Delivering better services, driving better outcomes

PROJECT SHOWCASE 2020

CONTENTS

03 Cancer Care Initiative of the Year

06 Cardiovascular Care Initiative of the Year

08 Clinical Support Services Award

10 Diabetes Care Initiative of the Year

13 MSK Care Initiative of the Year

15 Pharmacy and Medicines Optimisation Award

18 Respiratory Care Initiative of the Year

20 Facilities Management or Estates Initiative of the Year

22 Finance Team of the Year

24 IT & Digital Innovation Award

27 Operations and Performance Initiative of the Year

30 People & Organisational Development Initiative of the Year

33 Acute Service Redesign Initiative

36 Mental Health Service Redesign Initiative

39 Primary Care or Community Service Redesign Initiative

42 Specialist Service Redesign Initiative

45 System or Commissioner Led Service Redesign Initiative

48 HSJ Value Award of the Year

CANCER CARE INITIATIVE OF THE YEAR

WINNERS

WESSEX CANCER ALLIANCE AND UNIVERSITY HOSPITAL SOUTHAMPTON FT

WESFIT: PROMOTING SPREAD AND ADOPTION OF PERSONALISED PREHABILITATION CARE PLANS FOR PEOPLE WITH CANCER

WesFit is a completely innovative approach to delivering Personalised Prehabilitation Care Plans (PPCP) to people recently diagnosed with cancer. The impact of the service is best described by a patient himself; “I was at a very low point, having been ill for 18-months. I was offered the WesFit trial, where I received counselling and fitness sessions. My physical abilities and emotional outlook were transformed prior to surgery, meaning I was discharged day 4 and made a full recovery. I continue to be far more aware of my fitness, WesFit changed my life.” (Keith Cockerton).

JUDGES COMMENTS

The judges felt that this was an innovative and excellent programme with clear patient benefit and evidence of widespread dissemination both nationally and globally. There was a clear focus on improving outcomes, and excellent research outputs further enhanced the project. The judges were particularly impressed with the inclusion of nutrition into the programme, and the adaptation to a virtual programme during the pandemic.

CANCER CARE INITIATIVE OF THE YEAR

HIGHLY COMMENDED

East Lancashire CCG and Blackburn with Darwen CCG
Pennine Lancashire Primary Care Cancer Team

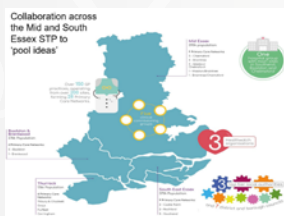
This cancer initiative is a long term sustainable primary care local incentive scheme for cancer. It has improved investment and education in primary care to transform services and improve patient care. It incorporates multiple projects over several years and is still ongoing. The incentives are outcome based and have or can be adopted by other organisations.

The Pennine Lancashire Cancer Team serves 540,000 patients. It includes EL & BwD CCGs and covers the same geographical footprint as East Lancashire Teaching Hospital Trust. The team comprises of Dr Neil Smith, clinical lead, Carol Hedley, commissioning manager and Angela Dunne, project manager.

JUDGES COMMENTS

The judges felt that this was high quality project which demonstrated great evidence of how a primary care group can work with their colleagues to improve the patient pathway for cancer, particularly in the area of screening and early two week wait referrals. The initiative has clearly improved allocation of the limited resource available to primary care colleagues, with patient centred outcomes and good evidence of financial value.

FINALISTS



Mid and South Essex CCGs
Making colorectal cancer diagnosis FIT for the future

The Faecal Immunochemical Test (FIT) is a system-wide programme launched in mid and south Essex on 14 February 2019.

FIT is designed to improve patient experience, simplify diagnostic testing and capture early diagnosis of colorectal cancer. The test detects human blood in stools when it cannot be seen by the naked eye and is easy for patients to undertake. The FIT centre guarantees a 72-hour turnaround for negative results and direct same-day reporting back to GPs when positive.

The program supports national ambitions to improve cancer diagnosis, increase survival rates and enable patients to "livewell" with and beyond cancer.

North Central London CCGs
Quantitative Implementing Faecal Immunochemical Test (FIT)

Faecal Immunochemical Test (FIT) is a non-invasive, inexpensive and highly sensitive test detects hidden blood in a stool sample that could be suggestive of colorectal cancer (CRC). Led by a team of clinicians and commissioners the test was rolled out on 1st April in 220 practices of North Central London CCGs. The test is expected to deliver the following key benefits:

- Early (stages 1 and 2) detection and diagnoses of colorectal cancer after clinical presentation
- Better patient experience of care compared to colonoscopies
- More efficient use of limited endoscopy capacity across NCL which will deliver financial savings

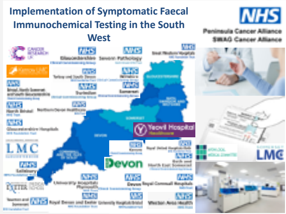
FINALISTS

Northern Devon Healthcare Trust
Acute Oncology Service

The establishment of the Nurse Led Acute Oncology Service (AOS) at Northern Devon Healthcare Trust in 2015 ensured the availability of dedicated staff to care for the acutely unwell cancer patients in North Devon.

The AOS scope of practice covers patients who present with complications from their systemic anti-cancer treatments (SACT), complications from their disease or a new presentation of a cancer as an inpatient.

The service started with two part time specialist nurses but has been such a success it now has an Acute Oncology Nurse Consultant, five specialist nurses, a trainee assistant practitioner and full time administrative support.



South West Cancer Alliances
Implementation of Symptomatic Faecal Immunochemical Testing in the South West

In December 2017, the South West Cancer Alliances embarked on an ambitious project together, to provide access to FIT for over 600 General Practices, serving a population of approximately 4.5 million across Cornwall, Devon, Somerset, Wiltshire, Avon, and Gloucestershire.

The programme was led by the SW Cancer Alliances (Peninsula and SWAG) working in partnership with 7 CCGs, 14 Trusts, GP Cancer Leads, CR-UK, Exeter Pathology Service, Severn Pathology Service and the DISCOVERY Team at the University of Exeter.

Tameside and Glossop Integrated Care FT, Pennine Care FT and Macmillan Cancer Support
Creating a psychological therapy service for people living with cancer

“This project is about improving access to psychological support and talking therapies for people affected by cancer; promoting self-management and coping skills, reducing depression, anxiety and pain.

Working with existing community mental health services, this service offers psychological support for people, and their family members, affected by cancer through a specialist pathway. ‘The emotional support service for people affected by cancer’.

Tameside and Glossop ICFT serves a population of approximately 250,000 people living in the surrounding area. From this population, there are approximately 1645 new cancer diagnosis per year, with 8792 people living with, and beyond, cancer.

The Royal Hallamshire Hospital, Sheffield Teaching Hospitals FT
DIEP Flap multidisciplinary surgery team, empowering women with breast cancer

Breast cancer is a devastating diagnosis, where many women are required to have a mastectomy, with approximately 23,000 mastectomies undertaken each year on the NHS. Yet only 21% of women go on to have a breast reconstruction, with concerns that this number is too small and future funding for breast reconstruction for many women is being threatened across England. Yet we are two professional women who have survived breast cancer and have been empowered by having the DIEP breast reconstruction procedure, which has resulted in a shorter hospital stay, good clinical outcomes and we are feeling like ourselves again!

University Hospitals of Leicester Trust
FIT for symptomatic

This project was set up between primary and secondary care in the Leicester, Leicestershire, and Rutland (LLR) region which serves a population of one million and involved the primary care cancer lead, trust cancer lead, radiology and colorectal surgical lead.

In February 2018 the two week wait pathway was modified so that patients aged 60 and above with a change in bowel habit had a FIT test to stratify whether a straight to test (STT) investigation with a CT Colon was indicated.

CARDIOVASCULAR CARE INITIATIVE OF THE YEAR

WINNERS

WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP AND YORKSHIRE AND HUMBER AHSN

WEST YORKSHIRE AND HARROGATE HEALTHY HEARTS PROJECT

The West Yorkshire & Harrogate Health and Care Partnership has commissioned Yorkshire & Humber AHSN to deliver a Healthy Hearts project on behalf of the nine local NHS Clinical Commissioning Groups.

This is a large scale quality improvement project, across a population of 2.6 million people. The aim is to reduce the number of people affected by CVD by 10%, consisting of an estimated reduction of 800 heart attacks and 350 strokes over the course of the project by addressing the risk factors of hypertension, cholesterol and diabetes.

JUDGES COMMENTS

The judges found this to be an inspiring programme to prevent heart attacks and strokes at scale, with a systematic approach to optimising detection and management of high blood pressure and high cholesterol. The team showcased impressive results in improving care in large numbers of patients and demonstrated an improved use of primary care services alongside a wider range of allied healthcare professionals. This ultimately helped achieve significantly improved health outcomes alongside cost benefits. Overall, the programme brings a lot of added value across a system that will have undoubted patient benefit.

CARDIOVASCULAR CARE INITIATIVE OF THE YEAR

HIGHLY COMMENDED

The Leeds Teaching Hospitals Trust
Combined Heart Failure And Device services

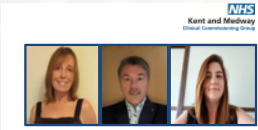
The Combined Heart Failure And Device (CHAD) clinic integrates numerous heart failure services in a single appointment to optimise cardiac device and medical therapy. Our novel clinic, led by heart failure nursing and healthcare science specialists adopts a preventative culture towards patient care to improve patient survival and quality of life, and reduce their risk of hospitalisation.

Each patient is assessed holistically by experienced professionals working collaboratively utilising device technology to detect early deterioration and initiate evidence-based therapy promptly. We offer tailored care promoting self-management while reducing the appointment burden of people living with heart failure and a cardiac device.

JUDGES COMMENTS

The judges felt that this entry demonstrated a clear commitment to improving service design to positively impact the outcomes for service users with heart failure. It is a truly innovative service designed around the needs of the patient rather than the needs of the service. The project also shows good dissemination of learning nationally through the wider networks and the opportunity to engage proactively in preventative care.

FINALISTS



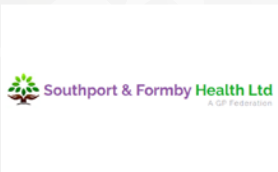
Medway CCG
Clinical Variation - Tackling Cardiovascular Disease in Primary Care

- Detect undiagnosed high risk patients
- Ensure patients receive all of their annual checks
- Work with partner organisations
- Increase the number of patients being offered healthy lifestyle options
- Reduce Clinical Variation for patients living with CVD conditions
- Detect patients in need of a medication review
- Introduce new detection methods in Clinical systems
- Engage with Community and National Healthy living providers
- Reduction in the number of Cardiovascular patients presented and admitted through A&E
- Reduction in Clinical Variation for patients living with long term conditions
- Increase in the number of annual checks
- Increase in the number of medication reviews

Tameside and Glossop CCG, Health Innovation Manchester and Interface Clinical Services
Stroke/Atrial Fibrillation Project

Tameside and Glossop Clinical Commissioning Group (CCG) identified a 'case for change' involving the management of Atrial Fibrillation (AF) in primary care and mobilised a collaborative project to prevent stroke incidence within the AF population.

The service was designed to improve all aspects of patient care from the correct identification and diagnosis of AF, to ensuring patients with AF are optimally anticoagulated. This was achieved through clinical system interrogation, virtual patient notes review and patient-facing clinics. This programme of work supported a 22% reduction in stroke admissions within the CCG in the period before the project commenced and post completion.



Southport & Formby Health
Southport & Formby Community Cardiology Service

Southport and Formby Health (GP Federation) flagship service is a Community Cardiology Service which commenced on 1st April 2017 as a pilot scheme operating out of a local GP practice. The service is available to 120,000 patients in Southport and Formby. The service has been hugely successful and nearly three years on the Clinical Commissioning Group (CCG) are looking to formally commission the service as the blueprint for all community cardiology services.

The service is clinically led by Dr Clare Hammond who is a consultant cardiologist and Dr Stuart Bennett who is a GP with a specialist interest in cardiology.

University Hospitals Plymouth Trust
Piloting specialist heart failure nurse intervention in acute admissions and emergency care

As a small nurse led heart failure team currently set up to review inpatients, we felt more could be done in an emergency care setting to provide specialist nurse input for patients with heart failure/atrial fibrillation and other cardiac condition with an aim for same day emergency care.
We identified that some heart failure patients do not need to have an acute admission but are admitted for symptom control, diagnostic tests and on-going treatment.

We embedded a heart failure specialist nurse service working through the emergency department and the Acute Assessment units to provide early intervention, management enabling patients to return home, achieving same day emergency care.

CLINICAL SUPPORT SERVICES AWARD

WINNERS

OXFORD UNIVERSITY HOSPITALS FT

TEA TROLLEY TEACHING

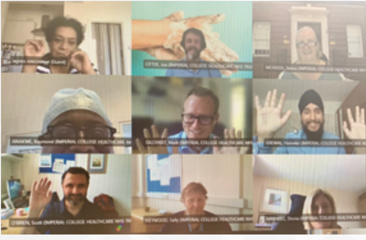
Tea trolley teaching is a novel training method, where a trolley loaded with tea, cakes and educational materials is taken to the place of work, providing short, 10-minute educational sessions at the times and in locations that suit learners. A small group of nursing and medical staff have established a regular program of tea trolley teaching sessions within our Intensive Care Units (ICU), improving the education and wellbeing of our staff, at negligible cost. This allows staff members from multiple disciplines to receive education on topics pertinent to the unit, whilst minimising the impact on patient care.

JUDGES COMMENTS

The judges felt that this was a very interesting presentation providing a fresh, flexible and innovative way of taking teaching to the shop floor. This initiative can be replicated across all areas of practice and it is fantastic to see it being targeted at challenging areas. The project is particularly relevant in a COVID world, and provides a great link to overall staff well-being.

CLINICAL SUPPORT SERVICES AWARD

HIGHLY COMMENDED



Imperial College Healthcare Trust
Hand Hygiene Improvement Programme

The Hand Hygiene Improvement Programme is a collaborative, stakeholder-led quality improvement initiative across five hospitals that brings together all staff on the wards, patients, QI leads and infection control experts to raise our hand hygiene awareness and practice, to significantly improve our hand hygiene compliance scores, and to share and spread learning and successes across all of our wards to support safe and effective care for the million patients we serve across north west London and beyond.

JUDGES COMMENTS

The judges felt this was a very interesting presentation providing a fresh approach to a routine infection control aspect of care. The honest approach to the lack of engagement leading to review the need for the project was refreshing. The information was inspiring, and the strap lines and catch phrases should be rolled out nationally as such a different approach to the topic will be well received!

FINALISTS

Barking, Havering and Redbridge University Trust
Acute Frailty Therapy Team

Acute Frailty Therapy Team is comprised of occupational therapists, physiotherapists and therapy assistants working predominantly with frail older people across a busy NHS trust. The team covers an elders receiving unit, medical receiving unit and elderly short stay ward. From January 2019 we have been started to develop the service into the Emergency department at Queen's Hospital.

NHS England and NHS Improvement and Health Protection Scotland
National Infection Prevention and Control Policy

To establish the infection prevention and control and care standards developed in NHS Scotland as the national standards in England.

The principal author of the National Infection Prevention and Control Manual (NIPCM) Scotland, has been working with NHS England and Improvement as a Clinical Fellow over the last two years, initially developing a national hand hygiene policy for NHS England, launched 13th March 2019; and continuing to collaborate with IPC colleagues across England to agree the content of Chapters 1 - Standard Infection Control Precautions (SICPs) and 2 - Transmission Based Precautions (TBPs) of the NIPCM for adoption and implementation across England.

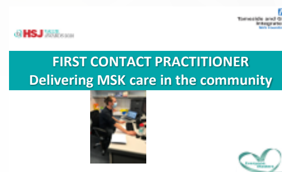
NHS London Procurement Partnership and North West London STP
A shared Radiology Technology Platform

The NWL STP approached NHS LPP for support to procure an enabling technology for a shared imaging service, integrating systems and enabling instant access across 6 acute trusts.

The impetus came from the STP Radiology clinical network seeking to treat more patients, more effectively. Despite being supported by CEOs and operational leads they had not identified a solution.

NHS LPP successfully constructed a bespoke framework with individual call off arrangements - each trust within the collaborative can join when current contracts expire.

The procurement translates into £6.3m savings over 10 years and is a firm blueprint, replicable within other STPs/regions.



Tameside and Glossop Integrated Care FT
First Contact Practitioner

In 2018 the Trust have worked collaboratively with the nine GP Surgeries in the Stalybridge Neighbourhood to introduce a First Contact Practitioner (FCP i.e. physiotherapy first) model. The model allows patients contacting their GP practice complaints of muscular or bony aches and pains to be appointed to see an experienced physiotherapist at a local practice, as opposed to a GP as their first appointment.

The service is under implementation across the remaining 4 neighbourhoods alongside the new Primary Care Networks to further support Tameside and Glossop residents.

Tameside and Glossop Integrated Care FT and Tameside and Glossop CCG and Tameside Metropolitan Borough Council
Establishment of a local gram negative blood stream infection group to improve knowledge of blood stream infection (GNBSi) and basic measures to reduce in risk in the community setting in care homes and the wider community

The infection Prevention team at Tameside and Glossop Integrated Care NHS Trust are a combined team of hospital and community specialist. The team are based at the acute Trust headquarters and support both primary and secondary care, including care homes and GPs. Together with NHS Tameside and Glossop Clinical Commissioning Group and Tameside Metropolitan Borough Council the Infection Prevention Team established a GNBSi group to improve collaborative working and reduce risk from GNBSi improving both care staff and the general public knowledge.

DIABETES CARE INITIATIVE OF THE YEAR

WINNERS

GUY'S AND ST THOMAS' FT
YOUTH EMPOWERMENT SKILLS PROGRAMME (YES)

The Youth Empowerment Skills (YES) programme is a novel psycho-educational intervention for young people(age 14-20 years) with type 1 diabetes, co-developed by young people and co delivered by a multidisciplinary team of healthcare professionals, youth workers and peer educators.

YES programme consists of following elements and methods of learning.
- group-based learning;
- immersive simulations, such as treating an episode of severe hypoglycemia, with a structured debriefing;
- learning together in adventurous/challenging and social activities to build self-confidence;
- role-play, to develop confidence in health consultations and reduce conflict in interactions with parents and friends
- peer-to-peer delivery.
- What'sApp youth-worker moderated peer support network

JUDGES COMMENTS

The judges felt that this was an extremely important project and much needed for young people in the community. This project demonstrated excellent outreach to a mix of young people and young adults attending the course. Learning about diabetes mixed in with the everyday events that they do on the course allowed these young people to put the learning into practice.

HIGHLY COMMENDED

East Midlands Network, De-Montfort University and University Hospitals of Leicester Trust
Diabetes Education Application (deapp)

Deapp is a structured education program for children and young people with type 1 diabetes at diagnosis, delivering flipped learning along with bedside training, physical resources and games. Deapp has 12 sessions consisting of 37 bite sized videos. Developed to embed knowledge and empower patients in self-management of their diabetes.

We had involvement from a sub group of health care professionals (HCPS), the Design Team at De Montfort University, patients and parents who with their input helped create deapp and its contents. It has now started to be used for re-education, training schools, nurseries, school clubs and HCP training.

JUDGES COMMENTS

The judges felt that this was an excellent project and particularly liked the collaboration with patients and the fact that the children and parents have the resource at their fingertips at all times. This is a great way to standardise and optimise education in a fun way. Having the resources translated into Polish as they know that the prevalence is high in the community is a real step to improving inclusion.

DIABETES CARE INITIATIVE OF THE YEAR

FINALISTS

Barking and Dagenham, Havering and Redbridge CCGs
Diabetes Quality Improvement at Scale

Barking & Dagenham, Havering and Redbridge CCGs (BHR CCGs) tend a population of 770,000 with a type 2 diabetes population of 52,325 patients.

A diabetes quality improvement (QI) programme was implemented in 34 practices in 2016, and following its success we up scaled it to all 119 BHR practices (2017-2019). It involved primary, secondary and community care.

The objectives critical for the health economy were to arrest the escalating prevalence of diabetes, to increase the care quality through delivery of NICE care processes and treatment controls, and also to reduce the gap between actual and expected prevalence.

Bedfordshire CCG, Bedford Hospital Trust, Luton and Dunstable University Hospital FT and East London FT
Improving Outcomes for people with Diabetes Accross Bedfordshire

The Bedfordshire CCG Operating Plan 2017-20 highlighted Diabetes as one of the five Clinical Priorities to improve outcome of 6% people in Bedfordshire who have Diabetes.

Bedfordshire CCG has a diverse population and there was huge variation in care and poor outcomes for people with Diabetes. A multi-disciplinary improvement group decided to put a comprehensive improvement program to improve - access to Structured Education, Treatment Targets (Blood Pressure, Cholesterol and Blood Glucose) in primary care by achieving the eight Diabetes care processes, offering multi-disciplinary footcare and mental health support. Post-natal pathways for gestational diabetes via NHSDPP.

Brigstock & South Norwood Partnership
Embedding diabetes group consultations

The Brigstock and South Norwood Medical Partnership serves a diverse Black and Minority Ethnic (BME) and Eastern European community of 11,000 people in an area of acute deprivation in Croydon. The practice's prescribing pharmacist and nurse prescriber have introduced group consultations as their first contact point for General Medical Services (GMS) Quality and Outcomes Framework (QOF) diabetes reviews. They have reviewed and followed up 60% of the practices' 1,054 patients with Type Two Diabetes in group clinics, and measured quality and efficiency gains for patients and the practice.

Calderdale and Huddersfield FT
Developing the Diabetes In-patient Nursing Team to provide safe and effective care

Diabetes inpatient specialist nurses (DISN) are the lynchpin for delivering safe and patient- centred service. At a time when there was national shortage of DSN's, Calderdale and Huddersfield Foundation Trust (CHFT) also experienced significant issues in staff retention and recruitment. There was only 1 WTE DISN covering 650 bed cross sites. Diabetes UK recommends that each trust should have at least 1 DISN per 300 beds.

CHFT diabetes services has a reputation of innovation and delivering the best care and responded to the above challenge by applying for a slice of the transformation fund to expand the DISN service.

Kettering General Hospital FT
Outpatient IV antibiotics in the diabetic foot: delivery model and outcomes of an antimicrobial pharmacist and podiatry led service

Worldwide every 30 seconds a leg is amputated and 85% of these amputations are the result of a diabetic foot ulcer (DFU)." We developed a weekly outpatient DFU clinic co-led by antimicrobial pharmacist and diabetes specialist podiatrist overseen by diabetes consultant for infected DFU. Intravenous (IV) and high-risk oral antibiotics are initiated, reviewed, amended and stopped, including 24-hour infusion devices to enable care at home. Data (Dec17-Oct19): 131 patients, 46 on infusion devices. 2114 bed days or 4467 home nurse visits saved using devices. The service cost effectively improves patient care closer to home, avoids admissions (89/131) and enables earlier discharge.

FINALISTS

Sussex Community FT, Here (Care Unbound)
Diabetes Care For You

Diabetes Care For You is a multi-professional Consultant Led Community Specialist Diabetes service serving people in Brighton and Hove and High Weald, Lewes & Havens clinical commissioning group areas. Following stakeholder consultation and competitive tender the service commenced in July 2016 to support to adults with Type 1 diabetes and a cohort of people with Type 2 Diabetes. We provide clinics at multiple locations, Structured group education, Carb awareness, group insulin management, Psychological interventions, Foot protection, Healthcare professional education, webinars and Virtual clinics.

We have regular meetings with Commissioners and wider stakeholders and contribute to local and national audits.

Tameside and Glossop Integrated Care FT, Pole Bank Care Home, Balmoral Care Home and Charnley House Care Homed
A review of administration of insulin in the community setting – pilot scheme to for care home staff to deliver insulin injections, supported by District Nursing

In May 2019, the district nursing service raised concerns at a staff engagement session related to the number of occasions insulin was administered following food or missed completely. The team proposed they wanted to work differently to support the insulin dependent patients in the community. A plan was developed to test applying the NHS new models of care in the residential care homes in one locality, to train senior care staff to be competent in administering insulin to the insulin dependent diabetic patients in their care. This was piloted in three cares homes between July and August 2019.

Walsall Healthcare Trust
Diabetes Transformation Project

Half the population of Walsall are in the lowest economic position of deprivation with poor educational attainment. Nationally it also has the 3rd highest proportion of people living with diabetes. The project was to reduce diabetic lower limb amputation rates and inpatient stays over a 3 year period achieving over a 50 % reduction. The project involved developing seamless responsive care across multiple disciplines as a part of the organisations ambition to be an outstanding trust.

MSK CARE INITIATIVE OF THE YEAR

WINNERS

HEALTH INNOVATION NETWORK
ENABLING SELF-MANAGEMENT AND COPING OF ARTHRITIC PAIN THROUGH EXERCISE, ESCAPE-PAIN

10 million people in the UK suffer pain and/or disability from knee and/or hip osteoarthritis. Enabling Self-management & Coping with Arthritis Pain using Exercise, ESCAPE-pain, is a rehabilitation programme that combines education, self-management strategies and exercise. The programme:

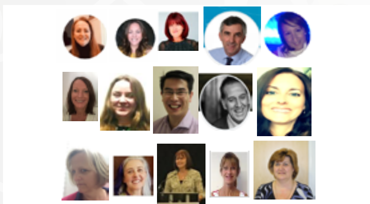
- reduces pain
- improves physical function, activity and mental wellbeing,
- reduces healthcare utilisation
- is more cost-effective than usual care.

We have delivered training and support to enable NHS and leisure providers to transform care. Starting from just 2 sites in 2014, ESCAPE-pain is now delivered by physiotherapists and exercise professionals at nearly 300 locations across the UK; 20,000 people have benefited from the programme.

JUDGES COMMENTS

The judges felt this this was an excellent initiative which enables self-management for people with hip and knee pain. Clear rationale was given for the initiative with supporting evidence and references, which has led to improvement in patient care. The team demonstrated great overall cost saving benefits to the system in terms of total and social health, and the overall ambition to improve general health, fitness and wellbeing was commendable.

HIGHLY COMMENDED



West Kent Alliance and Partners: Maidstone and Tunbridge Wells Trust, West Kent CCG, Kent Community Health FT, West Kent Health, High Weald Lewes Havens CCG, Sussex/East Surrey CCG, Kent and Medway NHS and Social Care Partnership Trust
West Kent Alliance MSK Pathway Transformation

West Kent Alliance (WKA) - brings together the dynamic, innovative, collective of organisations, to transform system wide services for the West Kent population, supported by, the dedicated and specialised Joint Programme Management Office/Transformation Team (JMPO). Maidstone & Tunbridge Wells NHS Trust (MTW), West Kent CCG (WKCCG) and Kent Community Health Foundation NHS Trust (KCHFT) came together to deliver efficient, sustainable improvements in care and experience for both patients and staff, sharing best practice and lessons learnt in the MSK pathway re-design.

JUDGES COMMENTS

The judges were extremely impressed with the 25 stakeholders involved in this project, which demonstrated a great collaboration between primary and secondary care. Integration of pathways has led to a smoother patient journey and improved patient outcomes and experience. The initiative had a clear aim and was extremely cost effective, reducing unnecessary appointments by ensuring patients are seen by the right person at the right time.

FINALISTS

Northern Devon Healthcare Trust
Enhanced recovery programme for elective joint replacement

In 2018 the NDDH Arthroplasty Enhanced Recovery programme was re-invigorated with an evidence-based change to the patient journey. With a focus on achieving better protocols, enhancing team-work and accuracy in data collection, we have shown considerable improvement in length of stay for patients and advancement in positive outcomes. In conjunction with saving £170,000 per annum on orthopaedic implants and improving education for both staff and patients, the model hospital data shows the trust having improved from 41st best trust, to 8th best in hip replacements and from 34th to 4th best trust in the country for knee replacements.

Sussex MSK Partnership Central, Here (Care Unbound), Sussex Community FT, Sussex Partnership FT and Horder Healthcare
Cultivating a Culture of Evidence Based Value Medicine

The aim of the project is to ensure patients' have access to evidence based value medicine. Meaning that i) patients see the right clinician first time; ii) that the clinician provides them with up to date treatment options based on national evidence and guidelines and iii) that they work together to select the treatment option that best fits the patients values and preferences. Stakeholder involvement included patients with lived experience, clinicians, commissioners and subcontractors. The contract serves a population of 650K across the central Sussex corridor.

PHARMACY AND MEDICINES OPTIMISATION AWARD

WINNERS

THE GREAT NORTH CHILDREN'S HOSPITAL, THE NEWCASTLE UPON TYNE HOSPITALS FT

THE KIDZMED PROJECT - TEACHING CHILDREN TO SWALLOW TABLET MEDICATION

This was a quality improvement project to teach children and young people how to take tablet medication.

Tablets are safer, more convenient and cheaper than liquid medications. Children and young people (CYP) often remain on liquids due to habit, reluctance to change or staff and parents' lack of knowledge about switching to tablets.

In a short timeframe we embedded a system of training and system change to convert children to tablet medication so improving families' experiences of obtaining medication and realising considerable cost savings. We encourage all units to set up pill swallowing training for their patients.

JUDGES COMMENTS

The judges unanimously agreed that this was a brilliant and impressive project which has something so simple but so life changing at its centre. There was fantastic demonstration of the impact and benefits to children, with easy to replicate cycles of improvement adding value at each stage. This project addresses an issue for children that will provide significant benefit for them and their parents and carers and will make a huge difference to children's experience of healthcare. The multidisciplinary approach taken to trying to manage this is great to see and clearly correct given the impact achieved. This could be spread across the whole country.

HIGHLY COMMENDED

Mid Essex CCG

Technology-enabled rapid access clinic for infants with Cow's Milk Protein Allergy

Mid Essex CCG, which serves a population of about 394,000 in its footprint, recently commissioned a service for infants with suspected Cow's Milk Protein Allergy (CMPA).

We developed this unique approach with a provider that uses technology to provide rapid access to a specialist dietician through virtual appointments. The resulting service has increased benefit to infant patients and reduced waiting times and prescription costs, offering better value to the whole system.

JUDGES COMMENTS

The judges felt that this was a very valuable project addressing a complex area where diagnosis and treatment is often delayed for children. This has addressed a clear need and has enabled patients to be seen quickly and diagnoses made rapidly, clearly benefitting patients, their families, and the children. The scope, delivery and outcomes achieved are great involving simple yet effective technology and access to skilled healthcare professionals.

PHARMACY AND MEDICINES OPTIMISATION AWARD

FINALISTS

Brighton and Hove CCG
A dietitian lead medicines management team model of practice to address inappropriate oral nutritional supplement prescribing in primary care

The project addressed the inappropriate prescribing of adult oral nutritional supplements (ONS) in primary care. The medicines management team (MMT) covers two clinical commissioning groups (CCGs), supporting 52 GP practices with a population of approximately 470,000. The MMT dietitian established the QIPP project to assist GPs in managing malnutrition effectively and to reduce the burden on the wider health economy from inappropriate prescribing. MMT pharmacy technicians were trained to assess the clinical appropriateness of ONS prescriptions using the Malnutrition Universal Screening Tool (MUST). Prescriptions without clinical necessity were stopped. Clinically necessary prescriptions were switched to more cost and clinically effective first line formulary products.

Bristol, North Somerset and South Gloucestershire CCG
The implementation and evaluation of a GP practice led centralised repeat prescription management hub in North Somerset

The NHS Five Year Forward View aims to enhance multi-disciplinary working in GP practices, working at scale to better support GPs in delivering high quality care for their population. To support this, a Repeat Prescription Management Hub was developed by the CCG Medicines Optimisation team in conjunction with 4 GP practices in North Somerset serving around 32,000 patients.

A prescription management hub allows repeat prescription requests to be processed by one dedicated team. A 16-month pilot was undertaken with objectives of reducing demands on GP workload, reducing growth and issuing unnecessary prescription items and ensuring good medicines optimisation and safety.

Central London Community Healthcare Trust
Evaluation of clinical pharmacists in a community integrated multi-disciplinary care model

The Complex Care pharmacy service in Wandsworth has been commissioned to support patients on the Complex Care caseload via optimisation of medicines. Two clinical pharmacists work within the multi-disciplinary team (MDT), which was created to reduce hospital admissions for adults with multiple co-morbidities and social needs. Our strength is integration, offering joined up care in the community as emphasised by the NHS Long Term Plan (1). The core MDT consists of GPs, community matrons and pharmacists, who carry out domiciliary visits across four localities. The team works closely with local hospitals, social services, community health services and the voluntary sector.

East of England NHS Collaborative Procurement Hub
Parenteral Nutrition Framework

The East of England NHS Collaborative Procurement Hub (the Hub) and East of England Neonatal ODN Dietitian Lynne Radbone (Cambridge University Hospitals FT) developed a Parenteral Nutrition (PN) framework, giving trusts consistent, cost-effective access to PN products. This includes updated East of England Standardised Neonatal Formulations and, for the first time, standardised paediatric formulations.

This framework supports trusts in moving towards standardised formulations, easing capacity pressures, increasing staff productivity, improving patient safety and allowing local units to accurately initiate PN – releasing beds and allowing care closer to home. It also seeks to support wider NHS objectives, such as Carter recommendations to reduce unwarranted variation.

East Sussex Healthcare Trust
Pharmacist Led Fast Track Biosimilar Switching

An expert prescribing Pharmacist led a fast track approach to switching of the biologic medicine adalimumab originator product to the biosimilar product within the specialities of Dermatology, Rheumatology and Gastroenterology within East Sussex. Patients on adalimumab were identified, contacted, assessed, and categorised to either being suitable for switching by a pharmacist prescriber or referred to a Multi-Disciplinary Team (MDT) for discussion to assess switching suitability (See pathway in Appendix A). Stable patients were consented for switching and medicines supply was managed collaboratively between the pharmacy department and homecare provider to reduce waste and expedite switching.

PHARMACY AND MEDICINES OPTIMISATION AWARD

FINALISTS

Kettering General Hospital FT
Delivery Cycle Optimisation to Reduce Medicines Wastage in Homecare Services

This is an integrated, collaborative MDT within Rheumatology with very close working relationships between Pharmacy and our Commissioners. This collaboration has been successful, evidenced by Kettering General Hospital Trust demonstrating £360,000 cost efficiencies in terms of rapid biosimilar uptake which was income to the Trust, innovative medicines use within 30 days of NICE guidance, and savings realised to the NHS of £980,000 if Delivery Optimisation of Homecare was replicated. The team comprises 3 Rheumatology consultants - one clinical lead, 4 Specialist nurses, OT, Physiotherapist, Specialist Homecare, High Cost Drugs Pharmacist and a Homecare Technician. We serve a population of 365,000 patients.

King's College Hospital FT
Liver Transplant Pharmacy Service

In order to improve ease of access to medications information, medicines optimisation and to improve continuity of care for liver transplant recipients, a pharmacy service to the liver outpatient department was introduced. This service is provided by two specialist pharmacists and a specialist pharmacy technician. The specialist pharmacists are in the outpatient department during both of the post-transplant clinics that run each week and are available to both patients and the clinicians to answer medication related questions and resolve any medication-related issues.

Manchester University FT
Pharmacy led peri-operative medicines optimisation: The Enhanced Surgical Medicines Optimisation Service (ESMOS)

We report a pioneering and innovative service development initiative delivering safe, patient centred care to patients undergoing major surgery at the Manchester University Hospitals NHS Trust, one of the largest acute trusts in the UK serving a population of approximately 750,000 people.

The Enhanced surgical medicines optimisation service (ESMOS) is one of its kind in the country aimed at improving medication management before and after surgery. This service was launched on the back of a National Institute for Health and Care Excellence (NICE) fellowship project. This service model has led to enhanced patient care at local, regional and national levels.

Wirral University Teaching Hospital FT
A Medicines Management Technician supporting Medicines Administration

A Medicines Management Technician (MMT) to support nursing staff by administering oral and inhaled medicines to patients. The MMT is also able to perform a second check for intravenous medicines and provide patient counselling regarding their medicines.

This specialist role was implemented on a general medicine ward and the MMT and nurse administer medicines simultaneously on both the morning and lunchtime medicine rounds.

The aim of this MMT service is to provide a high quality medicines optimisation service to patients and to support nursing colleagues to ensure the right patient receives the right medicine at the right time.

RESPIRATORY CARE INITIATIVE OF THE YEAR

WINNERS

UNIVERSITY HOSPITALS OF DERBY AND BURTON FT

IMPACT+

The ImpACT+ service is delivered by a team of Respiratory Consultants, Specialist Respiratory Nurses, Physiotherapists and Occupational Therapists along with admin and clinical support staff. The service has transformed specialist community respiratory services for people with Chronic Respiratory Disease living in Southern Derbyshire and Erewash. The service re defines the patient pathway so that all patients are assessed using a Bio-Psychosocial model providing comprehensive holistic assessment and treatment plans. We are embedded in Primary Care and actively review all patients from the point of diagnosis through to the later stages of disease including advance planning.

JUDGES COMMENTS

The judges felt that the University Hospitals of Derby and Burton FT was an excellent service with a very enthusiastic and engaging team involved. The change brought together several services into one with a single point of referral, clearly keeping the patient is at the centre, and with a strong evidence base to the service change. The project had clear aims to reduce variation of treatment by clinicians, and for patients to see one member of staff rather than several. The lung line is a great example of the way patients are supported by a holistic model of care, which also includes areas outside the traditional medical model such as social prescribing.

HIGHLY COMMENDED

West Hertfordshire Hospitals Trust, Central London Community Healthcare Trust and Herts Valleys CCG

Respiratory point of care testing (R-POCT) to facilitate diagnosis and treatment in the community for COPD exacerbations

Herts Valleys CCG commissioned a pilot service utilising a rapid point-of-care testing panel for respiratory infection (RPOCT), to improve antibiotic prescribing and reduce hospital admissions for patients identified with an exacerbation of chronic obstructive pulmonary disease (COPD). The service was delivered by the Respiratory Team from West Hertfordshire Hospitals NHS Trust in conjunction with the Enhanced Community Respiratory Service provided by Central London Community Healthcare NHS Trust (CLCH). The pilot targeted 100 patients who had symptoms suggestive of a COPD exacerbation and who would have hitherto required an admission to hospital.

JUDGES COMMENTS

West Hertfordshire Hospitals Trust, Central London Community Healthcare Trust and Herts Valleys CCG displayed great outcomes for patients, improving quality of life and showing significant cost savings. This project promotes care at home rather than admission to hospital. The judges feel that this is transferrable to other communities and something that other services could learn from and replicate.

RESPIRATORY CARE INITIATIVE OF THE YEAR

FINALISTS

Kettering General Hospital FT
Day case thoracoscopy with pleurodesis

Design and Implementation of the 'Day-case thoracoscopy with pleurodesis' protocol.
All patients had their procedure on the allocated day-case slot. Admissions were reduced by >90% and patient experience has improved significantly, without any unplanned admissions. Effective partnership while working with community healthcare staff and patients, ensured success of this initiative. This is highly replicable elsewhere with minimum effort and little additional training required for the district nurses.

Following 2 audit cycles, this initiative has proven to be cost effective for the regional healthcare economy with excellent outcomes.

Mid Essex CCG
Giving mid Essex COPD patients GOLD-standard care

This 10-month pilot programme rolled out across a primary care locality the Global Initiative for Chronic Obstructive Lung Disease framework for determining the severity of COPD patients' condition.

The cross-organisation initiative involved: the CCG's Clinical Lead; our Chief Pharmacist; respiratory clinicians from the local acute trust; the COPD team lead from the CCG's main community provide; the GP locality lead; GPs and other members of local practice teams; the COPD GOLD pilot Primary Care Practitioner; our RightCare Delivery Partner; and operational respiratory service leads.

The initiative served the registered COPD population within the nominated locality to improve these patients' outcomes.

North Tees and Hartlepool FT
Transformation of OPAT services to improve capacity and patient experience

The aim of this project was to improve and expand the provision of OPAT services to respiratory patients within the Trust. It involved collaboration between the Antimicrobial Pharmacist and the Out of Hospital Care Team, who currently provide this service. By using novel elastomeric devices for antibiotic administration, our Out of Hospital Team could increase their capacity, save nursing time and money and also improve patient experience. Patients using the new service would only require once daily visits from the team rather than the previous 2-3 times per day visits, allowing them more freedom for their normal daily routine.

Respiratory Care Solutions
Standardising Care and reducing Variation

Respiratory Care Solutions is a social enterprise, set up by two practice nurses in 2015 who wanted to improve the respiratory care for patients in Leeds. As a social enterprise our profits are re-invested back into pay for nurses to attend conferences and leadership courses.

Leeds was one of the worst in the country for respiratory outcomes, so the idea initially was to try make improvements through education of healthcare professionals. This led to setting up the organisation and one of the nurses taking the risk of giving up her job hoping that the business could secure a contract.

Tameside and Glossop CCG and Health Innovation Manchester
COPD Therapy Review Service

The COPD Therapy Review Service was a non-promotional medical service provided by a team of clinical pharmacists employed by Interface Clinical Services on behalf of Tameside & Glossop CCG. The service was funded by GlaxoSmithKline. The service provided full clinical reviews of COPD patients to assist practices implement a systematic approach to the management of patients with COPD/to reduce symptoms and risk of exacerbations. The clinician responsible for the care of his/her patients retained full control over the entire process and treatment choices arising from the patient review process. Clinical responsibility for every patient remained the responsibility of the practice.

FACILITIES MANAGEMENT OR ESTATES INITIATIVE OF THE YEAR

WINNERS

UNIVERSITY COLLEGE LONDON HOSPITALS FT

THE NEW ROYAL NATIONAL ENT AND EASTMAN DENTAL HOSPITALS

The project was to:

- design and build a new facility for the services provided at the Royal National Throat Nose and Ear Hospital (RNTNEH) and the Eastman Dental Hospital (EDH),
- manage the move of those services into the new facility
- manage the decommissioning of the EDH and its handover to its new owner.

The team included project management, capital, estates, facilities and communications as well as contractors.

We worked with the clinical teams to ensure the new facility would achieve their clinical ambition and improve patient care. We also worked with the local authority, build contractors, local residents and patients.

JUDGES COMMENTS

The judges felt this was a strong entry with quality throughout. It is a great scheme which addressed many different complications and ultimately focused on patient needs. It is a fantastic example of clinical, staff and patient input into the design of an excellent facility, enabling a good reduction of space/footprint and costs.

HIGHLY COMMENDED

The Leeds Teaching Hospitals Trust

Leeds Teaching Hospitals Portering Safety Huddles; Reducing Waste, Improving Efficiency and Patient Care

Leeds Teaching Hospitals NHS Trust is one of the largest teaching hospitals in Europe, St James's University Hospital (SJUH), is one of the principle sites within the Trust, employing 18,000 staff, 125 of which are porters. Porters heard about an initiative called 'safety huddles' to highlight safety issues and the consequential improvement in moral and teamwork that had resulted from their implementation in clinical areas. They set about establishing a portering safety huddle to improve safety culture and teamwork to raise important issues to both their management team and wider clinical staff in order to improve patient care.

JUDGES COMMENTS

The judges thought this was a fantastic project displaying solid patient outcomes, true innovation, and great engagement. It was a strong example of a frontline initiative resulting in real difference to patients and the host trust, and showcased strong evidence of partnering across support staff and clinical staff and wider sharing across the health network.

FINALISTS

Central and North West London FT, Quality Trusted Solutions LLP
Design and Build of Crystal House - clearing the way for young people with learning difficulties.

In June 2019, Estates & Facilities experts Quality Trusted Solutions (QTS) completed the creation of 'Crystal House' - a five bed inpatient facility specifically designed for children with complex learning needs. The successful opening of the facility followed a nine-month design and development programme. As well as offering 24-hour inpatient care, the unit now offers its users facilities that include tailor-made classrooms and sensory environments. QTS worked with patients, families and CAMHS staff, as well as specialists within the field of learning disabilities to develop and deliver a facility which is recognised as the 'gold standard' for CAMHS inpatient units.

Derbyshire Community Health Services FT
Agile Working Initiative

Estates have moved from a workshop based model to an agile working model. This was achieved through excellent engagement with managers and trade staff. Estates provide a comprehensive maintenance service to Trust properties and primary care properties across Derbyshire covering an area of over 1000 square miles.

Lewisham and Greenwich Trust
A new way of procuring and delivering Soft FM Services

Lewisham and Greenwich Trust (LGT) provide a comprehensive range of high quality hospital services to more than 660,000 people living in the area. The Trust includes 2 acute hospitals at Lewisham and Woolwich. This project is retender of their Soft FM Services across the Trust. The tender included the following services:

- Cleaning
- Patient Catering
- Portering
- Linen and Laundry
- Waste
- Staff and Visitor Catering
- Helpdesk and Switchboard

Guys and St Thomas' (GSTT) Trust provide the procurement services for LGT and it was agreed that GSTT would provide the project management services for the Soft FM Tender.

Royal Cornwall Hospitals Trust
Mission Impossible: The 12 week mortuary makeover

The project was an urgent upgrade of mortuary facilities at Royal Cornwall Hospital, with no interruption of service.

The mortuary at West Cornwall Hospital was refurbished, recommissioned and the post mortem service transferred.

Additionally the bereavement rooms at both sites were refurbished. The whole project was given 12 week to be completed.

It involved numerous stakeholders: Estates, Mortuary team and Pathologists, HM Coroner, Council, Police, Forensics, Funeral Directors, other Hospital departments (Finance, Pathology, Quality, Infection Control, IT, Health and Safety) and various external contractors.

We are the only mortuary service for Cornwall and the Isles of Scilly.

FINANCE TEAM OF THE YEAR

WINNERS

SHERWOOD FOREST HOSPITALS FT
FINANCE DEPARTMENT

Over the past 18 months the Finance Team has focused on 'Working towards excellence'.
To do this we have embraced an initiative called Future-Focused Finance (FFF), which is about improving NHS finance for everyone; recognising the need for strong financial skills and understanding across all professional groups to deliver good patient care and value for tax payers.
We have successfully used this initiative to improve the quality of our finance team and financial management through a range of networks, frameworks and toolkits, as well as events, workshops and other learning and development opportunities with very positive outcomes.

JUDGES COMMENTS

The judges were particularly impressed with the honesty of the team in identifying their need for improvement. They clearly demonstrated their journey from their baseline through to the outstanding team that they demonstrate now, in which staff are clearly engaged and supported to develop personally and professionally. It was refreshing to see an acknowledgement of the wider physical and mental health support provided to the team. The willingness of the finance team to understand the clinical and operational aspects of the organisation together with the desire to share the finance role and contribution is an example of best practice that should be shared with other organisations.

FINANCE TEAM OF THE YEAR

HIGHLY COMMENDED

Maidstone and Tunbridge Wells Trust
Finance supporting Outstanding Care, Exceptional People

Maidstone & Tunbridge Wells NHS Trust (MTW) have embarked on an organisation-wide change, inspired by a commitment to "Outstanding Care, Exceptional People".
This commitment is reflected in, and supported by, the Finance Team, and it is a team in the widest sense, incorporating strong, traditional technical skills in areas like Financial Management, Contracting, and Financial Services, but broadened to incorporate Clinical Coding, PMO/Transformation, BI and IT.
The Team have supported the Trust from Financial Special Measures to recurrent surplus within 3 years, and have developed links with industry, research and national bodies.

JUDGES COMMENTS

The judges were impressed by how the trust has transformed the traditional role of finance to integrate and add value to the whole patient pathway through quality improvements and cost savings. Their involvement regionally and nationally was evident and their desire to influence was strong. At the same time, their focus on the small things that make a real difference to staff experience was commendable. They particularly liked the cross specialty working with ophthalmology and orthopaedics to look at the holistic care of the patient - this practice should be shared far and wide.

FINALISTS

Mid Essex CCG
Placing Finance at the heart of a commissioning organisation

Mid Essex CCG has a relatively low allocation per capita, receiving significantly less funding than neighbouring CCGs. Our actual settlement was below target funding for years and the CCG accrued a £24.9m deficit in its first two years' operation. The CCG Finance team played a pivotal role in turning the tide and promoting the ethos of Best Value from Public Money.

Over the past three years the CCG has repaid £17.1m of the accumulated deficit and if the 2019/20 Control Total is delivered will have reduced the accumulated deficit to £3.7m through close working with colleagues across the organisation.

Suffolk and North East Essex ICS
ICS Directors of Finance Team

Suffolk and North East Essex ICS (SNEE) is a high performing (independently verified) health system creating a genuine partnership of health, social services, community and charitable organisations serving a population of 1.02million. The ICS Directors of Finance Group comprises senior finance leaders that have facilitated rapid improvement in the quality of health provision whilst reducing the system financial deficit ahead of the trajectory set by Regulators.

Tameside and Glossop Integrated Care FT
Generating Efficiencies through Engagement

Following recognition that the trust has an extremely challenging financial control total to achieve, a number of dedicated initiatives were implemented to support delivering efficiencies and best practice through increased engagement. The initiatives were led by the Finance Improvement Team and Procurement and involve internal and external stakeholders ranging from financial, operational and clinical members of staff.

A multi-disciplinary approach supported to ensure that all stakeholders were actively engaged and to ensure collaboration and best practice was rolled out. The projects have resulted so far in over £800k of recurrent savings being identified and also a number of non-financial efficiencies.

IT & DIGITAL INNOVATION AWARD

WINNERS

FOCUS GAMES AND NHS PARTNERS
FLUBEE GAME

The Flu Bee Game is designed to improve vaccination rates by engaging, educating and encouraging staff to get vaccinated. The game presents flu facts, busts vaccine myths and tells players where and how they can get vaccinated in their organisation.

The game is an HTML5 web app with a supporting website. The game works on any device through a web browser and only takes a few minutes to play.

JUDGES COMMENTS

The judges felt that this was an almost perfect example of one member of staff taking their passion to solve a local issue and producing something which has the potential to have a global impact. So far they have spread across 40 trusts and 300 more care homes, using an interactive app as well social media to engage users across all settings. The outcomes from the Flu Bee digital app are truly impressive.

HIGHLY COMMENDED

Crawley CCG
Early identification of patients reaching end of life - a Digital decision tool

According to the World Health Organization (WHO) definition, palliative care should be initiated in an early phase and not be restricted to terminal care. In the literature, as yet no validated tools predicting the optimal timing for initiating palliative care have been determined.

The CCGs EOL team working in partnership with Docobo, Primary, Hospice & Community Care, have created a web based digital approach to enable early identification of patients in Primary Care who may be in the last 12 months of their life. The tool is web based, designed for intuitive navigation by end user, and regularly updated.

JUDGES COMMENTS

The judges found this to be an impressive collaboration between CCGs and an industry provider. Whilst the project had a clear patient-centric focus, it also produced better cost and service delivery outcomes. The project was truly clinically led and collaborative, ensuring close engagement with patients and carers.

IT & DIGITAL INNOVATION AWARD

FINALISTS

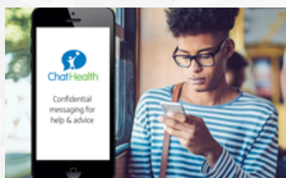
Cambridge University Hospitals FT
eHospital - joined-up healthcare for our patients

At Cambridge University Hospitals we recognise the importance of accurate and timely access to clinical information – for patients themselves, for our hospital clinicians, for a patient's primary care providers and for other hospitals involved in a patient's care – but the timely sharing of records has been challenging across the NHS. Working collaboratively with our patients, clinicians and healthcare partners, and utilising the unique skills of our in-house eHospital digital division to configure integrated capabilities of our electronic patient record, we are successfully overcoming this national challenge and sharing clinical records digitally, in real-time; benefitting our patients locally, nationally and internationally.

Derbyshire Community Health Services FT
Digitising end-to-end immunisation and vaccination systems to reduce clinical and administrative burden, improve service delivery and parents/schools experience

Derbyshire Community Health Services (DCHS) school immunisation team delivers protective vaccinations to pupils attending the 98 secondary schools and 464 primary schools in Derby and Derbyshire each academic year.

This project was designed to digitise immunisation process through which parents/carers give consent for children/young people to receive vaccinations by embracing technology. Traditionally this was a time-consuming paper based process which relied heavily on engagement with clinical staff, schools, children and their parents. The project sought to increase the effectiveness of service delivery, reduce time and resources wasted, reduce clinical risks and enhance information governance arrangements for all.



Leicestershire Partnership Trust
ChatHealth

The ChatHealth team is better safeguarding thousands more hard-to-reach vulnerable young service-users and families across the UK. We help NHS teams set-up confidential messaging helplines using our safe and secure text platform and our well-evidenced clinical models.

Travelling the country to engage other public-health nursing services, we've fast-tracked diffusion of proven innovation to more than 70 healthcare teams – achieving 100% ubiquitous spread in some regions.

Access to help/information is now easier for over 3-million people and outcomes are improving for over-stretched professional teams, now able to provide blanket first-line support for whole populations with just one of their duty nurses.

NHS London Procurement Partnership
NHS Temporary Staffing Bank and Agency Spend Dashboards

NHS London Procurement Partnership (LPP) manages £580m spend annually (£261m alone from London members) on the NHS National Clinical Staffing framework, comprising 365 agencies.

NHS LPP recognised the value of better visualisation of supplier spend management information and trust bank spend, in order that we and our member trusts can understand trends and behaviours in terms of:-

- Cost/ rate cap breaches;
- Use of bank versus agency;
- Risk/compliance;
- Overall market/ demand management.

On-line analytical dashboards, free to our members, enable instant visibility/analysis of all types of temporary clinical staffing activity, informing collaboration between key stakeholders both within trusts and across STPs/regions.

Royal Free London FT
Improving Joy at Work - Electronic Self Rostering

Turnover for nurses and midwives was high across the Trust but highest in the intensive care units. A quality improvement project was undertaken to understand the reasons why.

Clinical staff focus groups identified flexibility and choice regarding shifts would improve work-life balance, promote roster fairness and increase their joy at work.

The implementation of electronic self rostering was key to offering staff shift flexibility and choice. This new way of working improved communication, enhanced staff work life balance, released time to care and improved staff recruitment and retention supporting safer patient care.

IT & DIGITAL INNOVATION AWARD

FINALISTS

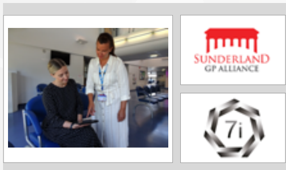
South, Central and West CSU
Development, delivery, and support of multiple major integrated care record and interoperability programmes

"I could not do without it"

Driving forward the effective use of digital technologies to revolutionise citizens and staff experiences, SCW CSU is working in collaboration with multiple stakeholder organisations to develop and deploy multiple shared care records.

Covering a population of 3 million+ these shared care records support the delivery of safer and faster care by providing the right information at the right time in the right place to the right person. These records enable better quality care provision, reduce service cost and support better decision-making and commissioning.

"It's fantastic ... allowing continuity of care, and minimising repeat investigations"



Sunderland GP Alliance and 7i Group
Voice of the Patient

The Voice of the Patient is a collaboration between the Sunderland GP Alliance and 7i Group Ltd, running since September-2018, to evaluate patient experience of the Extended Access Service (EAS) commissioned by Sunderland CCG. Sunderland has a population of 281,500 people. The patients visiting are predominantly working during core GP opening hours and would struggle to access an appointment. The patients evaluated EAS, providing an improved access to primary care, to demonstrate impact. The data are aligned to KPIs to maintain funding for the service, supporting improved access to GP, and provided invaluable behavioural insight encouraging improvement in urgent-care delivery.

Univeristy Hospitals Coventry and Warwickshire Trust
Digital Empowerment for Patients with Diabetic Foot Disease; A Topol Fellowship Project

Ten percent of people with diabetes will develop a foot ulcer and 50% with an ulcer die within 5-years. Diabetic foot disease costs the NHS >£1.13billion annually.

In the Coventry region >230 people were being admitted for foot disease annually, with 20 amputations and 27% readmission rates.

Foot care models nationally have been slow to innovate and leverage benefits of digital. University Hospitals Coventry & Warwickshire NHS Trust have collaboratively designed, implemented and disseminated the first patient-led cloud-based digital photography foot disease tool, which is free to use and empowers patients to act as the keystone in management of their disease.

University Hospital Southampton FT
digiRounds

digiRounds is an in-house designed app and technology innovated entirely within the NHS by UHS Digital who worked closely with a critical care consultant, the clinical lead, and the critical care team.
Care teams can see valuable patient information needed to carry out a ward round, in a concise format and is used on a mobile touchscreen device.

Designed for clinicians to access up to date patient information in a user-intuitive manner, which can also be accessed from home.

digiRounds is an example of integration which pulls data from all Trust systems, databases and is shown in a standardised view.

OPERATIONS AND PERFORMANCE INITIATIVE OF THE YEAR

WINNERS

KETTERING GENERAL HOSPITAL FT

CLINICAL CODING TRANSFORMATION PROGRAMME - GETTING IT RIGHT FOR OUT PATIENTS, OUR STAFF AND OUR TRUST

The Clinical Coding team are vitally important for Kettering as clinically coded data forms the bedrock of information we have on our patients. We are on a journey to take this department from 'lost and unloved' to our 'superheroes' of the organisation.

The Clinical Coding transformation programme put the clinical coding team at the heart of the changes. This programme is one of our proudest success stories because improving the accuracy of our clinical coding benefits our staff, our Trust and our patients. We have helped patients of tomorrow by supporting our staff to more accurately code patient information.

JUDGES COMMENTS

The judges were impressed by the sustainability of this project, which provides great support for staff wellbeing and increases the awareness of a little known but crucial service. There was good focus on quality improvement as a process and overall goal. Detailed information was included to show improvements in data quality as well as the staff engagement and the impact this can have on patient care.

OPERATIONS AND PERFORMANCE INITIATIVE OF THE YEAR

HIGHLY COMMENDED

Sheffield Children's FT
Modernising Outpatient Programme

The Modernising Outpatients programme has transformed Outpatients for staff and patients by focusing on increasing access to care through improving communication with families, modernising systems and helping patients to attend appointments.
We've worked with internal and external partners to improve processes and systems. The projects within the programme have included everything from large digital rollouts to small improvement teams working to transform patient care at a specialty level.
The programme has improved the Was Not Brought (WNB – known as Do Not Attend in Adult context) rate to the lowest on record and increased utilisation by around 32 patients per day.

JUDGES COMMENTS

This entry evidenced very impressive stakeholder engagement, effective communication through the "take my place" campaign, and close working which clearly resulted in the programme's success. The judges found it particularly interesting to learn about the reorganisation using the clinical microsystems methodology as a means of quality improvement. The work on reducing missed appointments was a strong service improvement initiative and really focused on the patient and family experience.

FINALISTS

Bolton FT
Bolton Combined Deflection Scheme

The Admission Avoidance Team (AAT) and Home First Team (HFT) work across the community and urgent care footprint of Bolton NHS Foundation Trust to deflect unnecessary admissions to hospital. Both teams are multidisciplinary and work together with stakeholders including Primary Care, North West Ambulance Service (NWAS), Commissioners, Local Authority and the Community and Voluntary Sector. The teams respond to patients over 18; in physical or social crisis in the community or have presented to the Emergency Department (ED) and can be safely managed at home with or without support. The teams main cohort of patients are aged over 65.

Doncaster and Bassetlaw Teaching Hospitals FT
Quality Improvement in Medical Education and Training (QiMET) - Hybrid International Emergency Medicine (HIEM) Training

Developed by QiMET International, delivered through Doncaster and Bassetlaw Teaching Hospital (DBTH) with candidates from Chitwan Medical College (CMC) in Nepal, HIEM is the first collaborative International Emergency Medicine training programme in the UK, providing a solution to the shortage of EM doctors.

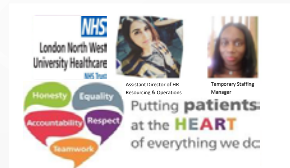
Using new and innovative models of globalised medical training, the concept of Brain Share, HIEM's holistic approach offers enhanced skills in leadership, management and quality improvement by providing a systematic approach to support international trained doctors to work in the UK and to bring benefit for both countries.

This presentation will explain more: https://youtu.be/N52BPFPoovI

Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG
The Frail and Vulnerable Patients Scheme Quality Review

The East Sussex Frail and Vulnerable Patient Scheme (FVPS) is a locally-commissioned GP service with a unique quality improvement aspect.

The FVPS provides clinical review and personalised care planning. To ensure that care plans are of high quality, all practices contribute to an annual peer review of plans produced under the scheme.
By harnessing clinician experience, the peer review helps to increase awareness and share best practice across general practice and the wider system; patients and carers benefit from reviewed and improved care plans, whilst the CCG can be confident of value for money in commissioned work.



London North West University Healthcare Trust
Direct Engagement Efficiency Project

A six month project to reduce the use of umbrella workers and increase the numbers of 'directly engaged' medical and AHP workers at the trust in order to reduce risk and realise potential savings. It was implemented in a joint capacity by HR staff at the trust and the Medacs Healthcare's onsite team (Managed Service Partners). LNWH serves a population of over one million people in Brent, Ealing, Harrow, and beyond and is a university trust, active in training and research.

FINALISTS

London North West University Healthcare Trust
High calibre staff improving patient outcomes

London Northwest University Healthcare NHS Trust (LNWH) has an enviable reputation as a world-class leader in research, working at the cutting edge of research and governance with a proven track record of working with industry and developing a highly skilled workforce. The Trust continues to ensure it attracts and retains high calibre research staff by promoting the sharing of good practice and embarked on a workforce quality accreditation process with the International Accrediting Organisation for Clinical Research (IAOCR). The process for securing this accreditation was led by the R&D department, but also involved clinical staff, patients and external collaborators.

Mid Essex CCG and All Saints' Church of England Primary School, Maldon
Maldon Up Project

Maldon Up emerged from a series of visits to a local care home by children at a primary school within Mid Essex CCG's footprint. Many of the residents at Longfield Care Home in Maldon have dementia, and All Saints' CofE Primary School pupils began visiting them for an afternoon a week. The CCG became aware through a staff member's connection to the school and recognised the possible benefits to those involved.

The CCG supported a crowdfunding exercise to keep the project running while Anglia Ruskin University conducted a proper evaluation that would facilitate a wider rollout of the scheme.

North Tees and Hartlepool FT
Best Value Biologic Pathway

North Tees and Hartlepool NHS Foundation Trust serve 400,000 people in the area we cover with a range of services including the provision of specialist rheumatology and gastroenterology care. The aim of our quality improvement and productivity project was to ensure that the most cost efficient brand of adalimumab was readily available to 200 patients, in a timely manner, with appropriate information and governance arrangements surrounding its distribution and supply. A multi-disciplinary team, involving internal/external stakeholders redesigned patient pathways to ensure that an efficient, safe, patient-focused process of switching to the best value biologic was possible.

Oxford University Hospitals FT
Tea Trolley Teaching: A novel teaching method in a challenging environment

Tea trolley teaching is a novel training method, where a trolley loaded with tea, cakes and educational materials is taken to the place of work, providing short, 10-minute educational sessions at the times and in locations that suit learners. A small group of nursing and medical staff have established a regular program of tea trolley teaching sessions within our Intensive Care Units (ICU), improving the education and wellbeing of our staff, at negligible cost. This allows staff members from multiple disciplines to receive education on topics pertinent to the unit, whilst minimising the impact on patient care.

Tameside and Glossop Integrated Care FT
New models of care using a data driven service transformational approach

In 2014 our local health and care system highlighted the need to deliver focused support to aid transformation and improvement of services delivering health provision.

The ambition was to deliver rapid improvement projects/longer-term transformational strategies that would result in well-led, high quality and safe services to our patients. The Trust established the Service Transformation Team; highly skilled improvement managers with specific knowledge of Trust services and delivery models. This team, working alongside Operational/Clinical Leaders and the Corporate Information Team, identified opportunities and through the usage of data and intelligence developed a tangible starting point (baseline), clear actions and measurable outcomes.

PEOPLE & ORGANISATIONAL DEVELOPMENT INITIATIVE OF THE YEAR

WINNERS

BLACK COUNTRY HEALTHCARE FT
CULTURAL AMBASSADOR PROGRAMME

The Cultural Ambassador programme was an opportunity to make a difference and challenge any unconscious bias and discrimination that may occur for those BAME employees entering or during formal HR processes.

The Cultural Ambassador's project in partnership with the Royal College of Nursing (RCN) provided the Trust the opportunity to demonstrate the Trusts commitment to BME staff. The partnership between the RCN, Trust HR, Staff Side and E&D were crucial in the successful delivery of this programme.

JUDGES COMMENTS

The judges felt that this project was one of the most important ways to make a difference to staff experience. It evidenced a just culture and a way of really seeing and acting on the voice of those from underrepresented groups, to change outcomes and make a real difference to people's lives. They were impressed by the truly data-driven ambition, the good signs shown so far in terms of outcomes and overall excellent value driven. A superb piece of work!

HIGHLY COMMENDED

Mersey Care FT
Respect and Civility at Mersey Care

Our project comes from the Trust's proactive, energised and committed Respect and Civility workstream, part of our Just and Learning Culture. Staff surveys show that inappropriate behaviours in the workplace are real concerns for staff and are recurring themes for those who support them through times of crisis: FTSU/staff side/HR/H&WB colleagues. We are cultivating psychological safety in our Trust using practical staff tools we have developed through lived experience. The workstream has wide representation, from healthcare assistants to consultants. Our message is clear: we do not tolerate poor behaviours and we want staff to speak up about them.

JUDGES COMMENTS

The judges found this to be an excellent initiative, addressing a range of issues using respect and civility. There was clear impact and commitment to all people from all backgrounds to deliver a just culture. It is an entirely replicable process and way of caring for staff and staff caring for one another.

PEOPLE & ORGANISATIONAL DEVELOPMENT INITIATIVE OF THE YEAR

FINALISTS

Dorset HealthCare University FT
Brilliant Bands 2-4

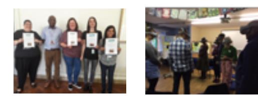
The creation of a web based one-stop-shop using a digital platform dedicated to our Bands 2-4 was designed to support them to either be the best they can be in their current role or to embark on a new career. It offers a bucket-load of techniques including top tips around creative conversations, understanding job descriptions and completing application forms. Colleagues share unique stories on screen about their endeavours to deliver high quality care through career development. We made it happen using skilled, enthusiastic colleagues whose commitment to bring this to life and reach county wide community services staff was incredible.

Hertfordshire Community Trust
Healthcare Assistants administering insulin project

Hertfordshire Community NHS Trust (HCT) has around 300 patients in a domiciliary setting who require insulin injections at specific times of the day, e.g. 8am, 12pm, 6pm. This procedure has traditionally been carried out by Registered Nurses (RNs). A project was established to provide training and competency assessment for Healthcare Assistants (HCAs) to release registered nurse capacity and to potentially improve efficiency and patient experience. Furthermore, providing HCAs with additional skills would support a nursing career pathway. HCAs would be allocated a caseload of appropriate patients requiring insulin injections against a defined criteria agreed by the Diabetes Specialist Nurse (DSN).

London North West University Healthcare Trust
Bronze Accreditation for Workforce Quality Assurance from IAOCR

London Northwest University Healthcare NHS Trust (LNWH) has an enviable reputation as a world-class leader in research, working at the cutting edge of research and governance with a proven track record of working with industry and developing a highly skilled workforce. The Trust continues to ensure it attracts and retains high calibre research staff by promoting the sharing of good practice and embarked on a workforce quality accreditation process with the International Accrediting Organisation for Clinical Research (IAOCR). The process for securing this accreditation was led by the R&D department, but also involved clinical staff, patients and external collaborators.



Manchester Local Care Organisation, Manchester City Council
Our Manchester Strengths-Based Development Programme

Founded in our aspiration of bringing to life 'Our Manchester' values and behaviours (our terminology for a person-centred, community approach) this is an innovative Manchester Health and Social Care system-wide development programme. Participants go on an immersive journey, starting with innovative use of virtual reality, giving them first hand experience of the benefits of this approach and creating emotional buy-in. They participate in several interactive, interpersonal activities, finally putting their learning into practice in their local community. Over 70% of participants report working differently two months later. It works because it was codesigned and is co-delivered by practitioners for practitioners.

North Middlesex University Hospital Trust
Staff-led improvements

We wanted to improve engagement in staff-led change at North Mid. We did this by implementing Listening into Action (LiA), a programme that empowered staff to make the changes they wanted to see to improve patient and staff experience and outcomes. We created a project team formed by a programme manager with a clinical background, a communication and engagement manager, an admin support officer and an executive sponsor. We involved a wide range of stakeholders across the hospital and monitored the results through the NHS Staff Survey and the LiA Pulse Check Survey.

FINALISTS

Northamptonshire CCGs
Primary Care Nurse Training Programme

The Primary Care Workforce Group consists of Northamptonshire CCG, The Local Medical Committee and GP Federations. Together we collaboratively wrote a strategy in 2018/19 to address the workforce crisis in general practice in Northamptonshire. This strategy focused on two main aims of 'Attract' & 'Retain'. The group service all 71 practices and 16 PCNs in the county, but also support workforce initiatives alongside our community provider Northamptonshire Healthcare NHS Foundation Trust. Through our initiatives, this gives us complete coverage of county. This submission focuses in on one of our projects improving the recruitment and retention of practice nurses in the county.

University Hospitals Coventry and Warwickshire Trust
Medical Retina Nurse Led Intra-vitreal Injection Service

Medical Retina Nurse-Led Intra-vitreal Injection Service provides the majority of the intravitreal injections at UHCW. These injections are sight saving procedures given to patients with Age related Macular degeneration, Diabetic Macular oedema and Retinal vein occlusion. Medical retina service is led by Mr NP Manjunatha, Consultant in-charge including education and training. Sister Jas Mann, Clinical Nurse Specialist also provides training and support. Julie, Mac and Hazel are Band 6 nurse injectors. They perform nearly 150 injections each week, which has helped to cope with the increased demand. Recent audit confirmed excellent service and patients' feedback.

University Hospitals of Derby and Burton FT
Working for Longer Project

The Working for Longer project demonstrates how we are innovating to support our workers. Trends show that the average age of NHS workers will increase to 47 years by 2023, with our profile showing that 28% of staff are 51+, and many factors, including the increase in state retirement age, means people are indicating their intention to work for longer.

We identified challenges and embraced opportunities around working for longer, having engaged with our staff through surveys, focus groups, 1-2-1 discussions, to find out what really matters, resulting in a multi-disciplinary action plan, and a bespoke conference for managers.

Wrightington, Wigan and Leigh FT and Edge Hill University
Postgraduate partnership programme changes lives around the world and boosts NHS staff numbers

A tried and trusted partnership between Wrightington, Wigan and Leigh NHS Foundation Trust, Health Education England and Edge Hill University has gained the support of 35 Trusts to create a successful postgraduate training package for British and overseas doctors and nurses through a earn, learn and return programme.

Around 350 students have, or are benefitting from the Royal College of Surgeons' accredited surgical master's programme, the largest of its kind in the UK.

All students advance their clinical skills in their chosen specialist area, working within the NHS for three years, obtaining a postgraduate qualification, which hand-in-hand improves patient care.

ACUTE SERVICE REDESIGN INITIATIVE

WINNERS

TAMESIDE AND GLOSSOP INTEGRATED CARE FT AND TAMESIDE METROPOLITAN BOROUGH COUNCIL

INTEGRATED URGENT CARE TEAM - HOME FIRST

The Integrated Urgent Care Team now work together with other transformation services to support older people living in the community in an integrated model of care to deliver 'integrated urgent care at home'. Enabling a rapid crisis response service (within 2 hours) aligned to the NHS Long Term Plan for referrals received from GPs, Ambulance Services (NWAS) and local care homes, by creating capacity and resilience within the system.

The collaborative approach to crisis response has ensured that the ICFT are delivering;

- crisis response within 2 hours of referral
- re-ablement to people within 2 days of referral

JUDGES COMMENTS

The judges felt that this winning team were ambitious, passionate, enthusiastic health and care professionals who continue to drive forward improvements. Tameside and Glossop Integrated Care FT and Tameside Metropolitan Borough Council actively look for opportunities to extend services to more and more patients and successfully balance performance against centrally set targets with compassionate, personalised care. The judges were extremely impressed with the savings and spread of the initiative which had patient safety at its core.

HIGHLY COMMENDED

Royal Manchester Children's Hospital, North West Paediatric Allergy and Infection Network and North West TB Control Board

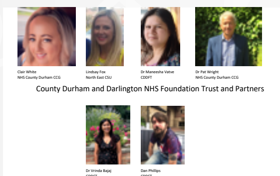
A new approach to an old disease; delivering specialist care to children with TB close to home

Driven by clinical concerns and feedback from the coroner a North West Regional Paediatric Tuberculosis Network was developed. Sustained collaboration between doctors and nurses from multiple healthcare Trusts and community teams, adult and paediatric TB experts, PHE, commissioners and charity partners, facilitated an innovative service redesign: A weekly virtual clinic and rolling regional audit, supported by targeted education and networking opportunities has ensured resources are used more effectively to improve quality of care for patients close to home. This model could easily be adapted for other services to provide high quality care without the need to travel to tertiary care centres.

JUDGES COMMENTS

The Royal Manchester Children's Hospital, North West Paediatric Allergy and Infection Network and North West TB Control Board had a highly commended innovative approach building on clinical skills, ambition and teamwork to deliver impressive outcomes in challenging contexts. The judges felt that the delivery model has significant potential for adaption to address a range of other relatively rare conditions safely and consistently. They agreed that this was an innovative model for paediatric TB especially for travelling families, and highlights the importance of safeguarding

FINALISTS



County Durham and Darlington FT and Partners: Durham Dales, Sedgefield & Easington CCG, Sunderland CCG, North Durham CCG, Darlington CCG, South Tyneside CCG and Consultant Connect

Tele-skin Two Week Wait Pathway

This partnership project between CDDFT, local partner CCGs and an independent company, Consultant Connect, covers a population of over one million people, to whom CDDFT provides a sub-regional dermatology and plastics service. Instead of sending a traditional two-week-wait (2ww) referral for an out-patient skin cancer appointment, GPs attach photos of the lesion to their eRS referral. A consultant dermatologist views the images and the referral details within one working day and triages the patient into the appropriate service. The project has the full support of the local cancer network, the North East Cancer Alliance.

East Lancashire Hospitals Trust

Ambulatory Emergency Care - A service developed from the front line

The AECU promotes same day emergency care for patients attending via ED or GP referral. The service has been developed from the bottom up, by our Acute Medicine team who continuously strive to identify opportunity, developing pathways to facilitate the safe and effective patient care. This redesign hasn't come with project support or dedicated admin time; it has been and continues to be developed by the team delivering the service.

Our vision was to consider every patient ambulatory until proven otherwise, to receive immediate assessment and treatment at the right time, by the right person in the right place.

Kettering General Hospital FT

Using QSIR to support the delivery of a Urology - One-Stop

Urology One-Stop service - to reduce the number of visits that the people of Northamptonshire have to receive their Urology diagnosis using the Quality Service Improvement & Redesign methodology to support the transformation.

Stakeholders included: Urology staff, Radiology staff, Endoscopy staff, previous service users, Housekeeping, Estates, Third party suppliers, Cancer Services, Hospital GIRFT team, Finance business partners, Health care partnership (STP), Northampton General Hospital, Luton & Dunstable Hospital, Bristol Urology Services.

Who we serve - the people of Northamptonshire that require Urological investigations and diagnosis.

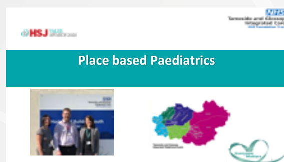
London North West University Healthcare Trust, Imperial College Healthcare Trust and Ealing CCG

Heart Lounge Ealing ACU

Heart Lounge in Ealing ACU is a holistic day care centre for complex heart failure patients. Team involves consultant cardiologist, heart failure nurses, registrar, GP trainees and other specialist nurses. The aim is to review and treat patients with heart failure by early intervention to avoid de-compensation, medical optimisation and review by various other specialist teams with a holistic approach centred about their care. Patients who predominantly benefit are the ones who had multiple admissions with de-compensation or are very symptomatic requiring frequent GP visits or A&E visits. They are encouraged to join patient support group program designed for HF.

ACUTE SERVICE REDESIGN INITIATIVE

FINALISTS

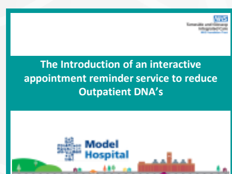


Tameside and Glossop Integrated Care FT

Place Based Paediatrics

The place based paediatric offer across Tameside and Glossop consists of a number of initiatives that support children and their families being seen and treated by the most appropriate professional, at the right time and in the right place:

- Electronic Advice and Guidance (A&G); a system that allows GPs to request electronic pre-referral advice from consultant paediatricians from the Trust.
- Children's Community Clinical Meetings; regular forums between secondary care and general practice clinicians to discuss clinical cases and pathways.
- Emergency Department In-Reach; support to the ED to assess acutely unwell children and determine the most appropriate treatment pathway.



Tameside and Glossop Integrated Care FT

The introduction of an interactive appointment reminder service to reduce Outpatients DNA's

The implementation of a 'text reminder service' for Tameside and Glossop Integrated Care NHS Trust acute outpatient appointments initially commenced in 2015/16 when the trust had DNA rates of 11%. A text reminder service was introduced, which over a 2 year period delivered steady improvements of 11% to 8.1% and financial savings of £36,000+ (see figure one, slide 2). However, in 2018/ 19, the trajectory declined with the trust failing the internal target (7.5%) for financial year. The trust committed to develop an innovative solution to further reduce Outpatient DNA rates and use digital tools to better communicate with patients.

Tameside and Glossop Integrated Care FT, Tameside and Glossop CCG and Tameside Metropolitan Borough Council

Improving System Flow - Tameside and Glossop System Approach to reducing Stranded and Super Stranded Patients

Tameside and Glossop have introduced an Executive led system wide stranded and super-stranded patient meeting to challenge the clinical management of patients who have been in the Acute Hospital for longer than 7 days and to reduce the numbers of patients staying in hospital for longer than necessary.

The meeting is a weekly meeting attended by all stakeholders including staff from our five integrated neighbourhoods (including community health care staff and local authority social care staff), Local Authority Directors, CCG representatives, Trust Chief Operating Officer, GP leads, the patient flow team and crucially Business Intelligence teams.

MENTAL HEALTH SERVICE REDESIGN INITIATIVE

WINNERS

CHESHIRE AND WIRRAL PARTNERSHIP FT, EASTERN CHESHIRE CCG, SOUTH CHESHIRE CCG AND VALE ROYAL CCG

REDESIGNING ADULT AND OLDER PEOPLE'S MENTAL HEALTH SERVICES

Service users, providers and commissioners working together to transform services for people severely affected by mental health problems, to improve:

- Patient outcomes and experience; through more person-centred care, improved inpatient facilities and through a wider range of out-of-hospital services;
- Productivity; through detailed needs analysis and shaping the workforce around people's needs;
- Efficiency; using resources differently to meet national standards for care and, at the same time, improving the financial position across the health economy.

The redesign covers the populations of Cheshire East and Vale Royal (7000 people accessing specialist mental health services).

JUDGES COMMENTS

The judges felt this project evidenced real passion and has enormous potential for scalability and replicability. There was great evidence of co-production and patient engagement, as well as a positive impact on staff experience and a reduction in variation. Overall the project provided a good level of detail on the redesign, with clear tabulated outcomes.

HIGHLY COMMENDED

NELFT, Downshall Primary School, London Borough of Redbridge and AgeUK Barking Havering & Redbridge

Downshall Intergenerational Provision

Downshall Intergenerational Provision (DIG) is the UK's first older adults activity centre, permanently embedded within a school. We provide a social hub that brings together older adults and reception class children at Downshall Primary three days a week from 10am to 1pm, providing structured activities, incorporating the ideas behind Cognitive Stimulation Therapy whilst still following the National Curriculum. Referrals are from Redbridge Older Adults Mental Health Team, Memory Service and AgeUK. The adult participants are chosen due to loneliness/social isolation and risk to mental health and quality of life.

JUDGES COMMENTS

The judges found this to be an innovative, practical service with the potential to go nationwide. It is a highly inclusive project that prioritises user experience; with clear testimonial evidence displaying how social isolation and loneliness in the elderly have been reduced, and how the young and vulnerable were nurtured.

MENTAL HEALTH SERVICE REDESIGN INITIATIVE

FINALISTS

Harrow CCG, Harrow Local Authority and Barnardo's (Harrow Horizons)
Harrow Horizons

Harrow Horizons is an ambitious project developed over three years. It is an emotional health and wellbeing service. It offer's access to Children and Young Peoples (CYP) mental health services post 16 (with Special Educational Needs and Disabilities), as well as to the 0-16 year olds. The service is jointly commissioned between the Harrow CCG and the Local Authority and is provided by Barnardos. It is a multi-disciplinary team based in and delivering within the community, including schools. The service provides short-term focused therapeutic interventions, either individually or in small groups, to support a range of mental health issues.

Hertfordshire Partnership University FT
CAMHS Home Treatment Team

The CAMHS Home Treatment Team (HTT) supports young people with complex needs aged 13-18 in their home environment wherever possible. When a young person needs to be admitted, the team works hard to discharge them as quickly as possible with a robust care and safety plan. They have introduced shorter length admissions which is less disruptive for the young person and to encourage resilience, rather than promoting an over dependency on professionals.

Since introducing HTT, numbers of youngsters in non-specialist out of area adolescent beds has reduced to zero and average lengths of stay have reduced by 42%.

Kent and Medway NHS and Social Care Partnership Trust
Criminal Justice and Liaison Diversion Service (CJLDS)

The Criminal Justice Liaison and Diversion service offers assessment and supported referrals to people in contact with the criminal justice system, with the aim of addressing health/social issues that may support offending.

The service carries out assessments in custody to identify a broad range of vulnerabilities affecting individuals aged 10 and over.
Referrals to community based services including housing/drug and alcohol services are supported by STR workers.

The team offers reports to magistrates and decision makers to support appropriate diversion from the criminal justice system or ensure that efforts to address their issues are considered as part of sentencing.

Liverpool University Hospitals FT, Liverpool CCG & Stroke Association
Liverpool Stroke Recovery Partnership - Psychological & Emotional Wellbeing

Project leadership:
Dr Mark Griffiths (Consultant Clinical Psychologist & Head of Clinical Health psychology services)
Kate Charles (Zone Director - North, Stroke Association)

In Liverpool stroke specific psychological services sit within a wider care pathway under the umbrella of the Liverpool Stroke Recovery Partnership (collaborative pathway between Liverpool NHS Trust, Liverpool CCG and the Stroke Association).

Stroke Clinical Psychology Services provide specialist psychological/neuropsychological input to the Stroke ward, Stroke Out-patient rehabilitation pathway and the Liverpool Community/ESD. Delivering step 3 & 4 stroke psychological interventions.

The Stroke Association provides level 1& 2 emotional support - including stroke specific counselling as part of this pathway.

NHS 24
Mental Health Team

NHS 24 is best known for delivering Scotland's 111 service, providing safe and effective care in the out-of-hours period. NHS 24 also delivers scheduled services in partnership with NHS Boards, as well as digital services supporting wellbeing across Scotland.

NHS 24's Mental Health Team, working collaboratively with patients, staff and other key stakeholders, embarked on a redesign of the way we support mental wellbeing. By establishing a dedicated Mental Health Hub in 2019, and improving access to mental health information and digital support, NHS 24 has transformed the way it provides support for people in mental health distress.

MENTAL HEALTH SERVICE REDESIGN INITIATIVE

FINALISTS

SDSmyhealthcare
SDSmyhealthcare Mental Health Community Clinic

SDSmyhealthcare is a GP Federation in Birmingham covering over 60 practices. In the area of Mental Health, the priority for service users is to receive the right care 'first time' and maximising the limited resources available.

Our challenge was to redesign our services to enable patients to receive the benefits of clinicians' specialist knowledge in the most efficient and convenient manner possible.

Our clinics utilise innovative ways of working and specialist skills from across the community, taking responsibility for any onward referrals, and providing the patients' GPs with rapid clear updates regarding treatment.

Our team is made up of specialists from Birmingham and Solihull Mental Health Foundation Trust, Forward Thinking Birmingham, and Birmingham MIND.

TalkPlus, North East Hampshire CCG and Oakley Health Group
Integrated Mental Health and Long Term Physical Conditions Service

TalkPlus, an IAPT (Improving Access to Psychological Therapy) service and Oakley Health Group, a group of GP practices in North-East Hampshire, set up a joint clinic where both physical and mental health needs were addressed. TalkPlus therapists and Oakley Health staff provided collaborative initiatives to support patients with long-term physical conditions and the impact on their mental wellbeing, often overlooked by patients.

Results show a significant reduction in health utilisation in secondary care which can be quantified in monetary terms, positive patient feedback and GP recognition of improved self-management of both physical and mental health conditions.

Tees Esk and Wear Valleys FT
North Yorkshire and York Community Learning Disability Service – Initial Assessments : more co-production, timely clinical documentation and improved staff wellbeing

Our project involved all four of our community learning disability multi – disciplinary teams working across the newly formed North Yorkshire and York (NY&Y) area.

We wanted to develop a standardised initial assessment, offered in a planned and timely way which promotes co-production and the wellbeing of service users, their families and staff to set the foundation to a meaningful journey to optimise people's quality of life outcomes.

Those directly involved in the event were staff but with partnership discussions and feedback from service users, carers and our Service User (Shadow) Quality Assurance Group (QUAG).

PRIMARY CARE OR COMMUNITY SERVICE REDESIGN INITIATIVE

WINNERS

PRIMARY INTEGRATED COMMUNITY SERVICES (PICS)

ACUTE HOME VISITING SERVICE

What is it?
A responsive and effective home visiting service for patients that prevents them attending A&E and relieves GP workload (Reference 1).

Who is involved?
Any housebound or care home patient requiring an acute same day visit from a GP was seen by a highly skilled and experienced Advanced Nurse Practitioner, with non-medical prescribing skills, highly experienced in Primary Care with good skills and competencies in urgent conditions, including acute respiratory and cardiac conditions.
Who we serve
Acute Home Visiting Service was piloted Newark in 2017, providing support to 7 general practices in the locality serving 76,000 patients.

JUDGES COMMENTS

The judges felt that Primary Integrated Community Services has a hugely impressive service with a wide impact and spread, that closely involves multiple system partners. This winning team has very clear transformation ambition and a good deal of this need for change is recognisable in other parts of the country. The savings returned on the initial investment is impressive. This service demonstrates very well efficiencies that benefit commissioners, clinicians and most importantly patients.

HIGHLY COMMENDED

Northern Devon Healthcare Trust

Improving outcomes through the Lower Limb Leg Ulcer and Well Leg Service

The Lower Limb Leg Ulcer and Well Leg Service was set up by Northern Devon Healthcare Trust in July 2018. Historically the service was provided by individual GP surgeries. Through an ambitious service redesign project, we have drastically improved heal rates for patients, patient experience and professionally developed community nurses in northern Devon.

Patients with open wounds on their lower legs or with a history with leg ulcers are now able to attend any clinic in a community hospital in northern Devon or a well leg event, and the service can be flexible, such as through home visits.

JUDGES COMMENTS

The judges commented on how clear to see the passion and pride in this nurse led service was. The judges were impressed to learn how the service has adapted during the current pandemic with the self-care aspect of this project and how empowering this has been for patients. It is no wonder that Northern Devon Healthcare Trust have received incredible feedback from patients with 100% of patients recommending the service for the last 18 months.

FINALISTS

Brigstock & South Norwood Partnership

Embedding group consultations for people with Type 2 Diabetes

The Brigstock and South Norwood Medical Partnership serves a diverse Black and Minority Ethnic (BME) and Eastern European community of 11,000 people in an area of acute deprivation in Croydon. The practice's prescribing pharmacist and nurse prescriber have introduced group consultations as their 'first contact' for General Medical Services (GMS) Quality and Outcomes Framework (QOF) diabetes reviews. They have reviewed and followed up 60% of the practices' 1,054 patients with Type Two Diabetes in group clinics, and measured positive outcomes and quality and efficiency impacts for the team, patients and the practice.

Kent Community Health FT and Maidstone Borough Council

Rough Sleeper Project (Maidstone)

As temperatures plummet in the winter months, cold weather can prove fatal for people sleeping on the streets.

Many already have health issues and these can be made worse by the freezing cold weather.
With statistics showing that the average age a homeless man dies is 44 and for a woman, 42, our Complex Care Nurse Community Service is helping some of those in need.

Last April KCHFT were approached by Maidstone Borough Council to provide a nurse led clinic for the rough sleepers in the town. The drop in clinic also provides support to those living in temporary accommodation.

Bristol, North Somerset and South Gloucestershire CCG

Reducing unwarranted variation in primary care chronic disease monitoring

The aim was to reduce over-testing in primary care for chronic disease monitoring across Bristol, North Somerset and South Gloucestershire (BNSSG). Over-testing increases staff workload, wastes patients' time and causes patient and staff anxiety.

The BNSSG CCG Clinical Effectiveness Team standardised the blood tests by working with local GPs, a practice nurse and biochemists from our three hospitals to redesign this important area of care.

BNSSG serves a population of 1 million people who live in urban and rural areas and has 83 GP practices that have 923 GPs, 488 nurses, 182 HCAs and 41 phlebotomists between them.

FINALISTS

Lewisham and Greenwich Trust, South London and Maudsley FT and Lewisham CCG
CATFORD Care Homes Project

257 falls were recorded in 15 Lewisham Care homes over a six month period. The greatest numbers occurred in residential homes and 71% of those that had fallen had dementia.

The service redesign initiative involved collaboration between Lewisham Community Falls Service, Lewisham Care Home Intervention Team and Lewisham Clinical Commissioning Group. The starting point was the development, delivering and evaluation of a joint falls training programme for care home staff which had a specific focus on residents with dementia.

Post training evaluation demonstrated improved identification of physical and psychological falls risk factors and a reduction in resident falls.

NHS 24
Primary Care Triage Scotland

Demand for 'same day' access to Primary Care has been consistently rising and redesign of primary care models is needed to support sustainable safe services.

Scotland's national digital healthcare provider NHS 24 partnered with Riverside Medical Practice and East Lothian Health and Social Care Partnership to develop a new clinical pathway to:

- Support primary care demand through NHS 24's bespoke care navigation
- Effectively triage patients with 'same day' needs to most appropriate healthcare professional
- Increase GP capacity to focus their expertise on the most complex patients
- Raise awareness of the community multidisciplinary team's high quality skills and expertise

North Bristol Trust and Hanham Secure Health
HMP Bristol Hand Injury Project

Violence levels within prisons are high. Hand injuries represent a significant cause of morbidity, and impact upon rehabilitation. The challenges of transporting prisoners led to missed appointments and wasted resources.

Clinicians at Bristol Prison and North Bristol developed tools for triage in the prison setting and a pathway for access to clinic, surgery and physiotherapy. A "one stop shop" reduced number of visits required. Missed appointments and delays to treatment were both significantly reduced.

Patients received better care, sooner, in fewer visits. Prison and Hospital resources were saved, improving care for other patients & prisoners, along with significant financial savings.

Northumberland CCG, Northumberland County Council and Northumbria Healthcare FT
The Northumberland Continuing Healthcare Partnership

The Northumberland CHC partnership is an innovative agreement which enables Northumberland County Council to manage the CHC process on behalf of NHS Northumberland Clinical Commissioning Group, with nurse assessment carried out by Northumbria Healthcare, and managed under the council and trust's integrated management structure.

The aim is improve patient care and mitigate the impact of increasing CHC costs.

Both objectives were achieved this year with the CCG coming out of financial special measures and the CHC team achieving 95% on the 28-day target, with patients receiving seamless integrated services as they move between CHC and social care funding streams.

Tameside and Glossop Integrated Care FT
District Nursing Service Redesign – A service fit for the future

Anecdotally, the District Nursing Team reported low staff levels and an increased demand in complex patient care across the Tameside & Glossop population. However, the core activity data did not support this theory as activity had remained static. Working in partnership with our Corporate Information Team the District Nursing Team wanted to take an innovative approach to redesign their service. The ambition of the project was to create a level of detail and insight which highlighted changes in complexity, to facilitate safer caseload management and demonstrate additional resource requirements in terms of staffing numbers and skill mix.

University of Manchester, Health Innovation Manchester, Heywood, Middleton and Rochdale CCG, Bury CCG, Salford CCG, Wigan Borough CCG
The DECIDE™ Education Programme; supporting community clinicians

This project is was an education innovation (The DECIDETM programme) supporting primary care decision making skills. The programme was undertaken by GPs, practice nurses and advanced nurse practitioners from 39 practices across one CCG. This project involved collaboration between Heywood Middleton and Rochdale (HMR) Clinical Commissioning Group, the University of Manchester and Health Innovation Manchester. The aim was to improve patient outcomes, change referral and prescribing patterns: addressing skills gaps to change clinicians' practice through evidence-based education. By developing this at an organisational level we were able to target health priorities for local populations and services.

SPECIALIST SERVICE REDESIGN INITIATIVE

WINNERS

Place based Paediatrics

TAMESIDE AND GLOSSOP INTEGRATED CARE FT

PLACE BASED PAEDIATRICS

The place based paediatric offer across Tameside and Glossop consists of a number of initiatives that support children and their families being seen and treated by the most appropriate professional, at the right time and in the right place:

- Electronic Advice and Guidance (A&G); a system that allows GPs to request electronic pre-referral advice from consultant paediatricians from the Trust.
- Children's Community Clinical Meetings; regular forums between secondary care and general practice clinicians to discuss clinical cases and pathways.
- Emergency Department In-Reach; support to the ED to assess acutely unwell children and determine the most appropriate treatment pathway.

JUDGES COMMENTS

The judges were wowed by this trailblazing project that implemented the RCPCH 'Facing the Future' standards. This excellent entry highlighted a value-based approach across a specialist pathway with clear evidence of improved outcomes and better patient experience. The judges felt that there was significant potential for spread and adoption/adaptation across the NHS.

SPECIALIST SERVICE REDESIGN INITIATIVE

HIGHLY COMMENDED

Moorfields Eye Centre at Croydon University Hospital, Moorfields Eye Hospital FT

The Chronicles of the Moorfields Rapid Access Clinic at Croydon: The Right patient, the Right clinic and the Right time

The Rapid Access Clinic (RAC) provides a streamlined service providing emergency eye care for patients in the London Borough of Croydon.

A secure email based referral process is available to referrers: GPs, Optometrists, and hospital doctor. All referrals are triaged and patients booked into the RAC. This provides safe and timely care for the patients and allows direct communication and feedback to the referrers. This facilitates learning and maintains high standards of clinical governance.

From the launch date of 1 November 2018, we have seen a 49% sustained decrease in attendances to urgent care, with good user experience and feedback.

JUDGES COMMENTS

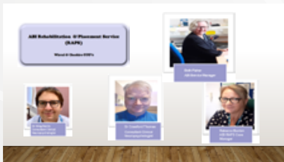
The judges felt that this project provided clear proof that simple changes can have massive impacts on a service for the benefits of service users and cost savings. There were good outcomes from service redesign with impressive reduction in self-referral. This was an excellent example of effective communication with the relevant stakeholders and has potential for spread across similar NHS settings.

FINALISTS

Central and North West London FT

Crystal House Project, CAMHS LD Specialist Inpatient Unit

A project team was formed in order to create the first London based CAMHS LD inpatient service, it involved all critical service area development with Estates, HR, Operational, Clinical, Finance, ICT, Comms and most importantly our service users. This unit was designed in response to the urgent need of inpatient beds for young people aged 13-18years with a learning disability, mental health issues and/or challenging behaviour. The criteria is a national service, however focuses on supporting London service users to be able to deliver specialist care closer to home.



Cheshire and Wirral Partnership FT

ABI Rehabilitation and Placement Service (RAPS)

The Acquired Brain Injury (ABI) Rehabilitation and Placement Service (RAPS) is an innovative service, commissioned by Wirral and Cheshire West CCGs, replacing previous IEFR management; in 2020 we will extend provision across the whole of Cheshire. ABI rehabilitation needs are not always met within statutory services. Our role is to identify and review placements in the independent sector ABI rehabilitation units. We have achieved outcomes including reduced hospital stay and reduced length of stay in independent units, with associated cost efficiency savings. We provide a consistent source of practical and emotional support for patients and carers throughout though their journey.

Doncaster and Bassetlaw Teaching Hospitals FT

Quality Improvement in Medical Education and Training (QiMET) - Hybrid International Emergency Medicine (HIEM) Training

Developed by QiMET International, delivered through Doncaster and Bassetlaw Teaching Hospital (DBTH) with candidates from Chitwan Medical College (CMC) in Nepal, HIEM is the first collaborative International Emergency Medicine training programme in the UK, providing a solution to the shortage of EM doctors.

Using new and innovative models of globalised medical training, the concept of Brain Share, HIEM's holistic approach offers enhanced skills in leadership, management and quality improvement by providing a systematic approach to support international trained doctors to work in the UK and to bring benefit for both countries.

This presentation will explain more: https://youtu.be/N52BPFPoovI

SPECIALIST SERVICE REDESIGN INITIATIVE

FINALISTS

Leeds Community Healthcare Trust and Leeds Teaching Hospitals Trust
Leeds Community Neurological Discharge Team

In 2018 neurological services from across Leeds NHS trusts worked in partnership to redesign community services to provide immediate occupational therapy interventions to traumatic brain injury patients following discharge from hospital. The data showed that there was significant potential to improve patient experience and system flow by working differently to ensure patients receive appropriate and timely input in the right place. Following development the service went live in January 2019. The Community Neurological Discharge Team works together with ward therapists to identify appropriate patients, coordinate discharges and provide appropriate interventions to this group of patients in their own environment.

NHS England and NHS Improvement, Portsmouth Hospitals Trust and University Hospital Southampton FT
Improving Vascular Services in South East Hampshire

Vascular surgery in South East Hampshire is undertaken at University Hospital Trust and Portsmouth Hospitals Trust. The hospitals are 20 miles apart, they are a similar size, and both have a history of providing specialised services. Because of the need to have a comprehensive rota of vascular surgeons and interventional radiologists, NHS England (NHSE) asked Wessex Clinical Senate Council for advice. Following the Clinical Senate's recommendations, the stakeholders worked together to implement the changes. The number of patients affected is small but 12 lives were lost following vascular surgery in 2013 and only 3 lives were lost in 2018.

North Tees and Hartlepool FT
Best value biologic pathway

North Tees and Hartlepool NHS Foundation Trust serve 400,000 people in the area we cover with a range of services including the provision of specialist rheumatology and gastroenterology care. The aim of our quality improvement and productivity project was to ensure that the most cost efficient brand of adalimumab was readily available to 200 patients, in a timely manner, with appropriate information and governance arrangements surrounding its distribution and supply. A multi-disciplinary team, involving internal/external stakeholders redesigned patient pathways to ensure that an efficient, safe, patient-focused process of switching to the best value biologic was possible.

The Royal Wolverhampton Trust
The CRAFT System (The Colour Risk Assessment File and Treatment System)

The Black Country Cystic Fibrosis (CF) Service provides CF out-patient care and is part of the wider North Midlands Specialist Centre based at UHNM. We have a full, locally-based multidisciplinary team providing out-patient and home care services aimed at keeping individuals with Cystic Fibrosis well and at home. We provide care for 45 Cystic Fibrosis patients and their families.

Torbay and South Devon FT
Group clinics: saving time, maintaining quality

We are a Rheumatology Department based in a district general hospital, in Torbay, South Devon. We serve a population of about 385,000, with patients living in both rural and urban environments, with a large range of incomes. We have a proportionately large elderly population, leading to a higher than average prevalence of patients with Rheumatoid Arthritis.

Our service re-design includes the whole Rheumatology team.

Patients were being delayed in starting important medications such as methotrexate, as our clinics were overwhelmed. We, therefore, developed GROUP clinics to start patients on methotrexate (and other important rheumatology drugs) quickly, to fulfil national guidelines and improve outcomes.

University Hospital Southampton FT
A Data Driven Service Improvement of an IBD helpline

For the benefit of our inflammatory bowel disease patients (IBD), the specialist nurses led by SSR Louise Downey and IBD Consultant Markus Gwiggner together with Florina Borca (analyst) and Hang Phan (data-scientist) conducted a data-driven service evaluation to facilitate service redesign.

Large volumes of electronic healthcare record (EHR) data were extracted. A machine-learning driven model was used to look for key areas to target for optimisation; this model guided substantial improvement to the clinical service model. This project acts as an exemplar of a novel data-driven method for service improvement, which can now be applied to other services.

SYSTEM OR COMMISSIONER LED SERVICE REDESIGN INITIATIVE

WINNERS

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

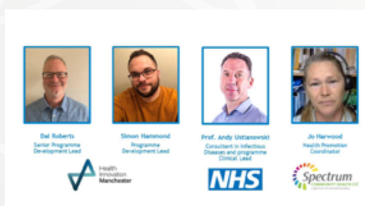
RESTORE2 - RIGHT CARE, RIGHT PLACE, RIGHT TIME FOR CARE HOME RESIDENTS

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



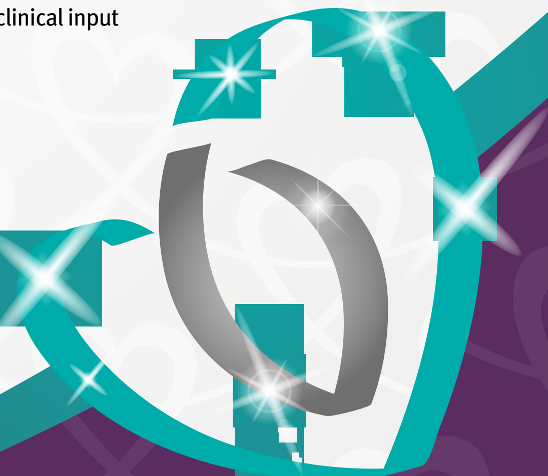
Health Innovation Manchester, North Manchester General Hospital, HMP Styal and Spectrum Healthcare

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.



FINALISTS

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

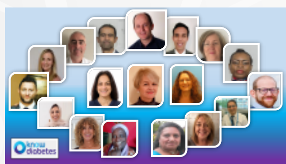
The redesign of the Deep Vein Thrombosis (DVT) pathway re-engineered five existing pathways with varied costs and structures into one single community-based pathway delivered by a specialist provider. The pathway now provides a consistent offer with equitable access to the people of Bristol, North Somerset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

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.

HSJ VALUE AWARD OF THE YEAR

WINNERS

KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST

VOCATIONAL REHABILITATION SERVICE INCLUDING THE JOB TASTER PROGRAMME

Just one in four people suffering from a long-term mental illness are in work. Mental health problems at work cost our economy £34.9bn with a cost to business of £26bn each year. The service offers support to people with complex mental health to achieve their employment goals with hope, optimism and confidence. The Vocational Rehabilitation Service is occupational therapy-led and forms part of core community services. The multidisciplinary service includes a 12 week job taster programme.

JUDGES COMMENTS

The judges said this was an outstanding and engaging presentation that made good use of patient stories. The project is about facilitating an early return to work for patients with long term mental illness. They exceeded their target of supporting 120 people back to work and reported good outcomes in terms of self-esteem and improved mental health. Overall the project has helped nearly 300 people, many of whom have provided testimonials about the impact on their lives and recovery. Information about the project has also been well disseminated, through publication by the Royal College of Occupational Therapists, a presentation to MPs, and numerous other communication channels.

HIGHLY COMMENDED

Greater Manchester Urgent Primary Care Alliance (in collaboration with NWAS and the GMHSCP)

Clinical Assessment Service Pilot

(Early March 201, 90-day pilot)
6,102 low acuity, NWAS 999 cases were electronically sent to an Alliance of Urgent and Primary Care providers (using one integrated Patient System- Adastra) for Clinical triage, signposting, and treatment under a pan GM, 24/7 Clinical Assessment Service.

Any cases not closed at advice, or appropriately escalated within 999 (post triage), were dealt with by the locality specialist Alliance partner member or forwarded via an onward specialist community or secondary care referral. The CAS has positively impacted NWAS conveyance and 'hear and treat' rates, Acute non-elective admission rates and system flow for patients in GM.

JUDGES COMMENTS

The judges saw this as a very good example of working in partnership to achieve good outcomes for the benefit of the patient. It was a detailed presentation with the aims of the project clearly laid out, and a real change in the conveyance rate was demonstrated. They felt that financial savings alone justified the success of the project, but the improvement in quality for patients, reduction in A&E attendance, and release of ambulance time is even more important.

FINALISTS

Bolton FT
Bolton Combined Deflection Scheme

The Admission Avoidance Team (AAT) and Home First Team (HFT) work across the community and urgent care footprint of Bolton NHS Foundation Trust to deflect unnecessary admissions to hospital. Both teams are multidisciplinary and work together with stakeholders including Primary Care, North West Ambulance Service (NWAS), Commissioners, Local Authority and the Community and Voluntary Sector. The teams respond to patients over 18; in physical or social crisis in the community or have presented to the Emergency Department (ED) and can be safely managed at home with or without support. The teams main cohort of patients are aged over 65.

Bristol, North Somerset and South Gloucestershire CCG
Reducing unwarranted variation in primary care chronic disease monitoring

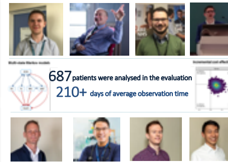
The aim was to reduce over-testing in primary care for chronic disease monitoring across Bristol, North Somerset and South Gloucestershire (BNSSG). Over-testing increases staff workload, wastes patients' time and causes patient and staff anxiety.

The BNSSG CCG Clinical Effectiveness Team standardised the blood tests by working with local GPs, a practice nurse and biochemists from our three hospitals to redesign this important area of care.

BNSSG serves a population of 1 million people who live in urban and rural areas and has 83 GP practices that have 923 GPs, 488 nurses, 182 HCAs and 41 phlebotomists between them.

Croydon CCG
Spreading Group Consultations

NHS Croydon Clinical Commissioning Group is supported GP practices to introduce group consultations for a range of long-term conditions. The Brigstock and South Norwood Medical Partnership and Parchmore Medical Practice serve a diverse Black and Minority Ethnic (BME) and Eastern European community in Thornton Health, and have introduced group consultations to support people with pre-diabetes, diabetes and COPD. Brigstock have followed up 60% of their 1,054 patients with Type Two Diabetes in group clinics, measuring positive outcomes, quality and efficiency gains for the team, patients and the practice. This evidence is now supporting design of a local commissioned service.



East Kent Hospitals University FT, Ashford CCG and Health Navigator
Performance evaluation of an NHS commissioned service (Health Navigator) in East Kent

East Kent Hospitals University sought to evaluate the health economic impact of HN Clinical Coaching CARE. Delivered by health-tech company, HN, this AI-guided service identifies high-cost, high-need patients and inducts them onto a nurse-led proactive health coaching programme, to avoid future unplanned admissions. Our East Kent NHS team analysed the impact of this service on the Trust and health economy, including activity impact, cost effectiveness, mortality, QALY, and ICER. The project was open, transparent, and brought together private, acute and commissioner organisations, sharing information and creating a scientific methodology to evaluate a service – a model for future commissioning and evaluation.

Mid Essex CCG and All Saints' Church of England Primary School, Maldon
The Maldon Up project – intergenerational interaction that builds wellbeing and community

Maldon Up emerged from a series of visits to a local care home by children at a primary school within Mid Essex CCG's footprint. Many of the residents at Longfield Care Home in Maldon have dementia, and All Saints' CofE Primary School pupils began visiting them for an afternoon a week. The CCG became aware through a staff member's connection to the school and recognised the possible benefits to those involved.

The CCG supported a crowdfunding exercise to keep the project running while Anglia Ruskin University conducted a proper evaluation that would facilitate a wider rollout of the scheme.

HSJ VALUE AWARD OF THE YEAR

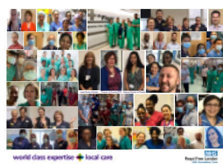
FINALISTS

North Tees and Hartlepool FT
Quality Improvement through Efficient & Cost Effective use of Medicines

NTH annual expenditure on medicines is over £15 million. Getting best value for medicines is core business of Pharmacy teams, through significant collaboration with multidisciplinary team of senior medical/nursing/finance/commissioning teams.

Effective leadership has led to organisational savings of £2.4 m against an allocated target of £1 m. Savings contributed towards financial sustainability and improving patient care e.g. increased medicines safety practices, purchase of scanners to improve waiting list.

Additional system-wide £11 m efficiency savings have been achieved for the region (North east and North Cumbria) through hosting regional medicines procurement team, and successful collaborative work with the Commercial Medicines Unit.



Royal Free London FT
Improving Joy at Work - Electronic Self Rostering

Turnover for nurses and midwives was high across the Trust but highest in the intensive care units. A quality improvement project was undertaken to understand the reasons why.

Staff focus groups identified flexibility and choice regarding shifts would improve work-life balance, promote roster fairness and increase their joy at work.

The implementation of electronic self rostering was key to offering staff shift flexibility and choice. This new way of working improved communication, enhanced staff work life balance, released time to care and improved staff recruitment and retention leading to safer patient care.

Tameside and Glossop Integrated Care FT, Tameside Metropolitan Borough Council and Tameside & Glossop CCG
CARE TOGETHER - an integrated approach to health and care in Tameside & Glossop to improve population health

Our 'Care Together' Programme is an innovative, whole health and care system programme to transform the way in which services, care for, involve and support the 250,000 residents, to improve health and wellbeing, as well as supporting financial sustainability.

The programme has involved behavioural transformation to deliver new ways of working whilst delivering system transformation. With the Local Authority and CCG coming together to become a strategic commissioner of services and the local Acute Trust becoming the first Integrated Care FT in England, responsible for delivery of integrated health and social care services for the Tameside and Glossop population.

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