SYSTEM OR COMMISSIONER LED SERVICE REDESIGN INITIATIVE

WINNERS

WEST HAMPSHIRE CCG, WESSEX AHSN, SOMERSET CCG, KERNOW CCG

RESTORE2 - RIGHT CARE, RIGHT PLACE, RIGHT TIME FOR CARE HOME RESIDENTS

RESTORE2 is a project to support staff in care and nursing homes to proactively recognise and manage physical deterioration in order to improve resident experience and outcomes, reduce 999 calls and prevent admissions to hospital. RESTORE2 stands for Recognise Early Soft-Signs, Take Observations, Respond and Escalate and uses National Early Warning Scores as a common language across the healthcare system (figure1/2). The project was started by West Hampshire CCG in partnership with 66 care/nursing homes, local GPs, the ambulance service, secondary care clinicians and the Wessex AHSN. It has now been adopted by 16 CCGs nationally including Somerset and Cornwall.

JUDGES COMMENTS

The judges felt this project was a clear winner that addressed so many different needs with a straightforward tool which works for all involved. The programme had excellent results in the localities using it. There was a clear common goal that everyone could sign up to, a focus on outcomes and great potential for spread.

HIGHLY COMMENDED

Health Innovation Manchester, North Manchester General Hospital, HMP Styal and Spectrum Healthcare

Greater Manchester Hepatitis C Elimination: Prison-Based Rapid Test and Treat

System-led redesign of a Hepatitis C (HCV) prison pathway: reducing time from entry into prison to testing from >2 weeks to 1 week and time to treatment from 4 weeks to 72 hours. Developed by a collaboration between Health Innovation Manchester, HMP Styal/Spectrum Healthcare, specialist clinical input (North Manchester General Hospital) and industry partner Cepheid.

JUDGES COMMENTS

The judges felt that this project demonstrates what is possible when sectors come together to address key public health issues such as Hep C. This ambitious programme helps tackle a vulnerable, neglected patient cohort with an innovative approach, achieving excellent and impressive results and improving lives. There was clear evidence of an effective partnership across multiple organisations, which has led to transformation of the patient pathway and an immediate impact on treatment initiation and compliance.

SYSTEM OR COMMISSIONER LED SERVICE REDESIGN INITIATIVE

FINALISTS

Bristol, North Somerset and South Gloucestershire CCG
System Redesign of DVT Services

The redesign of the Deep Vein Thrombosis (DVT) pathway re-engineered five existing pathways with varied costs and structures into one single community-based pathway delivered by a specialist provider. The pathway now provides a consistent offer with equitable access to the people of Bristol, North Somerset and South Gloucestershire (BNSSG).

This process involved three Acute Trusts, 82 GP practices, an independent provider and patients.

BNSSG CCG serves a population of over one million people, combining urban Bristol with the rural settings of North Somerset and South Gloucestershire. 17.5% of our community live in some of England's most deprived areas.

Health Education England
General Practice Nurse Specialty Training

Addressing workforce shortfalls is a key priority for England's Chief Nursing Officer. General Practice Nurse Specialty Training (GPN-ST) successfully creates a pipeline of new GPNs across STPs and resolves inter-practice poaching and recycling from the diminishing pool of experienced GPNs. GPN-ST offers nurses a way into an exciting and dynamic first destination GPN career, providing invaluable 'on the job' exposure, postgraduate education and supervision whilst also financially supporting practices to train. Showcased nationally as a model of good practice and a forerunner of the Long Term Plan's 'GPN Fellowships', GPN-ST is delivering a viable solution to the GPN workforce crisis.

NW London Collaboration of CCGs
Integrated mental health pathway in NW London Diabetes Transformation Programme

WHAT:
System wide Quality Improvement approach for integrating mental health into diabetes care planning, commissioning, service delivery, education and evaluation.

WHO IS INVOLVED:
All diabetes and mental health stakeholders in NW London- 8 CCGs and commissioners, 5 acute trusts, 4 community trusts, 400 GP practices, patient groups and diabetes and mental health third sector organisations.

WHO WE SERVE:
1)NW London residents who are living with diabetes including people with severe mental illness.
2)NW London Staff and volunteers supporting people with diabetes.

Salford CCG, Salford Care Organisation, Salford Council, AQuA and GMMH
Salford Care Homes Improvement Journey

Salford partners (CCG, Local Authority, Salford Royal Foundation Trust (SRFT), Mental Health Trust, AQuA) established a targeted approach with home managers to improve the quality of life for care home residents. Achievements over 2 years include improvements in:

- CQC ratings
- Safety indicators
- Resident experience feedback
- Staff confidence and engagement
- Home managers perception of being partners in the wider system
- Reduction in A&E attendances and non-elective admissions

There are 44 nursing and residential homes within Salford (1500 beds). Salford is 22nd most deprived of 326 local authority areas with a population of 280k and 38k people over the age of 65.

Small Steps Big Changes
Small Steps Big Changes - Family Mentor Service

Small Steps Big Changes is a £45m transformation programme, supported by The National Lottery Community Fund's 10 year 'A better start' funding programme to improve the lives of young children.

Accountable to Nottingham CityCare Partnership, a third sector provider of community services in the city, SSBC is a partnership of parents and professionals. The SSBC programme covers 4 key wards across the city (Aspley, Bulwell, Hyson Green and Arboretum, and St Ann's) and is now in its 5th year of operation. The Small Steps at Home programme is delivered by our Family Mentor Service as part of the SSBC offer.

SYSTEM OR COMMISSIONER LED SERVICE REDESIGN INITIATIVE

FINALISTS

Tameside and Glossop Integrated Care FT and Tameside Metropolitan Borough Council
Living Well at Home Redesign through collaborative care planning

The Living Well at Home Trailblazer project rapidly designed and tested new ways of working to deliver positive changes of increased choice and control for people and families receiving health and social care and support in their own home.

The issues tackled was based on feedback from people and families experience of what they wanted to see improved around their lives. A total of 391 people across 2 neighbourhoods, 3 Homecare agencies, 2 integrated health and social care teams were involved in this redesign of care and support. The project was also supported by GM Health and Social Care partnership.

Tameside and Glossop Integrated Care FT, Tameside and Glossop CCG, Tameside and Glossop Action Together, The Bureau and Cressbrook
Tackling Social Demand in General Practice through a collaborative asset based approach

GPs consistently reinforce the idea that a significant percentage of their workload is driven by social need. This is backed up by policy and evidence repeatedly highlighting the fact that as little as 10% of the things that keep us healthy are directly related to the provision of traditional health and care services. Yet, for the very most part, General Practice continues to provide relatively linear, bio-medical solutions.

This programme set out to understand the nature of demand in general practice and put in place approaches/services that respond to this demand, including social prescribing, collaborative practice and building community assets.

The West Midlands Regional CCGs in partnership with West Midlands Ambulance Service
England's First 111/999 Fully Integrated Urgent & Emergency Care Service

In 2019 West Midlands commissioners realised a vision to create across 6 STP's covering a population of over 5 million the first fully integrated urgent and emergency care service (IUEC) in England, responding consistently to callers from 999 and 111 and incorporating the previously separate elements of 999 emergency ambulance, NHS 111 and Primary Care Out of Hours services. The service and overarching Alliance Agreement are a demonstrable first in forging together the resources and expertise of three crucially important services. Work is underpinned with true partnership working between Commissioners and Providers, driving innovation and seeking best experience and outcomes for patients.

Thurrock Integrated Care Partnership: NELFT, Thurrock Borough Council, Thurrock CCG, Mid and South Essex University Hospitals Group and Essex Partnership University FT
Better Care Together Thurrock

Better Care Together Thurrock is a transformation programme with a shared vision and track record of successful implementation. The programme is "whole system" covering primary care, community healthcare, social care and the community and the individual in promoting well-being. The programme is holistic, strengths based and person centric, building upon an analysis within the Case for Change written in 2017 by The Director of Public Health. Consistency in system leadership and collaboration sit at the heart of the programme; as shown by our strong partnership with the Voluntary and Community Sector and commitment to co-design and delivery with our communities.