patients' average length of stay in hospital is now 2.5 days, reduced from 5 days.

The most recent outcomes data shows that:

- The service has saved over 8,800 bed nights;
- The multidisciplinary team have conducted over 11,600 home visits;
- Patient satisfaction is 97%.

Financial implications

The scheme costs £1.04m per year to run with 20 beds at 93% occupancy. A fixed bed cost for general specialty is £65,000 per year resulting in a saving of £1.3m annually. This is equal to a net saving of £260,000. These savings have come from freeing up services on wards, increasing productivity among staff, and allowing more bed space, thus avoiding capital expenditure on refurbishment or new premises.

The recovery at home service will continue to expand across additional surgical and medical directorates, which will result in greater financial savings. To date, the numbers of patients being transferred into the service has increased from 1,200 in the first year to 2,400 in the second.

Contact

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WINNER

Listening into action — owning the future

John Adler and Gaynor Farmer

Sandwell and West Birmingham Hospitals Trust

Background

The Listening into Action (LiA) initiative is based on the evidence that engaged staff deliver more, and aims to increase staff satisfaction and identification with the organisation's goals. The object has been to put staff at the centre of change and fundamentally alter the trust's style of leadership.

LiA quickly mobilises people around a common mission that matters to them. It builds pride and inspires spread, positioning managers as enablers, securing the commitment of staff, engaging with them to release their creativity and enthusiasm, and supporting them in facilitating change.

It was introduced following evidence from the 2007 staff survey in which trust scores around engagement were lower than those of other comparably sized trusts.

The process

LiA is a way of securing the commitment, enthusiasm and knowledge of staff to address service and workforce challenges. The trust committed to listening to, and acting on, concerns raised by staff. This was initially through a number of "conversations" with 350 staff hosted by the chief executive.

Nine key themes were identified as a result of asking three key questions and enabling staff to prioritise their answers and ideas. The approach has now spread across the organisation and is used by thousands of staff in clinical and non-clinical teams to improve services, and enable change.

It is based on collaboration between all those involved in providing a service, and on working together to achieve results. The initiative is supported by a significant communications campaign to ensure the brand is understood.

Divisions present their LiA activity to a sponsor group chaired by the chief executive on a quarterly cycle. The sponsor group ensures any barriers are quickly removed to enable swift action.

Advice to other organisations

Other trusts in similar stages of development may find our experiences useful. We have had active encouragement from our CLRN management team to share best practice through lead research management and local and national NIHR networks.

Benefits of the initiative

Listening into Action has improved patient care, staff satisfaction, and communication and change management.

The project began with staff survey results from 2007, and one of the key ways of measuring progress has been the comparison of the survey in 2007 and every year since.

The proportion of staff who believe senior managers involve staff in important decisions have increased by 15%, taking the trust from 6% below the national average in 2007/8, to 11% above the national average in 2011.

Effective communication between senior management and staff has improved by 17%, moving from 5% below the national average to 14% above the national average in 2011. Individual



teams have delivered specific changes in their areas which benefit patients — including improved ward environments, better food choices, more accessible services at times to suit patients and improved patient information.

Most importantly of all, there has been a 23% rise in the proportion of staff that thinks care of patients is the trust's top priority, it is now 10% higher than the national average.

Financial implications

An initial investment of £250,000 was used for:

- Consultancy support to set up the project;
- Venue hire;
- Communication materials.

Consultancy support was replaced by a part time facilitator and is now supported by LiA champions — staff substantively employed in other jobs in the trust. The trust has delivered annual cost improvement plans of around £20m for the last few years. Ideas for savings have come through LiA, such as new rotas that reduce reliance on on-call cover, extended working hours, and better equipment management.

LiA has contributed to a significant reduction in sickness absence from 4.78% in 2007/08 to 3.9% in 2012/13, a saving in time lost at an average cost of £2,490,000.

LiA is now being used to drive the trust's response to QIPP and save £125m over five years. For example community staff are using LiA to create a plan to support earlier discharge of patients that will help close over 100 acute beds this year.

Future plans

We are now building on LiA to create a permanent structure for engagement within the trust, through the election of staff ambassadors in every team.

Contact

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Judges

June Chandler, national officer, Unison,

Jo Cubbon, chair of NHS Employers and chief executive of Taunton and Somerset FT

Marisa Howes, national officer, communications and policy, Managers in Partnership (MiP)

Karen Lynas, head of delivery and deputy managing director, NHS Leadership Academy

Professor Michael West, professor of organizational psychology, Lancaster University Management School

Award sponsored by



HIGHLY COMMENDED

People strategy in practice

Natalie Forrest, Liz Rippon and Susan Whiterod
West Hertfordshire Hospitals Trust

The initiative

Previous national survey results did not reflect the dedication of our staff. The People Strategy 2012 (PS) is "mission critical" as we progress towards foundation trust status.

We believe our staff possess "caring values", therefore exploring values, per se can be disengaging and patronising. We switched the term "Organisational Development" to "Developing the Organisation, People Strategy in practice". This communicates what we do; people centred engagement aligned to people centred services delivering demonstrable outcomes for patients and staff.

The model evolved from our outpatients work, adapted for different contexts. The PS is continuous improvement; four interrelated elements empower staff to deliver their best:

- Core standards;
- Competent workforce;
- Collegiate working and engagement;
- Demonstrable outcomes.

Core interventions in 2011–12 include:

- All staff surveyed in 2011, with outcomes acted upon;
- 200 People Leaders identified for competency profiling/development;
- Embedding quality and quantity of appraisals;
- "Balance For Life" well being programmes;
- Collegiate working across functions/teams;
- New leadership academy programmes; business skills, patient experience, managing inclusivity offering a pathway to full masters degree;
- 20 multidisciplinary staff trained as accredited coaches;
- Development for newly appointed/promoted clinical/medical leaders, underpinning skills and relational shifts;
- Supporting junior doctors integrating into clinical teams.

Bespoke interventions in specific care settings integrate outcomes across:

- Service redesign/reconfiguration;
- Communications, team working;
- Environment, systems/processes and "how we do things around here".

Benefits

The 2011 staff survey shows significant improvements in 33 of 38 indicators.

In June 2012, the trust achieved 2% surplus against unprecedented activity increases, it is currently 15% and rising.

Pharmacy staff turnover was reduced from 18% to below 5%; TTA waits were reduced from average 2.5 to 1.25 hours; inpatient medicines from 3 to 1.5 hours, a £574,000 cost improvement programme was achieved

Financial implications

Direct costs of the initiative were for room hire, refreshments, therapy treats, and limited external coaching and facilitation.

The initiative saved about £200,000 in reduced sickness, improved recruitment and retention and bank and agency savings

Contact

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FINALIST

Women and children's patient safety incident review team

June Davies and Louise Dowell
Blackpool Teaching Hospitals FT

The initiative

The purpose of the initiative was to improve the quality of care for the women and their babies. To achieve this we wanted to ensure that all staff felt confident to report incidents, and would receive the appropriate feedback and support. In addition all staff involved in the incident would be involved in the investigation of the incident and be at the heart of the decision making.

The initiative started with a weekly meeting to review of all incidents from that week, with feedback from the previous week. Terms of reference for the group were drawn up and included membership from the multidisciplinary team including paediatricians and anaesthetists.

Besides the core team, any member of staff can attend the meeting. There is active involvement of the supervisors of midwives who are integral to good risk management within the unit.

Feedback is given to staff on an individual basis and a quarterly *Lessons Learned* newsletter is published and sent to all staff. To proactively manage risk, measures such as risk assessment, staff discussion, mentoring and problem solving have been introduced.

All serious incidents are subject to a case review / root cause analysis. These reviews are attended by senior clinical staff — anaesthetists, surgeons, physiotherapists — from outside the maternity service to ensure learning is shared across the organisation.

A culture of fair blame is inherent to our ethos. The whole team are involved, no one is excluded. Risk management training is provided to all staff, a programme of multidisciplinary skills drills further enhances the culture of safety throughout the unit.

Benefits

Quality improvements implemented following incident reviews include:

- A new process for neonatal blood spot transportation, ensuring the baby is screened correctly;
- A review of the pathway for twin pregnancies;
- Change of notes; ensuring maternity patients have 100% compliance with VTE;
- 100% reduction in the number of babies admitted to NNU for substance abuse mothers;
- Integrated documentation on the paediatric unit and the use of Early Warning Scoring for HDU patients;
- Ensuring the SBAR system is used for handovers with the implementation of a specially designed board on the delivery suite;
- Ensuring that women with medical problems are reviewed by a consultant;
- Development of a specialist clinic for cardiac, endocrine and obese patients;
- Ensuring that cardiotocograms are reviewed using the Dr C. BraVADO mnemonic, and the introduction of an annual test for midwives and doctors;
- The introduction of a Hepatitis B screening pathway in conjunction with the PCTs;
- The introduction of live skills drills which include PPH, shoulder dystocia, breech delivery and eclampsia.

Staff engagement

In addition staff are now comfortable reporting incidents and aware they will be involved in the investigation, and that support is always provided.

Financial implications

The reduction in admissions to the neonatal unit alone has produced a cost saving of £600 per baby per day, which gives an estimated saving of £134,400 per annum for the trust.

Contact

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FINALIST

Together we can

Jo Vaughan, Neil Savage and Vicki Davies
Birmingham Women's FT

The initiative

Together We Can (TWC) was launched at a time of significant organisational change affecting almost 20% of staff directly. It was against the backdrop of a new leadership team and national uncertainty (pension strike action). Despite this, or perhaps because of this, TWC is delivering service quality improvements that have a direct impact on patient experiences such as the QIPP programme and CQC scores.

Our Brief, a monthly newsletter written by staff, about staff and for staff is improving communication. The antenatal pathway project is tackling patient experiences as well as ensuring mothers see the correct specialist from their very first visit — preparing the way for the incoming maternity services pathway payment system.

One group wrote the hospital's "values", standards by which patients/staff could be expected to be treated. They developed the values using:

- Colleague/patient feedback;
- Consultations;
- Workshops;
- Face-to-face surveys.

These values were put to the trust board and are now part of the fabric of the hospital — on walls, in literature, contracts, training, induction.

Sickness absence was heading for 6%, it dropped to 3.5% and is now routinely below 5%. It was tackled by looking at the issue from the staff, rather than the management, perspective.

The staff-led interventions include:

- Simple guides that explain policy,
- Performance charts that allow teams to monitor annual performance year on year, and
- Persuading the CEO to sign almost 600 cards for those with 100% attendance.

Another group wanted to give a tired reception area a facelift. They planned and executed — over one weekend — a revamped reception through a combination of:

- Negotiation with the management team;
- Fund raising;
- Identifying DIY skills among colleagues.

Benefits

Against a challenging background, staff engagement has held its own with the 2011 NHS staff survey demonstrating a 6% increase in staff engagement over the previous year and the percentage of staff working extra hours, reflecting

the changing culture of staff working together to resolve challenges — whatever the odds.

The editorial team of *Our Brief* has regular access to the senior management team, which has helped communicate the roles and objectives of the new leadership team.

To date there have been almost 700 hours of staff consultation:

- 10% of staff are actively involved in delivering projects;
- 12 have been appointed ambassadors to spread, support and encourage involvement.

Twenty six staff-led projects have been, or are being implemented. These include improving opportunities for recycling, improving signage and availability of personal safety alarms to larger projects such as helping to develop the trust IT policy.

The 2011 Birmingham Women's Hospital CQC report stated that people had said that staff "were very helpful, kind and approachable" — reflecting the staff determined values.

Financial implications

The financial resources required for this project were £25,000 for consultancy support and £10,000 for marketing.

A number of savings have been achieved in the first year:

- A staff led review of hospital bureaucracy identified immediate pharmacy savings of £25,000 and the group continues to identify potential savings and more effective ways of doing things.
- The opportunity costs of reducing absence and raising awareness has realised savings equivalent to £450,000.

Contact

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FINALIST

Staff engagement — from possibility to habit

Nicky Ingham and Sue Whittam
Bolton FT

The initiative

Securing high levels of staff engagement within the NHS is recognised as being critical in order to respond effectively to current and future changes and challenges.

Since 2009 we have been steadily developing and implementing our own staff engagement approach. We began the practical element with a series of Big and Small Conversations. Through the use of appreciative inquiry these events allowed us to discover what really matters to staff. This added value to the results from the annual NHS Staff Survey. We have continued to use this approach.

Following this initial work we discovered the importance of deeper engagement with individual teams and developed engagement case work which enables us to track improvements by increasing engagement in teams. As a result we:

- Launched the trust core values;
- Integrated values into the appraisal process;
- Implemented quarterly Staff Temperature checks to monitor engagement quarterly;
- Designed an in-house engaging manager programme — a 180° appraisal and coaching support programme;
- Spread the engagement methodology to increase HR intervention and effectiveness;
- Reviewed staffing levels.

Benefits

As a result of the initiative, we have achieved an increase in the overall staff engagement score and above average ratings in 31 of the 38 key factors as reported through the 2011 NHS staff survey. This was achieved despite undergoing major integration with our community services and a reconfiguration of maternity services in Greater Manchester. Through the team deep engagement casework we are able to evidence the following:

- Tracking and improvements in staff engagement usually by two points, from two to four on a five point scale (as measured through our temp checks);
- Reductions in sickness absence;
- Diagnosis of hot spot areas and benefits tracking through development of workforce composite matrix;
- Improvements in effectiveness of managers through the engaging manager programme and 180° appraisal;
- Improvements in team working, greater willingness to participate actively in service improvements;
- Staff stories presented to trust board demonstrating how it feels to be engaged and the impact upon discretionary effort;
- Increase in patient access times for clinics resulting in achievement of CQINs targets maximising income;
- Ability to identify emerging themes for management development through the 180° appraisal tool for managers.

Financial implications

The initiative started using internal resources, and was later supported by £40,000 from the social partnership forum.

The project has now become a permanent service within the workforce directorate, led by a full time senior manager with other lead responsibilities, a part time advisor and administrator. However the strategy is to spread engagement methodology and behaviour to key experts and to line managers, and there are targets agreed by the trust board to support this.

Contact

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FINALIST

Great staff, great care, great future

Miles Howell and Lucy Vere

Hull and East Yorkshire Hospitals Trust

The initiative

One of the key priorities for our chief executive on his arrival at the trust (October 2010) was the development of a clear vision with values and a set of key behaviours that would drive the leadership and staff of the trust.

Values driven leadership and staff engagement had been missing from our trust over a numbers of years at all levels in the organisation. It was recognised that without this focus our performance and aspirations for achieving foundation trust status would be compromised.

This view has been evidenced by our staff survey results which have been significantly lower than the national average, especially under the key staff engagement questions, ie "Would you recommend the trust as a place to work or receive treatment?"

Making the vision and values really live through our 7,500 staff was and still is an ambitious and challenging objective that is key to the trust becoming a truly outstanding provider of care and services. This work has required innovative and creative solutions.

This was a consultation process that enabled staff to agree on five key behaviours that they wanted all staff to adhere to. Staff suggested over 400 "I will" statements. From this number they voted on a top five.

The vision, values and behaviours have now been officially branded and are evident on all corporate materials from posters to websites and stationery.

The next step saw a reward scheme introduced based on the behaviours set by staff. The Golden Hearts Awards is an annual event that reflects the behaviours in 11 categories. It enables us to recognise outstanding individuals and teams with a glitzy award ceremony. Two winners, voted for by their colleagues, receive a car and a holiday.

In addition we ask staff to nominate colleagues for Moments of Magic awards. Staff can post online when they think a colleague has gone above and beyond the call of duty. The best Moments of Magic receives a Golden Heart Award.

Benefits

By establishing the ground rules for staff we have taken the first step towards a new culture for the trust. This will be a long journey for us but the first phase was all about establishing a set of behaviours and introducing a reward scheme for these.

The benefits have been in providing the foundations for future engagement work and in giving staff the chance to decide what they want from their colleagues and their services.

Since the work has been done we have begun to see some improvements in both our staff surveys and the most recent patient survey. For many years the trust has found itself in the bottom 20% of trusts across many measures in the national surveys.

This year we have seen ourselves move in to the High Score/High Improvement quadrants for both inpatient and outpatient surveys for the first time.

In terms of the staff survey we have seen the trust improve against the majority of scores including K34. There is a lot of work left to do but we feel we are, at last, moving in the right direction.

Financial implications

The staff engagement initiative has been largely cost neutral. We have spent a negligible amount on printing corporate documents but all rebranding and design work has been done in-house.

The staff lottery is the financial enabler in most of the engagement work we are doing. Established in February 2011 this is a salary deduction scheme introduced to pay for engagement activities. The trust currently employs 6,500 eligible staff of whom 2,500 are in the lottery.

Half of the lottery money goes on monthly prizes, the rest is used to fund the Golden Hearts Awards, a trust choir, a valentine's ball, a summer barbecue. It has paid for 17 teams to take part in the Global Corporate Challenge as well as a host of other events and schemes which are helping to bring staff together socially as well as at work.

Contact

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FINALIST

Development of the Merseyside Commissioning Support Service with stakeholders

Michael Gibney and Jane Raven

NHS Merseyside/Merseyside Commissioning Support Unit

The initiative

The aim of the initiative was to develop a new, dynamic, values driven, staff led organisation, fit to deliver in the new healthcare landscape. In many ways the most challenging aspect was that this organisation needs to be commercially viable and have the capacity to become a social enterprise before April 2015.

This is in response to the *Health and Social Care Act* disestablishing PCTs and developing new organisation forms, including Clinical Commissioning Groups and Commissioning Support Services.

This created and supported development of a set of values and behaviours to form the core of Merseyside Commissioning Support Service (Merseyside CSS).

We were also committed to making as many opportunities available as possible for staff to be able to engage in discussion directly with leaders and other stakeholders.

The values reflect the NHS Constitution and we make it real by describing the “give and the get” for both managers and staff.

A cross section of staff took part in workshops to determine what values were important to them and therefore the future organisation. These informed the development of posts in the new organisations, appraisal and performance management standards.

Staff also took part in an activity analysis, which provided an evidence base of the technical competencies the organisations possesses and a foundation for the future. Trade union colleagues were actively involved in the development of the project.

During recent large scale staff events, staff testimonies on the CSS were heard, teams were invited to literally “set out their stall”, to show colleagues what they do and discuss how they could work more closely together.

We have appointed change champions who will be advocates of the CSS values, and will support the embedding of the values in day to day use — this will ensure the work is sustainable.

In terms of formal trade union engagement, we initiated a development programme to upskill them, comprised of technical/legal inputs, and sessions with directors on their topic areas.

This enables staff side to be upstream of decisions about the future of staff and the organisation. Trade union colleagues appeared in the DVD that Merseyside CSS put forward as part of their authorisation process.

Benefits

In terms of Checkpoint two authorisation, Merseyside CSS was commended for their approach and achieved the highest scores possible. We have been commended for our partnership approach by the North West Partnership Forum.

We have undertaken leadership development activity on our model and this is being used by the Merseyside CSS senior team to inform their activities and approach to work, and the behavioural framework underpins the training programme being offered in the new organisation.

The commitment to prioritise our stakeholders needs in our

values has influenced the recruitment of our business critical account manager posts, whose job description and role profiles were developed with the CCGs they would be working with, and the CCGs took part in the recruitment and assessment process. Their feedback has been that they appreciated being involved and valued the experience.

We have instigated director walkabouts, particularly to discuss with staff their views on the organisation and will continue to evaluate staff experience through staff surveys, developing joint action plans with trade union colleagues and staff.

The initiative shapes all the strategies, policies and tools for the new organisation, providing true strategic alignment.

In addition to developing strategies and policies that embed the behavioural framework (appraisal, capability, reward), we intend to develop an in-house e-learning platform that has articles and blended learning for every organisational behaviour. We are already working with Cumbria and Lancashire CSS to deliver this model across their region and to their CCGs as well as to those in Merseyside.

Financial implications

The overall direct cost is around £75,000. The activity analysis has enabled us to develop the basis for an affordable workforce. All other work has been undertaken in house, providing learning opportunities for our staff and sustainability for the organisation.

We are the sole franchisee of the Values and Behaviours work in the country and regional expert organisation in competency based workforce planning, which will enable us to improve performance in other organisations, and be income generating and self sustaining.

As a CSS, we will work across the regional footprint and provide guidance to our CCGs, and support them working across their organisational boundaries, in order to improve patient care and also QIPP savings.

We are working on a three year plan to maximise the benefits to the organisation, although the direct spend will be repaid within the year. Taking a risk based approach to shaping the organisation enabled us to release 150 staff in the last year, saving around £9m.

Contact

For more information on this initiative please contact hr.projects@knowsley.nhs.uk

FINALIST

Leading our people through transition

Michael Gibney and Jane Raven

NHS Merseyside

The initiative

The NHS has been going through unprecedented change and financial challenge. At the same time as the new clinically led commissioning landscape is developing, PCTs were facing requirements to make reductions in management costs in the period leading up to their abolition in 2013.

During 2011/12, NHS Merseyside sought to achieve a significant headcount reduction through a series of supported voluntary measures.

NHS Merseyside was clear that it had a duty of care to support staff as effectively as possible during this period of transition while making every effort to maintain talent within the system.

Locally four PCTs were clustering in the summer of 2011 but it was recognised that career transition support had to start as soon as possible and not be delayed. The model was developed in partnership with trade unions.

The career transition programme was designed to enable staff to make sense of the changing environment and to make the best/informed decisions possible for themselves and the NHS. We established a creative package of support that empowered people to leave and enabled those who remained to step up into new roles.

We worked in partnership with staff-side representatives to agree the principles of the programme and its implementation. Some elements (eg outplacement) were procured externally with a commercial partner. This tendering process included staff side representation at every stage. The approach was fully endorsed at executive and board level.

The full menu was launched across the newly configured NHS Merseyside and open to all staff at all levels. It offers a comprehensive menu of 45 potential interventions that are delivered via training events, online resource, in teams and individually. This also supports and enables the post migration period when the new services are established.

Some examples of the content are:

Learning and development

Full menu of commissioning skills, employability skills (targeted by staff bandings), leading and managing change.

Health and wellbeing

Stress management, staff support service, stress checks, pensions awareness sessions, financial education seminars, 1-2-1 financial advice, HR surgeries, and occupational health service.

Staff engagement

Communication, 1:1S — quarterly, CEO blog, staff briefing sessions, intranet recent posts/updates, team brief, staff side engagement.

Career transition support

Pensions advice, "our futures", bespoke interview skills, bespoke interviewing skills, career coaching/mentoring, personalised transition road map, total marketing plan approach, outplacement and online career transition tool.

Benefits

The career transition programme has been a crucial part of the transition process. It effectively supported the reduction in headcount through supporting staff. It has supported the overall transition process by ensuring that the workforce could be more flexible. This in turn has enabled NHS Merseyside to continue to meet the requirements of business as usual, and work smarter across the cluster to ensure resources are focused on the most important areas of development.

The programme continues to be extremely well received by all staff, offering them support at a time when they most need it. After the launch, a total of 202 workshops were held over a six month period, and 53 staff accessed a career support on a 1:1 basis during the same period. This allowed people to decide if they wished to take advantage of the mutually agreed resignation scheme (MARS) and facilitated (risk based) workforce planning and assured business as usual.

It also underpinned the following phase of voluntary early retirement/voluntary redundancy, once again ensuring individuals made informed decisions and the organisation was

able to plan/redesign its workforce.

The full programme is still available to all staff and it now supports individuals into the new commissioning organisations across the Merseyside system.

Financial implications

One of the strongest business drivers for this initiative is that it galvanises a number of existing organisational initiatives to produce more targeted and effective implementation.

In addition, it has enabled staff to make use of online resources and in some cases to signpost freely available support. There was a cost implication to running more training but this was absorbed within existing budgets so the one real cost has been to enable Savile Fairplace for out placement support and access to their website. We have negotiated a pay as you go model that cost £61,000 to 31st May 2012.

The initiative has underpinned £9m worth of savings in one year alone, with no detrimental impact on service delivery. Over 150 staff took voluntary redundancy (from a workforce of 1,000) and a further 150 have found alternative employment.

Contact

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FINALIST

Connecting with staff to embed clinical commissioning

Maria Principe

NHS Nottingham City
Clinical Commissioning Group

The initiative

Following significant reorganisation the Connect programme was launched to bring staff through a period of unprecedented change unscathed and empowered. Connect also aims to bring clinicians and commissioning staff together under a new NHS organisation, creating solid foundations and a dynamic corporate culture for the emerging NHS Nottingham City Clinical Commissioning Group (CCG).

A recent workforce reduction and redeployment initiative had resulted in some staff voluntarily leaving the former PCT organisation and many more being transferred to provider organisations, the new PCT cluster or the local authority.

A number of talented and committed staff were retained and assigned to the new NHS Nottingham City CCG, which began operating in shadow form in April 2011.

Bringing NHS commissioning, back office and clinical staff together in this new commissioning organisation meant exploring new ways of working together and the development of a shared vision and underpinning values.

Key aims are to ensure that staff and GP members feel a sense of ownership and an understanding that to improve patient care they need to work together in new ways.

An integrated communications and engagement strategy identified and prioritised "quick wins" including the establishment of monthly engagement forums with the senior team, newly appointed GP executive and CCG staff.

The forums are informal and designed to encourage two-way communication. An interactive feature is available on the staff intranet which can be used to ask questions and give feedback freely (and anonymously if they wish) to the

Staff engagement

executive team.

A monthly e-bulletin was launched in July 2011 and has proved an effective and powerful tool in improving communication and creating cohesion. The content covers a range of topics including commissioning development, medical and referral pathway updates and wider strategic and organisational news.

A number of live events have cemented the new relationships formed between clinicians and NHS commissioners

Benefits

In the 2011 NHS staff survey Nottingham City was in the top 20% of commissioning organisations in the country for the majority of indicators including staff feeling valued by their work colleagues (90%) and staff feeling able to contribute towards improvements at work (84%). Other high scores were for job satisfaction and support from immediate managers.

Annual internal evaluation of our staff engagement saw colleagues rating the CCG highly for internal communication and opportunities to input and share ideas and best practice. Feedback from this evaluation has also seen engagement activities extended to include extra curricular and social events.

Improvements in patient care have come through a new organisational structure that facilitates engagement between clinicians and commissioning staff to better design patient pathways.

A recent whole system approach to improving quality in care homes has seen engagement with commissioners, primary care, secondary care consultants and community nursing teams.

Productivity levels have increased and sickness and absence rates have fallen. Information sharing and joint working between clinicians and commissioners are now embedded throughout the organisation.

Financial implications

A significant piece of our engagement work has been our programme of practice visits and peer support. This involved the CCG's GP executives visiting all of our 64 GP practices, which serve a patient population of 347,000. The time/costs of the GP executives were met within existing CCG resources.

The programme was developed to support practices to reduce variations in quality and ensure that high quality is a consistent part of everyone's primary care experience. Positive outcomes include:

- More practices now within budget than ever before;
- A reduction in patient referrals to secondary care;
- More patients now seen in community settings closer to home;
- A reduction in emergency admissions;
- Reduced spending on prescribing.

Contact

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FINALIST

The Walton Way

Joanne Twist and Jean Blevin

The Walton Centre FT

The initiative

The Walton Way values and behaviours were developed and

implemented by our own staff. Staff were asked to set out what the Walton Centre meant to them. The five values they chose were:

- Openness;
- Dignity;
- Caring;
- Respect;
- Pride.

Staff were then asked to describe the behaviours that they believed demonstrated these values being brought to life.

The initiative has many strands, but the key to its success is strong visible board leadership that believes that staff engagement is key to core of the business. Staff are openly involved in all changes and developments happening within the trust.

The trust hold quarterly staff summits by profession where the executive team meet with staff groups (open invitation to all staff). Staff are informed by the CEO of national and regional changes and how they impact locally to the trust, the summits are used to develop the trust's strategies.

The CEO and the UNISON staff side lead conduct bi-monthly staff walkabouts, including night visits. Members of the executive team attend the staff physical exercise classes.

Our Forward to Excellence (F2E) service improvement projects are led and delivered by staff.

Benefits

Our scores in staff survey results have dramatically improved over the last two years. We have seen our completion rate of the staff survey increase from 30% to 62% in three years. We believe this is due to the executives and UNISON staff side lead personally delivering the surveys to staff.

Once the results are received HR, managers and staff side take the results to the staff and develop divisional action plans, which is then followed up with an annual "you said we did" campaign.

We have seen key movement in key HR KPI indicators such as reduced sickness from over 7% to 4%. Our Forward to Excellence Programme (F2E) is focusing on three major service improvement projects:

- Delayed discharge;
- Back marking;
- Outpatients.

Scoping exercises have taken place with multidisciplinary staff working groups. Once all the data has been analysed we move into the design phase to ensure improved patient experience and more efficient service.

We are building into our recruitment process selection, questions that will test the Walton Way behaviours at interview, to ensure we employ staff who demonstrate the trust values and behaviours.

Financial implications

Savings have been made on significant KPIs such as sickness and agency spend. A number of health and wellbeing projects have been funded to provide equipment, but staff are contributing to the cost of fitness trainers.

All the F2E projects have received initial funding to support the project teams, but are QIPP initiatives and will improve service design, reduce length of stay, improve quality, reduce duplication and inefficiency.

Contact

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WINNER

Healthcare Assistant recruitment initiative

Lucy Connolly and Lydia Larcum

York Teaching Hospital FT

Background

Workforce information clearly demonstrated that prior to the introduction of this project the turnover rate of 15.59% within this staff group was significantly higher than the trust average of 12.1% and that 52% of health care assistant (HCA) leavers had less than one year's service.

Feedback from directorate managers, matrons and ward sisters at workforce performance management meetings indicated that a major reason for this was a lack of understanding about the role by new recruits. New starters expectations were not matching the realities of the role in an acute setting. To address these issues the whole HCA recruitment process was reviewed.

The process

An initial project group consisting of the HR director, chief nurse, assistant chief nurse (workforce) and the recruitment manager identified key actions. It quickly became clear that candidates needed more information before applying. It was agreed that compulsory pre application open days could facilitate this, along with the added benefit of more manageable applicant numbers.

It was also agreed that a clearer message would be essential and a review of the HCA person specification was important. To ensure new recruits were more prepared it was identified that there was a need for better initial training and induction.

Once a basic recruitment and induction process was developed, a pilot was agreed. The first programme of the revised recruitment process provided an opportunity to assess and evaluate the open day, new values-based interview and off-ward induction. Feedback was key and regular reviews took place whereby ward sisters and newly recruited HCAs were asked to share their experiences of the new programme. Each round of recruitment was reviewed and changes made to hone the process.

Advice to other organisations

The efficiencies produced through generic recruitment are invaluable in the current economic climate. Many organisations struggle with high numbers of often unsuitable applicants. Our approach provides an easily implemented and effective solution to this.

The values based approach, and the robust and structured induction, implemented through this project ensures that these crucial front line employees have the ability and desire to provide high quality patient care.

Benefits of the initiative

Of the HCAs who have started employment since the introduction of this initiative only 6% have left the trust to date. Of the HCA leavers who were recruited through the new process 34% had less than one year's service, compared with 52% before the introduction of the initiative.



Since the introduction of this initiative the trust has seen a 10% reduction in reliance on temporary workforce, due to a more stable substantive workforce. Recruitment to HCA posts has moved from monthly to quarterly.

Further evidence of the positive impact of the programme on the whole staff group (including those not recruited through the new process) is demonstrated by the significant reduction in the annual sickness absence rate among HCAs.

These trends indicate improved morale, better health and job satisfaction among HCAs. This inevitably contributes to improved continuity and quality of patient care due to a more stable staff base.

In the past 12 months it has been identified that there are other roles within the organisation to which it is difficult to recruit or retain staff. Where appropriate some elements of the revised generic recruitment process for HCAs has been used as part of the process for recruiting into these roles.

Financial implications

No additional resources were required to support the delivery of this recruitment initiative. The project required redistribution of existing resources within the recruitment department and senior nursing workforce. It has resulted in substantial workforce cost savings associated with reduced sickness and temporary workforce, additionally, recruitment costs have reduced from £1000 per month to just £600 per quarter.

Future plans

In the past 12 months it has been identified that there are other roles within the organisation to which it is difficult to recruit or retain staff. Where appropriate some elements of the revised generic recruitment process for HCAs have been used as part of the process for recruiting into these roles. It is anticipated that our use of non-traditional methods of recruitment will expand into areas where there is the potential to achieve the same positive outcomes.

Contact

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Judges

Stephen Burke, *chief executive officer, HCL Workforce Solutions*

Dr Linda Patterson, *clinical vice president, Royal College of Physicians*

Dean Royles, *director, NHS Employers*

Award sponsored by

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Workforce Solutions

HIGHLY COMMENDED

Community Works for Health Andrew Attfield and Nazmin Begum Barts Health Trust

The initiative

Barts Health Trust serves East London communities, thriving, diverse communities but with some of the most challenging health needs anywhere in the developed world. In addition, although 35% of Tower Hamlets residents are of Bangladeshi origin, only 50 registered nurses (out of a staff group of over 3,000) identified Bengali as their ethnicity.

The trust set up the Community Works for Health team to address this significant under-representation of local people among its staff through:

- Creating new pathways using apprenticeship and access models;
- Working with community partners to provide training and placement models based on workforce needs;
- Using innovative ways of engaging local communities.

The aim was to educate the Tower Hamlets community about:

- The positive benefits work can have on people's health;
- Career opportunities in the trust;
- Secure employment and apprenticeships for locals.

Several campaign elements were implemented, including:

- A website and media campaign to recruit nurses from the local Muslim communities;
- A bilingual TV programme was commissioned. Featuring male and female Bangladeshi nurses, an Imam, and experts from the trust and QMUL, School of Medicine and Dentistry. A phone in encouraged people to express their interest. Over 200 callers responded;
- The launch of Eastlondonworks.com, a website that promotes health careers in east London.

We also set up practical training courses for a local talent pool of eligible candidates, and workshops providing free employment advice in Bethnal Green and Mile End. A course — giving recruits advice on training and placements — was delivered in partnership with the Bromley by Bow Centre. There were extended apprenticeships for staff including placements in operating theatres, renal outpatients and pathology.

In addition there were two week courses run by clinicians, which provided job-ready clients for nursing assistant and administrative roles. Four courses trained over 40 local people, 30 of who were placed in work.

Benefits

Community Works for Health has a wide scope and some of its approaches will not bear fruition for some time — for example working with local schools to improve awareness of health careers. However, the project has already yielded significant results:

- 75 new apprenticeships created within the trust, in new areas including operating theatres and medical laboratories;
- Finding employment for 80 local people, including successful recruitment to hard to fill vacancies such as nursing assistants though NHS Ready courses;
- The accreditation and launch of the practical nursing access course;
- The launch of community recruitment campaigns including the use of Eastlondonworks.com to promote NHS vacancies, outreach campaigns in GP surgeries and the use of bilingual media.

Recruiting more than 50% of targeted job vacancies locally.

Financial implications

The programme was financed by a combination of NHS and external funding from the European Social Fund and Skills Funding Agency.

An evaluation of the return on investment was achieved through a series of Social Return on Investment (SROI) evaluations conducted by London Southbank University. These calculated the total saving to public services by reduced benefits costs and use of health and other public services by participants and divided it by the investment made.

The studies showed a return on investment of between 1:4 and 1:12 on the overall benefit, and 1:1 on the return on health investment. The work placement scheme created over £500,000 worth of savings in terms of reduced benefits, increased taxes, reduced health consultations and reduced medication against an investment of £40,000.

Another benefit of this programme is the amount of external funding drawn into the trust as a result of its investment, which in 2012/13 exceeded £100,000. It is also expected to further reduce transaction and recruitment costs over time.

Contact

For more information on this initiative please contact Communications@bartshealth.nhs.uk

FINALIST

Service user need centred service improvement

Sue Watson and Silvia Ferrer 5 Boroughs Partnership FT

The initiative

As part of wider organisation service redesign and cost improvement targets, Intermediate Care Services (IC) within 5 Boroughs Partnership FT in Knowsley undertook a six month project of service improvement and redesign.

The first stage of the initiative involved:

- A review of workforce skill mix to meet service user needs;
- A review of workforce skill mix in relation to commissioning requirements;
- A review of workforce skill mix to meet cost improvement targets.

The project used current IC staff knowledge of service user needs to inform and structure the service improvement.

A population-centric approach integrated with competency based workforce planning plus capacity and demand analysis enabled a cohesive approach to the redesign.

Staff engagement and ownership of the service improvement was established from the start with staff workshops, communication events and project work streams. The project aimed to be clear and transparent to all staff, regular emailed updates were sent out and all work streams provided access to project work electronically. Staff initially defined a hierarchy of service user needs in terms of:

- Highly complex;
- Complex;
- Non complex;
- Brief intervention.

An interprofessional work stream identified competences relevant to service user needs within IC and these were mapped against complexity. All IC staff self assessed against the competences identifying current knowledge and skills within the service — enabling identification of competence gaps and development needs. Competences were analysed in

relation to profession, band and service area.

Staff capture of time and motion information provided capacity and demand data in relation to service user need. Analysis highlighted trends in demands on service areas, professional groups and across bands.

Integration of hierarchy of service user needs, workforce competence and capacity and demand data have enabled workforce redesign in response to service user requirements and staff skill mix capability.

Benefits

Staff restructuring is a contentious process. However, consistent staff involvement has enabled staff to question and inform proposed changes throughout the process.

Financial implications

A band 7 project lead was appointed on secondment for six months from existing staff. Backfill to cover their clinical work was provided from within current staffing levels. Therefore no additional costs were incurred.

The IC service was required to achieve a cost improvement target of £64,000. This has been fully met through the service improvement process while working to ensure no loss of quality to service users. In addition a further £39,000 saving has been achieved making a total of £103,000.

Service improvement methodology has allowed cost improvement targets to be met through workforce skill mix changes in response to service user needs. These savings have been achieved within the six month time frame of the first stage of the service improvement.

Contact

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FINALIST

Working with and through our people

Sara Pearson and Patrick Appleyard

Hull and East Yorkshire Hospitals Trust

The initiative

The purpose of the initiative was to provide a comprehensive and holistic approach to developing and harnessing the capacity and capability of our workforce for all staff groups. It seeks to respond to a number of national and local issues, including:

- The *Health and Social Care Act 2012*;
- The need for cash releasing efficiency savings of £66m over the next three years;
- The need to improve quality of care and provision;
- An aging workforce and the imminent loss of organisational knowledge;
- The complexity of the NHS knowledge and skills framework and the withdrawal of national funding for the eKSF electronic tool.

The initiative began with identifying aims and objectives which clearly identified what we wanted to achieve. A gap analysis identified good practice and areas for improvement. This led to the development of a workforce strategy (2011/2016) and leadership strategy (2011/2013).

We developed a cohesive model that provides a solid structure to base the initiative on and incorporates five interlinking areas:

- 1 Right focus — clearly identifying and knowing the needs and requirements of our commissioners and customers;

- 2 Right people — identifying, planning and putting in place the people we need to deliver our services;
- 3 Right skills — ensuring we develop our people of today and tomorrow so we can deliver our services;
- 4 Right motivation — engaging and motivating our people to deliver quality and safe services;
- 5 Right way — providing our services effectively, efficiently and safely.

This led us to develop a new simplified PDR process that embeds leadership behaviours at all levels and supports talent management and succession planning.

We also implemented a leadership development framework and programme and the Skills for Health 6 step workforce planning model.

Benefits

Evidence shows that staff engagement is critical in driving up quality, while seeking to reduce costs. Our new PDR process sits at the heart of our initiative by providing a two way feed to all other strands within our holistic approach. This provides us with the following benefits:

- Staff clearly understanding their roles, responsibilities and contribution to the trust;
- There is an improved level of staff engagement.

This will result in us:

- Being more responsive to patient needs;
- Focusing on outcomes;
- Releasing time to care;
- Reducing costs through streamlined service provision.

Financial implications

The initiative required a fairly low level of financial resources in its early stages. The main expenditure is in relation to the development of the eSolution for the PDR process.

Our forecasts demonstrate that the financial costs of maintaining the existing eSolution and paper based option would be £25,000 per year. Over the three years ending 2015/2016, the costs would stand at £75,000. The development, introduction and use of a single new simplified eSolution will cost £40,000, thus providing a direct cost saving of £35,000. However, this does not take into consideration the savings that will be made through increased productivity and effective use of organisational intelligence.

Contact

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FINALIST

Advanced training practices project

Louise Berwick and Peter Lane

Primary Care Works

The initiative

Workforce issues arising from the convergence of a number of factors drove the initiative. These factors were:

- 90% of all patient contact is in primary care;
- In the NHS reforms GPs will be taking responsibility for 60% of healthcare budget;
- Demand for consultations will double in next 10 years;
- There are financial pressures to reduce A&E attendance and admission;
- 22% of GPs are over 55 and many nurses are approaching retirement.

The Advanced Training Practices pilot, which has six pilot sites across Yorkshire and Humber, is the first initiative of its type to tackle these workforce issues. It is doing this by:

- Developing high quality placements in general practice for pre registration student nurses;
- Ensuring students receive gold standard training in the business of general practice to encourage first destination employment in primary care;
- Providing a placement that has a strong inter professional education (IPE) approach.

Pilot sites were developed from training practices with a strong education and training ethos. They presented proposals for development of placements and then built infrastructure in order to take part. A hub and spoke model developed with all administration and support done by the hubs.

Marketing strategies were developed to encourage practices to enrol in the initiative. Strong links were developed with the HEIs and with their placement and PLF teams. PLFs audited placement sites for suitability and ensured they were appropriate.

Benefits

The initiative has raised the profile of primary care nursing as a viable rewarding first destination career to undergraduate nurses. Practices are empowered to look at service delivery and begin planning how they will meet predicted increase in activity by training the future workforce.

Student evaluations are extremely positive and this has influenced peers to apply for placements in general practice. Sheffield Hallam University has reported an increase of 30% for students requesting these placements. On registration, student nurses from the pilot are beginning to be employed as practice nurses across the pilot sites.

Practice nurses are working together to develop their mentorship competencies and expertise. Their evaluations state they are learning from and with the students and this is good for their professional development and job satisfaction.

The sites have developed strong links with the HEIs and as a result are impacting on the curriculum content for the taught nursing degree courses thus raising the profile of practice nursing further. Sites have also developed many other initiatives including; management training, HCA training and apprenticeship support.

Financial implications

The funding was provided by the SHA, NHS Yorkshire and Humber. Initial funding and costs of the pilot were used to develop a model of infrastructure and interprofessional education that could be replicated across the region and potentially nationally.

The development funding was £1.1m over three years and resulted in 1,300 students taking part in IPE in general practice. This year the project has moved from development to long term sustainability. The focus is now to increase the numbers of student placements.

The activity is funded by a tariff per student nurse week of £120, which will gradually align with the national tariff once agreed. We intend to increase this activity further by recruiting additional practices across the region. The scheme is beginning to see an economy of scale that will deliver real value for money and cost savings. Return on investment will be measured by monitoring students' career intentions pre and post placement and tracking first employment destination.

Contact

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FINALIST

Primary care workforce supply mapping in the Southwest Peninsula: preventing a crisis

Ben Titford and Julia Oxenbury

The South West Peninsula Deanery

The initiative

The main aim of the initiative was to provide an evidence base for regional primary care workforce planning decisions. Of particular importance was providing a reasoned argument for annual GP trainee intake numbers needed to maintain a healthy and sustainable primary care service.

Nationally the numbers of trainee doctors in all specialties including general practice have been determined by many factors, of which predicted future need has historically often been the weakest, if included at all. The needs of secondary care in terms of service provision by trainee doctors has been the dominant factor. This results in a demand for specialty trainee doctors in excess of the need for the consultants that this training produces. This pressure is absent from primary care as GP registrars are supernumerary. Therefore the numbers of GP trainees have typically been determined by a combination of historical precedent and what can be afforded by the SHA.

As a result consultant numbers have been increasing while GP numbers have been relatively static. There is increasing evidence that this is unsustainable for both primary and secondary care, and concern that primary care is facing a workforce crisis with a steadily increasing workload and a potential supply/demand mismatch.

The core of this initiative was an online survey sent to all the practice managers in our region. This included questions on the age demographic, working patterns and likely retirement plans of their GPs.

One of the main problems with research in this area in the past has been the very low response rate (typically around 30%), with consequently poor predictive power for the GP population as a whole. This is because previous surveys have typically been sent to individual GPs.

We surmised that most practice managers have a very shrewd idea of the likely retirement plans of their GPs, to a level of accuracy far better than any other source short of the GPs themselves. We also felt that they would recognize the importance and relevance of our project and thereby provide a much higher response rate.

This proved correct and was unprecedented, with an overall response rate of 78%. This covered data for 86% of practice based GPs, reflecting a slightly better response rate from larger practices. Data from the NHS information centre and local PCT performers lists were used to provide whole population estimates.

Benefits

Primary care lies at the heart of the efficiency of the NHS, handling 90% of patient contacts. Even a small shift to secondary care would swamp the service. In addition, any shift of care from primary to secondary care carries a disproportionate escalation in cost.

The project has allowed us to map future GP retirements in our region over the next 10 years. Interestingly this data does not show a significant sustained retirement bulge over and above yearly variation.

However it does predict a strong need to increase GP trainee intake from the current 86 per year to 100–110 per year from 2013 in order to prevent a workforce crisis in primary care. This will be essential to ensure that the primary care system is able to maintain its current level of service into the future.

Financial implications

The online survey was part of an annual package costing less than £200. The majority of the work was done as part of an GPST4 year project. This involved background research, survey design, analysis and data processing.

Savings are difficult to quantify. To meet the Nicholson challenge there needs to be significant shift in delivery of care from secondary to primary care. This can only occur if primary care is appropriately trained and staffed. This work reduces the risk of a crisis of undersupply or the expense of overtraining.

Contact

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FINALIST

Advanced care planning and medication reviews in care homes using a speciality trainee workforce

Paula Marrett and Julia Oxenbury
The South West Peninsula Deanery

The initiative

Care home patients make up a large proportion of primary care workload. Audits carried out elsewhere in the Deanery revealed a need for advanced care plans for people with advanced dementia. Other work showed that this group of people, who often cannot advocate for themselves are prescribed a lot of medication some of which may be unnecessary.

Pathways exist to remedy both of these issues but the logistics of instituting leadership in primary care for them is a barrier. The deanery is using GP trainees — dementia champions — who have completed their training, to lead these initiatives locally. The deanery provides training to the dementia champions, they then disseminate the training to the local GPs and care homes and lead to change local procedure.

The work is based firmly around national guidance and the intention is that all care homes will adopt the initiatives as standard practice in time. But this takes resources that GPs don't have. Our strategy is to empower care home staff to continue to implement these initiatives by providing them with local support and training. The GPs are involved and thereby engaged with the change, which will benefit their patients and their practice.

A dementia champion in Cornwall instituted advanced care plans (ACP) in care homes and showed that this reduced unnecessary admissions. A package was also developed medication reviews (STAR initiative).

The deanery recruited GP trainees who were coming to the end of their training scheme and extended the training for a year. These second generation dementia champions were trained in medication reviews and advanced care planning. They then took this knowledge back to a designated area and supported local staff to institute reviews there. The hope is that the medication review and the ACP's will be adopted as standard practice.

Benefits

The benefits of the initiative are:

- Improved end of life care;
- Reduced numbers of deaths in acute hospitals;
- Reduced hospital admissions;
- Improved communication between all agencies.

The initiative also promoted anticipatory care planning and ensured family involvement.

Financial implications

The cost of an GP ST4 salary and training grant was required, however, this is funded through the South West Peninsula Deanery for all ST4s, therefore was not an extra cost as budgets have already been coordinated to account for this outlay. The salary is in line with the GPST NHS pay scale at £7,674 for the training grant per year.

Initial findings show that there has been a 50% reduction in unplanned hospital admissions; these are at a cost of £2,000 per admission. The data we have collected so far is based on ten care homes in Cornwall. It is estimated that in these ten care homes there has been £105,000 saved in avoiding inappropriate admissions. This could result in over £1m saved if projected into Devon and Cornwall.

Contact

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FINALIST

Career not a job — development pathways for band 1–4 staff

Anita Esser and Clare Aspden
University Hospital Southampton FT

The initiative

This aim of the initiative was to:

- Develop a flexible career pathway for band 1–4 support staff, resulting in competent individuals to meet the workforce plans and service development needs;
- Use apprenticeships or QCF and foundation degrees in the pathway where they existed;
- Work efficiently to fund and deliver the programmes;
- Work in partnership with local organisations to support skills development and recruitment for the long term unemployed in the local labour market.

This links to the national initiative to increase the number of apprentices in entry level posts and supports the trust's long term workforce plan.

The trust's NVQ centre converted existing NVQ awards into apprenticeship programmes, enabling access to more funding through partnership working with Southampton City College. We also introduced an on line QCF portfolio assessment tool; making the assessment process more efficient.

In partnership with Southampton Solent University, we developed a foundation degree (Fd) in Health and Social Care. The programme was validated as individual units and a full Fd. This allows flexibility to use the Fd to meet workforce needs and enables career progression AP roles. The core and option structure of the Fd has enabled AP roles to be developed to support nursing and healthcare scientists.

The trust led an apprenticeship project across Southampton to recruit unemployed people into work through Southampton (Solent) Skills Development Zone project.

The trust now regularly recruits into some band 2 vacancies as 12 month apprenticeship contracts using AFC Annex U, thus reducing salary costs in that year. Most apprentices have been retained in substantive posts.

Benefits

We created a new recruitment process with Job Centre Plus (JCP), with JCP undertaking initial vetting of recruits, two week pre employment training with assessment centre prior to interviews.

Using Annex U of AfC for SSDZ apprentices (75% of top of band 2 instead of bottom of band 2) on 12 month fixed term contracts making a saving on the post. Most of 12 month apprentices were retained, reducing recruitment costs.

Working in partnership with local college has given access to Skills Funding Agency apprenticeships funding sub contractor arrangements. The local colleges also work in partnership with the trust to deliver non clinical apprenticeships such as business administration.

Currently there are 117 staff undertaking apprenticeships with 66 apprentices trained in the last three years. Before the change to apprenticeships, staff undertook NVQs with an average of 80 staff in training per year.

Enabling staff to undertake the foundation degree or the Open University pre-registration nursing programme has meant that we have retained support staff. The initiative grows our own workforce at band 3 and band 4 and supports progression routes. It has also created a career pathway with stepping on and off points.

Financial implications

Funding for the apprenticeships was from MPET funding from South Central SHA, and working in partnership with Southampton City College as a sub contractor for health apprenticeships delivered through the trust's NVQ centre.

Funding for the Fd has been in part by the SHA and by HEFCE for this first cohort. Some of the Fd funding will be given to UHS to deliver some of the Fd units.

Further partnership working with FE and HE institutes will enable the trust to access funding streams outside of the NHS to deliver more training programmes for workforce development.

Contact

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FINALIST

Process Plus+ enhancing systems of care

Andy Williamson and Jot Hyare

University Hospitals of Leicester Trust

The initiative

Over 80% of clinical decisions involve some form of pathology investigation. How pathology requests are managed directly affects the timeliness of treatment.

Pathology is a vital aspect of modern healthcare services and the Carter report highlighted large variations in costs and turnaround times between organisations. It found there could be savings in excess of £250m on the current £2bn spent on pathology services across the UK if best practice was applied.

The aim of the initiative was to review the current processes and working practices to identify areas for improvement through simulation software. The scope of the work focused specifically on:

- Looking at the laboratory process in isolation;
- Redesigning and optimising the current process to deliver agreed quality measures;
- Producing scenario models to show the impact of taking on additional activity;
- Identifying and confirming resources, utilisation and align with safety legislation;
- Clarifying roles of current staffing levels;
- Producing the evidence to support a business case;

- Exploring impact assessment in terms of reducing the number of sites the service is delivered from (centralisation).

This work started as a single discreet project within cytology. The results and outcomes realised were so significant that it was decided to look at a larger project to see if the scale of efficiency would translate.

This project proposed a core hub lab that would process all routine high volume pathology and bring together specialist testing and technologies whilst providing a sub hub with associated hot labs on each hospital site.

Both projects adopted the same approach:

- Identifying staff representatives from each part of the pathway to form a project team and collectively set out the terms of reference;
- Undertaking a shadowing exercise as part of the project scope to examine the current functions of the pathway;
- Auditing areas that were perceived as causing delays;
- Collecting timings for each part of the process, identifying which staff members undertook each task;
- Presenting baseline data to department staff to verify;
- Developing the "ideal process" with stakeholders;
- Simulating various scenarios such as changing staff working patterns, allocating staff resources to meet demand levels, maximising equipment usage and activity allocation to meet proposed model;
- Presenting findings to project and management teams.

Benefits

Cytology

Through running various scenarios, it was identified that by changing staff working patterns and processes, overtime could be eliminated, currently in excess of £30,000 pa, and the need to outsource could be significantly reduced, currently 14% of activity at £35,000 pa. This is in conjunction with a reduction in turnaround times from 36.6% in three days and 87% in five days to 75% in three days and 95% in five days.

Blood transfusion

At the project outset it was envisaged that an additional 5.5 wte staff would be required at a cost of £204,600. Additionally staff breaks being paid at a cost of £30,000 (0.8 wte) and elimination of overtime

Through the ability to model different scenarios we identified the department could deliver a 24/7 service with its existing establishment. Providing competency training to BMA staff would extend their roles reducing the need for BMS with significant savings.

The use of simulation removes the costs of piloting changes that can be demonstrated to be ineffective and reduces associated wasted time and resource.

Financial implications

The software cost £46,000 pa (based on AFC B8 plus software costs). Project teams met within contracted hours so no additional costs were incurred.

Benefits:

Cytology — £85,000;

Blood transfusion — £234,600;

Costs:

£46,000 pa (based on AFC B8 plus software costs).

The return on investment within a six month period was £273,600.

Contact

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